

**ATTACHMENT D**  
**AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM**  
**DSH 102**

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

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

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- ~~Governmentally-operated hospitals (Group 4 eligibility)~~
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

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**Eligibility Requirements**

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

COLUMN A	COLUMN B	COLUMN C
1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state ("Group 1")	1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients  2. The hospital is outside a Metropolitan Statistical	<del>The hospital has an MIUR of at least 1 percent.</del>

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<p>1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the State of Arizona (“Group 1A”)</p> <p>2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% (“Group 2”)</p> <p>2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the State of Arizona (“Group 2A”)</p> <p>4. The hospital is a governmentally-operated hospital (“Group 4”)</p>	<p>Area 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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- Deleted: The hospital is a privately owned or privately operated acute care general hospital (psychiatric and rehabilitation facilities excluded) whose LIUR exceeds the mean LIUR for privately owned or privately operated hospitals receiving Medicaid payments in the state or which provides at least 1% of the total Medicaid days across hospitals in the state (“Group 3”)
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Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are “deemed” to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Column B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

- In Group 4, the term “governmentally-operated hospital” refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from “non-governmental”, “non-public”, “private”, “privately operated” or “privately owned” hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities.

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

### **Data on a State Plan Year Basis**

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.<sup>1</sup>

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

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

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed

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<sup>1</sup> 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.

separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

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

### Timing of Eligibility Determination

The eligibility determination calculations will be performed annually for all hospitals located in the State of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
  - a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
  - b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
    - i. Meets the criteria for Group 1
    - ii. Meets the criteria for Group 1A
    - iii. Meets the criteria for Group 2
    - iv. Meets the criteria for Group 2A
    - v. Meets the criteria for Group 4
  - c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.
2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:

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- a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
- b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
  - i. Meets the criteria for Group 1
  - ii. Meets the criteria for Group 1A
  - iii. Meets the criteria for Group 2
  - iv. Meets the criteria for Group 2A
  - v. Meets the criteria for Group 4
- c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

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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 rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment and providing information to AHCCCS by the specified date, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:

- a. Fee-for-service and managed care days, and
  - b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
2. “Medicaid Inpatient Days” includes:
- a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
  - b. All adjudicated inpatient days for waiver eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below
3. “Medicaid Inpatient Days” does not include:
- a. Inpatient days in which a categorically or waiver eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

#### *Data Sources for MIUR Calculations*

1. For “Medicaid Inpatient Days” the PMMIS claims and encounters
  - a. For the initial determination of a hospital’s MIUR, extracted based on date of service for the hospital’s fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
  - b. For the second determination of a hospital’s MIUR, extracted based on date of service for the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.
2. For “Total Number of Inpatient Days” the CMS 2552-96
  - a. For the initial determination of a hospital’s MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the “finalized” or “settled” version (i.e., the CMS 2552-96 that has been settled by the hospital’s Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
  - b. For the second determination of a hospital’s MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the “finalized” or “settled” version (i.e., the CMS 2552-96 that has been settled by the hospital’s Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

### *Calculation of the mean MIUR and the Standard Deviation*

In calculating the mean MIUR, the MIUR calculated for the state plan year for all registered hospitals that have provided information to AHCCCS by the specified date will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

### **LIUR Calculation (Group 2 Eligibility)**

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

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

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

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)
2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges
3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
  - a. Payments made for:

- i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
    - ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children’s Rehabilitative Services program
    - iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
    - iv. The support of trauma centers and emergency departments
  - b. Payments made by:
    - i. An appropriation of state-only funds
    - ii. The Arizona State Hospital
    - iii. Local governments including (but not limited to):
      - (1) Tax levies dedicated to support a governmentally-operated hospital
      - (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
      - (3) Subsidies for the general support of a hospital
4. “Total State and Local Cash Subsidies for Patient Services” does not include payments for or by:
  - a. Inpatient or outpatient services for employees of state or local governments
  - b. Governmentally-operated AHCCCS health plans or program contractors
  - c. Tax reductions or abatements
5. “Total Charges for Patient Services” includes total gross patient revenue for hospital services (including hospital subprovider charges).
6. “Total Inpatient Charges Attributable to Charity Care” includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital’s charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.
7. “Total Inpatient Charges Attributable to Charity Care” does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital’s charity care policy.
8. “Cash Subsidies Portion Attributable to Inpatient” means that portion of “Total State and Local Cash Subsidies for Patient Services” that is attributable to inpatient services.
9. “Total Inpatient Charges” includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

