# Board of Supervisors



**AGENDA FOR WORK SESSION**
**Tuesday, October 23, 2012 at 9:00 a.m.**
BOARD OF SUPERVISORS EXECUTIVE CONFERENCE ROOM
1415 MELODY LANE, BUILDING G, BISBEE, AZ 85603

**ANY ITEM ON THIS AGENDA IS OPEN FOR DISCUSSION**

**ROLL CALL**
***Members of the Cochise County Board of Supervisors will attend either in person or by telephone, video or internet conferencing.***

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## *INTRODUCTIONS*

## *ITEMS FOR DISCUSSION*

### Board of Supervisors

1. Discussion and general direction on a report from Community Healthcare of Douglas (CHD) regarding Southeast Medical Center and request for financial assistance in the form of a contribution not to exceed $300,000 in order to participate in a federal matching fund program with Arizona Health Care Cost Containment System (AHCCCS).

Pursuant to the Americans with Disabilities Act (ADA), Cochise County does not, by reason of a disability, exclude from participation in or deny benefits or services, programs or activities or discriminate against any qualified person with a disability. Inquiries regarding compliance with ADA provisions, accessibility or accommodations can be directed to Chris Mullinax, Safety/Loss Control Analyst at (520) 432-9720, FAX (520) 432-9716, TDD (520) 432-8360, 1415 Melody Lane, Building F, Bisbee, Arizona 85603.

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**DIS-1022** **Items For Discussion 1.**

**Work Session Board of Supervisors3** **Board of Supervisors**

**Meeting Date:** 10/23/2012

Work Session - CHD of Douglas AHCCCS grant assistance request

**Submitted By:** Kim Lemons, Board of Supervisors

**Department:** Board of Supervisors

**Presentation:**

**NAME of PRESENTER:**

**TITLE of PRESENTER:**

**ORGANIZATION NAME of PRESENTER:**

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**Information**

**Agenda Item Text:**

Discussion and general direction on a report from Community Healthcare of Douglas (CHD) regarding Southeast Medical Center and request for financial assistance in the form of a contribution not to exceed $300,000 in order to participate in a federal matching fund program with Arizona Health Care Cost Containment System (AHCCCS).

**Background:**

to come

**To BOS Staff: Document Disposition/Follow-Up:**

TBD

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**Attachments**

Safety Net Care Pool Presentation

# SAFETY NET CARE POOL

Presentation to the Douglas, Arizona
City Council
By
Brian E. Bickel
Chief Executive Officer
Southeast Arizona Medical Center
August 31, 2012

# What is the SNCP?

- Established in 2011 and approved by AHCCCS in 2012, reimburses participating hospitals for uncompensated care costs provided to AHCCCS members and the uninsured.
- Eligible hospitals: Arizona hospitals receiving disproportionate share payments and that have a local governmental entity sponsor (IGA model).
- Approximately $332 million/yr. (federal and state)., with a portion used to fund the "Kids Care II" program.
- Program expires January 1, 2014.

# Why Us? Why Now?

- The Safety Net Care Pool requires an affiliation with a taxing authority
- The county will not participate because of the "me too" factor
- This is a short term solution to a long term problem
- The program expires January 1, 2014
- Douglas needs a hospital

SOUTHEAST ARIZONA MEDICAL CENTER

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August, 2

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ARIZONA HEALTH FACILITIES AUTHORITY

# The Economic Impact of Southeast Arizona Medical Center on the Local Economy

Prepared by:

National Center for Rural Health Works
Oklahoma State University

This study was made possible with funding support from the Rural Hospital Medicare Flexibility (Flex) Program, Rural Health Office, The University of Arizona, Mel and Enid Zuckerman College of Public Health. The Flex Program is funded by HRSA Office of Rural Health Policy.

May 2009

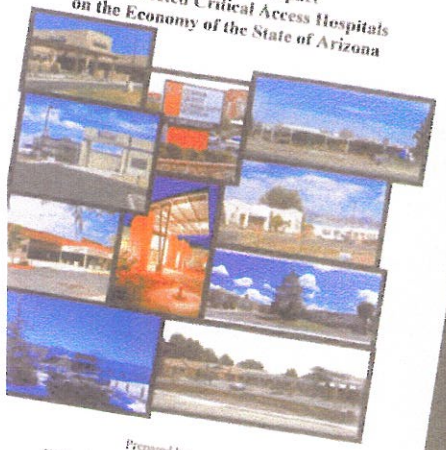
The LEWIN GROUP

nalysis of Hospital Cost Shift in
izona

Report

for:
ona Chamber Foundation

The Economic Impact
of Ten Selected Critical Access Hospitals
on the Economy of the State of Arizona



Prepared by:
National Center for Rural Health Works
Oklahoma State University

made possible with funding support from the Rural Hospital Medicare Flexibility
m, Rural Health Office, The University of Arizona, Mel and Enid Zuckerman
Health. The Flex Program is funded by HRSA Office of Rural Health Policy.

July 2010

# Recent AHCCCS Changes

**AHCCCS Cost Reduction Scenarios for FY 2009 and 2010**

| | FY2009 | FY2010 |
|---|---|---|
| 1.AHCCCS Payment Freeze<br>Assumes updates prior to freeze would be based on Global Insight, Inc. Market Basket increase projections of 3.6% in FY2009 and 2.9% in FY2010 | Freezes payment rates at FY 2008 levels | Freezes payment rates at FY 2008 levels |
| 2. AHCCCS Payment Reduction in FY2010 | Freezes payment rates at FY 2008 levels | 5% payment reduction in payment rates |
| 3. Reduce Graduate Medical Education Payments (State's estimate) | Reduces total funding by $20.4 million ($15.3 million federal) | Reduces total funding by $20.4 million ($15.3 million federal) |
| 4. Eliminates Disproportionate Share Hospital Payments (State's estimate) | Reduces total funding by $30.2 million ($17.1 million federal) | Reduces total funding by $30.2 million ($17.1 million federal) |
| 5. Reduce funding for rural hospitals | Reduces SAVE Program funding | Reduces SAVE Program funding |

# Revenue by Financial Class

| PAYER | PERCENTAGE |
|---|---|
| Blue Cross | 6.9% |
| HMO/PPO | 14.2% |
| Self Pay | 7.4% |
| Medicare HMO | 8.2% |
| AHCCCS | 36.4% |
| Institutional | 0.5% |
| Medicare | 20.2% |
| Tricare | 0.5% |
| Other Government | 3.2% |
| Commercial | 1.8% |
| Workman Comp | 0.8% |

