



# Arizona State Senate Issue Paper

July 12, 2010

## Note to Reader:

The Senate Research Staff provides nonpartisan, objective legislative research, policy analysis and related assistance to the members of the Arizona State Senate. The *Research Briefs* series, which includes the *Issue Brief*, *Background Brief* and *Issue Paper*, is intended to introduce a reader to various legislatively related issues and provide useful resources to assist the reader in learning more on a given topic. Because of frequent legislative and executive activity, topics may undergo frequent changes. Additionally, nothing in the *Brief* should be used to draw conclusions on the legality of an issue.

## ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

### INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) was originally established by the Legislature in 1981 as Arizona's Medicaid program to provide health insurance coverage for certain low-income individuals and families. Over time, AHCCCS has evolved to administer other health-related programs in addition to retaining its core function as the state's Medicaid managed care program.

### MEDICAID HISTORY

The passage of Title XIX of the Social Security Act in 1965 created the federal Medicaid program, which is the nation's health insurance program for persons with little or no income. Medicaid pays for medical assistance for eligible individuals and families and is jointly funded by the federal and state governments. Medicaid operates as an entitlement program; thus, individuals who meet specified eligibility requirements are entitled to Medicaid services.

The federal government developed extensive federal guidelines for the program and, in Arizona, pays for approximately two-thirds of the costs of the program. Within the federal guidelines, states may develop their own standards for eligibility, services provided and rates of payment. States are responsible for administering the program.

Arizona first chose not to participate in the Medicaid program, instead relying on the counties to provide indigent health care on a county by county basis. By establishing AHCCCS in 1981, the Legislature sought to bring federal Medicaid dollars into the state to relieve the burden of the growing cost of health care. On October 1, 1982, Arizona became the last state in the nation to implement a Medicaid program, and the first to implement a statewide, Medicaid managed care system using prepaid, capitated arrangements with contracted health plans. While numerous other states provide some services through managed care, Arizona is unique in that, once an individual is enrolled in the Medicaid program, all services are provided in a managed care setting. The only exception is for Native Americans who may choose to obtain services through the federal Indian Health Services or a tribally-operated facility.

Originally, AHCCCS provided only acute care services. In 1987, the Legislature created the Arizona Long Term Care System (ALTCS). AHCCCS implemented long-term care services in a two-phase process: persons who were developmentally disabled began receiving services in December 1988 and services for the elderly and physically disabled were added in January 1989.

AHCCCS began phasing in behavioral health services in 1990 when Congress mandated that all states offer behavioral health services for Medicaid members under the age of 21 years. The phase-in of behavioral health for all Medicaid eligible members was completed in October 1995.

### ***Federal Waivers***

Current federal law allows the Centers for Medicare and Medicaid Services (CMS) to waive certain laws related to Medicaid. Under waivers, states may change provisions of their Medicaid programs such as eligibility requirements, the scope of services available, service settings, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers and the statewide application of the program. States must demonstrate that these changes will be budget neutral for the federal government over the term of the waiver (compared to what federal spending would have been without the waiver).

There are several types of waivers with different purposes and requirements, which are named for the sections of law that authorize them. Section 1115 of the Social Security Act allows the federal government to grant five-year research and demonstration waivers that allow states, for a limited time, to conduct pilot, experimental or demonstration projects to test ideas that have not been widely proven or allowable under Medicaid law.

Federal law does not allow a managed care program like AHCCCS to operate without a waiver. AHCCCS operates under the time-limited authority of a Section 1115 Waiver. From 1982 until 1993, AHCCCS was the only Medicaid program operating under an 1115 Waiver, but other states have since adopted

waivers. CMS has approved an extension of Arizona's 1115 Waiver through September 30, 2011. Prior to the expiration of the 1115 Waiver, AHCCCS will negotiate a reauthorization of the program with CMS.

