



County Supervisors
A S S O C I A T I O N
o f a r i z o n a

AHCCCS Overview

A Brief History and Outline of County Nexus to
the State Run Medicaid Program

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16

AHCCCS Overview

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Arizona Health Care Cost Containment System

History of the Arizona Health Care Cost Containment System

Overview

Established in 1982, the Arizona Health Care Cost Containment System (AHCCCS) serves as Arizona's Medicaid program. As of July 1, 2015, AHCCCS provided healthcare coverage for 1,746,175 members, almost 26 percent of Arizona's total population (**Figure 1**).^{1,2,3} The program is a prepaid capitation system in which contractors administer patient care at a pre-determined rate set by the state. State, county and federal funds are used to pay for costs associated with maintaining the program.⁴

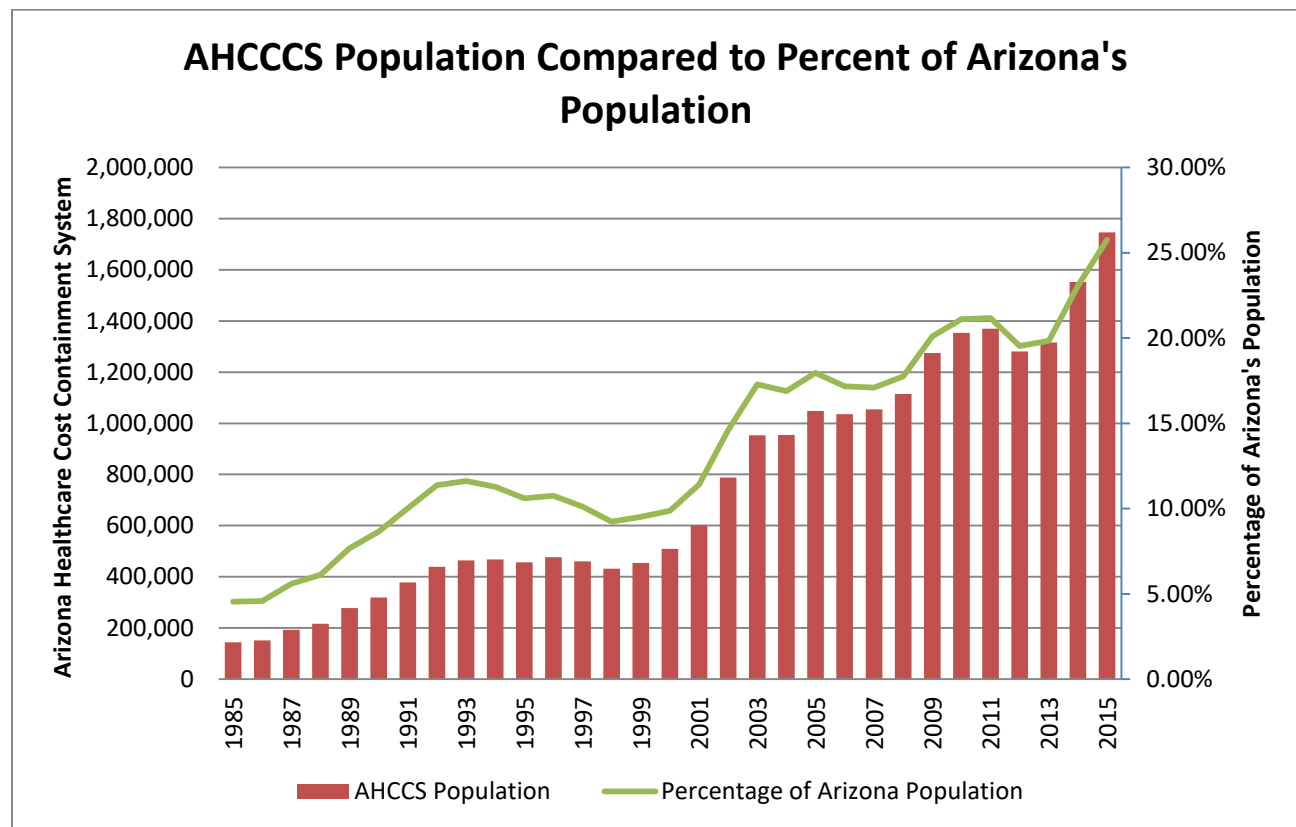


Figure 1

¹ Arizona Healthcare Cost Containment System: Population Statistics (1985-2014)

² Arizona Population estimates: U.S. Census Bureau, Population Division Inter-decennial Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico

³ 2015 Arizona Population estimate: Arizona Department of Administration, Office of Employment & Population Statistics 12/7/2012

⁴ 42 U.S.C. § 1396b(a), 1396d(b): Enacted by the Social Security Amendments of 1965, ["an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency;"] <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXIX-sec1396d.pdf>

Healthcare Pre-1982

Counties have had a long history of providing health care to indigent or dependent poor. Preceding Arizona becoming a state, the Arizona Territorial Revised Statutes of 1901 required counties to erect offices and maintain hospitals to provide care.⁵ Some of the services counties provided were medical care, medicine, food and lodging. The programs remained largely unchanged preceding the enactment of AHCCCS.