# The Community Economic Cycle

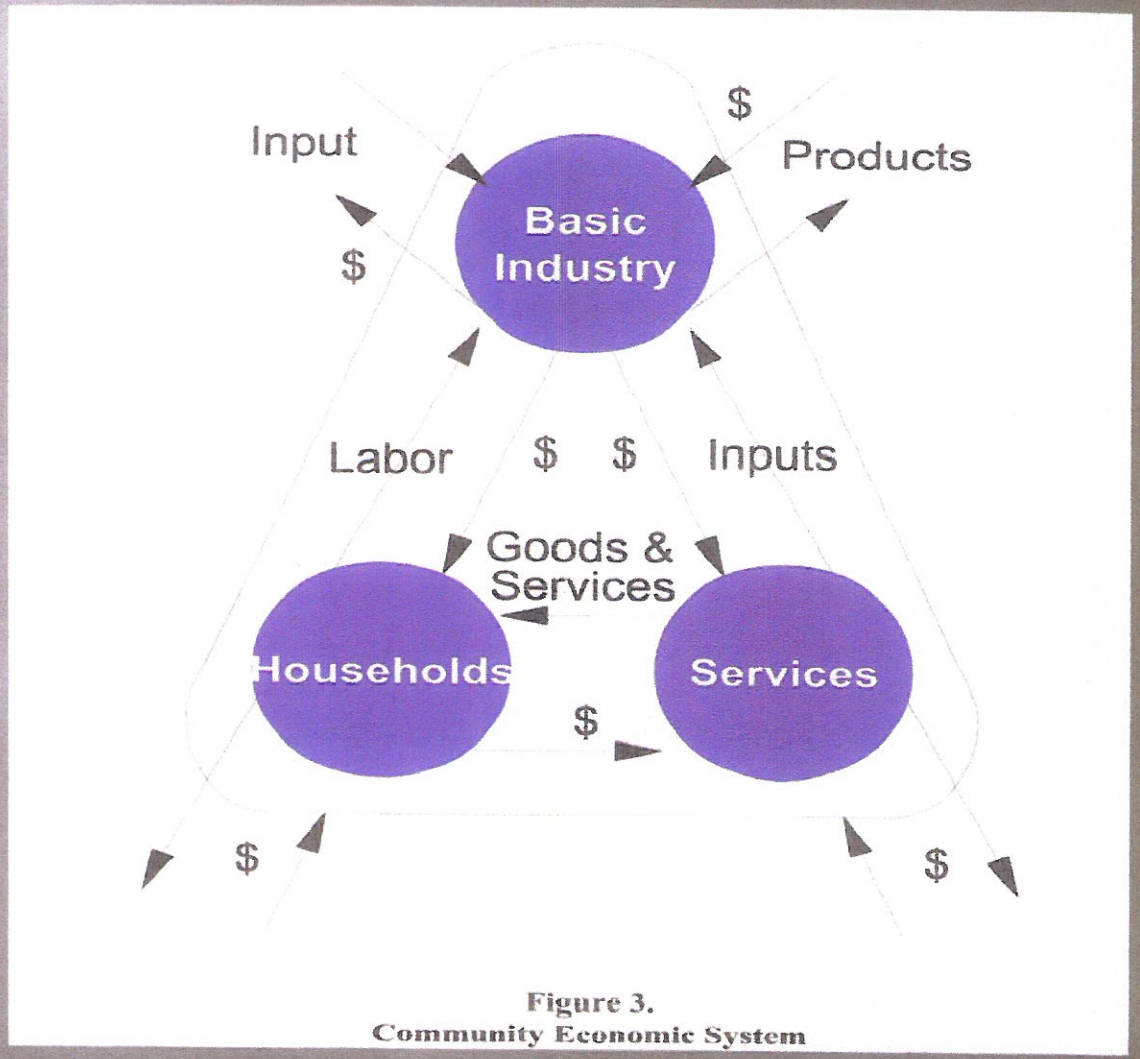



**Figure 3.**
**Community Economic System**

# Why This Matters to Douglas

- The jobs multiplier for SAMC is 1.35
  - This means for every 100 jobs at the hospital, there are 35 jobs created in the community to support that activity
- The financial multiplier for the hospital is 1.24
  - The total net revenue for FY2012 was $9,366,631 so the direct and indirect impact on the community is $11,614,622

# What SAMC would like Douglas to consider

- The federal match requires an IGA with a taxing authority
- The last estimate from AHCCCS was a maximum $932,000 benefit
- To achieve this, the city would have to contribute ~$300,000
- All funds are paid to AHCCCS, matched and distributed to the hospital quarterly

# We're Not Alone!

## TMC gets $5.4M from Pima County

Partnership qualifies hospital to receive federal matching funds

# AHCCCS FFS INPATIENT HOSPITAL RATE UPDATE
# October 1, 2012 - SEPTEMBER 30, 2013

In accordance with Arizona Revised Statute (ARS) 36-2903.01, AHCCCS reimburses hospitals for inpatient hospital services based on a prospective tiered per diem methodology in which payment for each day of care is based on the level of care (tier) provided.

Pursuant to Arizona Administration Code, R9-22-712, individual hospital inpatient cost-to-charge ratios will be decreased by the same percentage as those hospital's charge master increases after June 1, 2012.

## Statewide Weighted Average Tier Rates, Effective 10/1/12-9/30/13

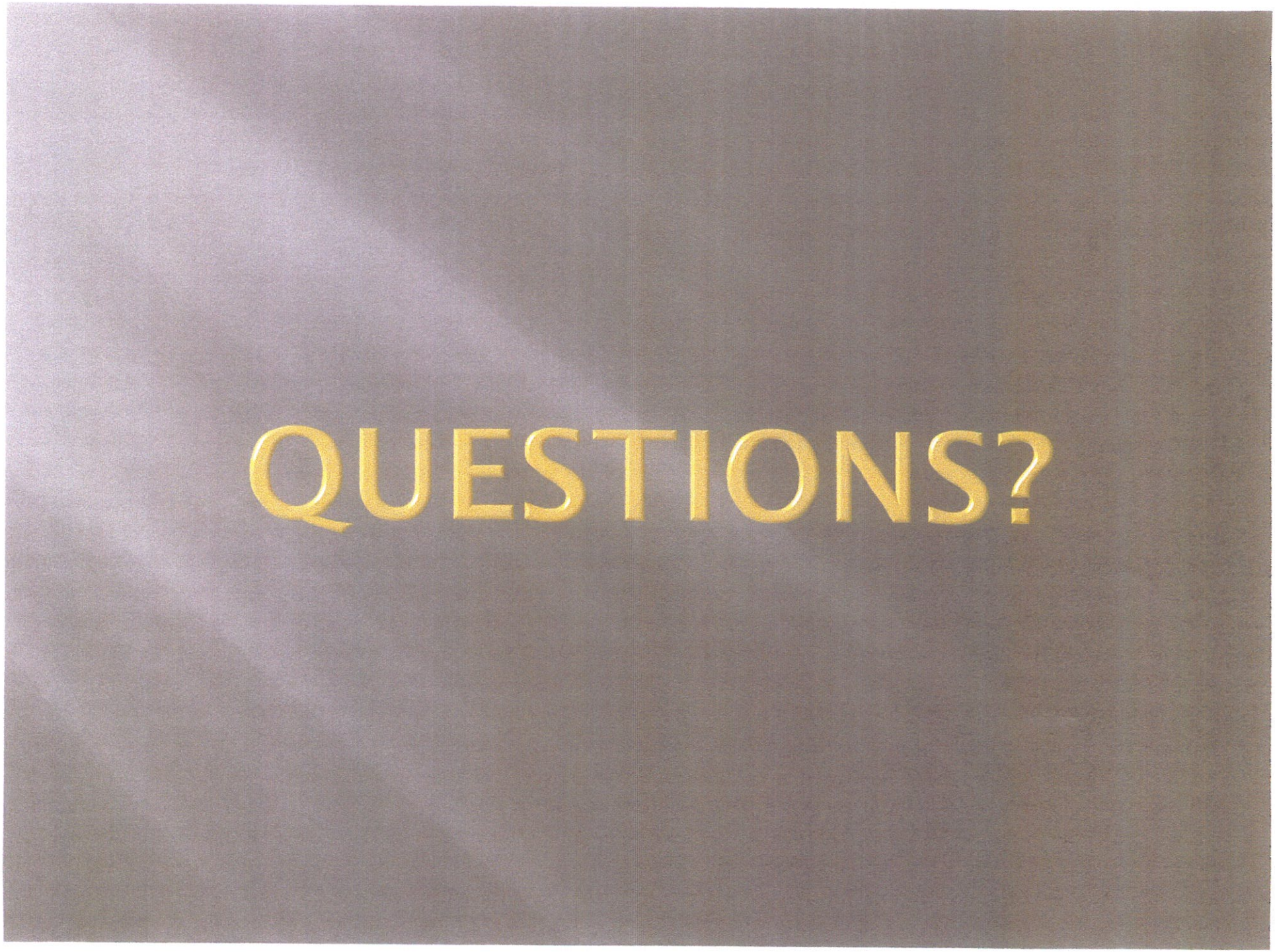
| | |
|---|---|
| Maternity | $1,334.34 |
| NICU Level III | $1,352.17 |
| NICU Level II | $1,144.47 |
| ICU | $2,667.33 |
| Surgery | $1,547.68 |
| Psychiatric | $ 844.76 |
| Nursery | $ 524.99 |
| Routine | $ 1,041.48 |
| Routine Specialty | $ 971.53 |