### ***AHCCCS ORGANIZATION***

#### ***Administration and Contracts***

AHCCCS's main responsibilities include setting policy and controls for eligibility administration, member enrollment, quality assurance of medical care, provider and plan oversight, federal and state financial management and reporting, and procurement of contract providers.

AHCCCS contracts with a number of public and private entities to provide services to members. In addition to the health plans and long-term care contractors, which provide the benefits described below, AHCCCS contracts include:

- DHS, Division of Behavioral Health Services, for behavioral health services.
- DES, Comprehensive Medical and Dental Program, for acute health care services for children in foster care.
- DES, for certain administrative services such as eligibility determination.
- DHS, Children's Rehabilitative Services, for services for children with special health care needs.
- a private third party administrator, for claim payments associated with the Medicaid in the Public Schools Program.

#### ***Benefits***

AHCCCS administers two main types of benefits, acute care and long-term care:

**Acute Care Services** – AHCCCS delivers acute care services through contracted prepaid, capitated health plans to Medicaid eligible members and members in the KidsCare Program. The contracted health plans provide all mandatory acute care services: inpatient and outpatient hospital services, physician services, laboratory and x-rays, family planning, home health, specialty care, and emergency and

medically necessary transportation services. For children under age 21, federal law requires certain periodic screening, vision, dental and hearing services and mandates coverage of any medically necessary health service, even if the service is not covered for other Medicaid enrollees. AHCCCS also provides behavioral health services through a separate contract with the Department of Health Services (DHS), which, in turn, subcontracts with regional behavioral health authorities (RBHAs).

**Arizona Long Term Care System** – The ALTCS program provides acute care services, behavioral health services, institutional services, home and community-based services (HCBS) and case management services to ALTCS members who are elderly or physically disabled. Similar to the acute care program, ALTCS delivers its long-term care services through a managed care approach by combining all acute medical care services, institutional services, case management and HCBS through a network of program contractors. Program services are provided through contracted prepaid, capitated arrangements with program contractors. ALTCS members who are developmentally disabled are served through the Department of Economic Security (DES), Division of Developmental Disabilities. Program contractors may directly contract with providers or with RBHAs for behavioral health services. The ALTCS program emphasizes delivery of care in home and community-based settings when possible. The AHCCCS Administration reports that over 70 percent of ALTCS members live in home and community-based settings.

### ***Populations Served***

#### *Title XIX Medicaid*

Federal guidelines require states that are participating in the Medicaid program to provide benefits to specified categories of persons, including certain low-income children, pregnant women, the aged, blind and disabled and some Medicare beneficiaries. States also have the option to cover other populations and receive federal matching funds for those individuals. In November 2000, voters passed Proposition 204, which expanded the eligibility for AHCCCS to

all persons with income under 100 percent of the federal poverty level (FPL). Previously, AHCCCS had provided services to some of these individuals using state dollars only. The federal government agreed to provide federal matching funds, and coverage of this population was fully implemented in October 2001. AHCCCS also uses Title XIX monies to pay for Medicare premiums, deductibles and coinsurance for certain low-income Medicare beneficiaries who do not qualify for full AHCCCS benefits.

In 1999, Congress passed the Ticket to Work and Work Incentives Improvement Act, which allows states to provide benefits to certain disabled individuals so that they may work without losing their Medicaid coverage. Arizona began providing Medicaid benefits to this population in January 2003. The program serves individuals who meet Supplemental Security Income requirements (except for earned income), who are between the ages of 16 and 64 and who have income below 250 percent of FPL.

The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, signed into law on October 24, 2000, allows states to offer Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (administered in Arizona by DHS) and found to have breast or cervical cancer. In 2002, Arizona established this type of AHCCCS coverage for uninsured women who typically have incomes between 100 and 250 percent of FPL.

#### *Title XXI KidsCare*

As part of the Balanced Budget Act of 1997, Congress created Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). Similar to Medicaid, SCHIP is jointly funded by the federal and state governments and provides health insurance to children whose families are low-income but earn too much to qualify for Medicaid. SCHIP was originally authorized for ten years. Congress subsequently reauthorized the program through September 30, 2015.