Medical assistance legislation was a core issue for President John F. Kennedy upon his election in 1960, increasing the national discussion around healthcare. In his State of the Union Message in 1963, Kennedy called on the Congress to enact a health insurance program under the Social Security Act. Though the session ended without a substantive resolution, the Eighty-ninth Congress convened in 1965 with the intent of considering the legislation.⁶ Shortly thereafter, President Lyndon Johnson signed into law the Social Security Amendments of 1965, which in turn enacted the federal Medicaid program. By 1972, 49 states had joined the Medicaid system while Arizona continued to serve the indigent through a system of county-run health care programs that had remained largely unchanged since territorial days. These county-run programs held the counties financially responsible for indigent care and due to Arizona's lack of a Medicaid system, made federal funds unavailable. Though a Medicaid program had been authorized by the Arizona State Legislature in 1974, continued delays in implementation and a lack of funding led to the authorization being repealed in 1977.

Cochise County v. Dandoy

In 1977, the Arizona Department of Health Services (DHS) attempted to force implementation of Medicaid by ordering the counties to budget and levy funds to finance the program. DHS directed each of the, then fourteen,⁷ county boards of supervisors to include in their annual budget, and levy taxes for, their share of the Medicaid program.

In response, the counties brought a special action suit against DHS, *Cochise County v. Dandoy*.⁸ Counties argued that the Medicaid program could not be implemented without legislative appropriations, citing Laws 1976, Ch. 132 § 4,⁹ and, therefore, counties should not be mandated to levy taxes regarding Medicaid.

DHS argued that county interpretation of section 4 was too broad and viewed section 4 as "a minor fiscal measure prohibiting the expenditure of state funds for staff until funds are appropriated".¹⁰

⁵ Revised Statutes of Arizona Territory 1901

⁶ Wilbur J. Cohen and Robert M. Ball, *Social Security Amendments of 1965: Summary and Legislative History* [After President Kennedy's assassination in 1963, Vice-President Lyndon Johnson assumed Presidential duties.]

⁷ Yuma County held jurisdiction of what is today La Paz County until 1984

⁸ Apache County was originally listed as a petitioner in the lawsuit, however Apache County chose to join Pima County in a respondent role between DHS and the remaining 12 counties

⁹ Laws 1976, Ch. 132 § 4: ["The hiring of staff necessary to provide medical assistance services as authorized by title 36, chapter 21, article 1, Arizona Revised Statutes, shall begin July 1, 1977 and shall be subject to legislative appropriation."]

¹⁰ *Cochise County v. Dandoy*, 116 Ariz. 53 (Ariz. 1977)

The Arizona Supreme Court ruled that the forced implementation would not come into effect until legislation was passed to properly appropriate money for the program. In his opinion, Justice Hays stated “[T]here can be little doubt that unless the legislature provides the necessary funds, a program cannot function, and for the legislature to fail to provide the funds is not a use of the appropriations function for legislative purposes”.¹¹

Rising Costs

By 1981, political differences within state government led to a rift between the state legislature and the Governor’s office. Following continued attempts to initiate a Medicaid program from the Executive Tower, counties began introducing alternative indigent health care plans to mitigate the soaring costs, which had risen from \$58.6 million in 1975 to \$122.6 million in 1980, a 110 percent increase in five years. Originally, Governor Bruce Babbitt vetoed legislation creating and funding an Arizona Medicaid program due to disagreements with the legislature over the consideration of the Veteran and Native American populations. The legislature argued that the Indian Health Services (IHS) and Veterans’ Administration (VA) clinics provided adequate care for those populations.¹² Fiscal pressures were beginning to take a toll on county budgets, and projections at the time expected counties to pay upwards of \$250 million (roughly \$550 million in 2014 dollars) for indigent care by 1985.¹³ In November of 1981, Governor Babbitt called on the legislature to convene for a special session to initiate a compromise package.

Arizona Health Care Cost Containment System

On November 18, 1981, during the 35th Legislature’s 4th Special Session, S.B. 1001 was signed into law, creating and funding the Arizona Health Care Cost Containment System (AHCCCS) within DHS. After numerous negotiated waivers with the U.S. Department of Health and Human Services (HHS), including the exclusion of home and Long-term Care (LTC) services, and limiting psychiatric care, which counties would continue to provide, AHCCCS officially began operations on October 1, 1982, to administer prepaid capitated care.

County Liabilities

Following the creation of AHCCCS, counties were required to contribute to the funding of the program; provide and allocate costs for eligibility workers to ensure the patient qualified for the AHCCCS program; and be financially liable for the first 48 hours of treatment (48 hour retro) for an AHCCCS-eligible patient.

Until 2001, determining whether an uninsured patient was eligible for AHCCCS was considered a county responsibility. Eligibility workers were county employees, paid for by the counties, tasked with the enrollment and application process of the indigent. Upon determination by the

¹¹ *Cochise County v. Dandoy*, Op: Justice Hays

¹² Kunasek, Carl, Former Senator, Arizona State Senate. Interview January 17, 2008

¹³ County Supervisors Association: AHCCCS Overview (2004)

county that the applicant was eligible for AHCCCS, the county would issue a certification and provide the application to the AHCCCS administrator. This function shifted from the counties to the state with the approval of Proposition 204 in 2000 (*Please see Proposition 204 for more information*).