## Hospital Claim Processing

The processing of an inpatient claim is hierarchical. Each day is classified into **one** tier based on diagnosis, procedure, and/or revenue codes. Once the criteria are met within a tier for a particular day, the day is classified into that tier even if it meets the condition of a lower tier in the hierarchy. Inpatient claims may split across no more than **two** tiers per continuous stay. The attached hierarchy for tier assignment chart lists the qualifications for each tier, and the allowed tier splits.

# How Bad Is It, Really?

- FY 12 Gross Revenue $28,736,001
- Times 39% is $11,207,040 AHCCCS Revenue
- Times 22.61% is $2,533,912
- FY12 Expenses $11,173,105
- Times 39% is $4,357,511 in AHCCCS Expense
- A shortfall of $1,823,599
  - Reimbursement at 58.2% of cost


QUESTIONS?

## AHCCCS Receives Approval of Two Important Waiver Amendments

On Friday, April 6, 2012, AHCCCS received approval to move forward with two new programs critical to Arizona's safety net healthcare delivery system – the Safety Net Care Pool and the Indian Health Services/tribal 638 facilities supplemental payment program. These two new programs were approved under the State's Section 1115 Research and Demonstration Waiver.

### Avoiding Cost Shift to Indian Health Services and Tribal 638 Facilities

AHCCCS provides care to qualified Native Americans who receive services at Indian Health Services (IHS) or tribally operated 638 facilities with 100% federal dollars. Recent reductions to the AHCCCS program have placed an undue burden on these fragile networks without yielding any savings to the State. The waiver was requested as part of a partnership with Arizona's 22 tribes to address this cost shift to IHS and tribally operated 638 facilities.

This approval allows AHCCCS to make supplemental payments through December 31, 2013 to IHS and tribally operated 638 facilities to cover their uncompensated care costs associated with AHCCCS benefit reductions and the childless adult enrollment freeze. These payments are critical to ensuring the viability of these programs dedicated to providing care to Arizona's Native American population.

### Safety Net Care Pool

*Safety Net Care Pool*

The Safety Net Care Pool (SNCP) was passed by the Legislature and signed into law by Governor Brewer on April 25, 2011 as SB1357. SNCP is a funding pool that uses monies from political subdivisions to draw down federal matching dollars. The funds are then distributed to participating hospitals to help defray the costs of uncompensated care provided to AHCCCS members and the uninsured.

The SNCP is open to all Arizona hospitals, including rural hospitals, safety net hospitals and hospitals receiving Disproportionate Share Hospital (DSH) payments. The non-federal match must be provided by a political subdivision. This program gives local governments, like counties, cities or special healthcare districts, the ability to directly support hospital systems in their communities.

As approved, the SNCP will provide $332 million each year for two years to three participating hospitals – Maricopa Medical Center, Phoenix Children's Hospital and University Medical Center. The program terminates January 1, 2014.

*Coverage for KidsCare II*

Approval of the SNCP also opens the door to additional coverage for children in the Children's Health Insurance Program (CHIP), known as KidsCare in Arizona. KidsCare

enrollment has been frozen since January 1, 2010. The approval of SNCP permits the three participating hospitals – Maricopa Medical Center, Phoenix Children's Hospital and University Medical Center – to apportion some of their political subdivision dollars toward coverage for 21,700 children in what is being called "KidsCare II."

KidsCare II is a statewide program with the same benefits offered and the same premium requirements as regular KidsCare. Coverage for KidsCare II will also be handled by the same AHCCCS health plans. Additionally, KidsCare II children are not limited to receiving their healthcare services at the participating SNCP hospitals.

There are a few differences, however, between KidsCare II and the regular KidsCare program. KidsCare II has a lower income eligibility threshold; it is only open to children in households with incomes from 100% to 175% of the Federal Poverty Level. In addition, KidsCare II is temporary. Coverage for KidsCare II begins May 1, 2012 and will end January 1, 2014.

Finally, KidsCare II is only open to children currently on the KidsCare waiting list and to children currently enrolled in Medicaid who will "age out" of the SOBRA children eligibility category[1]. There are over 100,000 children currently on the KidsCare waiting list and there will be 21,700 openings for KidsCare II. Notices will be sent beginning Monday, April 9, 2012 to households of children on the waiting list in the order their original application was received. Households receiving a notice will be required to apply using Health-e-Arizona, the online application process. Applications for KidsCare will still be accepted and applicants will be placed on the waiting list in the order their application was received. Households on the waiting list will be notified as additional slots for KidsCare II become available. For more information, visit the KidsCare section of the AHCCCS website at www.azahcccs.gov.

*Federalizing Prop. 202 Trauma/Emergency Department Fund*

Proposition 202 is a fund that assists Arizona hospitals with the cost of operating trauma centers and Emergency Departments. Currently, this funding pool distributes approximately $20 million annually to Arizona hospitals. Approval of the SNCP will add just over $13 million in new federal funds that will be directed primarily to rural hospitals, and also to hospitals with Emergency Departments and trauma centers across the State to assist these facilities in managing their uncompensated care costs.

[1] These are children currently enrolled in SOBRA 0-5 who turn 6. The income limit for SOBRA children ages 0-5 is 133% FPL; the income limit for SOBRA children who turn 6 is 100% FPL.

# An Overview of The Section 340B Drug Discount Program

### *Background:*

To understand the genesis of the 340B program, one must begin in 1990 when Congress created the Medicaid rebate program to lower the cost of pharmaceuticals reimbursed by state Medicaid agencies. The Medicaid rebate program requires drug companies to enter into a rebate agreement with the Secretary of the Department of Health and Human Services (HHS) as a precondition for coverage of their drugs by Medicaid and Medicare Part B. The rebate agreement specifies that, for each brand name outpatient drug covered under Medicaid, the manufacturer of the drug must pay a rebate to Medicaid based in part on the manufacturer's "best price" for that drug. As a result of the Medicaid rebate law, many pharmaceutical companies had a disincentive to continue giving deep discounts on drugs because they would have to pay larger rebates to Medicaid if they gave deeper discounts in the non-Medicaid market (establishing even better "best prices"). When manufacturers began raising their prices, the Medicaid savings achieved through the rebate program were offset by increased government spending on drugs purchased by other federal- and state-supported providers.

To correct this situation, Congress, in November 1992, enacted Section 340B of the Public Health Service Act (created under Section 602 of the Veterans Health Care Act of 1992), which requires pharmaceutical manufacturers participating in the Medicaid program to enter into a second agreement with the Secretary—called a pharmaceutical pricing agreement (PPA)— under which the manufacturer agrees to provide front-end discounts on covered outpatient drugs purchased by specified government-supported facilities, called "covered entities," that serve the nation's most vulnerable patient populations.