To provide coverage to SCHIP enrollees, states had the option to either expand their Medicaid programs or establish a separate, stand-alone program. In May 1998, the Arizona Legislature authorized the implementation of a stand-alone Title XXI children's health insurance program, commonly referred to as the KidsCare program.

KidsCare provides health care coverage for children up to the age of 19 years with family income at or below 200 percent of FPL who are not eligible for other AHCCCS coverage. From 2002 through 2009, the Legislature expanded the program to include parents of children enrolled in KidsCare.

The KidsCare program receives federal Title XXI monies at approximately a 3-to-1 match rate, which is higher than the roughly 2-to-1 rate for the regular Title XIX portion of AHCCCS.<sup>1</sup>

Parents pay a monthly premium, which may not exceed 5 percent of income, that is based on a sliding scale to obtain coverage for their children. Services are provided to children through the same health plans that provide services to Medicaid-enrolled individuals. KidsCare includes most of the same health care services, including dental and vision care, that are provided to persons in the Medicaid population.

The table on the following page outlines general eligibility for AHCCCS, excluding the Ticket to Work and Breast and Cervical Cancer populations.

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<sup>1</sup> Unlike Title XIX, Title XXI funding is not provided as an entitlement; rather, it is a block grant and each state has a specified allotment. According to the Congressional Research Service, only Alaska and Rhode Island have depleted their available Title XXI funding in a given year. They were able to file their remaining SCHIP claims under their Medicaid program but received the lower federal Medicaid match for the claims. In addition, numerous states, including Arizona, have faced allotment shortfalls; however, the federal government has both redistributed unused funds from other states and appropriated additional federal funding to address these shortfalls.

### ***Healthcare Group***

In 1981, the Legislature authorized AHCCCS to provide affordable health care coverage to self-employed individuals, small businesses with 50 or fewer employees and political subdivisions (state, counties, cities, towns, school districts and agricultural districts) within the state. In 1985, the Legislature established Healthcare Group (HCG) as a prepaid guaranteed issue medical coverage program for eligible employers, and the program, administered by AHCCCS, began operation in the following year. To qualify for the program, businesses must have been without health insurance for at least 90 days, referred to as the "go bare" period.

A self-employed individual or eligible employers may participate in HCG by purchasing health care for their employees and the employee's dependents through the participating AHCCCS health plans. Employers contract directly with the selected health plan and choose the benefit level and cost sharing option suitable for their organization.