AHCCCS and Medicaid

AHCCCS operates under the 1115 Research and Demonstration waiver granted by HHS giving states the flexibility to design and improve their own programs.¹⁴ With this waiver in place, the state can operate a statewide, managed care system requiring all patients to enroll in a contracted Health Plan.

Since its inception, AHCCCS and a “traditional Medicaid program” have held striking differences. For example, in a “traditional Medicaid program,” a patient chooses a doctor or health care provider, with the provider receiving fees for the services. With AHCCCS, members are enrolled into a health care program contracted by the agency, and are then assigned a physician within the program who provides the member with general health services. AHCCCS then pays the provider regardless of whether services were provided, or at what level they were provided.

At its core, AHCCCS consists of a network of contracts between healthcare providers. Based on a prepaid capitation mechanism, a contractor receives a pre-determined amount from the state based on the number of patients enrolled under the provider’s supervision. Ultimately, it is the provider’s job to manage the member’s care within those financial constraints.

A primary care physician acts as the “gatekeeper” physician within each plan. The “gatekeeper’s” primary objective is to assure a high quality of care and contain costs by reducing unnecessary services and encouraging preventive care, which is less expensive over time.

By 1984, AHCCCS was removed from DHS and established as its own independent agency, responsible for ensuring that their programs comply with federal and state law. Additionally, the agency is tasked with awarding contracts, enrolling members and regulating healthcare policy within the state.

While the legislation establishing AHCCCS proved difficult to craft, experts regarded the program as a “model of innovative public policy”.¹⁵ A 1989 report by Stanford Research International indicated that in the first five years of existence, AHCCCS program costs were 6 percent less than traditional Medicaid, while still providing a higher quality of health care for children and better access for routine care.¹⁶ Similarly, a study by the Flinn Foundation of

¹⁴ Medicate.gov, section 1115 Demonstrations

¹⁵ Hall, J. S., & Hollinshead, M. S. (2000). Connecting public policy and management: The Arizona Health Care Cost Containment System experiment. Albany, NY: Nelson A. Rockefeller Institute of Government.

¹⁶ Evaluation of the Arizona Healthcare Cost Containment System: Final Report. (1989). Washington, DC: Government Printing Office.

Arizona in 1995 found high-satisfaction rates and an increase in private-sector physician and hospital usage.¹⁷

Master Settlement Agreement¹⁸

In November of 1998, a Master Settlement Agreement (MSA) was reached between cigarette manufacturers and 46 states, including Arizona, the District of Columbia and six territories to recover the health care costs to treat illnesses resulting from use of tobacco products by residents. The MSA requires the four largest cigarette manufactures known as Original Participating Manufacturers (OPMs) and Subsequent Participating Manufactures (SPMs) participating in the MSA to make significant payments to states in perpetuity and places restrictions on marketing and advertising of cigarettes. Since signing the MSA on November 23, 1998, through FY 2015, Arizona has received more than \$1.69 billion in settlement payments.

Funds received from the MSA are deposited into the Tobacco Litigation Settlement Fund and allocated to a variety of sources based on the current fiscal year's budget pursuant to Arizona Law.¹⁹ The director of AHCCCS is required to use the monies to fund expanded eligibility and programs established by Prop. 204 (*please see Proposition 204 section for more information*). Any funds remaining may be appropriated by the legislature to programs that benefit the health of Arizona residents.

The MSA requires states to implement the model statutes provision and requires states to ensure Non-participating Manufacturers (NPM) of tobacco make deposits into an escrow account based on total cigarettes sold. Laws 2000, Chapter 83 § 1 enacted requirements outlined in the model statutes by establishing an NPM escrow account, directing the Arizona Department of Revenue (ADOR) to regulate the enforcement of tobacco excise taxes and creating penalties for noncompliance with the MSA.

To aid in the enforcement of the model statutes, state law was further amended to outline certification requirements for NPMs and to direct the state Attorney General (AG) to establish regulations to implement the statute.²⁰ The AG's office maintains a directory of all tobacco manufactures that are certified and in compliance with statute. The AG's office also established the Tobacco Enforcement Unit created to ensure the state receives the annual payments. Fund allocation has varied based on the litigation requirements associated with the MSA.

ADOR receives funds to enforce luxury tax and audits for the state to comply with the model statutes provision within the MSA requiring states to ensure NPMs make deposits. Without proper enforcement, states can have a portion of their MSA payment reduced based on the loss

¹⁷ Henry J. Kaiser Family Foundation and the Flinn Foundation of Arizona: Intergovernmental Health Policy Project: Applying the Lessons of Arizona's Medicaid Managed Care Program, AHCCCS (1995)

¹⁸ State of Arizona, Joint Legislative Budget Committee. (2015). Master Settlement Agreement - JLBC Staff Program Summary. Phoenix, AZ: Joint Legislative Budget Committee.

