

Arizona Long Term Care System

Arizona Health Care Cost Containment System

Program Summary

Program Description

The Arizona Long Term Care System (ALTCS) delivers long term care services to financially needy individuals who are at immediate risk of institutionalization in a nursing or intermediate care facility. AHCCCS administers ALTCS for the elderly and physically disabled (EPD) population, and the Department of Economic Security administers ALTCS for the developmentally disabled (DD) population. This program summary focuses on ALTCS services for the EPD population.

ALTCS provides an integrated package of services to enrollees that includes long term care services, acute care services, behavioral health services, and case management. The long term care services available to enrollees include both institutional care at a nursing facility and home and community-based services (HCBS). HCBS includes health or personal services provided in the enrollee's home by a nurse, personal care attendant, or spouse, as well as alternative residential settings like assisted living facilities, adult day health centers, or behavioral health facilities. In FY 2018, roughly 75% of the EPD population received their services at home or in the community.

ALTCS services are delivered through program contractors that receive capitation payments for each enrollee that they serve. There are currently 3 program contractors operating in the state: Banner-University Family Care, Mercy Care Plan, and UnitedHealthcare (UHC) Community Plan. ALTCS contracts divide the state into 3 Geographic Service Areas (GSAs). Enrollees in the North GSA must enroll with UHC Community Plan. Those enrolled in the South GSA may choose between Banner-University Family Care and Mercy Care Plan, while enrollees in the Central GSA can use any of the 3 contractors.

Program contractors currently receive an average capitation payment of approximately \$3,600 per member month for each ALTCS beneficiary enrolled, or \$43,200 per member per year. The capitation rate is lower for ALTCS clients enrolled in Medicare (\$3,100) than for ALTCS members who are not (\$6,200). Most ALTCS clients (84%) are enrolled in Medicare. As of September 1, 2018, there were 30,287 EPD individuals enrolled in ALTCS.

ALTCS Eligibility

Eligibility for ALTCS is determined by income and resource limits as well as medical and functional requirements. The income limit for ALTCS is 300% of the Federal Benefit Rate (FBR), which is equivalent to approximately 222% of the Federal Poverty Level for a single individual. In 2018, for a single individual the ALTCS income limit is equal to approximately \$27,000, and for a 2-person household the income limit is equal to \$40,500.

Income

In the eligibility determination process, "countable" income includes earned sources, such as wages, in addition to some unearned sources, such as cash received from Temporary Assistance for Needy Families (TANF). Some deductions are allowed, including a portion of child support payments received, a work expense deduction, and deductions for dependent children, among others. Certain government benefits, such as Supplemental Security Income (SSI) and SNAP benefits, are excluded from the income calculation.

If the applicant has a spouse that lives in the community, the spouse's income is also counted towards the limit. In most cases, 50% of a couple's combined income is counted towards the eligibility limit. Unmarried couples do not have their income counted jointly.

Assets

The limit on assets is \$2,000. Assets are counted if they can be converted to cash in less than 20 days, such as property, stocks, bonds, and pensions. Non-liquid resources like land or loan agreements are not counted as long as a good faith effort has been made to sell the assets. The beneficiary's home, household goods/personal effects such as clothes, and 1 vehicle are excluded from the asset limit.

A community spouse is allowed to retain some assets. For the first year following application for ALTCS (which is called the “Initial Period”), married couples can use the Community Spouse Resource Deduction (CSRD). The CSRD gives the couple time to transfer ownership of assets to the community spouse. Assets over which the community spouse retains sole ownership are not counted for the purposes of ALTCS eligibility. After the Initial Period, any assets that are still jointly owned are counted towards the ALTCS asset eligibility limit.

The CSRD amounts are set at the federal level, and in 2018 the minimum CSRD is approximately \$25,000 and the maximum CSRD is approximately \$124,000. The amount of CSRD allowed for each applicant depends on the amount of assets owned by the couple. For example, if the community spouse’s share of the assets (which is equal to 50% of the couple’s assets) exceeds \$25,000, but is less than \$124,000, then the community spouse can keep his or her entire share of the couple’s assets.

ALTCS also uses a “look-back” period to prevent prospective ALTCS enrollees from selling off assets to friends or family members below fair market value for the purposes of qualifying for ALTCS. The look-back period lasts 5 years before the prospective enrollee’s ALTCS application date. If the prospective enrollee made below market-value transfers during the look-back period, the enrollee will have his or her eligibility delayed. For example, if an enrollee made \$100,000 of below-market-value transfers, and the monthly cost of a privately paid for nursing home was \$5,000, the prospective enrollee’s eligibility would be delayed by 20 months. Any below-market-value transfers also shorten the length of the Initial Period in which assets can be transferred to community spouses.