### *Who is eligible to participate in the 340B program?*

The definition of "covered entities" includes six categories of hospitals: disproportionate share hospitals (DSHs), children's hospitals and cancer hospitals exempt from the Medicare prospective payment system, sole community hospitals, rural referral centers, and critical access hospitals (CAHs). Hospitals in each of the categories must be (1) non-profit, (2) be owned or operated by or under contract with state or local governments and, (3) with the exception of CAHs, meet payer-mix criteria related to the Medicare DSH program. There are also eleven categories of non-hospital covered entities that are eligible based on receiving federal funding. They include federally qualified health centers (FQHCs), FQHC "look-alikes", state-operated AIDS drug assistance programs, the Ryan White CARE Act Part A, Part B and Part C programs, tuberculosis, black lung, family planning and sexually transmitted disease clinics, hemophilia treatment centers, public housing primary care clinics, homeless clinics, Urban Indian clinics, and Native Hawaiian health centers.

Over 17,000 participating covered entity sites and hundreds of pharmaceutical companies participate in the program.

### *Who administers the 340B program?*

The Office of Pharmacy Affairs (OPA), which is located within the Health Resources and Services Administration (HRSA) within HHS, administers the program. HRSA and OPA are located in Rockville, MD and are responsible for interpreting and implementing Section 340B. You may contact OPA through its government contractor, the Pharmacy Services Support Center (PSSC), at 1-800-628-6297 or pssc@aphanet.org, or via contacts links on the OPA website at http://www.hrsa.gov/opa. The OPA office e-mail address is opastaff@hrsa.gov.

### *What is the Pharmacy Services Support Center (PSSC)?*

PSSC is a federal contractor that HRSA funds to provide guidance and technical assistance to 340B covered entities and to enhance the staffing resources available to OPA. PSSC is a non-profit organization based at the American Pharmacists Association (APhA). PSSC's website is located at http://pssc.aphanet.org.

### *How does the Program work?*

Facilities that believe they meet the criteria of a "covered entity" can apply to participate in the 340B program by submitting their applications at least one month in advance of the beginning of the next calendar quarter, which is when OPA updates the list of covered entities on its website. Facilities are registered in the program and are eligible for 340B discounts as soon as their name and other requested information are posted on the OPA website and their listed start dates have passed. Once admitted into the program, covered entities are entitled to receive discounts on all covered outpatient drugs, regardless of the patient's payer status and whether the drug is intended for self-administration or administration by a clinician. The 340B discount is the average manufacturer price (AMP) reduced by a minimum rebate percentage of 23.1 percent for most brand name prescription drugs, 17.1 percent for brand name pediatric drugs and clotting factor, and 13 percent for generic and over-the-counter drugs. Manufacturers must offer even greater discounts on brand name drugs if the manufacturer's best price for a drug is lower than AMP minus 23.1 percent for that drug and/or the price of the drug has increased more quickly than the rate of inflation. (This is also true for innovator, multi-source drugs, *i.e.*, brand name drugs that have generic competition.) In addition, covered entities are free to negotiate discounts that are lower than the maximum allowable statutory price. The discounted prices are typically available through a covered entity's wholesaler unless the manufacturer requires that its drugs (both 340B and non-340B) be purchased directly from it.

### *How do covered entities obtain discounts?*

Upon registration, a covered entity should contact its wholesaler to set up its 340B account and to request a 340B price list. The entity also may request a 340B pricing file from a manufacturer. Manufacturers should check the OPA website each quarter to identify the providers that are participating in the program. The manufacturer may not charge more than the 340B ceiling price to

those entities regardless of whether the covered entity purchases pharmaceuticals through a wholesaler or directly from the manufacturer. If a covered entity suspects that it is not receiving the 340B price for a given outpatient drug, it should immediately notify its wholesaler, the manufacturer, and/or OPA. In many cases, the absence of a 340B price is the result of human error and is resolved when the mistake is identified and, if necessary, brought to OPA's attention. HRSA also has implemented a provision of Section 340B mandating the creation of a Prime Vendor Program (PVP) by entering into an agreement with Apexus to help with negotiating discounts below the mandatory 340B ceiling price. A covered entity does not have to join PVP in order to participate in the 340B program and may negotiate subceiling discounts on its own. However, because PVP can negotiate prices on behalf of a large number of 340B purchasers, it has been able to negotiate favorable prices and develop a national distribution system that may not be possible for some covered entities to obtain individually. To learn more about PVP, go to http://www.340Bpvp.com.

### *To whom may covered entities dispense discounted drugs?*

Section 340B prohibits the resale or transfer of discounted outpatient drugs to anyone other than a patient of the covered entity. HRSA has defined a covered entity patient through a *Federal Register* notice available on OPA's website and through informal guidance. The current patient definition guidelines establish a three-part test that individuals must meet to be eligible to receive 340B -priced drugs. The penalty for failing to comply with the program's anti-diversion provision is forfeiture of the discounts back to the manufacturer. Where the violation is knowing and intentional, covered entities may be required to pay interest on the discounts that they refund. In addition, if diversion by an individual is intentional, he or she may be criminally liable under the Prescription Drug Marketing Act. Finally, if the violation is systematic and egregious as well as knowing and intentional, a covered entity may be disqualified from participation in the program for a reasonable time, to be determined by HRSA. Manufacturers have the right to audit the records of covered entities to protect against diversion. HRSA published proposed changes to the 340B definition of patient in 2007; however, those changes have yet to be adopted. HRSA has indicated it plans to withdraw the 2007 proposed definition and replace it with a new proposed definition.

### *Are there billing restrictions?*

There are no billing restrictions applicable to drugs dispensed to non-Medicaid patients. However, with respect to drugs dispensed or administered to Medicaid recipients, the law says that a drug purchased under 340B cannot be subject to both a 340B discount and a Medicaid rebate. HRSA directs covered entities to follow state guidance when billing 340B drugs. In most states, participating covered entities may not bill Medicaid for drugs dispensed at retail for more than actual acquisition cost (AAC) plus the state-allowable dispensing fee for covered outpatient drugs purchased with 340B discounts. This policy does not apply if (a) the drug is dispensed to a Medicaid recipient enrolled in a capitated managed care plan and the drug is paid for by the plan under the terms of the pharmacy's participation agreement with the plan; (b) the drug is reimbursed by Medicaid as part of an all-inclusive rate or is otherwise paid for as part of a bundled rate; (c) the state Medicaid agency has established a different billing and reimbursement arrangement for 340B drugs; or (d) the entity elects to purchase its Medicaid outpatient drugs outside the 340B program (often referred to as the Medicaid "carve-out") and the state permits the carve-out. Note that with respect to the first exception, at least one state requires Medicaid managed care drugs to be reimbursed at AAC. With respect to non-retail covered outpatient drugs, the above policies generally still apply, but providers should contact their state Medicaid agency if they have any questions. This is true whether the non-retail drug is administered or dispensed by a physician or other health care provider.

### *What if a covered entity facility lacks an "in-house" pharmacy?*

HRSA has developed guidelines to allow such facilities to contract with one or more outside pharmacies to act as a dispensing agent. Under these guidelines, the covered entity is required to purchase the pharmaceuticals, and the contractor provides some or all pharmacy services. Covered entities with contract pharmacies should use a "ship to-bill to" procedure in which the covered entities purchase the drugs, and manufacturers and wholesalers bill the covered entities but ship the drugs directly to the contract pharmacy. A contractor must provide the covered entity quarterly financial statements, a detailed status report of collections, and a summary of receiving and dispensing records. It must maintain those records as long as is required under federal law (generally 10 years). The contractor also must establish and maintain a tracking system to prevent diversion of drugs to individuals who are not patients of the covered entity. Covered entities are expected to have an independent audit of the contract pharmacy performed at least annually, to monitor pharmacy compliance and to self-report any instance of noncompliance to HRSA.

