Payments to Hospitals
Arizona Health Care Cost Containment System
Program Summary

Key Points
1) AHCCCS has several programs that provide supplemental funding to hospitals over and above reimbursements for services provided to Medicaid enrollees.
2) The current state match cost of the program is $113.5 million, including $12.6 million from General Fund monies and $100.9 million from political subdivisions.
3) Most federal revenues from Disproportionate Share Hospital (DSH) payments serve as a General Fund revenue source to offset the General Fund costs of the AHCCCS program. The total DSH General Fund deposit was $95.1 million in FY 2019.
4) In accordance with the Affordable Care Act, federal DSH payments are currently scheduled to decrease by $4.0 billion nationwide in FFY 2020. Payments will then decline by $8.0 billion in FFY 2021 and each year thereafter.
5) Graduate Medical Education (GME) funding has significantly expanded in recent years due to the option for local and tribal governments and universities to draw down federal funds through a voluntary match. At $303.6 million in FY 2020, it is the largest supplemental payment program.

Program Overview and Funding
The Payments to Hospitals program includes supplemental monies paid to hospitals outside of the regular fee-for-service or capitated system to assist the hospitals in absorbing costs. This category contains 5 programs:

- Disproportionate Share
- Rural Hospital Payments (including Critical Access Hospital Payments)
- Graduate Medical Education
- Safety Net Care Pool
- Proposition 202 - Trauma and Emergency Services

On an annualized basis, hospital supplemental payment programs represent $506.5 million in Total Funds.

Disproportionate Share (DSH)
The DSH program provides supplemental payments of federal and state dollars to hospitals that serve a large, or disproportionate, number of low-income patients. To qualify as a participating hospital, the hospital must:

- Serve a significantly higher number of Medicaid patients than other hospitals in the state, or have at least 25% of the effort and time of the medical staff spent on inpatient care being spent on low-income individuals; and
- Have at least 2 obstetricians with staff privileges who have agreed to provide service for citizens under the State Medicaid plan.

Arizona’s DSH program began in 1992. At that time, negotiations were made so that all participating hospitals would see a net gain. The negotiations detailed that revenue received through DSH would also be applied to pay for the increasing costs of AHCCCS.

The DSH program is funded by a combination of General Fund and Federal Fund monies, with the option for local governments or universities to provide additional state matching funds. The federal government provides the state with roughly a 2:1 match on the state’s monies based on the Federal Matching Assistance Percentage (FMAP), which changes from year to year. The total amount of eligible funding is adjusted annually for changes in prices and the federal match rate. The FY 2020 eligible funding of $167,644,000 is 63.1% above the FY 2001 eligible funding (See Table 1).
Table 1

<table>
<thead>
<tr>
<th>Eligible Funding</th>
<th>FY 2001</th>
<th>FY 2007</th>
<th>FY 2019</th>
<th>FY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Hospitals 1/</td>
<td>$59,149,000</td>
<td>$88,854,700</td>
<td>$97,304,100</td>
<td>$97,304,100</td>
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<tr>
<td>State Hospitals</td>
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<td>28,474,900</td>
<td>28,474,900</td>
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<tr>
<td>Private Hospitals</td>
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<td>26,147,700</td>
<td>884,800</td>
<td>884,800</td>
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<tr>
<td>Voluntary Match 2/</td>
<td>0</td>
<td>0</td>
<td>38,220,300</td>
<td>40,980,200</td>
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<tr>
<td><strong>Total Funding</strong></td>
<td><strong>$102,773,900</strong></td>
<td><strong>$143,477,300</strong></td>
<td><strong>$164,884,100</strong></td>
<td><strong>$167,644,000</strong></td>
</tr>
</tbody>
</table>

1/ The budget establishes a MIHS DSH limit of $113,818,500 in the FY 2020 Health BRB to maximize the DSH General Fund revenue deposit. As a result, the actual General Fund deposit from MIHS could reach a maximum of $75,254,400 in FY 2019 and $75,493,400 in FY 2020.
2/ Although the FY 2020 General Appropriation Act appropriated $40,980,200 for voluntary payments, a footnote appropriates any amount over that to the administration in FY 2020.