*Data Sources for LIUR Calculations*

1. For “Total Medicaid Patient Services Charges”:
  - a. For the initial determination of a hospital’s LIUR:
    - i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
  - b. For the second determination of a hospital’s LIUR:
    - i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.
2. For the portion of “Total State and Local Cash Subsidies for Patient Services” and “Cash Subsidies Portion Attributable to Inpatient” attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
  - a. For the initial determination of a hospital’s LIUR:
    - i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
  - b. For the second determination of a hospital’s LIUR:
    - i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
  - c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services
3. For all other “Total State and Local Cash Subsidies for Patient Services” and “Cash Subsidies Portion Attributable to Inpatient”:
  - a. For the initial determination of a hospital’s LIUR:
    - i. The hospital financial records for the payments received during the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
  - b. For the second determination of a hospital’s LIUR:
    - i. The hospital financial records for the payments received during the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.
  - c. In the case of “Cash Subsidies Portion Attributable to Inpatient”, if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For “Total Inpatient Charges Attributable to Charity Care”:
  - a. For the initial determination of a hospital’s LIUR:
    - i. The hospital claims and financial records for the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
  - b. For the second determination of a hospital’s LIUR:
    - i. The hospital claims and financial records for the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.
5. For “Total Inpatient Charges”:
  - a. For the initial determination of a hospital’s LIUR, the cost report (or reports) for the hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the “finalized” or “settled” version (i.e., the CMS 2552-96 that has been settled by the hospital’s Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
  - b. For the second determination of a hospital’s LIUR, the cost report(s) for the hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the “finalized” or “settled” version (i.e., the CMS 2552-96 that has been settled by the hospital’s Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
6. For “Total Charges for Patient Services”:
  - a. For the initial determination of a hospital’s LIUR, the cost report (or reports) for the hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the “finalized” or “settled” version (i.e., the CMS 2552-96 that has been settled by the hospital’s

Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

- b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

**Deleted: Group 3 Eligibility Calculation¶**

¶ A privately owned or privately operated hospital's eligibility for Group 3 will be determined based on a) whether the hospital's LIUR exceeds the mean LIUR for all privately owned or privately operated hospitals receiving Medicaid payments in the state that have provided information to AHCCCS by the specified date or b) whether the hospital provides at least 1% of the total Medicaid inpatient days. Psychiatric and rehabilitation facilities are excluded from consideration for eligibility in Group 3. The calculation of a hospital's LIUR is discussed above; presented below is the calculation of the mean LIUR and the calculation of a hospital's percentage of total Medicaid inpatient days¶

**¶ Calculation of the mean LIUR ¶**

¶ In calculating the mean LIUR, the LIUR for all registered privately owned or privately operated hospitals that have provided information to AHCCCS by the specified date will be calculated pursuant to the LIUR formula. The mean LIUR – the average of the individual LIURs – will be calculated based on all the individual LIURs greater than zero. ¶

**¶ Percentage of Total Medicaid Days ¶**

¶ A hospital's Medicaid Days Percentage is calculated using the following equation:¶

$$\text{MedicaidDaysPercentage} =$$

¶ In performing the calculations:¶

¶ <#>"Inpatient Days" includes: ¶  
¶ <#>Fee-for-service and managed care days, and ¶

¶ <#>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. ¶

¶ <#>"Medicaid Inpatient Days" includes:¶

¶ <#>All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below¶

¶ <#>All adjudicated inpatient days for waiver eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below¶

¶ <#>"Medicaid Inpatient Days" do ... [1]

### Group 4 Eligibility Determination – Governmentally-operated Hospitals

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required.

