

FREQUENTLY ASKED QUESTIONS



Understanding AHCCCS and Proposition 204

Q. What is AHCCCS? How is it different from other state Medicaid Programs?

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's version of Medicaid. It was the final Medicaid program to be enacted in the United States, and was, therefore, able to build upon the lessons learned in other states in order to develop some of the best practices in the country. Prior to the creation of AHCCCS, indigent medical care was the responsibility of the counties, which appealed to the Legislature to have the state take over the program in a more cost-efficient and coherent manner. AHCCCS is a managed care model of Medicaid which is designed to improve quality and reduce costs for taxpayers. Competition and choice are guiding principles for the program. Private health plans engage in a competitive bidding process to manage the care of AHCCCS enrollees. Among the program's notable accomplishments are that it has among the lowest costs per enrollee in the country, the lowest cost prescription drug program in the country, an eligibility error rate of 1.1% versus the national average of 6.7%, and a very high percentage of long-term care patients receiving home or community based services rather than becoming a patient in a nursing facility. AHCCCS marked its 30th anniversary in 2012 and currently covers 1.26 million Arizonans.

Q. What populations are covered under AHCCCS?

Medicaid was created in 1965 when Congress added Title 19 to the Social Security Act with the purpose of helping states provide health insurance coverage for low income individuals who meet certain requirements, such as the aged, blind and disabled. The federal government sets minimum coverage standards for each category of beneficiary. Arizona has chosen to provide a higher level of coverage for certain populations in order to reduce the number of uninsured. In order to receive federal funds for expanded populations, Arizona has been granted a waiver by the Centers for Medicaid and Medicare Services (CMS). Eligibility for each population is based on income as a percentage of the federal poverty level (FPL). Currently, for a single person the FPL is \$11,170. For a family of four it is \$23,050.

AHCCCS also provides long-term care under Arizona Long Term Care System (ALTCS) as well as behavioral and mental health care services which are delivered through the Department of Health Services to patients who suffer from mental illnesses.

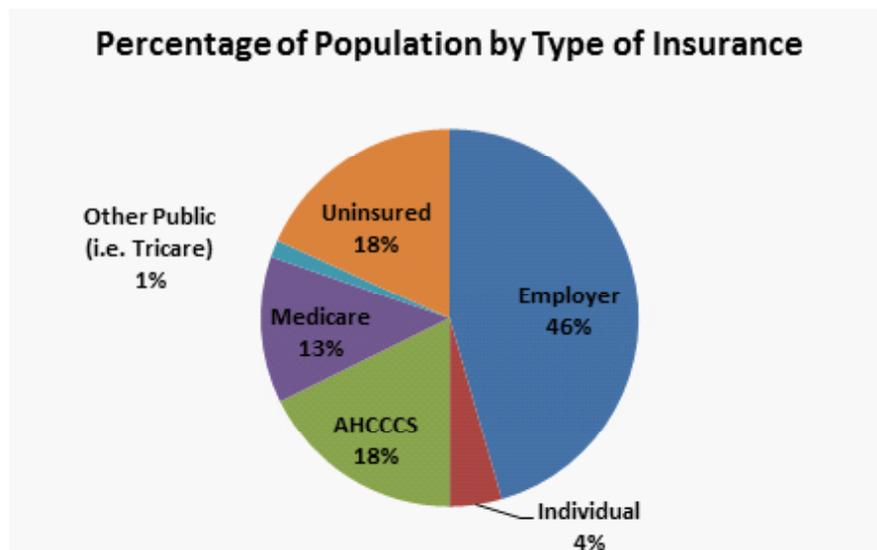
The chart below shows the traditional minimum eligibility levels that were in place prior to the passage of the Patient Protection and Affordable Care Act (PPACA, Obamacare). The PPACA raises the federal minimum to 133% FPL for childless adults and parents. However, the U.S. Supreme Court found that the federal government could not require states to accept the new, higher eligibility levels. Increasing eligibility is now voluntary for states, but doing so results in substantially increased federal funds.