### *How much do Section 340B participants save in the program?*

Pharmaceutical prices available under Section 340B are significantly lower than both retail and wholesale prices. 340B prices for brand name drugs are, on average, 51 percent of average wholesale prices, according to a report released by the Congressional Budget Office. Another government study found 340B prices to be 27 percent lower than prices available to group purchasing organizations. Note that these estimates were determined before manufacturers were required to adjust their AMP and minimum rebate percentage calculations as a result of health reform legislation in 2010.

### *How do you receive the latest information on the Program?*

OPA disseminates information through its website at http://www.hrsa.gov/opa, the PSSC website at http://pssc.aphanet.org, and the PVP website located at http://www.340Bpvp.com to program participants. The OPA website includes the names of participating covered entities and manufacturers, *Federal Register* notices and current program guidelines, and other 340B program-related information. Other helpful information is available at the Safety Net Hospitals for Pharmaceutical Access's (SNHPA) website located at http://www.snhpa.org. In addition, SNHPA publishes a real-time news service on the 340B program called the *Drug Discount Monitor*, which can be found online at http://www.drugdiscountmonitor.com.

**For questions, please visit www.snhpa.org or contact SNHPA Assistant General Counsel Maureen Testoni at maureen.testoni@snhpa.org or 202-552-5851, Associate Counsel Greg Doggett at greg.doggett@snhpa.org or 202-552-5859 or Associate Counsel Jeff Davis, at jeff.davis@snhpa.org or 202-552-5867.**

**JAMES RILEY**

**From:** "Roberta Berry" <berryrobi@hotmail.com>
**To:** "Jim Riley" <jriley520@msn.com>
**Sent:** Thursday, October 18, 2012 10:03 AM
**Subject:** Carlos de la Torre's suggestions

Mr. Riley:

As requested, following please find the suggestions by Carlos de la Torre. If you need anything else, please let me know. Thank you.

*Robi Berry, CHC, HACP*
Executive Assistant
Southeast Arizona Medical Center
2174 W. Oak Avenue
Douglas, AZ 85607
(520) 805-5943
FAX: (520) 364-2551

> From: carlos.delatorre@douglasaz.gov
> To: berryrobi@hotmail.com; luciakmspikes@hotmail.com; jriley520@msn.com
> Date: Fri, 12 Oct 2012 07:04:15 -0700
> Subject: Robin:
>
> Robin:
> Please forward these notes to Mrs. Spikes:
>
> 1) Bring back with billing functions to Douglas only if will expedite the billing process. Ensure that billing is done within 72 hours after services are rendered
> 2) Make contact with the Emergency Room provider, not just their management but their Board and request their support and assistance as you guys go through the restructuring process, as they are critical to the short and long term sustainability of the hospital
> 3) Look at facilitating the intake and processing of patients at the emergency room
> Its better to wait in the ER room and to wait in the lobby
> 4) Paint and change the furniture at the ER Lobby
> 5) Solicit input from every single employee in the development of the turn-around plan
> 6) Administrative Staff and the Board should be visible during this administrative and business plan transition
> 7) Ensure that the basic maintenance and janitorial functions are taken care off, don't give the impression that things are falling though the cracks, ensure that floor are mopped and garbage is picked up.
> 8) Give staff the flexibility to talk to Douglas EMS/Fire in order to determine what things may be changed that can enhance the quality and type of services that you provide
> 9) The board shall boldly demonstrate a sense of confidence to every employee that things are bumpy but with everybody working together we have the opportunity to change things around. You have been there in the past, you have done it before, you can do it again, you have the experience and the resilience to do it.
> 10) At least for the first month or so, once you have developed and unveiled your plan, you shall be on a very regular basis to discuss the obstacles and progress of your plan. It is critical that you monitor the progress. If you are not making progress make a decision immediately and move on. If that decision did not work, then try something else, but continue this process.
> 11) While you go through this, celebrate your success's, and give credit where credit is due at the same time hold people accountable if they are not doing what they were asked to do or committed themselves to do it. You need to do this immediately.
> 12) You need to demonstrate a sense of urgency but demonstrate trust and confidence that by making hard

and difficult decisions you have the opportunity to success and you are not about to give up at this point.
> 13) You need to get the media's help, call the dispatch so they can make a story about the hospital, that you are going through difficult times but that you are making some bold changes not only administratively but in the various processes' to enhance the services that you are providing. Talk to Howard Henderson and see if you guys can pay him a visit and talk on the "Talk of the Town"
> 14) Solicit the help from Jim Pace or Mr. Dave Caveney
> 15) See if Chiricahua Clinic or Copper Queen Hospital are willing to set up some services within the Douglas Hospital.
> 16) Solicit the help and advise from other area hospitals, Benson and Willcox. You might be able to get some ideas from them not only on how to put in place a taxing district but how do they deliver rural health care.
> 17) If things don't turn around you need to begin developing your exit strategy. I am hopeful that you can begin the implementation of that not earlier than January or February 2013. I would not recommend you do that during the holiday season
>
> That is all I can think of at the moment! Again, they are general but once I begin to understand your field I might be able to provide you with some additional thougths.
>
> Thanks!
>
> Carlos A. De La Torre
>
> I will be in the road shortly 7:30 a.m. to 9:00, please feel free to call me if you have any questions. Mobile Number 520-508-0953
>
>
>
> Sent from my iPad

# INTERGOVERNMENTAL AGREEMENT

Between

## ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION ("AHCCCS")

and

## THE COUNTY OF COCHISE, ARIZONA ("COUNTY")

for

## Safety Net Hospital and Health System Funding Pursuant to S.B. 1357

WHEREAS, the County of Cochise is a political subdivision of the State of Arizona; and,

WHEREAS, the County of Cochise wishes to increase access to primary, specialty, and preventive health care services in order to improve the health care of its uninsured, underinsured, underserved and vulnerable residents, including children eligible for the Arizona KidsCare program; and

WHEREAS, Southeast Arizona Medical Center is a critical access hospital that provides primary, specialty, and preventive health care services to the citizens of southeast Arizona, including children eligible for the Arizona KidsCare program; and

WHEREAS, the Arizona legislature, during its Fiftieth Legislature, First Regular Session of 2011 enacted Senate Bill 1357 ("SB 1357"), which permits the County of Cochise, as a political subdivision of the State of Arizona, contingent upon the approval by AHCCCS and the Centers for Medicare and Medicaid Services ("CMS"), to contribute County (public) funds to be used as the Non-Federal Share of the Medicaid funding to further the purposes identified in SB 1357, which include but are not limited to funding for the Safety Net Care Pool ("SNCP"); and

WHEREAS, the federal government has approved a Demonstration Project that permits AHCCCS to claim as expenditures eligible for FFP costs associated with expanded enrollment in the Arizona KidsCare program and the SNCP; and

WHEREAS, as of December 21, 2009, AHCCCS, pursuant to A.R.S. § 36-2985, stopped processing applications under Arizona Revised Statutes, Title 36, Chapter 29, Article 4 for the KidsCare program due to insufficient funds; and

WHEREAS, A.R.S. § 36-2995 authorizes AHCCCS to accept donations from any source to pay for the administrative and program costs associated with the operation of the KidsCare program; and

WHEREAS, the County, is authorized to enter into this Agreement under A.R.S. §§ 48-5501 et. seq., and SB 1357, and _____ of the _____; and

WHEREAS, AHCCCS is authorized to execute and administer agreements under SB 1357 and under A.R.S. § 36-2903 et seq., and is also authorized to make payments to certain health care providers funded in part by the County pursuant to SB 1357; and

WHEREAS, AHCCCS and the County are authorized by A.R.S. § 11-951 et seq. as well as SB 1357 to enter into Intergovernmental Agreements for cooperative action pertaining to the advancements and reimbursement of public funds for services performed consistent with SB 1357; and

WHEREAS, the County has determined that it is in the best interest of the County to provide the Non-Federal Share of the Medicaid payment to further the goals set forth in SB 1357 by enabling Southeast Arizona Medical Center to participate in the SNCP Program; and

WHEREAS, the County and AHCCCS wish to enter into this Agreement in order to permit the County to provide the Non-Federal Share of the Medicaid payment for the SNCP, which monies will be expended to further these goals.

