

AZ HEALTH CARE COST CONTAINMENT SYSTEM - ACUTE CARE

A.R.S. § 36-2901

General Fund, Federal and Other Funds		FY 1998 Actual	FY 1999 Estimate	FY 2000 Approved	FY 2001 Approved
FTE Positions		0.0	0.0	0.0	0.0
Capitation	(SM)	334,286,600	384,185,800	369,291,800	385,221,900
	(TF)	764,393,400	839,618,100	860,502,400	902,781,000
Fee-For-Service	(SM)	107,693,100	73,031,800	69,028,800	72,087,100
	(TF)	252,728,800	229,566,700	215,377,400	225,133,800
Reinsurance	(SM)	15,592,400	15,955,800	18,188,000	19,197,500
	(TF)	27,637,600	34,012,700	39,477,200	41,949,800
Medicare Premiums	(SM)	5,556,700	6,759,700	9,354,300	10,037,300
	(TF)	16,052,000	19,569,800	31,052,600	48,724,100
Qualified Medicare Beneficiaries	(SM)	2,246,200	1,733,200	0	0
	(TF)	6,488,100	5,017,600	0	0
Specified Low Income Medicare Beneficiary	(SM)	373,400	0	0	0
	(TF)	1,078,500	0	0	0
Qualified Individuals I & II	(SM)	0	0	0	0
	(TF)	0	2,668,000	0	0
Disproportionate Share Payments	(SM)	53,548,100	45,278,900	43,891,500 ^{1/2/}	43,891,500 ^{1/2/}
	(TF)	134,167,500	127,349,600	124,891,500 ^{1/2/}	124,891,500 ^{1/2/}
Graduate Medical Education	(SM)	0	9,243,900	9,243,900	9,243,900
	(TF)	0	18,289,800	18,289,800	18,289,800
Total	(SM)	519,296,500	536,189,100	518,998,300	539,679,200
	(TF)	1,202,545,900	1,276,092,300	1,289,590,900^{3/}	1,361,770,000^{3/}
Additional Appropriations -					
Appropriations; AHCCCS;	(SM)	0	0	(205,100)	(205,100)
Healthcare Group, Ch. 313	(TF)	0	0	(600,000)	(600,000)
Total Appropriations	(SM)	519,296,500	536,189,100	518,793,200	539,474,100
	(TF)	1,202,545,900	1,276,092,300	1,288,990,900^{4/5/}	1,361,170,000^{4/5/}
Fund Summary					
General Fund		425,484,500	439,140,600	421,109,000 ^{6/}	440,656,700 ^{6/}
Tobacco Tax Funds		25,266,700	28,775,700	30,328,400	31,947,300
Third Party Collections		1,855,800	1,583,400	1,124,800	882,000
County Funds		66,689,500	66,689,500	66,689,500	66,689,500
Federal Funds		683,249,400	739,903,100	769,739,200	820,994,500
Total Appropriations		1,202,546,900	1,276,092,300	1,288,990,900	1,361,170,000

SM = State Match, and consists of the state General Fund, Tobacco Tax, Third Party Collections and County Funds.

TF = Total Funds, and represents the sum of the State Match and Federal Funds.

Program Description — *The AHCCCS Acute Care program is the medical services component of Arizona's Medicaid Demonstration Project. The program is based on prepaid monthly capitation payments to contracted providers for the full range of authorized medical services including some behavioral health services available to enrolled members. The program follows a health maintenance organization (HMO) model in which capitated providers accept a predetermined rate and are responsible for managing patient utilization and cost through a system of prior authorization and utilization review, coordinated by a primary care physician or practitioner. As a federal demonstration project, the Acute Care program operates under a series of federal waivers that make the "managed care" concept possible. AHCCCS covers the mandatory federal eligibility groups, as well as certain optional state groups, such as the Medically Needy/Medically Indigent (MN/MI.) In cases involving catastrophic medical expenses, AHCCCS supplements Capitation through Reinsurance in order to preserve health plan financial viability.*