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CHART 1: Current Eligibility Levels, Prior to Implementation of PPACA

Population	Federal Minimum Eligibility (percent of FPL)	Arizona Eligibility (percent of FPL)
Babies Ages 0-1	133%	140%
Children Ages 1-5	133%	133%
Children Ages 6-19	100%	100%
Parents	25%	100%
KidsCare - Children Ages 0-19 <i>Population frozen, but partially restored under KidsCare II, with eligibility up to 175% FLP</i>	N/A	100-200%
Pregnant Women	133%	150%
Elderly, Blind, and Disabled	75%	100%
Childless Adults (Proposition 204 AHCCCS Expansion) <i>Population currently frozen since 2011</i>	0%	100%
Long-Term Care (ALTCS)	Combination of assets and income	Combination of assets and income

Q. What percentage of Arizona’s population is uninsured, on AHCCCS, on other public programs and on private insurance?



Source: Kaiser Family Foundation, State Health Facts, 2011

Q. What is Proposition 204?

Proposition 204 is a voter-approved initiative that expanded AHCCCS coverage to persons (effectively childless adults) with income at or below 100% FPL. Prior to the implementation of Proposition 204, AHCCCS covered childless

adults up to 33% FPL under the Medically Needy, Medically Indigent program. Childless adults however were not categorically eligible for Medicaid, so this population was entirely funded by the state until CMS approved Arizona's waiver to implement Proposition 204.

Voters *twice* approved of extending AHCCCS coverage to childless adults with incomes at or below 100% FPL. In 1996, voters passed Proposition 203, Healthy Arizona I with 72% of the vote. While this initiative expanded eligibility up to 100% FPL, it was never funded. A funding source became available in 1998 when Arizona joined 46 other states in signing the Master Settlement Agreement with tobacco manufacturers that provided Arizona with \$3.2 billion over the first 25 years of the agreement. In 2000, the voters again approved coverage expansion up to 100% FPL by nearly 63% of the vote, funded by tobacco settlement funds and supplemented as necessary by other available sources. In 2002, the Legislature referred a ballot measure to the voters for approval of an additional revenue source to support Proposition 204. Voters approved Proposition 303, a 60 cents per pack cigarette tax to help with the state's share of funding the AHCCCS expansion under Proposition 204. The state's General Fund has covered the remaining outlays relating to the coverage expansion until 2011, when the Legislature froze the population.

Q. What was the basis and outcome of the lawsuit related to funding of Proposition 204?

In 2011, the Legislature faced a daunting budget deficit. As a cost cutting measure, the Legislature passed and the governor signed a budget that froze enrollment in AHCCCS for the Proposition 204 population. To date, enrollment has dropped from 227,000 to 86,000, meaning 141,000 people have lost coverage and become uninsured. Subsequently, a group of plaintiffs filed a lawsuit, *Anthony Fogliano et al vs. State of Arizona et al*. This lawsuit claimed that the State had violated Proposition 105, the Voter Protection Act, by not providing sufficient funding to AHCCCS for the Proposition 204 population. The Maricopa County Superior Court found that freezing the Proposition 204 population is clearly in conflict with the Voter Protection Act. The Court further determined that it did not have the authority to compel the Legislature to fund specific programs. The Court found that the phrase "all other available sources," is not an appropriation, and therefore it is up to the Legislature's discretion as to the "availability" of funding. For this reason, the freeze was allowed to stay in place.

Q. What is FMAP?

FMAP stands for Federal Medical Assistance Percentage and refers to the portion of Medicaid costs borne by the federal government. For every dollar the state contributes to AHCCCS, the federal government contributes two or more dollars. The U.S. Department of Health and Human Services sets the percentage for each state within a range. In Arizona the traditional FMAP has ranged from 65% to 67% for the Proposition 204 population. It is higher for other AHCCCS programs such as the Children's Health Insurance Program (CHIP), known as KidsCare in Arizona.