¹⁹ A.R.S. § 36-2901.02: <http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/36/02901-02.htm&Title=36&DocType=ARS>

²⁰ A.R.S. § 44-7111: <http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/44/07111.htm&Title=44&DocType=ARS>

of market share by the OPMs and SPMs for the previous year's sales. In April 2006, the state was entitled to a \$97 million payment, but only received \$86.3 million due to the market share lost in 2003. Arizona, along with other states, sued arguing the model statutes were enforced. A settlement was reached for the withheld NPM payments made from 2003-2014. Settling states split the monies withheld for NPM adjustments, and Arizona received a onetime settlement of \$48 million in FY 2013.

Arizona took a lead role in the MSA negotiations and was awarded additional payment as compensation. The Strategic Contribution Payments began in FY 2008 and will continue through FY 2017. The Strategic Contribution Payments have helped maintain the total annual payments; however, overall MSA payments have been gradually declining (**Figure 2**). This could place an additional burden on the state and counties to make up for the decline in payments once the Strategic Contribution Payments end.

Tobacco Payments Received²¹			
Fiscal Year	MSA Payment	Strategic Contribution Payment	Total Payments Received
FY 1999 - FY 2001	\$207,966,000		\$207,966,000
FY 2002	\$111,955,069		\$111,955,069
FY 2003	\$106,926,757		\$106,926,757
FY 2004	\$92,648,165		\$92,648,165
FY 2005	\$93,933,400		\$93,933,400
FY 2006	\$86,301,152		\$86,301,152
FY 2007	\$92,004,100		\$92,004,100
FY 2008	\$91,342,555	\$24,244,269	\$115,586,824
FY 2009	\$100,728,675	\$24,842,186	\$125,570,861
FY 2010	\$83,826,497	\$21,567,586	\$105,394,083
FY 2011	\$79,474,407	\$19,655,567	\$99,129,974
FY 2012	\$78,489,981	\$22,577,432	\$101,067,413
FY 2013*	\$122,925,501	\$26,199,893	\$149,125,394
FY 2014	\$79,872,741	\$20,598,428	\$100,471,169
FY 2015	\$79,293,353	\$20,681,785	\$99,975,138
Total	\$1,507,688,353	\$180,367,146	\$1,688,055,499
*FY 2013 MSA payment includes a one-time payment of \$48,090,600			

Figure 2

²¹ State of Arizona, Joint Legislative Budget Committee. (2015). Master Settlement Agreement - JLBC Staff Program Summary. Phoenix, AZ: Joint Legislative Budget Committee

Proposition 204

Voters approved an expansion of AHCCCS eligibility for childless adults with incomes up to 100 percent of the Federal Poverty Level (FPL) in 1996 through Proposition 203 with 72 percent of the vote but a funding source was not identified and it was never fully implemented.²²

In the general election of 2000, Proposition 204 (Prop. 204) passed with 63 percent of the vote, expanding the definition of an eligible person for AHCCCS to include individuals with income levels of up to 100 percent of the FPL guidelines.²³ Prior to implementation of Prop. 204, childless adults were covered by AHCCCS with incomes up to 33 percent FPL.²³

Prop. 204 allocated monies received from the MSA to fund the expansion. By 2025, the state is expected to have received \$3.2 billion in total tobacco settlement revenues. In short, Prop. 204 controls the future uses of tobacco settlement monies the state receives. The State Constitution restricts the legislature's ability to enact laws that use tobacco settlement monies for purposes other than those designated in Prop. 204.²⁴

After the implementation of Prop. 204, two new county payments were created: the Budget Neutrality Compliance Fund (BNCF) and the Disproportionate Uncompensated Care (DUC) Pool. The BNCF helps compensate the state for the taking over all the administrative functions for AHCCCS. After Prop. 204, the counties were no longer responsible for the first 48 hours of care or determining the eligibility of program participants. The DUC pool was set up as a means to compensate private hospitals based on uncompensated hospital emergency room care; however, the DUC pool was never implemented and the county contributions have been used to off set the state general fund share. In return, for the removal of administrative functions, counties relinquished any and all claims to the tobacco settlement monies.

In 2005, S.B. 1515 contained provisions that eliminated Maricopa County's DUC and BNCF payments, decreasing their Acute Care payments in exchange for the county taking over Adult Probation operations, as part of budget agreements (*please see County Payments for more information*).

²² Arizona Chamber Foundation, Frequently Asked Questions Understanding AHCCCS and Proposition 204, www.azchamberfoundation.org

²³ [A.R.S. § 36-2901.01](#) (as amended by Prop. 204)

²⁴ Ariz. Const. art. IV, pt. 1, §1(6), (14) (amendments from Proposition 105, approved by voters in 1998)

Expansion of Medicaid & AHCCCS Eligibility

Responding to budget shortfalls due to the economic recession, Arizona lawmakers froze enrollment of childless adults into the Prop. 204 program, effective July 1, 2011. This resulted in an enrollment drop of 141,000 people in 18 months.