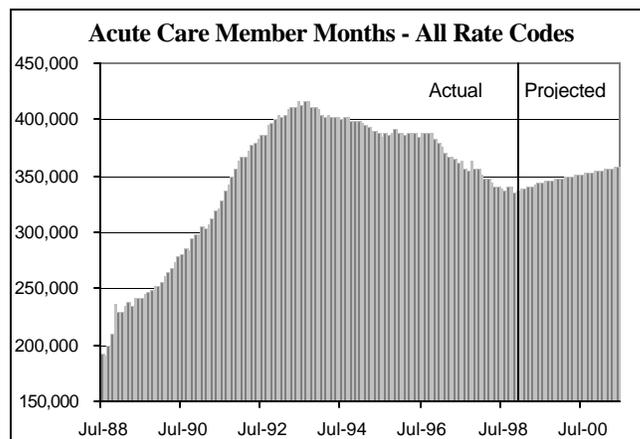
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FY 1999 Savings — Prior to estimating the FY 2000 funding requirement, the FY 1999 estimate is “re-based” to adjust for the latest demographic estimates. The FY 2000 approved amount includes a decrease of \$(34,214,200) GF and \$(71,238,200) TF due to savings accrued during FY 1999. The FY 1999 savings are primarily the result of 3 factors: enrollment declines, lower Capitation costs, and lower Fee-for-Service costs.

Since FY 1994, enrollment in the Acute Care program has been declining. The FY 1999 appropriation assumed that enrollment would level off in FY 1999; however, enrollment continued to decrease throughout the first half of FY 1999. In addition, the new capitation rates AHCCCS implemented on October 1, 1998 are lower than the estimates included in the FY 1999 appropriation. Lastly, a contract change AHCCCS implemented on October 1, 1997 has resulted in lower Fee-for-Service costs. The contract change allowed AHCCCS to enroll clients in a capitated health plan more quickly, thereby shortening the amount of time the enrollees are paid for on a more expensive fee-for-service basis. Due to these 3 factors, the FY 1999 base was adjusted downward before including the FY 2000 growth assumptions.

Medical Inflation and Caseload Growth — The FY 2000 approved amount includes an increase of \$17,192,900 GF and \$83,727,200 TF for Capitation, Fee-for-Service, and Reinsurance for caseload growth and medical inflation in FY 2000 after the FY 1999 base revisions described above. The FY 2001 approved amount includes a further increase of \$21,627,800 GF and \$60,530,100 TF above the FY 2000 level. These changes reflect demographic and inflationary increases for those AHCCCS members enrolled in capitated health plans, and other populations whose services are paid on a fee-for-service basis. The approved amounts assume that overall AHCCCS enrollment will grow by 2.2% in FY 2000 and 2.1% in FY 2001 as shown in *Chart 1*.

Chart 1



The approved amounts also include 3.5% cost growth in FY 2000 and FY 2001 in both Capitation and Fee-for-Service. For FY 2000, 50% of the cost of this inflationary increase has been funded by the Medically Needy Account of the Tobacco Tax and Health Care Fund pursuant to Laws 1999, Chapter 176. This amount is continued in FY 2001.

Children’s Health Insurance Program — Laws 1998, Chapter 4, 4th Special Session established the Children’s Health Insurance Program (CHIP) under Title XXI of the Federal Social Security Act to provide health insurance coverage to uninsured children who are ineligible for Medicaid and whose families meet the eligibility requirements. *See the Administration program for further information on the CHIP program.*

It is anticipated that outreach for the CHIP program will create a “woodwork effect” that will lead to higher AHCCCS costs. As CHIP outreach efforts encourage parents to apply for health coverage for their children,