NOW, THEREFORE, the County and AHCCCS (collectively, the "Parties"), pursuant to the above and in consideration of the matters set forth herein, mutually agree as follows:

1.0 DEFINITIONS: Unless otherwise defined in this Agreement, all terms have the same meaning as set forth in Title 36 of the Arizona Revised Statutes, Title 9, Ch. 22, of the Arizona Administrative Code (A.A.C.) and/or as set forth in SB 1357.

1.1 Agreement: This document, together with all attachments, appendices, exhibits, schedules and future amendments as agreed to by the Parties. The term "Agreement" is synonymous with "Intergovernmental Agreement", "IGA" "Intergovernmental Transfer Agreement," or "IGT Agreement".

1.2 AHCCCS: Arizona Health Care Cost Containment System, an agency of the State, which administers the Medicaid program under Title XIX and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act in Arizona.

1.3 CFR: Code of Federal Regulations, the official compilation of Federal rules and requirements.

1.4 CMS: Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

1.5 County: The County of Cochise, Arizona, a political subdivision of the State of Arizona

1.6 Day: A calendar day, unless specified otherwise.

1.7 Demonstration Project: The agreement between the State and CMS that includes: (1) a list of those provisions of Title XIX and Title XXI of the Social Security Act which have been waived by CMS with respect to the State's operation of programs under those Titles, (2) a list of expenditures which CMS has approved as claimable by the State for FFP notwithstanding the limitations on claims in those Titles, and (3) the Special Terms and Conditions associated with the waivers and expenditure authority, including provisions relating to the SNCP Program and the expansion of KidsCare as described in this Agreement.

1.8 Eligible Hospital: That hospital that is owned and operated by Community Healthcare of Douglas, Inc.

1.9 Eligible Providers: Physicians or non-physician practitioners employed by Eligible Hospital, if any, as approved by CMS as part of the Demonstration Project.

1.10 FFP: Federal Financial Participation refers to the federal monies that AHCCCS claims from CMS for the Federal share of AHCCCS expenditures for the administration of and services paid for through the Medicaid and CHIP programs, Titles XIX and XXI of the Social Security Act.

1.11 Safety Net Care Pool ("SNCP Program"): Those programs, goods, and services that are authorized by SB 1357, this Agreement, and the Demonstration Project which includes but is not limited to funding to support payments to Eligible Hospitals and Eligible Providers for uncompensated care via the Safety Net Care Pool.

1.12 State: The State of Arizona.

1.13 Non-Federal Share: The portion of AHCCCS expenditures for the administration and services paid for through the State's Medicaid and CHIP programs, Titles XIX and XXI of the Social Security Act, which are authorized by SB 1357.

2.0 PURPOSE:

The purpose of this Agreement is to set forth the procedures under which the County will, at its discretion and contingent upon AHCCCS and CMS approval, intergovernmentally transfer public funds as the Non-Federal Share of payments as authorized and permitted under SB 1357 and the Demonstration Project, in order to provide the monies necessary to qualify for federal matching monies in order to: (1) provide health care coverage to children who were potentially eligible for KidsCare under Arizona Revised Statutes, Title 36, Chapter 29, Article 4, but whose eligibility was not determined because the program was closed to new enrollment as of December 21, 2009, due to insufficient funds; and, (2) support safety net health systems through supplemental payments for the costs incurred by Eligible Hospital and Eligible Providers for uncompensated care including, but not limited to, uncompensated care as referenced in SB 1357.

Distributions from the Safety Net Care Pool to Eligible Hospital will be based on goods, and services provided by Eligible Hospital and as described in this Agreement during the period beginning October 1, 2011 and ending December 31, 2013. For each year ending September 30, the SNCP payments will be distributed to Eligible Hospital based on its proportionate share of projected uncompensated care (based on prior period data) of all hospitals eligible for participation in the SNCP Program. Furthermore, payments to each hospital in each year will be subject to a limit computed based on the hospital's uncompensated care costs incurred for a 12-month period covered by the that year, except in the third year when the limit will be computed based on uncompensated care costs incurred between October 1, 2013 and December 31, 2013. Actual distributions from the SNCP to Eligible Hospital and Eligible Providers may occur after December 31, 2013. In addition, expenditures under this Agreement will be made for expanded KidsCare coverage during the period beginning May 1, 2012 and ending December 31, 2013. The actual payments for KidsCare expansion services during the expansion period may occur after December 31, 2013. It is also the intent of the parties that the procedures herein fully comply with Federal and State laws, rules and regulations.

3.0 ELIGIBILITY AND DISTRIBUTION REQUIREMENTS.

Monies generated through this Agreement may only be utilized for expenditures by AHCCCS for the cost of expanding KidsCare enrollment under this Agreement and for payments from the Safety Net Care Pool to Eligible Hospital and Eligible Providers. AHCCCS will determine the amount of the funds provided under this Agreement to support the County's contribution to the expansion of KidsCare enrollment, which may not exceed 3.0% of the County's total Non-Federal Share contribution. In addition, AHCCCS will determine the extent to which Eligible Hospital and Eligible Providers qualify for payments made pursuant to the SNCP Program, and the amount of any SNCP Program distribution. The expenditure of funds for expansion of the KidsCare program, distribution amounts and related determinations for SNCP Program payments will be consistent with applicable federal and state statutes, regulations, rules, the Demonstration Project including any documents incorporated by reference in the Demonstration Project.

4.0 CONTACT INFORMATION.

AHCCCS. Questions, comments and concerns regarding the duties and responsibilities of AHCCCS are to be directed to:

Tom Betlach, Director, or
Michael Veit, Contracts Administrator
AHCCCS
701 E. Jefferson, MD 5700
Phoenix, AZ 85034
Phone: 6024174762
Fax: 6024175957
Email: Michael.Veit@azahcccs.gov

THE COUNTY. Questions, comments and concerns regarding the duties and responsibilities of the County are to be directed to:

County Administrator
County of Cochise
1415 Melody Lane
Bisbee, AZ 85603
Phone: 5204329469
Fax: 5204329479
Email:

5.0 AHCCCS RIGHTS AND OBLIGATIONS.

5.1 Receipt and Distribution of Funds.

Consistent with the Demonstration Project, state and federal law and regulations and with the Approved State Plans for Medicaid and CHIP, AHCCCS will utilize the funds provided by the County to obtain FFP for the cost of expanding KidsCare enrollment and to distribute payments consisting of combined State and federal Title XIX funds to Eligible Hospital and Eligible Providers as part of the SNCP Program. Both the Non-Federal Share and the FFP under this Agreement may only be used for purposes described in this Agreement.