### Obstetrician Requirements

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR

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

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

## Payment

### Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

If a non-governmental hospital qualifies for pool 1A it will be removed from pool 1. Similarly, if a non-governmental hospital qualifies for pool 2A it will be removed from pool 2. The non-governmental hospitals in pool 1 and pool 2 will be considered as a group and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The non-governmental hospitals in pool 1A and 2A will be considered as a group, and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. The maximization process will be performed separately for 1) the non-governmental hospitals that qualify for pools 1 and 2, and; 2) the non-governmental hospitals that qualify for pools 1A and 2A.

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There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).
2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.
4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.
5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is \$5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

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 only qualify for Group 1 or Group 2*

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A ~~or 2A~~). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

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1. Determine Points Exceeding Threshold.  
Each of the Groups 1 and 2 has thresholds established for qualification of the hospital.

For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.  
Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.
3. Determine Relative Weight of Each Hospital in Each Group.  
The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.
4. Initial Allocation of Dollars to Each Hospital in Each Group.  
The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.
5. Maximize Allocation of Dollars Between Group 1 and Group 2.  
This step selects the greater of the allocation to each hospital between Group 1 and Group 2.
6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.  
Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.
7. Second Allocation of Dollars Within Group 1 and Group 2.  
The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.
8. Identifying Minimum Payment.  
It is policy that the minimum payment made to any hospital qualifying for DSH is \$5,000. This step identifies any amount thus far determined for any hospital that is less than \$5,000.
9. Ensuring Minimum Payment.  
This step replaces any amount thus far determined for any hospital that is less than \$5,000 with a \$5,000 amount.
10. Determining Penultimate Payment Amount.

With the replacement of values with the \$5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A or 2A) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

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*Hospitals that qualify for Group 1A or Group 2A.*

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There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A or 2A. After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

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1. Determine Points Exceeding Threshold.

Each of the Groups 1A or 2A has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

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Deleted: ; for Group 3 there are two thresholds: LIUR greater than the mean for hospitals receiving Medicaid payment in the state or more than 1% of the total statewide Medicaid days

2. Convert Points Exceeding Threshold into a Value.

Each of the Groups 1A and 2A are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

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Deleted: In the case of Group 3, the multiplier is net patient revenue.

3. Determine Relative Weight of Each Hospital in Each Group.

The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.

The amount of funds available to each of the Groups 1A and 2A 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.

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5. Maximize Allocation of Dollars Between Group 1A and Group 2A.

This step selects the greater of the allocation to each hospital between Group 1A and

Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A. Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.
7. Second Allocation of Dollars Within Group 1A and Group 2A. The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.

It is policy that the minimum payment made to any hospital qualifying for DSH is \$5,000. This step identifies any amount thus far determined for any hospital that is less than \$5,000.

9. Ensuring Minimum Payment.

This step replaces any amount thus far determined for any hospital that is less than \$5,000 with a \$5,000 amount.

10. Determining Penultimate Payment Amount.

With the replacement of values with the \$5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A or 2A, a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 4*

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3.

OBRA Limits

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After having maximized each hospitals allotment between Group 1A and Group 2A and reallocating pool funding for each hospital remaining in each of the two groups (Step 7), a choice is made as to the highest amount for each hospital

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<#>Recalculating the Relative Weights of Each Hospital in Group 1A

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In making the selection in Step 8, hospitals were removed from

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¶  
<#>Third Allocation of Dollars Within Group 1A

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The third allocation of pool funds to each hospital remaining in each Group is determined by multiplying each hospital's recalculated relative weight pursuant to Step 9 by the amount of funds available for that Group.¶

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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:

$$\frac{\text{Uncompensated Care Costs Incurred Serving Medicaid Recipients} + \text{Uncompensated Care Costs Incurred Serving the Uninsured}}{\text{Total DSH Allotment}}$$

Pursuant to the above equation, the OBRA limit is comprised of two components:

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

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are<sup>2</sup>:

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.