**Publicly-Operated Hospitals**

Since FY 2008, publicly-operated hospitals are required to document uncompensated care costs to the federal government through a Certified Public Expenditure (CPE) process. Those CPEs serve as the state match for the drawdown of Federal Funds. The publicly-operated hospitals of Maricopa Integrated Health System (MIHS) and DHS’ Arizona State Hospital (ASH) receive eligible funding of 113,818,500 and $28,474,900 in FY 2020, respectively.

While the state retains most of the MIHS federal match as General Fund revenue, $4,202,300 of the federal drawdown is distributed to MIHS in FY 2020. This distribution to MIHS is appropriated in the Disproportionate Share Payments line. (The state match is part of the CPE and does not appear in the General Appropriation Act.)

Legislation was added for FY 2012 and FY 2013 that limited the DSH payment attributed to MIHS to $89,877,700. This limitation allowed MIHS to use monies they spend on uncompensated care as a match for the Safety Net Care Pool program (see below) and resulted in the diversion of some federal funding for DSH, which would have otherwise been distributed to the General Fund. Laws 2015, Chapter 14 increased payments attributed to MIHS to $105,945,500 in FY 2015 and $113,818,500 in FY 2016, thereby increasing the amount of Federal Funds transferred to the General Fund by $11,000,000 in FY 2015 and an additional $5,500,000 in FY 2016. While the FY 2019 Health BRB continued the $113,818,500 level of payments attributed to MIHS, actual certifiable uncompensated care from MIHS was $97,304,100 in FY 2018. The FY 2020 budget assumed no changes in uncompensated care levels, projecting a net General Fund deposit of $83,868,100 in FY 2020.

**Private Hospitals**

The state appropriates General Fund dollars, which receive a drawdown of federal dollars, for DSH payments to private hospitals. The FY 2020 budget includes an $884,800 total funds appropriation for this distribution in the Disproportionate Share Payments line. The appropriation includes $265,000 from the General Fund and $619,500 from the Federal Medicaid Authority. Prior to the FY 2016 budget, the state appropriated $9,284,800 of General Fund dollars to private hospitals a year. In FY 2018, 31 private hospitals received $884,800 in DSH payments.

**Voluntary Match**

Since FY 2010, the state has allowed local governments, tribal governments and universities to provide the state match in the form of voluntary payments to draw down federal dollars. Any eligible DSH funding remaining after the previously mentioned allocations is made available for voluntary match payments. The FY 2020 budget includes a $40,980,200 total funds appropriation for this distribution. In SFY 2018, 8 hospitals contributed the voluntary state match for $17,367,100 in DSH payments.

Under the federal Affordable Care Act (ACA), DSH payments were expected to decline nationwide by $500 million in FFY 2014 and $600 million in FFY 2015, or about 5% of overall payments. Subsequent federal legislation has delayed the start of reductions. Pending even further Congressional action, DSH payments are now expected to decline nationwide by $4.0 billion in FFY 2020 and by $8.0 billion in FFY 2021 and each year thereafter.
Rural Hospital Payments
The Rural Hospital Payments program provides supplemental payments to small rural hospitals. The program began in FY 2003 with annual total payments of $1.7 million. Payments were originally provided only for Critical Access Hospitals (CAH). To qualify as a CAH, the federal government requires that the hospital:

- Be located in a rural area or be reclassified as rural based on a special provision;
- Provide 24-hour emergency care services;
- Maintain an average length of stay of 96 hours or less;
- Maintain 25 or fewer inpatient beds that can also be used for swing bed services;
- Be located more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads or be certified by the state as being a “necessary provider” of health care services to residents in the area.

The federal “necessary provider” provision, allowing a state to waive the distance requirement, sunset on January 1, 2006. Those hospitals that were designated as a CAH prior to January 1, 2006, are grandfathered as CAHs on and after that date.