Medical and Functional Assessment

Once applicants meet the financial eligibility requirements, they must undergo a pre-admission screening test. The functional assessment determines the applicant’s ability to independently carry out activities of daily living (ADLs), such as mobility, transferring, bathing dressing, grooming, eating, and toileting. The medical assessment examines any medical conditions that relate to the applicant’s ability to carry out ADLs, including vision problems, medical stability, and level of cognitive functioning. If the combination of medical and functional needs is determined by a nurse to put the applicant at immediate risk of institutionalization, he or she will qualify for ALTCS.

Share of Cost

If an ALTCS applicant is deemed eligible, the enrollee must pay a “share of cost” of their care that is calculated based on the enrollee’s income and the type of services they use. Enrollees are given a “personal needs allowance” (PNA) deduction that reduces the share of cost. For users of home and community-based services, the PNA is 300% of the FBR, or \$2,250 per month in 2018, and for users of institutional services the personal needs allowance is 15% of the FBR, or \$112.50 per month in 2018. Because the income eligibility level and the PNA are the same for users of HCBS, HCBS users generally do not pay a share of cost. For example, for an enrollee with income at 100% of the Federal Poverty Level, their monthly share of cost would be approximately \$870 if they lived in an institutional setting and \$0 if they used HCBS.

There are additional deductions available for users of HCBS and institutional care with dependent family members or medical expenses incurred that are not covered by Medicare or Medicaid. All but \$30 of any SSI cash is not counted as income for the purposes of calculating the share of cost. In FY 2019, the share of cost contributions will cover about 5.2% of the cost of care.

Program Funding

The FY 2019 budget appropriated \$1.61 billion in total funds for ALTCS for FY 2019. As with other Medicaid-programs, AHCCCS uses state matching funds to draw down Federal Funds to finance ALTCS services. In FY 2019, the federal matching assistance percentage (FMAP) for ALTCS is the regular Medicaid match rate of 69.83%.

Table 1 provides a breakdown of funding for ALTCS by source. AHCCCS uses 4 funding sources to provide state matching dollars for ALTCS: the General Fund, County Funds, the Prescription Drug Rebate Fund (PDRF), and the Nursing Facility Provider Assessment Fund. In FY 2019, County Funds will provide the largest source of state matching funds (\$268.6 million), followed by the General Fund (\$198.7 million), the Nursing Facility Provider Assessment Fund (\$33.0 million), and the Prescription Drug Rebate Fund - State (\$7.6 million). These state matching funds are expected to draw down \$1.1 billion in federal matching dollars.

County Funds

County Funds are the largest state match source for ALTCS. Counties used to provide the entire state match for ALTCS, but in 1997, the Legislature adopted a formula requiring the state to provide funds for 50% of the growth in the state match beginning in FY 1998. The law also amended the formula for each county's share. Under the previous formula, each county's share was determined by its long-term care utilization rate in FY 1988, but the 1997 law required that the utilization rate be recalculated annually using data from 2 years prior to the current fiscal year.

County Funds	\$268,554,800
General Fund	198,722,900
Nursing Facility Provider Assessment Fund	32,989,400
Prescription Drug Rebate Fund - State	7,578,400
Federal Medicaid Authority ^{1/}	<u>1,097,911,800</u>
Total Funds	\$1,605,757,300

^{1/} Includes Prescription Drug Rebate Fund – In Lieu of Federal Funds

The Legislature also adopted a series of “circuit breakers” to provide additional relief to counties based on:

- Tax rate: Limits a county's contribution to ALTCS to no more than \$0.90 for every \$100 of assessed property value.
- On-reservation population: Provides relief to counties with an on-reservation population of at least 20%.
- Statutory growth cap: Limits a county's contributions so that the no county pays more than under the pre-1998 statutory formula, although this circuit breaker has not been used to provide relief to any counties.
- Per capita expenditures: Provides relief to counties with per-capita LTC expenditures larger than the state average.

<u>County</u>	<u>Pre-Circuit Breaker Share</u>	<u>Circuit Breaker Relief</u>	<u>Relief as % of Pre-Circuit Breaker Share</u>
Apache	\$ 9,577,600	\$ 8,933,100	93.3%
Cochise	5,681,300	392,300	6.9%
Coconino	5,729,600	3,794,400	66.2%
Gila	3,000,600	761,600	25.4%
Graham	2,154,300	575,800	26.7%
Greenlee	49,000	0	0.0%
La Paz	599,500	0	0.0%
Maricopa	176,878,500	6,392,400	3.6%
Mohave	9,147,500	668,100	7.3%
Navajo	11,041,400	8,373,400	75.8%
Pima	45,729,000	3,979,700	8.7%
Pinal	13,853,200	0	0.0%
Santa Cruz	3,884,500	1,800,100	46.3%
Yavapai	8,334,500	0	0.0%
Yuma	<u>8,565,400</u>	<u>0</u>	<u>0.0%</u>
Statewide^{1/}	\$304,226,000	\$35,671,100	11.7%

^{1/} Sums do not match totals due to rounding.