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<sup>2</sup> Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

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

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

#### The Medicaid Shortfall

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

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

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each non-governmental hospital the all payor per diem and ratio of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or

Federally Qualified Health Clinic services. The per diem amount will be calculated by dividing:

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

The ancillary RCC will be calculated by dividing:

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

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

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

#### Uninsured Costs

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

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and

- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled "Data on a State Plan Year Basis".

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

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

For each non-governmental hospital the all payor per diem and ratio of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

For each governmentally-operated hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

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

#### **Group 5 Eligibility Determination**

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

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Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, using public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities will notify AHCCCS of the hospitals designated to receive funds and of the amount of matching funds that are available through their IGAs.

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

Example:

Hospital A

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

Group 5 LOM score for Hospital A = \$54,734,467 x 0.3542 x 0.2946 = \$5,711,394

For the first round of distributions, each hospital’s percentage of the total group LOM score will be calculated using the hospital’s LOM score as the numerator and the total of all eligible hospitals’ LOM scores as the denominator. The total amount of DSH available as a result of the IGAs (Group 5 DSH funds) will be multiplied by each hospital’s LOM percentage of this first round. If any allocation from this round is higher than a hospital’s OBRA limit (remaining after Group 1 and 2 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

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For subsequent rounds, only the hospitals that have not hit their OBRA limit or matching fund limit will be considered in that round. The LOM score for only those hospitals will be totaled. Each hospital’s percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round will be multiplied by each hospital’s LOM percentage for that round. If any allocation from any round is higher than a hospital’s remaining OBRA limit or higher than the remaining total computable matching funds for that hospital, the lower of those two limits will be recorded as the allocation for that round.

Distribution rounds will continue until all Group 5 DSH funds are distributed, or all Group 5 qualifying hospitals have received the maximum distribution identified in the IGAs or reached their individual OBRA limits, whichever comes first. All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

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

## Aggregate Limits

### *IMD Limit*

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

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

#### *Overall Total Limit*

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

#### **Reconciliation**

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or

2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

### **Certified Public Expenditures**

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

### **Grievances and Appeals**

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals

have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

### **Other Provisions**

#### Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

DRAFT

**Attachment D**  
**AHCCCS Disproportionate Share Hospital (DSH) Payments**  
**Exceptions (Revised May 29, 2009)**

**An exception to the use of the Medicare Cost Report (Form CMS 2552-96) as a data source shall apply to:**

**I. Hospitals that:**

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-96 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-96 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-96 (Medicare Cost Report) as provided in this Attachment D.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described in this Attachment D shall be required from such hospitals.

**II. Indian Health Service (IHS) Hospitals** and tribally-operated 638 hospitals who do not file a full Form CMS 2552-96 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

## **EXHIBIT 1 to ATTACHMENT D**

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

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

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

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

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, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

## The Medicaid Shortfall

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

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

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled "Data on a State Plan Year Basis".

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

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

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

#### Uninsured Costs

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

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

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

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

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

Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

#### The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

#### Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan rate year of the initial DSH payment is calculated as described below under "Reconciliation".

#### Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment

are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

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## **EXHIBIT 2 to ATTACHMENT D**

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

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will 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, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

## The Medicaid Shortfall

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

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

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

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

The inpatient per diem amount will be found by dividing the amounts on Worksheet B Part 1 Column 25 Line 25 by the day total on Line 5 from Worksheet S-3 Column 6. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 37 to 63 (but excluding Subscript Lines 63.5 to 63.99) taken from Worksheet B Part 1 Column 25
2. Dividing the amount determined in step 1 above by the amount determined in step 3 below
3. Summing the Lines 5 and 17 from Worksheet S-3 Column 6

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

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

#### Uninsured Costs

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

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be

considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled "Data on a State Plan Year Basis".