- 1/ The FY 2000 and FY 2001 Disproportionate Share Payment of \$124,891,500 is based on federal FY 2000 and FY 2001 authorized expenditure level of \$81,000,000. If the final federal expenditure authorization is an amount different from the estimate, the Governor shall direct the Arizona Health Care Cost Containment System Administration, subject to the availability of monies and subject to the review of the Joint Legislative Budget Committee, to proportionately adjust authorization amounts among the identified recipients of disproportionate share hospital payment. Prior to the final payment, the Governor shall provide notification to the President of the Senate, the Speaker of the House of Representatives, the Chairmen of the House and Senate Appropriations Committees and the Staff Director of the Joint Legislative Budget Committee of the adjusted federal authorized expenditure level and the proposed distribution plan for these monies. (General Appropriation Act footnote)
- 2/ Of the appropriation for Disproportionate Share Payments for FY 2000 and FY 2001 made pursuant to A.R.S. § 36-2903.01R, the sum of \$83,894,300 is for qualifying county operated hospitals, \$23,831,900 is for deposit in the Arizona State Hospital Fund and \$15,150,000 is for other qualifying disproportionate share hospitals. The remaining \$2,015,300 is for in lieu payments to counties having a population of 500,000 persons or less according to the most recent United States decennial census in an amount that is the difference between the disproportionate share payments made pursuant to A.R.S. § 36-2903.01R, and \$201,700, if the disproportionate share payments are less than \$201,700. For each county that would receive less than \$100,900 from these in lieu payments, the Arizona Health Care Cost Containment System Administration shall make an additional in lieu payment that will provide the county with a total payment of \$100,900. (General Appropriation Act footnote)
- 3/ Of the \$1,289,590,900 expenditure authority for Acute Care in FY 2000, \$421,314,100 is appropriated from the state General Fund. Of the \$1,361,770,000 expenditure authority for Acute Care in FY 2001, \$440,861,800 is appropriated from the state General Fund. (General Appropriation Act footnote)
- 4/ General Appropriation Act funds are appropriated by Special Line Items for the Program.
- 5/ Before making capitation changes to current fee for service programs that may have a budgetary impact in FY 2000 or FY 2001, the Arizona Health Care Cost Containment System Administration shall report its plan to the Joint Legislative Budget Committee for review. (General Appropriation Act footnote)
- 6/ These amounts represent direct appropriations. All other expenditures are part of total expenditure authority.

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some of the applicants will be found eligible for the current AHCCCS program (Title XIX) rather than CHIP, resulting in higher enrollment. The FY 2000 approved amount includes an increase of \$5,000,000 GF and \$17,671,400 TF in Capitation for this issue. This amount is continued in FY 2001.

However, most of the children currently enrolled in AHCCCS through the Medically Needy/Medically Indigent (MN/MI), Eligible Assistance Children (EAC) and Eligible Low-Income Children (ELIC) programs will now be eligible for CHIP. Since these programs are funded entirely with state funds, Title XXI does not require them to be served by AHCCCS if they are eligible for the new CHIP. The approved FY 2000 amount includes a decrease of \$(5,450,900) GF to reflect the transfer of 4% of the MN/MI population (most MN/MIs are adults) and 90% of the EAC and ELIC population. The FY 2001 amount includes a further decrease of \$(205,900) GF.

Third Party Collections — The FY 2000 approved amount includes an increase of \$458,600 GF and a decrease of \$(458,600) in Third Party Collections. Third Party Collections are decreasing due to a contract change that shifted a large number of fee-for-service claims to capitation. AHCCCS now has more difficulty collecting from third parties since a capitated payment is made in advance to the AHCCCS Health Plan. Third Party Collections have historically been used to offset the General Fund portion of the State Match, so as they decline, the GF cost increases. The FY 2001 amount includes a further increase of \$242,800 GF and a corresponding decrease in Third Party Collections.

Acute Care Overview

The remaining sections provide explanations of the various line items in the Acute Care budget, as well as descriptions of AHCCCS eligibility categories.

Capitation — Represents payments made to health plans under contract with AHCCCS for the cost of care provided to enrolled members. These payments are made on a monthly basis and cover the full range of services required in statute. Contracts are awarded for a multi-year period upon the completion of a competitive bidding process in which health plans respond to a Request for Proposals from AHCCCS. Health plans bid by AHCCCS rate code, meaning that different rates are paid for different groups.

In general, capitation rates are based on an actuarial assessment of the medical services utilization and costs incurred by each of the AHCCCS rate codes. Rates vary by health plan and geographical area, but remain within the parameters set by actuarial study and contract negotiation. Additionally, capitation rates may reflect program changes, such as a required expansion of available services, or changes in eligibility requirements. The capitation rates for FY 2000 and FY 2001 are shown in the table below.