5.2 AHCCCS Payment Recoupment from Eligible Hospital and Eligible Providers.

5.2.1 AHCCCS, upon prior written notice, will require Eligible Hospital and Eligible Providers receiving payments as a result of this Agreement, to reimburse AHCCCS upon demand and, if not reimbursed upon demand, AHCCCS will deduct from any future payments to the receiving Eligible Hospital or Eligible Provider any amount that is:

5.2.1.1 Received by the Eligible Hospital or Eligible Provider from AHCCCS for payments under this Agreement that have been inaccurately reported or paid or are found by the hospital, provider or AHCCCS to be an excluded expense;

5.2.1.2 Paid by AHCCCS for which Eligible Hospital's or Eligible Provider's books, records, and other documents are not sufficient to clearly confirm that the Eligible Hospital or Eligible Provider was entitled to the amount of payments paid under this Agreement;

5.2.1.3 Identified as payments under this Agreement that, as the result of a CMS financial management review or audit, is not eligible for FFP.

5.2.2 AHCCCS is responsible to satisfy any reporting or FFP reimbursement requirements imposed by CMS, if made as a result of a recoupment as noted in this Paragraphs 5.2 of this Agreement or applicable federal laws, rules and regulations. In the event AHCCCS recoups any payments from Eligible Hospital or Eligible Provider, AHCCCS will promptly return to the County, without demand, that portion of the recoupment representing the Non-Federal Share contributed under this Agreement.

5.2.4 Eligible Hospital and Eligible Providers will receive and retain one hundred percent (100%) of all payments under this Agreement, and except as provided for in this Agreement or as required by federal law or regulatory authority, Eligible Hospital or Eligible Provider is not required to return any portion of any payment made under this Agreement to AHCCCS.

6.0 THE COUNTY'S RIGHTS AND OBLIGATIONS.

6.1 Payment of funds to support SNCP. The County may transfer, in its sole discretion, funds to AHCCCS for the implementation of this Agreement. The total funds the County will transfer to AHCCCS under this Agreement shall not exceed $310,000, which shall be used in furtherance of the provisions of SB 1357 and the SNCP Program and will be funded by local tax revenues.

6.1.1. Timing of Fund Transfers to Support of SNCP. The parties anticipate that funds will be transferred and SNCP distributions will be made quarterly, the first transfer and distributions occurring as soon as practical after federal approval of the Demonstration Project for SNCP, related protocols incorporated by reference in the Demonstration Project, and of the intergovernmental agreements necessary to fund the SNCP Program and the KidsCare expansion. At such time and prior to each quarter thereafter, AHCCCS will provide written notice to the County of the amounts necessary to make SNCP distributions for the quarter as described in this Agreement.

6.1.2. SNCP Distributions. Within fifteen (15) working days after the receipt of the necessary funds from the County, AHCCCS shall make quarterly supplemental payments under the SNCP Program to the Eligible Hospital and Eligible Providers. The maximum annual payment to Eligible Hospital and Eligible Providers shall be determined using the methodology described in the Demonstration Project for the SNCP Program. Total annual payments to Eligible Hospital and Eligible Providers shall not exceed an amount that is equal to the Non-Federal Share designated by the County for such hospital and providers as described in Attachment A plus the FFP associated with the Non-Federal Share.

6.2 Payment of funds to support expanded enrollment in KidsCare. In addition to the amounts set forth in section 6.1. of this Agreement, the County shall transfer such funds as are necessary to support the expansion of enrollment in KidsCare, as follows:

6.2.1. Installment Payments for the Estimated Cost of KidsCare Expansion. Initially, AHCCCS shall establish the amount to be transferred by the County necessary to fund its share of the estimated cost of the first six months of expanded KidsCare enrollment under the Demonstration Project. Thereafter, AHCCCS shall establish similar amounts estimating the cost of expanded KidsCare enrollment on a quarterly basis. The estimated funds shall include AHCCCS' estimate of the costs associated with, but not limited to, any fee-for-service payments (including estimates of the cost of claims Incurred But Not Reported), capitation payments and reinsurance payments to managed care organizations for expanded KidsCare Enrollment, any increase in payments by

AHCCCS to the Arizona Department of Health Services for vaccines for children eligible for KidsCare or to Federally Qualified Health Centers that result from the expansion of KidsCare, and related administrative costs. As part of the process of estimating the cost of expanded KidsCare enrollment for the period covered by each transfer, AHCCCS shall project the total cost of the KidsCare program (including children eligible before and after the expansion) for the same period and multiply that cost by a ratio equal to (1) the projected number of children added during the period due to the expansion by (2) the projected number of children eligible for KidsCare during the period.

6.2.2 Timing of Installment Payments. Following notice from AHCCCS of the initial estimated amount and prior to December 31, 2012, the County shall transfer the estimated amount to AHCCCS. Thereafter, the County shall transfer the estimated amounts at least 30 days prior to the beginning of each quarter.

6.2.3 Payments for Fee-For-Service Claims processed after December 31, 2013. All fee-for-service claims for health care services must be submitted as clean claims within 12 months of the date of service (these claims are sometimes referred to as Incurred But Not Reported claims and/or as the "lag claims"). As such, AHCCCS will receive and process lag claims for children eligible for KidsCare on a fee-for-service basis after expanded eligibility for KidsCare under this Agreement ends on December 31, 2013. Collectively, the County and all other political subdivisions participating in the funding of the SNCP Program shall be responsible for the payment of any difference between that portion of the installment payments that was estimated to be the cost of Incurred But Not Reported Claims and an amount equal to the cost of the lag claims multiplied by a ratio equal to the number of children added due to the expansion by the number of the total number of children eligible for KidsCare during the period.

6.2.4 Payments for Reinsurance Claims. Under the agreements between AHCCCS and managed care entities, AHCCCS may incur obligations to managed care entities to share in the cost of certain KidsCare eligible children (including children added to KidsCare under the Agreement) under the AHCCCS "reinsurance" program. AHCCCS' final payments to managed care entities under the reinsurance program are usually not complete until nineteen (19) months after the end of the contract year. Collectively, the County and all other political subdivisions participating in the funding of the Safety Net Care Pool Program shall be responsible for the payment of any difference between that portion of the installment payments that was estimated to be the cost of the reinsurance program and the actual the cost of reinsurance payments made by AHCCCS to managed care entities for services covered by the reinsurance program to children added to KidsCare under this Agreement.

6.2.5 Payments for Increased costs of Immunizations for KidCare. Under an agreement with the Arizona Department of Health Services ("ADHS"), AHCCCS pays for the cost of vaccines and the administration of vaccines for children enrolled in KidsCare. Collectively, the County and all other political subdivisions participating in the funding of the SNCP Program under this Agreement shall be responsible for the payment of any difference between that portion of the installment payments that was estimated to be the cost of the vaccines for KidsCare eligible children and the proportion of the cost of payments made by AHCCCS to ADHS for vaccines and vaccine administration attributable to children added to KidsCare under this Agreement.

6.2.6. Payment for Reconciliation of FQHC costs. Under the provisions of the Medicaid Act and the Arizona State Plan for Medicaid, AHCCCS is required to reimburse Federally Qualified Health Centers ("FQHC's"), FQHC "look-alikes," and Rural Health Centers ("Centers") at cost for AHCCCS covered services rendered through those Centers. Annually, AHCCCS conducts a reconciliation of the costs reported by these Centers to the total of the actual payments to the

Centers made by AHCCCS and its contracted managed care entities. Collectively, the County and all other political subdivisions participating in the funding of the SNCP Program under this Agreement shall be responsible for the payment of any difference between that portion of the installment payments that was estimated to be the cost of reconciliation payments to such Centers and the proportion of the actual cost of the services provided by the Centers attributable to children added to KidsCare under this Agreement.