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

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

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

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

#### The Governmentally-Operated Hospital OBRA Limit

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

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The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

#### Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

#### Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

## EXHIBIT 3 to ATTACHMENT D

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

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

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

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

The funding for pool 5 is \$26,000,000 and will be provided through voluntary intergovernmental transfers to hospitals designated by political subdivisions, universities, and tribal governments. Political subdivisions, public universities, and tribal governments will notify AHCCCS of the hospitals that will be designated to receive funds and of the amount of matching funds that will be available through their intergovernmental agreements (IGAs). AHCCCS will provide CMS with a list of designated pool 5 hospitals as soon as it becomes available. For SPY 2011, the funding amount for Pool 5 is \$16,000,000.

For SPY 2009, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated and distributed to DSH-qualifying hospitals in pools 1, 1A, 2, 2A or 3 until September 30, 2011. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. For SPY 2010, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, 3, and 5 until September 30, 2012. A determination will be made by June 30, 2012, by the Administration if any reallocation will occur. For SPY 2011, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2013. A determination will be made by June 30, 2013, by the Administration if any reallocation will occur.

Funding will be reallocated first to pools 1, 1A, 2, 2A, and 3, should the State make available

matching funds. This reallocation to the pools will be based proportionately on the SPY 2009 pool allocations. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2010 payments made from reallocated funds will be added to the hospital's original SPY 2010 payments with the total SPY payments subject to each hospital's OBRA limit.

For SPY 2011, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2011 pool allocation. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2011 payments made from reallocated funds will be added to the hospital's original SPY 2011 payments with the total SPY payments subject to each hospital's OBRA limit.

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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.

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[To Be Placed on Public Hospital Letter Head]

State Plan Year \_\_\_\_\_

Initial

Final

**CERTIFICATION STATEMENT  
DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the \_\_\_\_\_ of Maricopa Medical Center, I certify that:

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

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

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

\_\_\_\_\_  
Signature of CEO or CFO

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

[To Be Placed on Public Hospital Letter Head]

State Plan Year 2008

Initial

Final

**CERTIFICATION STATEMENT  
DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the \_\_\_\_\_ of Arizona State Hospital, I certify that:

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

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

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

\_\_\_\_\_  
Signature of CEO or CFO

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

DRAFT

|

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### Group 3 Eligibility Calculation

A privately owned or privately operated hospital's eligibility for Group 3 will be determined based on a) whether the hospital's LIUR exceeds the mean LIUR for all privately owned or privately operated hospitals receiving Medicaid payments in the state that have provided information to AHCCCS by the specified date or b) whether the hospital provides at least 1% of the total Medicaid inpatient days. Psychiatric and rehabilitation facilities are excluded from consideration for eligibility in Group 3. The calculation of a hospital's LIUR is discussed above; presented below is the calculation of the mean LIUR and the calculation of a hospital's percentage of total Medicaid inpatient days

#### Calculation of the mean LIUR

In calculating the mean LIUR, the LIUR for all registered privately owned or privately operated hospitals that have provided information to AHCCCS by the specified date will be calculated pursuant to the LIUR formula. The mean LIUR – the average of the individual LIURs – will be calculated based on all the individual LIURs greater than zero.

#### Percentage of Total Medicaid Days

A hospital's Medicaid Days Percentage is calculated using the following equation:

$$\text{MedicaidDaysPercentage} = \frac{\text{Hospital Specific Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days across All Hospitals}}$$

In performing the calculations:

“Inpatient Days” includes:

- Fee-for-service and managed care days, and
- 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.

“Medicaid Inpatient Days” includes:

- All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
- All adjudicated inpatient days for waiver eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

“Medicaid Inpatient Days” does not include:

Inpatient days in which a categorically or waiver eligible Title XIX client was in an IMD and the client was between 21 and 65 years of age

“Total Medicaid Inpatient Days across All Hospitals” includes the total of “Medicaid Inpatient Days” for all hospitals.

*Data Sources for Medicaid Days Percentage Calculations*

For the initial determination of a hospital’s Medicaid Days Percentage, the data source is the PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment.

For the second determination of a hospital’s MIUR, the data source is the PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital’s fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.