The approved Capitation amounts continue funding for 2 federal mandates that began in FY 1998. In accordance with federal law, health plans may not restrict hospital stays to less than 48 hours following a normal delivery or 96 hours following a cesarean section. The FY 1999 appropriation assumed that all mothers would stay the 48 hours allowed under the federal mandate. However, based on data from FY 1996, AHCCCS now estimates that only

Table 1

Federally-Eligible Rate Codes	FY 2000			FY 2001		
	Monthly Cap. Rate	Federal Share^{1/}	State Share	Monthly Cap. Rate	Federal Share^{2/}	State Share
TANF < 1	\$330.25	\$217.37	\$112.88	\$341.81	\$225.32	\$116.49
TANF 1-13	63.76	41.97	21.79	66.00	43.50	22.49
TANF 14-44 Female	175.99	115.84	60.15	182.15	120.07	62.08
TANF 14-44 Male	85.65	56.37	29.28	88.65	58.43	30.20
TANF 45+	212.82	140.07	72.74	220.26	145.20	75.07
SSI w/ Medicare	142.77	93.97	48.80	147.77	97.41	50.36
SSI w/o Medicare	321.65	211.71	109.94	332.90	219.45	113.45
Family Planning	21.24	19.12	2.12	21.98	19.78	2.20
Deliveries	4,396.66	2,893.88	1,502.78	4,550.55	2,999.72	1,550.83
<u>State-Only Rate Codes</u>						
MNMI	435.76	0	435.76	451.01	0	451.01
EAC/ELIC < 1	330.25	0	330.25	341.81	0	341.81
EAC/ELIC 1-13	63.76	0	63.76	66.00	0	66.00

^{1/} Federal share reflects a blended FMAP of 3 months at 65.50% and 9 months at 65.92%.

^{2/} Federal share reflects 12 months at 65.92%.

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59% of women stay the maximum number of days, resulting in a decrease of \$(4,987,700) TF in the approved amount for FY 2000. The approved amount for FY 2001 includes an increase of \$251,200 TF above the FY 2000 level to reflect inflationary adjustments. Funding for the cost of the State Match for the Maternity Length of Stay mandate is allocated from the Medically Needy Account of the Tobacco Tax and Health Care Fund pursuant to Laws 1999, Chapter 176. *See the table of Tobacco Tax expenditures in the Summary for further information.*

The approved amounts also continue funding for federally mandated coverage of Title XIX HIV/AIDS patients' protease inhibitors as a successful means of delaying the progression of AIDS and prolonging life. The FY 2000 approved amount includes a decrease of \$(2,038,900) TF because FY 1998 data show lower costs than expected. The FY 2001 approved amount includes an increase of \$217,500 TF from the FY 2000 level to reflect inflationary adjustments. Funding for the cost of the State Match for the HIV/AIDS mandate is allocated from the Medically Needy Account of the Tobacco Tax and Health Care Fund pursuant to Laws 1999, Chapter 176. *See the table of Tobacco Tax expenditures in the Summary for further information.*

Since the starting point for new or renewed health plan contracts coincides with the new federal fiscal year, the state fiscal year appropriation reflects 3 months of capitation rates paid at a level negotiated for the period of October 1999 through September 1999, and 9 months at new rates negotiated for the contract year beginning October 2000. As mentioned above, the FY 2000 appropriation provides for an overall increase in capitation rates of 3.5% for medical inflation. The FY 2001 appropriation includes funding for further inflationary growth of 3.5%. The capitation rates shown in *Table 1* are estimated averages of regular capitation rates.

Estimated FY 2000 and FY 2001 member years paid are shown in *Table 2*. As mentioned above, the approved amounts include enrollment growth of 2.2% in FY 2000 and 2.1% in FY 2001.

For federally qualified members also eligible for Medicare, AHCCCS pays the member's Medicare Part B premiums, thereby allowing AHCCCS to bill the federal Medicare program for a portion of the member's medical expenses. This Medicare "buy-in" substantially reduces total capitation costs and state share costs for Medicare-eligible members.

The federal share of capitation and other costs incurred by federally-eligible members is based on a predetermined federal matching rate known as the Federal Matching Assistance Percentage, or FMAP. This federal matching rate varies from state to state and is based on an inverse mathematical relationship between state per capita income

Table 2

<u>Federally-Eligible Rate Codes</u>	FY 2000 Member Years^{1/}	FY 2001 Member Years^{1/}
TANF < 1	33,910	35,033
TANF 1-13	172,909	177,299
TANF 14-44 Female	60,198	60,642
TANF 14-44 Male	12,739	12,773
TANF 45+	2,579	2,579
SSI w/ Medicare	20,310	20,278
SSI w/o Medicare	48,050	49,689
Family Planning	24,069	24,069
Deliveries	1,529 ^{2/}	1,578 ^{2/}
<u>State-Only Rate Codes</u>		
MNMI	19,159	19,161
EAC/ELIC < 1	12	12
EAC/ELIC 1-13	142	152

1/ Member years are calculated as projected member months divided by 12 and do not necessarily indicate actual number of clients enrolled.