In FY 2006, the total annual appropriation increased to $13,858,100. Under the Rural Hospital Reimbursement program, payments were also expanded to hospitals licensed as an acute care hospital that have 100 or fewer beds and are located in a county with a population of less than 500,000. While the annual appropriation remained constant from FY 2006 to FY 2014, the General Fund amount changed from year to year based on the FMAP.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Funding History</th>
<th>Rural Hospital Payments</th>
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<tbody>
<tr>
<td></td>
<td>FY 2003</td>
<td>FY 2007</td>
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<tr>
<td>Rural Hospital Reimbursement Program</td>
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<td>Federal</td>
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<td>Subtotal</td>
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<td>Critical Access Hospital Program</td>
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<td>General Fund</td>
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<td>$567,800</td>
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<tr>
<td>Federal</td>
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<td>$1,132,200</td>
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<td>$949,200</td>
<td>$1,700,000</td>
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<td>Total Payments</td>
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<tr>
<td>General Fund</td>
<td>$591,900</td>
<td>$4,660,200</td>
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<tr>
<td>Federal</td>
<td>$1,108,100</td>
<td>$9,197,900</td>
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<tr>
<td>Total</td>
<td>$1,700,000</td>
<td>$13,858,100</td>
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The Rural Hospital Reimbursement program and the Critical Access Hospital program are combined in the Rural Hospital Payments line item. The total annual appropriation for this line is $28,612,400 in FY 2020, which consists of $12,158,100 for the Rural Hospital Reimbursement program and $16,454,300 for Critical Access Hospitals (See Table 2). In FY 2018, 20 hospitals received Rural Hospital payments of $22,650,000, including 10 that received Critical Access Hospital payments.

Graduate Medical Education (GME)
The GME program reimburses hospitals with graduate medical education programs through 2 means: 1) direct allocations and 2) indirect payments. Direct allocations are Medicare payments for a program’s share incurred through residency stipends, benefits, salaries of faculty who supervise residents, and other overhead costs exclusively related to the GME program. Indirect payments are made to teaching hospitals to offset the additional costs of those teaching programs that provide patient care, medical training, and research.

Laws 2007, Chapter 263 allowed local, county, and tribal governments to increase federal funding for GME programs by providing additional voluntary state match monies. Laws 2010, Chapter 86 expanded this provision to public universities. In SFY 2018, 15 hospitals received $272.3 million in total funds.
FY 2020 represents the first fiscal year since FY 2010 that the state appropriated monies for GME. Table 3 displays the historical data on funding levels for FY 2001, FY 2007, and FY 2020. The $3.0 million General Fund contribution is intended to supplement political subdivision funds for GME programs. Funding will be prioritized for hospitals located in federally-designated health professional shortage areas.

The FY 2020 budget also includes a one-time $750,000 appropriation from the General Fund for Graduate Medical Education-Community Health Centers. The appropriation will be used to address health care provider shortages in northern Arizona.

Safety Net Care Pool
In April 2012, AHCCCS received federal approval to establish a Safety Net Care Pool (SNCP) to fund unreimbursed costs incurred by hospitals in caring for the uninsured and AHCCCS recipients through December 31, 2013. SNCP used monies from political subdivisions to draw down federal matching monies at a 2:1 match. The funds were then distributed to participating hospitals. Table 4 displays the historical data on funding levels for the program through FY 2018.

While participation in the program ended December 13, 2013, for all hospitals, the FY 2014 Health and Welfare Budget Reconciliation Bill (BRB) allowed Phoenix Children’s Hospital to continue to participate in the SNCP program through December 31, 2017, if approved by CMS. The FY 2018 Health BRB further extended the date to December 31, 2020, though the federal government ended program funding after December 31, 2017.

Proposition 202 – Trauma and Emergency Services
Proposition 202 (2002) allowed the Governor to enter into tribal gaming compacts allowing tribes to operate certain gaming activities in exchange for a percentage of the gaming revenues. The proposition further specified that approximately 25.5% would fund trauma and emergency services. AHCCCS distributes 90% of these monies to the 8 hospitals with trauma departments. The remaining 10% is distributed to hospital emergency rooms. In FY 2018, this funding source provided $23.8 million to hospitals.

Table 5 details monies received by specific hospitals through the Payments to Hospitals line items. Most recent payments totaled approximately $506.5 million for DSH, Rural Hospital payments, GME, and Prop 202.

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