After the passage of the federal Affordable Care Act (ACA), Governor Jan Brewer pushed to expand eligibility for AHCCCS through the FY 2014 Health and Welfare Budget Reconciliation Bill (Laws 2013, 1st Special Session, Chapter 10) to take advantage of the enhanced federal matching funds for expanded populations.

Child Expansion

Prior to the FY 2014 expansion, Arizona provided coverage for children up to 200 percent of the FPL through “KidsCare,” the state’s Children’s Health Insurance Program (CHIP). With the implementation of the FY 2014 expansion, children between the ages of 1 and 18 are covered up to 133 percent of the FPL through the traditional Medicaid program, while infants are covered up to 140 percent of the FPL.

Childless Adult Restoration

The expansion restored coverage for the childless adult population which had been frozen in July 2011 as a response to the budget crisis. Childless adults with incomes up to 100 percent of the FPL were eligible to re-enroll starting in January 2014, restoring Prop. 204 Medicaid eligibility. The program has grown to 280,700 as of April 1, 2015 with a current match rate of 89.05 percent in FY 2016. The match rate is expected to reach 90 percent in 2020.

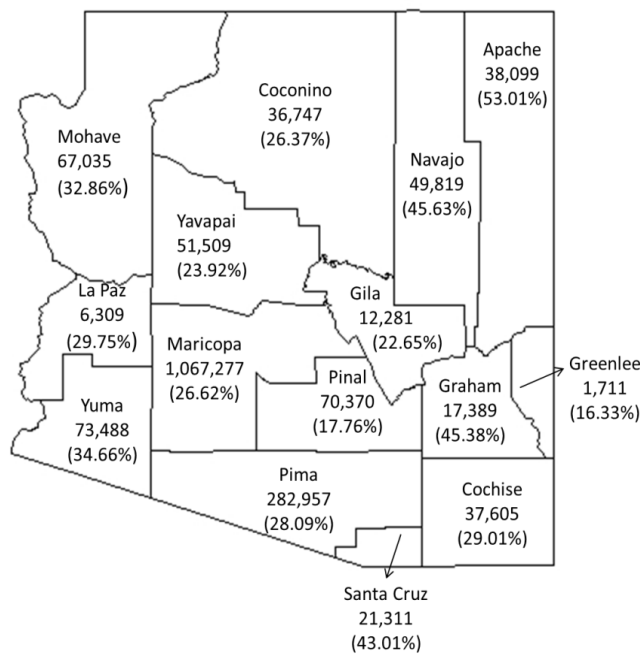
Adult Expansion

The expansion increased Medicaid eligibility for all adults between 100 and 133 percent of the FPL effective January 1, 2014. Currently the federal government match is 100 percent, but will decline to 90 percent by 2020. The Hospital Assessment Fund, created by the expansion, established an assessment on hospital revenue, discharges or bed days to fund the state portion of the program covering the adult Medicaid and Prop. 204 populations after January 1, 2014. There are some circuit breakers in place for this population, including eliminating coverage if the federal match rate falls below 80 percent, the hospital assessment is unable to pay for newly eligible populations, or the ACA is repealed.

Currently Eligible But Not Enrolled

ACA required all individuals to purchase health care or pay a fine after January 1, 2014 with some exceptions. Individuals with incomes up to 400 percent of the FPL are eligible for discounts and subsidies available within the health insurance exchanges.

AHCCCS enrollment by county is listed in **(Figure 6)**²⁵ and as of November 2015, 1,833,907 individuals are enrolled, roughly 27 percent of the population. The total AHCCCS population has seen about a 28.23 percent growth rate since September 2013, rising from 1,316,206 members to 1,833,907 as of November 2015.



²⁵ Population Statistics, Arizona Department of Administration, July 1, 2014, AHCCCS Population by County, 2015 Population estimate: Arizona Department of Administration, Office of Employment & Population Statistics 12/7/2012

Long-term Care

History of Arizona Long-term Care

The exclusion of Long-term Care (LTC) from the original AHCCCS program provided further financial trouble for the counties. As counties continued to cover 100 percent of the cost burden, LTC costs grew from \$35 million in 1980 to \$59 million in 1985, a 69 percent increase in five years.²⁶ In 1987, the County Supervisors Association (CSA) supported LTC reform, and in turn, Governor Evan Mecham signed S.B. 1418, establishing the Arizona Long-term Care System (ALTCS), allowing the state to draw down federal Medicaid funds and to participate in the federal LTC program.

ALTCS Program

Today, the ALTCS program is funded through a combination of five funding sources: Federal Medicaid, State General Funds, County Funds, Nursing Facility Assessment, Federal Prescription Drug Rebate (PDRF), and State PDRF.