2/ This is the projection of actual birth deliveries to be made by enrollees in AHCCCS health plans.

and the national average. The lower a state's personal income, as compared to the U.S., the higher the percentage the state receives, and vice-versa. Arizona's FMAP for the federal fiscal year ending September 30, 1999 is 65.50%. For the federal fiscal year beginning October 1, 1999, Arizona's FMAP will increase to 65.92%. The budget assumes the FMAP continues at 65.92% throughout FY 2001.

Fee-for-Service — This expenditure line item is for payments made by AHCCCS directly to health care providers on behalf of members not covered under Capitation.

One area of Fee-for-Service coverage is for AHCCCS members who are not yet covered by a health plan under Capitation. AHCCCS contract changes beginning October 1, 1997 expanded the period during which a member is covered by capitation, which shortens the fee-for-service "window." Since October 1997, federally-eligible members will be covered through capitation payments from the first day of the month of application. However, if these persons have unpaid bills for services received before then in the 90-day period prior to their application for eligibility and would have been eligible for some period of time in that 90-day period, AHCCCS pays these bills on a fee-for-service basis. This retroactive coverage is referred to as "prior quarter coverage." State-only MN/MI members, who previously received fee-for-service coverage for emergency services 48 hours prior to the notification of eligibility by a county office, will now be covered through prior period capitation for the 48 hours.

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The approved amounts for FY 2000 and FY 2001 reflect a continuation of the phase-out of "quick pay" discounts for both state-only and categorical payments to hospitals. The state-only discount will decrease from 7% to 6% effective March 1, 2000 and from 6% to 5% effective March 1, 2001. While the reduction in the discount results in an increased cost to the state, the FY 2000 approved amount includes a decrease of \$(5,535,400) TF from the FY 1999 level. This decrease is due to reinsurance no longer being included in the quick pay calculation. Reinsurance has a 9-month time lag and does not qualify for the discount. The FY 2001 approved amount includes an increase of \$1,742,900 TF from the FY 2000 level.

The State Match of \$6,794,600 in FY 2000 and \$8,206,700 in FY 2001 required for this phase-down is paid for from the Medically Needy Account of the Tobacco Tax and Health Care Fund pursuant to Laws 1999, Chapter 176. Under current law, the state-only discount will continue to decline by 1% per year until it reaches 1% in FY 2005. The discount for the categorical populations is already fully phased down to 1%. *See the table of Tobacco Tax expenditures in the Summary for further information.*

The Fee-for-Service approved FY 2000 and FY 2001 amounts also reflects continued funding for the discontinuation of a \$10,000,000 reduction of payments to hospitals for fee-for-service claims related to state-only eligibility groups. The discount was discontinued in FY 1997, and the \$10,000,000 increase is funded by the Medically Needy Account of the Tobacco Tax and Health Care Fund pursuant to Laws 1999, Chapter 176. *See the table of Tobacco Tax expenditures in the Summary for further information.*

In addition to temporary Fee-for-Service coverage prior to capitation, AHCCCS also covers certain groups not eligible for health plan enrollment or those that choose Indian Health Services (IHS) as their health plan. These groups include Native Americans living on reservations and those eligible for only emergency services coverage, due to a lack of U.S. citizenship or lawful alienage status but otherwise AHCCCS-eligible.

Pursuant to an agreement between the State of Arizona and the federal government, Medicaid-eligible Native Americans living on reservations may be referred off-reservation by the IHS for services if the IHS is unable to provide the necessary services. The state's cost for these referrals corresponds to the established state matching rate for other federally-eligible members. Native Americans eligible for an AHCCCS state eligibility group (MN/MI) may also be referred off reservation for services, with AHCCCS paying 100% of the cost from state dollars, as with other state-eligible members. For Medicaid-eligible Native Americans treated on reservations in an IHS facility, the federal government pays all costs, with AHCCCS passing through these Federal Funds to the IHS

facility. The approved amount for FY 2000 includes an increase of \$3,843,500 TF for IHS facility costs due to a contract change. Since this item is 100% federally-funded, this change does not impact the General Fund. The FY 2001 approved amount includes a further increase of \$187,800 TF.