6.2.6. Limit to County's Responsibility for Reconciliation Payments. Notwithstanding the above, the County's responsibility for payment of funds to support expanded enrollment in KidsCare, including the reconciliation payments described under Sections 6.2.3 through 6.2.6 shall not exceed 3.0% of the County's Non-Federal Share contribution.

7.0 AHCCCS REPORTING: EXPENDITURE REPORT

AHCCCS will submit to the County a report showing actual distribution of funds to the Eligible Hospital and Eligible Providers under the SNCP Program. The distribution report shall be submitted within fifteen (15) days after the date of distribution of the payments made pursuant to Paragraph 6.1 above.

8.0 GENERAL PROVISIONS.

8.1 Entire Agreement. This document, its attachments and appendices, including any approved subcontracts, amendments and modifications made thereto, shall constitute the entire Agreement between the Parties, and supersedes all other understandings, oral or written.

8.2 Exercise of Rights. Failure to exercise any right, power or privilege under this Agreement will not operate as a waiver thereof, nor will a single or partial exercise thereof preclude any other or further exercise of that or any other right, power, or privilege.

8.3 Contract Term. Notwithstanding the facts that certain AHCCCS or County obligations under this Agreement occur after the Term hereof, the parties agree that the Term of this Agreement is for the period of time from October 3, 2011 through December 31, 2013.

8.4 Compliance with Laws, Rules and Regulations. AHCCCS, the County, Eligible Hospital, and their subcontractors must comply with all applicable Federal and state laws, rules, regulations, standards and Executive Orders, without limitation to those designated within this Agreement. The laws and regulations, of the State of Arizona govern the rights of the Parties, the performance of this Agreement, and any disputes arising from the Agreement. Any action relating to this Agreement must be brought by arbitration to the extent required by A.R.S. § 12-1518 or in an appropriate court. Any arbitration award will be enforced in an appropriate court.

8.5 Non-Discrimination. The parties shall not discriminate against any employee, client or any other individual in any way because of that person's age, race, creed, color, religion, sex, disability or national origin in the course of carrying out their duties pursuant to this IGA. The Parties shall comply with the provisions of Executive Order 755, as amended by Executive Order 994, which is incorporated into this Agreement by reference, as if set forth in full herein.

8.6 ADA. The parties shall comply with all applicable provisions of the Americans with Disabilities Act (Public Law 101336, 42 U.S.C. 1210112213) and all applicable federal regulations under the Act, including 28 CFR Parts 35 and 36.

8.7 Amendments. This Agreement, including its term, may be modified only through

a duly authorized written amendment, executed with the same formality as the Agreement.

8.8 Termination. Pursuant to A.R.S. § 38-511, either party to this Agreement may terminate this Agreement without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Agreement is or becomes at any time while the Agreement or an extension of the Agreement is in effect an employee of or a consultant to any other party to this Agreement with respect to the subject matter of the Agreement. The cancellation will be effective when AHCCCS or the County receives written notice of the cancellation unless the notice specifies a later time.

8.9 Records. The Parties, including Eligible Hospital, agree to retain all financial books, records, and other documents and will contractually require each subcontractor to retain all data and other records relating to the acquisition and performance of the Agreement for a period of five (5) years after the completion of the Agreement. All records are subject to inspection and audit by the Parties at reasonable times. Upon request, the Parties will produce a legible copy of any or all such records.

8.10 Severability. The provisions of this Agreement are severable. If any provision of this Agreement is held by a court to be invalid or unenforceable, the remaining provisions continue to be valid and enforceable to the full extent permitted by law.

8.11 Indemnification. Each party (as Indemnitor) agrees to indemnify, defend and hold harmless the other party (as Indemnitee) from and against any and all claims, losses, liability, costs or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as "claims") arising out of bodily injury of any person (including death) or property damage, but only to the extent that such claims which result in vicarious/derivative liability to the Indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the Indemnitor, its officers, officials, agents, employees, or volunteers.

8.12 No Third Party Beneficiaries. Nothing in the provisions of this Agreement is intended to create duties or obligations to or rights in third parties not parties to or Eligible Hospital under this Agreement or effect the legal liability of either party to the Agreement.

8.13 No Joint Venture. Nothing in this Agreement is intended to create a joint venture between or among the Parties, including the Eligible Hospital, and it will not be so construed. Neither AHCCCS' nor the County's employees will be considered officers, agents or employees of the other or be entitled to receive any employment related fringe benefits from the other.

9.0 COMPLIANCE WITH ADMINISTRATIVE REQUIREMENTS FOR STATE FINANCIAL PARTICIPATION

9.1 County warrants that, consistent with 42 C.F.R. Part 433, Subpart B, no portion of the funds transferred to AHCCCS are derived from (1) provider-related donations other than bona fide provider-related donations or (2) health care-related taxes other than as permitted in 42 C.F.R. Part 433, Subpart B.

9.2 County agrees to provide AHCCCS with supporting documentation that provides a detailed description (including but not limited to the amount, source, and uses) and the legal basis for (1) each provider-related donation received by the County including all bona fide and presumed-to-be bona fide donations, and (2) all health care-related taxes collected. In addition, County agrees to provide AHCCCS, upon request, with supporting documentation that provides a detailed description (including but not limited to the amount, source, and uses) of any funds

transferred under this agreement regardless of whether the funds are derived from provider-related donations or health-care related taxes.

9.3 If County fails to provide supporting documentation, or if any funds transferred by County are determined to be derived from provider-related donations or health care-related taxes such that CMS adjusts future grant awards to AHCCCS or disallows any expenditures claimed by AHCCCS, then County agrees to reimburse AHCCCS, upon demand by AHCCCS, in the amount of the adjustment or disallowance that is attributable to the impermissible provider-related donation and/or health care-related tax, to the extent not already collected or offset from Eligible Hospital and Eligible Providers.

9.4 The County certifies that, consistent with 42 C.F.R. § 433.51(c), the funds transferred to AHCCCS under this Agreement are not federal funds, or are federal funds authorized by federal law to be used to match federal funds. If any funds transferred to AHCCCS under this Agreement are determined to be federal funds such that the Center for Medicare and Medicaid adjusts future grant awards to AHCCCS or disallows any expenditures claimed by AHCCCS, then the County agrees to reimburse AHCCCS, upon demand by AHCCCS, in the amount of the adjustment or disallowance that is attributable to the transfer of federal funds, to the extent not already collected or offset from Eligible Hospital and Eligible Providers.

9.5 The County certifies that the funds transferred to AHCCCS as described in this Agreement are made voluntarily and that neither the State nor AHCCCS has through statute, rule, or otherwise required the County to provide the funding.

NOW THEREFORE, AHCCCS and the County agree to abide by the terms and conditions set forth in this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date and year specified below.

COUNTY OF COCHISE
("COUNTY")

BY: Mike Ortega, Administrator Date

ATTEST:

Clerk of the Board Date

ARIZONA HEALTH CARE COST
CONTAINMENT SYSTEM ("AHCCCS")

BY: Michael Veit, Contracts Administrator Date

In accordance with A.R.S. § 11-952, undersigned counsel have determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of the State of Arizona, including but not limited to A.R.S. §§ 36-2903 et seq and A.R.S. §§ 48-5501 et seq .

Counsel for County of Cochise Date

Counsel for AHCCCS Date