ALTCS provides LTC for individuals who are financially needy and at risk of institutionalization. AHCCCS administers ALTCS to the elderly and physically disabled (EDP) and the Arizona Department of Economic Security administers ALTCS for the Developmentally Disabled population.²⁷

Individuals may receive nursing home and community-based care by meeting certain income, savings and medical criteria. To qualify for the program, the individual must earn no more than 300 percent of the Federal Benefit Rate (FBR) equating to an individual monthly income of less than \$2,199 with no more than \$2,000 in assets.²⁸ AHCCCS looks at any assets sold over a five-year period to ensure assets are not sold to family or friends below fair market value. If the findings show that assets were sold below fair market value, it will cause a delay in eligibility.²⁹

In addition, the person must be evaluated by a nurse and be determined an immediate risk of institutionalization in a nursing facility. This medical evaluation is conducted using a pre-admission screening tool developed by the state.²⁹ The purpose of the evaluation is to examine each applicant's ability to independently carry out activities of daily living.

ALTCS is the largest financial contribution made by counties of all AHCCCS programs increasing an average of 3.3 percent annually. However, because the 2.9 percent average annual

²⁶ County Supervisors Association of Arizona: ALTCS and Mandated County Contributions (2005)

²⁷ JLBC Staff Program Summary: Arizona Long Term Care System (July 16, 2015)

²⁸ AHCCCS Eligibility Requirements, Revised Eff. February 1, 2015;

<https://www.azahcccs.gov/community/Downloads/resources/EligibilityRequirements.pdf>

²⁹ The William E. Morris Institute for Justice: Health Mental Care(pg.12)

enrollment growth in ALTCS is a slower growth rate than other AHCCCS populations, the share of AHCCCS funding spent on ALTCS has declined from 26 percent in FY 2000 to 16 percent in FY 2016.³⁰

Financial Liabilities

In 1990, Attorney General Robert Corbin opined that ALTCS expenditures are not excludable from county expenditure limits and that the monies collected were satisfying county liabilities to the state under the ALTCS program.³¹ These payments were therefore local revenues not qualified for exemption under Article IX, Section 20, of the Arizona Constitution. In response, Maricopa County filed for an injunction in Arizona Supreme Court, which ultimately rejected jurisdiction.

In response, the Arizona State Legislature moved quickly and passed S.B. 1311 in 1991, which amended [A.R.S. § 36-2913](#).³² The bill adjusted the original 1979-80 base calculation for ALTCS payments. This adjustment was made permanent in 1993.

County Contributions

From 1989 through 1997, counties paid the entire non-federal share of the ALTCS program, creating a significant burden on county finances.³³ ALTCS contributions steadily grew to \$134 million by 1997 (**Figure 3**). Each county's share of the total non-federal portion of the program was based off percentages from the Auditor General's certified audit of FY 1987-1988. Counties were responsible for these payments regardless as to whether or not utilization had increased or decreased. Later changes reallocated payments based on utilization rates.

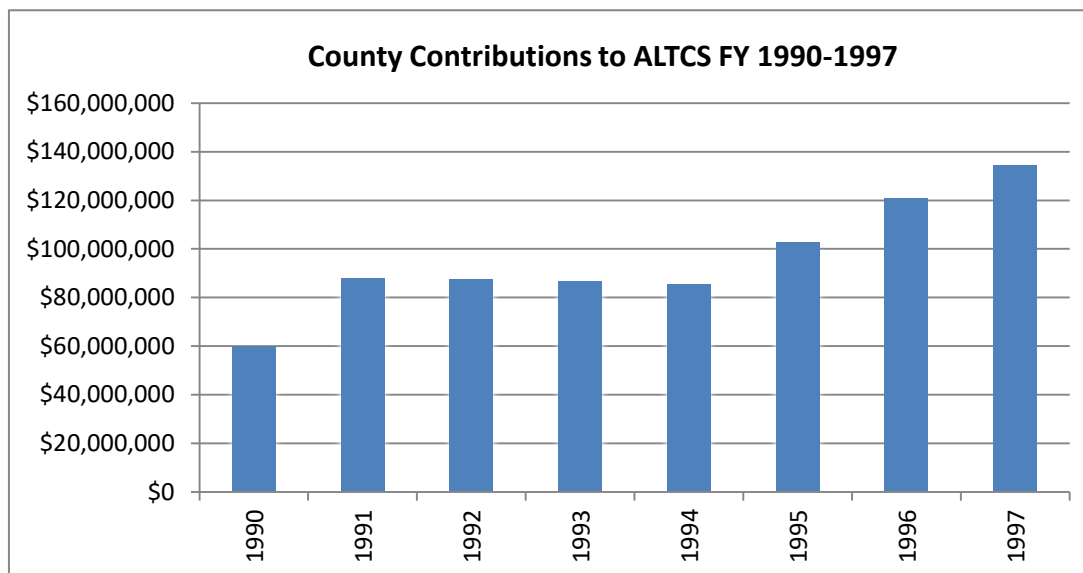


Figure 3

³⁰ JLBC Staff Program Summary: Arizona Long Term Care System (July 16, 2015)

³¹ AZ. Atty Gen. Op. 90-057 (June 26, 1990)

³² [A.R.S. § 36-2913](#)

³³ County Supervisors Association: ALTCS Overview (1997)

Through CSA advocacy efforts H.B. 2006 has introduced and ultimately passed in the 43rd Legislature's 2nd special session in 1997. H.B. 2006 split the future growth of the ALTCS program equally (50/50) between the state and counties and added in three circuit breakers for county contributions:

Property Tax Rates:

If a county's contribution, when expressed as an imputed property tax rate per one hundred dollars of Net Assessed Value (NAV), exceeds ninety cents, the county's contribution is reduced down to the ninety cent level, with the difference being paid by the state.