With the passage of Laws 1993, Chapter 6, 2nd Special Session, eligibility in state groups such as MN/MI was limited to applicants having proof of U.S. citizenship or lawful alienage status. Those unable to provide such proof but still fulfilling all other eligibility requirements can still receive coverage for emergency medical care through either federal or state emergency services eligibility. AHCCCS pays these claims for emergency medical care on a fee-for-service basis. As a result of an April 1996 federal court ruling, the federal government has ceased to reimburse AHCCCS for non-emergency prenatal/postpartum care under the Federal Emergency Services program. Since FY 1998, coverage for these services has been eliminated. Delivery-related and emergency prenatal services remain for the undocumented population.

Reinsurance — Payments from this line item are intended to supplement capitation in catastrophic cases. Such payments are made to AHCCCS health plans and have the effect of reimbursing health plans for extraordinary costs not reflected in the capitation rate. Effective October 1, 1997, health plans may select a lower reinsurance deductible. Health plans that choose a lower deductible will have their capitation rates reduced proportionately. The following table displays the Reinsurance deductibles offered. Three-fourths of the cost incurred by a health plan in excess of the appropriate deductible is borne by AHCCCS when costs have been incurred for the provision of payment for covered inpatient hospitalization.

Members <u>Enrolled</u>	FY 2000 <u>Reinsurance Deductible</u>	FY 2000 State <u>Co-insurance %</u>
1-19,999	\$20,000	75%
20,000-49,999	\$35,000	75%
50,000+	\$50,000	75%
MN/MI	\$15,000	75%

Medicare Premiums – This line item provides funding for the purchase of Medicare Part B (supplemental medical insurance) on behalf of those eligible for Medicaid and Part A (hospital insurance) coverage. This “buy-in” reduces state costs since the federal government, through Medicare, absorbs some costs that otherwise would have been paid by AHCCCS. In addition the line also includes the costs of payment of Part A premium costs for certain disabled workers.

Beginning in FY 2000, the line item also includes funding for Qualified Medicare Beneficiaries. Federal law requires the state to pay Medicare Part A and Part B premiums, deductibles and co-payments on behalf of certain low-

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income Medicare beneficiaries. An individual is eligible for this coverage if:

- They are entitled to Part A Medicare benefits;
- Their resources do not exceed twice the SSI resource limit, or \$4,000; and
- Their income does not exceed 100% of the FPL (\$8,240 for 1 person, \$11,060 for a couple).

Beginning in FY 2000, the line item also includes funding for qualified individuals. The 1997 Federal Balanced Budget Act requires that states expand the Medicare Part B buy-in program for certain qualified individuals with incomes between 120% and 175% of the FPL. Although the program is mandatory, it is 100% federally-funded up to the amount of the federal allotment provided. States are responsible for 100% of the costs of the program above the federal allotment, but they may cap enrollment. AHCCCS plans to cap enrollment so as to use only Federal Funds for this program.

Funding for these 3 programs was formerly held in 3 separate line items. The FY 2000 budget consolidates the 3 line items into 1 "Medicare Premiums" line item since all 3 programs are similar in that they provide funding to pay for Medicare premiums for various AHCCCS populations. The FY 2000 approved amount includes an increase of \$574,500 GF and \$2,965,700 TF for demographic and inflationary adjustments in the cost of covering Medicare premiums. The FY 2001 amount includes a further increase of \$683,000 GF and \$17,671,500 TF.

Disproportionate Share Payments — This line item represents supplementary payments to hospitals that serve a large, or disproportionate, number of low income patients. The federal basis for payments is either a reflection of a hospital's number of Title XIX inpatient days, or a "low income" utilization rate. States may also establish optional payment categories. Arizona has established optional groups that include county, state and private hospitals. Payments to county hospitals have been

based on a "pool" of expenses consisting of charity care, uncollectible or bad debt, county General Fund subsidies, and state payments to county hospitals for AHCCCS recipients. Additionally, this line item provides for in-lieu payments to counties that do not have county-operated hospitals.