The Patient Protection and Affordable Care Act provides for an enhanced FMAP for newly eligible Medicaid enrollees. This enhancement applies to eligible individuals with incomes above each state's current level up to 133% FPL. As one of only six states to expand eligibility up to 100% FPL prior to the passage of the PPACA, Arizona would be eligible for the full FMAP of 100% starting in 2014 and phasing down to 90% in 2020 for childless adults earning between 100% of 133% FPL. If Arizona chooses full expansion to 133% FPL, childless adults earning between 0% and 100% FPL would receive an enhanced FMAP starting at 83% and growing to 90%.

The Office of Governor Jan Brewer estimates the cost for full expansion to 133% FPL to be:

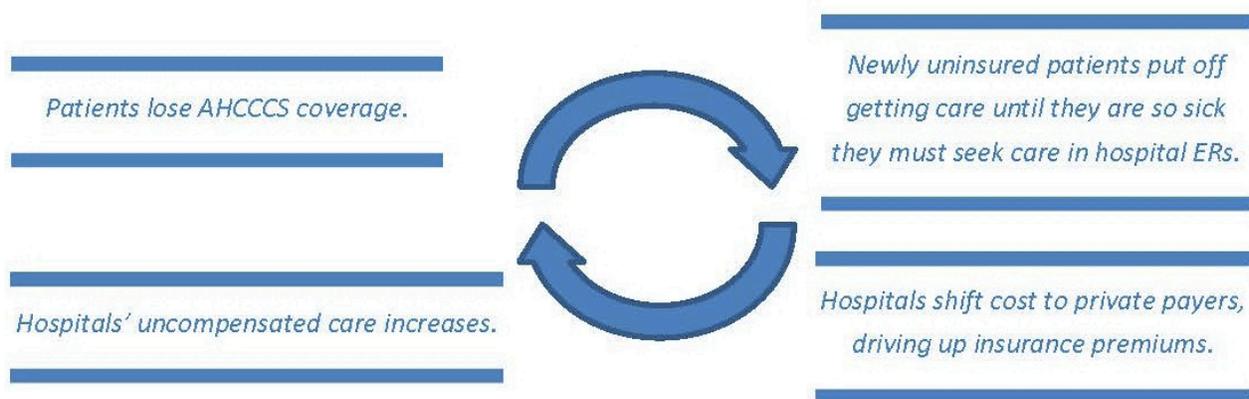
- \$27 million in FY 2014 drawing down an additional \$337 million in federal funds
- \$154 million in FY 2015 (first full year of implementation) drawing down an additional \$1.556 billion in federal funds

- \$105 million in FY 2016, drawing down an additional \$1.712 billion in federal funds

If Arizona does not expand to 133% FPL but rather only restores coverage up to 100% FPL (Prop. 204 Population), then the cost is estimated at \$435 million in the first full year of restoration, FY 2015. The state would further have to seek approval from CMS in order to continue receiving the standard FMAP of 67%. If CMS does not grant approval of this request, Arizona could lose all federal funds for this population because the state's waiver for the entire program expires at the end of 2013.

Refer to Chart 1 for a complete list of eligibility levels by category.

Q. What is the Cost Shift?



Federal law (EMTALA) requires hospitals to treat all patients who present themselves to an Emergency Department regardless of their ability to pay. When patients are unable to pay for services they receive, their care is considered to be “uncompensated” care. Hospitals seek to recover a portion of their uncompensated care by shifting these losses to private insurance. This means employers and their employees pay more for health insurance. This is called the “cost shift”. In Arizona, families now pay an additional \$2,000 per year in premium cost due to the shift of uncompensated care. The cost shift is expected to grow, likely causing health insurance premiums to rise further. Hospital uncompensated care rose 81% during the last two quarters of available data relative to the two quarters prior to the Proposition 204 freeze. It is estimated that hospitals in the City of Phoenix alone will have \$540 million in uncompensated care in fiscal year 2013.

Understanding the Role of a Provider Assessment in Helping to Fund the AHCCCS Expansion

Q. What is a provider assessment?

As described above, the costs of the AHCCCS program are split between the state and federal government. Federal law permits states to collect revenues from specified categories of health care providers or services (for example, hospital services, nursing facility services, home health services, services of managed care organizations) and use those revenues to pay a portion of the state's share of the Medicaid program. As with any allowable source of state funding for Medicaid expenditures, the federal government would then provide matching funds on the assessment revenues.