An example of this new ALTCS Contribution:

- NAV= \$1,000,000,000
- Pre-Circuit Breaker ALTCS Contribution = \$9,500,000
- Imputed Property Tax Rate = $\text{ALTCS Contribution} / \frac{\text{NAV}}{100}$
 - The Imputed Property Tax Rate for County A is \$0.95
 - $9,500,000 / \left(\frac{1,000,000,000}{100} \right) = 0.95$
 - $\text{ALTCS Contribution} = 0.9 \left(\frac{\text{NAV}}{100} \right)$
 - The new ALTCS Contribution for County A is \$9,000,000
 - $0.9 \left(\frac{1,000,000,000}{100} \right) = \$9,000,000$

Native American Population:

Counties with a Native American population representing at least 20 percent of the county's total population receive a reduction in their contribution by an amount equal to one-half the difference between the prior year's payment and the current year's calculated payment. For example, if County A's prior year contribution was \$1,000,000, and their current year contribution was originally calculated to be \$1,500,000, then County A's contribution with the circuit breaker is \$1,250,000.

Formula Change

After the reductions generated by the above circuit breakers are taken, any county that would otherwise be contributing more than if their contributions were based on the Auditor General's certified audit of FY 1987-1988, will receive a contribution reduction equal to the prior fiscal year's contribution plus 50 percent of the difference between the county's prior year and the current year contribution based on the FY 1987-1988 audit.

Additional Circuit Breaker

In 2005, CSA advocated for and the legislature adopted S.B. 1299, creating a fourth circuit breaker:

Per Capita

The “per capita” circuit breaker ensures that no county is required to pay costs above the statewide per capita contribution for the ALTCS program. If after applying the previous three circuit breakers, a county’s per capita ALTCS contribution is above the statewide average, then the county will receive an additional reduction. For example, if after applying circuit breakers 1-3, **County A’s** contributions come to \$50/person and the average contribution across the state is \$40/person. **County A** would receive additional relief equal to the difference - (\$50 – \$40)*(population).

County Contribution vs State Contributions

County funds made up \$157 million, or 82 percent, of the total state LTC costs in FY 2001, and \$249 million or 57 percent, of the state LTC costs in FY 2016.³⁴ The growth in the ALTCS program is split between the counties and the state and allocated to each county based on the prior year’s utilization. County contributions are limited by the circuit breakers at a different rate based on qualifications.³⁵

Figure 4

³⁴ Total AHCCCS Spending FY 2006 to FY 2016; <http://www.azleg.gov/ilbc/AHCCCSHistoricalSpending.pdf>

³⁵ JLBC Staff Program Summary: Arizona Long Term Care System (July 16, 2015)

Payments

County Payments

Counties are required to fund a portion of the state costs for maintaining AHCCCS programs; rising costs have continued to put pressure on county general funds.

ALTCS Payments

County ALTCS contributions surpassed \$249 million in FY 2016. Growth in the ALTCS program has been split evenly between the counties and the state since FY 1998. County contributions are determined using a county's utilization rate applying any applicable circuit breakers (*please see History of Arizona Long-Term Care for more information*).

Acute Care

Established in 1982, Acute Care Contributions are collected for the county share of hospitalization and medical care. From the time AHCCCS was first established until 2001 counties were responsible for the first 48 hours of treatment and for providing staff to determine eligibility. In 2001, the state took over all administrative functions and eliminated the 48 hour rule.

Acute Care costs have risen by 207 percent since FY 2001 and is the fastest growing AHCCCS cost.³⁶ County contributions are based off historical utilization and with the exception of a deflator for Maricopa in exchange for taking over Adult Probations, these payments have remained the same for counties for a number of years.

Disproportionate Uncompensated Care

The Disproportionate Uncompensated Care (DUC) Pool contributions were established as part of Prop. 204 implementation. Originally designed to pay hospitals for uncompensated care costs, the funds were soon redirected to the Acute Care program. This payment, which began in FY 2002, has remained unchanged, with the exception of eliminating Maricopa County's contributions in 2006, in exchange for taking responsibility for adult probation.

Budget Neutrality Compliance Fund

When Prop. 204 was implemented, some county administrative functions were transferred to the state. The state mandated counties contribute funds to assist with the cost and reimburse

³⁶ JLBC Staff Program Summary, August 2014

the state through the Budget Neutrality Compliance Fund (BNCF), established by [A.R.S. § 36-2928](#).³⁷ In FY 2016 the counties BNCF contribution exceeded \$3.5 million.

Pursuant to [A.R.S. § 11-292, Section O](#), the state treasurer is required to adjust the amount withheld according to the annual changes in the GDP price deflator. The allocation among the counties is adjusted by the Joint Legislative Budget Committee (JLBC), based on changes in population.³⁸

Overall county expenditures for AHCCCS in FY 2016 exceeded \$300 million; **(Figure 5)**³⁹ outlines the total expenditures contributed by counties for maintenance of the programs.