The circuit breakers reduced county contributions to ALTCS in the FY 2019 budget by \$(35.7) million. *Table 2* above shows the circuit breaker relief received by each county, and the total relief provided as a percentage of

what each county's contribution would have been without the circuit breakers in FY 2019. The 3 counties, Apache, Navajo, and Coconino, that qualified for the on-reservation circuit breaker received the largest percentage relief with 93.3%, 75.8%, and 66.2%, respectively.

Table 3 shows how ALTCS funding has changed over time. The County Funding formula has increased the share of ALTCS funding provided by the General Fund. In FY 2000, the General Fund provided \$19.8 million, or 11.3% of the ALTCS state match and 4.0% of total ALTCS funding. In FY 2019, the General Fund appropriation of \$198.7 million represents 39.1% of the ALTCS state match and 12.4% of total funding.

	<u>FY 2000</u>	<u>FY 2010</u>	<u>FY 2019 2/</u>	<u>Average Annual Growth</u>	<u>Share of Funds, FY 2000</u>	<u>Share of Funds, FY 2010</u>	<u>Share of Funds, FY 2019</u>
County Funds	154,588,000	186,816,400	268,554,800	3.1%	31.0%	14.8%	16.7%
General Funds	19,842,900	128,251,400	198,722,900	13.7%	4.0%	10.2%	12.4%
Nursing Facility Assessment	--	--	32,989,400	--	0.0%	0.0%	2.1%
PDRF - State	--	--	7,578,400	--	0.0%	0.0%	0.5%
Federal Medicaid Authority	324,595,400	946,442,900	1,097,911,800	7.0%	65.0%	75.0%	68.4%
Total Funds	499,026,300	1,261,510,700	1,605,757,300	6.7%	100.0%	100.0%	100.0%
EPD Enrollment 1/	18,640	27,118	30,687	2.8%			
Spending Per Enrollee	\$26,772	\$46,519	\$52,327	3.8%			

1/ Represents member months as of June 1st of each fiscal year, including prior period coverage and tribal coverage.
2/ FY 2019 figures represent appropriated funds and projected enrollment.

Nursing Facility Provider Assessment Fund

The Nursing Facility Assessment applies to facilities that provide 24-hour nursing care, and the revenue generated from the assessment draws down federal matching payments. The FY 2019 budget appropriates \$33.0 million in nursing facility provider assessment revenues to ALTCS, which is expected to draw down \$76.4 million in Federal Funds in FY 2019. The assessment revenues are passed through to the ALTCS program contractors, who use the assessment revenue to make supplemental payments to nursing homes in proportion to each nursing home's amount of Medicaid patient days.

The Nursing Facility Assessment was adopted in 2012 and was first implemented in 2014. The revenue was to be used to partially reverse a 5% reimbursement rate cut to nursing facilities in FY 2012. The rates paid by nursing facilities were raised most recently on January 1, 2017 from \$10.50 to \$15.63 for every non-Medicare patient day for facilities with fewer than 43,500 Medicaid patient days, and from \$1.40 to \$1.80 per non-Medicare patient day for facilities with more than that amount of Medicaid patient days. A.R.S. § 36-2999.52 requires that the revenues generated from the assessment not exceed 3.5% of net patient revenue.

Prescription Drug Rebate Fund (PDRF)

The PDRF provides rebates from drug manufacturers for prescription drugs used by ALTCS beneficiaries. The rebates offset a share of federal and state costs for prescription drugs. ALTCS began receiving PDRF revenues in FY 2012 after the Affordable Care Act required that prescription drug companies participating in the rebate program provide rebates to managed care organizations. Previously, only prescription drugs paid for on a fee-for-service basis were subject to rebates. The rebate for innovator drugs is equal to the higher of 23.1% of the average manufacturer price (AMP) per unit or the difference between the AMP and the best price per unit. Non-innovator drug rebates are equal to 13.0% of AMP per unit. The FY 2019 budget appropriates \$7.6 million from the PDRF - State for ALTCS in FY 2019, which is expected to draw down \$36.4 million in federal matching funds.

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