Q. How has the Governor proposed to use a provider assessment to help the state fund the expansion of AHCCCS coverage for low income adults?

To help with the state outlays relating to the expansion of Medicaid, Governor Brewer has proposed a statewide provider assessment on hospitals. The Governor has cited a need to balance the use of the General Fund to fund health care coverage for uninsured Arizonans with other needs, such as adequately funding education and public safety. Therefore, rather than funding the state cost of the expansion with existing state General Funds, the state would use an assessment on hospitals to raise additional revenues for this purpose. Under the Governor's proposal, not only would the assessment cover the expansion of AHCCCS up to 133% FPL, but rather it would cover the entire unfunded Proposition 204 population, which had been funded by the General Fund prior to the 2011 freeze.

In the first full year of implementation alone, the provider assessment would draw down nearly \$1.6 billion in federal matching dollars for the Medicaid expansion.

Q. Has Arizona used provider assessments to help fund the AHCCCS program before?

Yes. In 2003, the Arizona State Legislature adopted a 2% provider assessment on the AHCCCS health plans and, in 2012, lawmakers approved a provider assessment on skilled nursing facilities. As a short-term measure for 2013, the City of Phoenix recently adopted an "Access to Care" ordinance, which imposes a provider assessment for hospitals in the City of Phoenix. This assessment provides a source of funding for local matching dollars needed to draw down available federal dollars in the absence of a statewide provider assessment. It is estimated that this measure will result in reducing the uncompensated care burden for Phoenix hospitals for 2013 by approximately \$200 Million.

Q. Do other states use provider assessments to help fund the state's share of the Medicaid program?

Yes. According to the National Conference of State Legislatures, as of fiscal year 2013, the number of states with some form of Medicaid-related assessment has increased to 49 states and the District of Columbia. (Alaska is the only state without some form of assessment.)

Q. Will the costs of the assessment be passed on to patients of the hospital?

No. The assessment cannot be passed along to patients or third-party payers, such as insurance companies. In the case of the City of Phoenix Ordinance, hospitals are expressly prohibited from passing along the assessment. A similar approach could be used for a statewide assessment. The purpose of the assessment is to allow the state to afford to expand coverage to uninsured individuals, which will reduce the cost shifting that is happening today. Expanded coverage will help offset the significant increase in hospital uncompensated care and reduce the need for hospitals to shift those unpaid costs to private businesses and the self-insured.

Q. Have there been concerns about state uses of provider assessments in the past?

When states were first permitted to use provider assessments to fund their Medicaid programs, some states misused the opportunity, designing assessment and associated Medicaid reimbursements so that the assessment payments were returned to the providers that paid them. In 1991, Congress responded by prohibiting such practices and created strict rules that provider assessments must meet to receive federal approval.

Specifically, an assessment must be broad-based (i.e., imposed on all providers in a given category, subject to specific exceptions that must meet strict tests) uniformly imposed, and cannot hold a provider harmless (i.e., the state cannot

provide a guarantee to the providers that the assessments will be repaid to them). Additionally, assessments are limited to a maximum rate of 6%.

Q. How can the City exempt certain hospitals from the assessment and still comply with federal requirements that a Medicaid provider assessment be “broad-based” and “uniform”?

Federal Medicaid rules require that an assessment that will be used to finance Medicaid payments be broad-based, meaning that it is imposed on all providers in a given category. However, the same federal regulations explicitly permit a state, or in this case, the City, to seek a waiver of the broad-based requirement. The Phoenix assessment exempts certain categories of hospitals due to their special nature and unique patient populations. This is permissible under federal Medicaid rules as long as the Phoenix assessment can meet a statistical test. The test must show that, for assessments like Phoenix’s that will be funding the Medicaid program, the assessment with the exemptions does not put a higher burden on Medicaid revenues than the assessment would have without the exemptions. The Phoenix assessment meets this test.

Federal Medicaid rules also require that all of the hospitals subject to an assessment be assessed on a uniform basis. The Phoenix assessment meets this requirement because the City will assess all of the participating hospitals the same percentage of their revenues.