Table of Contents

State/Territory Name: AZ

State Plan Amendment (SPA) #: 23-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

April 13, 2023

Carmen Heredia, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

RE: Arizona State Plan Amendment Transmittal Number 23-0004

Dear Ms. Heredia:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 23-0004. This amendment, effective February 2, 2023, updates the Arizona disproportionate share hospital (DSH) state plan language on Medicaid shortfall to reflect statutory changes made by Section 203 of the Consolidation Appropriations Act of 2021 to Section 1923(g) of the Social Security Act.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 23-0004 is approved effective February 2, 2023. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 – 0004

2. STATE: AZ

3. PROGRAM IDENTIFICATION: TITLE 19 OF THE SOCIALSECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~January 1, 2023~~ February 2, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 1923(g) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 0
b. FFY: 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, pages: 43, 44, 45

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, pages: 43, 44, 45

9. SUBJECT OF AMENDMENT
INSERT HERE

10. GOVERNOR'S REVIEW *(Check One)*

- [X] GOVERNOR'S OFFICE REPORTED NO COMMENT
- [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- [ ] OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Alex Demyan

13. TITLE
Interim Assistant Director

14. DATE SUBMITTED:
March 16, 2023

15. RETURN TO
Alex Demyan
801 E. Jefferson St., MD #4200
Phoenix, AZ 85034

FOR CMS USE ONLY

16. DATE RECEIVED
March 16, 2023

17. DATE APPROVED
April 13, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
February 2, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
Pen-and-ink change made to Box 4 by CMS with state concurrence.

Instructions on Back

The steps to computing the OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine cost center-specific per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

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

The Medicaid Shortfall

AHCCCS will calculate the Medicaid shortfall consistent with Section 1923(g) of the Social Security Act and, in the calculation below, take into account changes made to the statutory definition of the Medicaid shortfall, including changes made by Section 203 of the Consolidated Appropriations Act of 2021. 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 information from AHCCCS will include, but not be limited to:

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

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

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

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

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

The ancillary RCCs will be calculated by dividing:

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

Costs will be offset by all applicable payments received for the Medicaid services, consistent with Section 1923(g) of the Act.

STATE OF ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

Supplemental payments will be based on the state plan year. During the initial calculation, AHCCCS may use actual data if available as opposed to two years prior payments.

Uninsured Costs

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

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

The Uninsured are defined as:

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

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

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