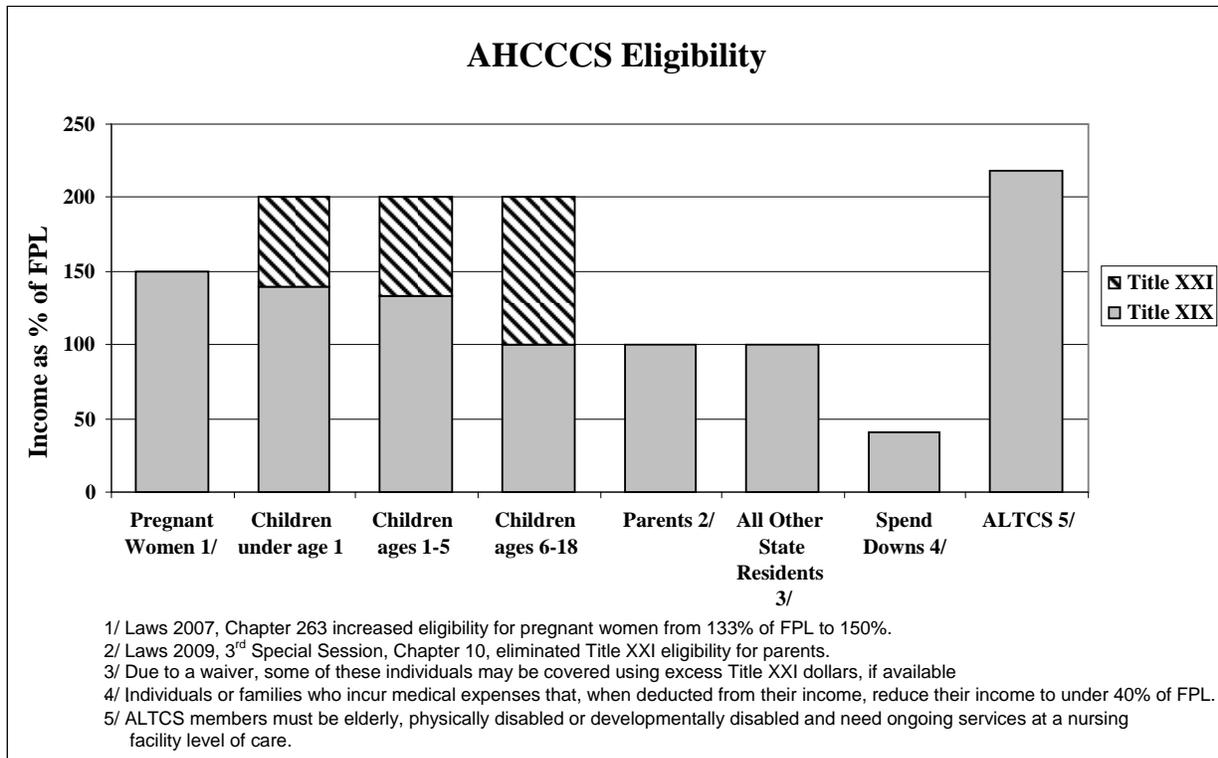
Beginning in 2004, displaced workers who qualify for a federal tax credit for health insurance are also allowed to participate in HCG.

In the spring of 2006, HCG reported that it was running an annual deficit. The FY 2008 budget provided \$8,000,000 from the state General Fund as a subsidy for the program. The budget also: a) capped enrollment at 9,800 businesses until September 19, 2007, after which no new businesses may enroll in HCG; b) set the default hospital reimbursement rate, when a contract does not exist between an HCG contractor and a provider, at 114 percent of AHCCCS reimbursement rates; c) directed the Department of Insurance to conduct a statutory financial examination of HCG; and d) established a study committee to examine whether to continue HCG or establish a state high-risk pool. The study committee conducted two public hearings in 2007.

In the FY 2008 budget, the Legislature enacted further reforms to HCG (Laws 2008, Chapter 288). Among the changes, the

legislation a) increased the required minimum number of employees in an eligible employer group, from one to two; b) reduced the “go bare” period from 180 days to 90 days; c) prohibited HCG from reimbursing a non-contracted hospital for non-emergency medical services, but established reimbursement rates for emergency services provided at a non-contracted hospital based on the AHCCCS reimbursement rates; d) required HCG to consider health status-

related factors when determining premiums and to base premiums on actuarial reviews of projected and actual costs; and e) required HCG to establish recognized utilization management control standards and submit quarterly financial statements to the Joint Legislative Budget Committee.



**ADDITIONAL RESOURCES**

- Arizona Health Care Cost Containment System  
602-417-4000  
[www.azahcccs.gov](http://www.azahcccs.gov)
- Centers for Medicare and Medicaid Services  
United States Department of Health and Human Services  
<http://www.cms.hhs.gov/>
- “Arizona Health Care Cost Containment System – Sunset Factors,” Office of the Auditor General, September 2002, Report No. 02-09

- Healthcare Group  
602-417-6755  
[www.healthcaregroupaz.com](http://www.healthcaregroupaz.com)
- “Federal Poverty Levels,” Arizona State Senate Background Brief  
[www.azleg.gov/briefs.asp](http://www.azleg.gov/briefs.asp)