The FY 1999 approved amount includes a GF supplemental appropriation of \$599,500 GF and \$1,670,200 TF. This increase reflects the allocation of \$1,670,200 in unspent FY 1998 Disproportionate Share Hospital (DSH) funds. In addition, the FY 1999 DSH allocation was revised from the FY 1999 estimate because the Arizona State Hospital (ASH) was not eligible to receive DSH monies due to its lack of Medicare certification. *See the Department of Health Services section for further discussion of ASH.* As a result, the DSH monies were reallocated among the county hospitals and recouped through increased county withholdings.

The FY 2000 approved amount includes a federal DSH award of \$81,000,000, which is a decrease of \$(1,070,700) from the amount available in FY 1999 (including the unspent FY 1998 monies). The GF DSH appropriation will decrease by \$(1,387,400) to reflect the lower State Match required for the lower federal DSH payment. In addition, the FY 2000 amount assumes that ASH will regain Medicare certification and will resume receiving DSH payments. These amount are continued in FY 2001.

The allocation of the FY 1999, FY 2000 and FY 2001 disproportionate share appropriations are shown in *Table 3*.

Graduate Medical Education — Pursuant to Laws 1997, Chapter 256, beginning in FY 1998 AHCCCS established a separate Graduate Medical Education program to reimburse hospitals that have graduate medical education programs. The Graduate Medical Education allocation is to be adjusted annually by the increase or decrease in the Data Resources Incorporated hospital market index for prospective hospital reimbursement.

	<u>Disproportionate Share Allocations</u>		
	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>
County-Operated Hospitals	\$109,918,000	\$ 83,894,300	\$ 83,894,300
Arizona State Hospital	0	23,831,900	23,831,900
Private Hospitals	15,385,000	15,150,000	15,150,000
County In-Lieu Payments	<u>2,046,600</u>	<u>2,015,300</u>	<u>2,015,300</u>
Total Appropriation	\$127,349,600 ^{1/}	\$124,891,500	\$124,891,500

^{1/} Laws 1999, Chapter 176 amended the DSH distribution plan. The FY 1999 DSH appropriation includes \$1,670,200 from the FY 1998 DSH allocation.

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AHCCCS Eligibility Categories — The following is a description of federal and state eligibility groups as defined in state law:

Federal Eligibility Groups

TANF — Under the 1996 federal welfare reform law, the Temporary Assistance for Needy Families (TANF) program replaced Aid to Families with Dependent Children (AFDC). Individuals receiving cash assistance from the TANF program in the Department of Economic Security (DES) are no longer automatically, or categorically, eligible for AHCCCS benefits. They are, however, eligible for federal AHCCCS benefits provided they would have qualified for AFDC under the eligibility guidelines that were in place before August 22, 1996. Federal law also allows for some individuals not eligible for cash assistance but still meeting certain TANF standards (e.g., Ribicoff Children), or those no longer eligible for cash payments (transitional medical assistance), to still be eligible for Medicaid. These are known as Medical Assistance Only (MAO) cases. Also, individuals in the TANF Unemployed Parent program are eligible for AHCCCS benefits.

While not a separate federal eligibility group, the Comprehensive Medical and Dental Program (CMDP) in DES has AHCCCS-eligible children among its total population. AHCCCS passes through funds to CMDP on behalf of these eligible children.

SSI — Individuals receiving Supplemental Security Income (SSI) monthly cash payments are automatically eligible for AHCCCS benefits. These individuals are eligible in one of following 3 SSI categories: those age 65 or older (aged), the blind, and the disabled. Eligibility for the SSI program is based on uniform nationwide requirements. Like TANF, SSI also has related MAO groups. Additionally, AHCCCS passes through funds to CMDP, as a health plan, on behalf of SSI-eligible children enrolled in that program.

SOBRA Women and Infants — States are required to provide care to pregnant women and infants (under 1 year old) whose family incomes do not exceed 133% of the Federal Poverty Level (FPL) (\$18,155 for a family of 3). A resource standard may be established, but AHCCCS has chosen to waive this requirement. SOBRA refers to the federal Sixth Omnibus Budget Reconciliation Act. The federal government allows states the option of increasing the income limit to 185% of the FPL. Arizona acted upon this option and moved the state's income standard to 140% of the FPL (\$19,100 for a family of 3) in 1990. Full coverage for women is limited to the term of pregnancy and 60 days of postpartum care. After the 60 day period, women are eligible for family planning services only.