FY 2016 Expenditures					
County	BNCF	ACUTE Care	DUC Pool	ALTCS	Total
Apache	\$114,800	\$268,800	\$87,300	\$618,900	\$1,089,800
Cochise	\$214,100	\$2,214,800	\$162,700	\$5,165,500	\$7,757,100
Coconino	\$211,200	\$742,900	\$160,500	\$1,858,500	\$2,973,100
Gila	\$86,700	\$1,413,200	\$65,900	\$2,117,900	\$3,683,700
Graham	\$61,700	\$536,200	\$46,800	\$1,336,700	\$1,981,400
Greenlee	\$15,800	\$190,700	\$12,000	\$79,700	\$298,200
La Paz	\$32,800	\$212,100	\$24,900	\$696,300	\$966,100
Maricopa	\$0	\$19,203,200	\$0	\$153,303,200	\$172,506,400
Mohave	\$246,600	\$1,237,700	\$187,400	\$8,033,700	\$9,705,400
Navajo	\$161,600	\$310,800	\$122,800	\$2,562,200	\$3,157,400
Pima	\$1,468,800	\$14,951,800	\$1,115,900	\$39,303,600	\$56,840,100
Pinal	\$287,400	\$2,715,600	\$218,300	\$15,539,700	\$18,761,000
Santa Cruz	\$67,900	\$482,800	\$51,600	\$1,942,200	\$2,544,500
Yavapai	\$271,500	\$1,427,800	\$206,200	\$8,416,600	\$10,322,100
Yuma	\$242,000	\$1,325,100	\$183,900	\$8,259,900	\$10,010,900
Total	\$3,482,900	\$47,233,500	\$2,646,200	\$249,234,600	\$302,597,200

Figure 5

[Payments to Hospitals](#)⁴⁰

Supplemental monies are provided to hospitals to help absorb costs associated with providing services to state AHCCCS patients. Payments come from a combination of general fund, federal funds, and voluntary matching funds from local government or universities.

³⁷ [A.R.S. §36-2928](#): ["The budget neutrality compliance fund is established consisting of third party liability recoveries pursuant to section 36-2913, county contributions deposited pursuant to section 11-292, subsection P and section 11-300, subsection D and appropriations. The administration shall administer the fund. Monies in the fund are continuously appropriated and do not revert to the state general fund."]

³⁸ [A.R.S. § 11-292](#): ["Beginning in fiscal year 2006-2007, the state treasurer shall adjust the amount withheld according to the annual changes in the GDP price deflator and as calculated by the joint legislative budget committee staff. Beginning in fiscal year 2006-2007, the joint legislative budget committee shall calculate an additional adjustment of the allocation required by this subsection based on changes in the population as reported by the office of employment and population statistics. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563."]

³⁹ 2015-2016 Arizona County Encyclopedia, County Supervisors Association

⁴⁰ JLBC Staff Program Summary – Payments to Hospitals (Updated August 27, 2015)

Disproportionate Share (for more information, please [click here](#))

The Disproportionate Share Hospital (DSH) adjustment under section 1886(d) (5) (F) of the Social Security Act provides payments to hospitals that serve low-income patients. To qualify for DSH payments, hospitals must meet specific qualifications; including treating a higher number of Medicaid patients than other hospitals – known as the disproportionate patient percentage (DPP), or a hospital must have 100 or more beds and can demonstrate that more than 30 percent of their total inpatient revenue is derived from sources for indigent care. The amount available in FY 2016 is over \$161 million, a 57.6 percent increase over FY 2001.

Rural Hospital (for more information, please [click here](#))

The Rural Hospital Payments program began in FY 2003 for small hospitals in rural parts of Arizona that met the federal government’s criteria to qualify as a Critical Access Hospital (CAH). The federal government requires that a qualifying hospital:⁴¹

- Be located more than a 35-mile drive from any other hospital, or be 15 miles away in areas with mountainous terrain or only secondary roads, or be certified as a CAH prior to January 1, 2006, based on state designation as a “necessary provider” to residents in the area.
- Have 24-hour emergency services seven days a week.
- Maintain an average length of stay of 96 hours or less.

Beginning in FY 2016, and subject to federal approval, local governments may make a voluntary contribution to the Rural Hospital program.

Graduate Medical Education (for more information, please [click here](#))

The Graduate Medical Education (GME) hospitals with GME programs are able to receive reimbursement for expenses related to the GME program. The funds are used to assist with stipends, staff salaries and benefits, and overhead associated with the GME program facilitated by the hospital. No general fund money is used to operate the GME, but [A.R.S. § 36-2903.01](#) allows for voluntary matching funds to be used to increase the federal match.

Safety Net Care Pool (for more information, please [click here](#))

The Safety Net Care Pool (SNCP) provides offsets for services unreimbursed from AHCCCS and uninsured patients. The federal government provides a approximate 2:1 match. Since there is no general fund contribution, the state’s match is funded by local or public universities providing the state match, usually through a hospital assessment.

⁴¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctshst.pdf>