SOBRA Children — The federal government requires states to provide medical assistance to children under age 6 whose family incomes do not exceed 133% of the FPL. Additionally, states are required to cover children born on or after October 1, 1983, with family incomes up to 100% of the FPL.

1902 (r)(2) Children — This eligibility group name refers to the relevant section of the federal Social Security Act that allows states discretion in establishing higher income eligibility standards than exist in other federal categories, such as SOBRA. Eligibility for this group requires an income below 100% of the FPL for children under the age of 14. Like SOBRA, this category has no resource limit. Most children in the 100% state-funded Eligible Assistance Children (EAC) category were transferred to this federally-funded group.

State Children's Health Insurance Program — Beginning in FY 1999, uninsured children with family incomes up to 150% of the FPL who are not Title XIX eligible will be able to participate in the State Children's Health Insurance Program. The income limit increases to 175% FPL in FY 2000 and 200% FPL from FY 2001 onward. Laws 1999, Chapter 313 accelerated the eligibility phase-in by 1 year. Pursuant to Chapter 313, eligibility for FY 2000 is now set at 200% FPL. See *Administration for discussion of the new program.*

Federal Emergency Services — All federal eligibility categories (TANF, SSI, SOBRA, and any federal MAO group) have an emergency service component. Applicants for these federal programs who would be eligible except for a lack of U.S. citizenship or lawful alienage status are eligible for coverage of emergency medical services, but not full Medicaid benefits.

State-Only Groups

Medically Needy/Medically Indigent (MN/MI) — State law provides for eligibility for individuals meeting specified resource limits and the following income criteria:

<u>Family Size</u>	<u>Maximum Net Income</u>
1	\$3,200
4	\$5,354
8	\$7,530

MN/MI statutes allow medical expenses to be used to reduce the applicant's total annual income, thus allowing an applicant to "spend-down" into eligibility. Spend-down provisions do not apply to the calculation of the applicant's liquid and non-liquid resources. Unlike most federal Medicaid categories, MN/MI eligibility standards contain no restrictions relating to age, gender, or the presence of dependent children in the household. As of July 1, 1993, MN/MI applicants have to be U.S. citizens or lawfully admitted aliens to be eligible for full AHCCCS services.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ACUTE CARE (Cont'd)

Non-residents may qualify for emergency services coverage.

Eligible Assistance Children (EAC) — Children, ages 0-13 years, in families certified by DES to be eligible for the federal Food Stamp Program qualify automatically for AHCCCS benefits. Because of the expansion of the federal SOBRA program and the creation of the 1902(r)(2) group, the state has been able to transfer a large number of these children into federally matched categories. Most of the children in this category are eligible for the new CHIP program. The FY 2000 budget assumes that 90% will convert to CHIP.

Eligible Low-Income Children (ELIC) — These are children, ages 0-13 years, in families whose annual income falls between the following guidelines, which represent the gap between the upper limit of the MN/MI income standard and the FPL:

Family Size	Minimum Income	Maximum Income
8	\$7,530	\$27,650

Except for the age restriction and the difference in income limits, applicants for ELIC must meet the same requirements as applicants for the state-only MN/MI program. Most of the children in this category are eligible for the new CHIP program. The FY 2000 budget assumes that 90% will convert to CHIP.

State Emergency Services — This eligibility category provides coverage of emergency medical services to those otherwise eligible for a state group, such as MN/MI, except for the lack of U.S. citizenship or lawful alienage status. Services covered are the same as those in the Federal Emergency Services program, except the cost is 100% state-funded.

Additional Appropriations: Appropriation: AHCCCS: Healthcare Group (Chapter 313) - Transfers coverage of behavioral health services for persons who are 18-20 years old and are not seriously mentally ill from AHCCCS to the Department of Health Services. The bill transfers \$205,100 GF and \$600,000 TF from AHCCCS to DHS in FY 2000 for this function. This amount is continued in FY 2001.

Excess Balance Transfers: AHCCCS Fund - Laws 1999, Chapter 6, 1st Special Session transfers \$1,000,000 from the AHCCCS Fund to the General Fund in FY 2000. The AHCCCS Fund consists of Federal Title XIX matching funds, county contributions for AHCCCS, transfers from the Tobacco Tax Medically Needy Account, and other miscellaneous revenue. The FY 1998 ending fund balance was \$7,209,300. In addition, Chapter 6 transfers \$1,000,000 in FY 2001.