

ARIZONA STATE LEGISLATURE

**REPORT OF THE AD HOC COMMITTEE**

**ON THE**

**AHCCCS BUDGET**

**FEBRUARY 1, 1993**



# Arizona State Legislature

1700 West Washington

Phoenix, Arizona 85007

February 1, 1993

President John Greene  
Speaker Mark Killian  
Arizona State Legislature  
Phoenix, AZ 85007

Mr. President and Mr. Speaker:

Submitted herewith is the Report of the Ad Hoc committee on the AHCCCS Budget.

The report contains the minutes of the two meetings of the Ad Hoc Committee which were held on January 21 and January 28, 1993, and the materials distributed at the meetings for your review.

During the course of our meetings, the Executive Budget recommendation and the JLBC Staff recommendation were both presented and discussed. Public testimony on the budget recommendations, as well as related materials was received. Finally, alternative approaches were presented in various forms before the Committee and discussed.

We appreciate the opportunity to serve on this Committee and will be happy to answer any questions that you might have.

Sincerely,

Senator John Huppenthal  
Co-Chair

Representative Bob Edens  
Co-Chair

am/ga  
Enclosure

JOHN GREENE  
DISTRICT 24

STATE SENATOR  
FORTIETH LEGISLATURE

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COMMITTEES:  
APPROPRIATIONS  
COMMERCE & LABOR  
JUDICIARY

## Arizona State Senate

Phoenix, Arizona

January 15, 1993

Senator John Huppenthal  
Arizona State Senate  
1700 West Washington  
Phoenix, AZ 85007

Representative Bob Edens  
Arizona House of Representatives  
1700 West Washington  
Phoenix, AZ 85007

Re: Appointment to Joint Ad Hoc Committee on the AHCCCS Budget

Dear Senator Huppenthal and Representative Edens:

You are hereby appointed to Co-Chair the Joint Ad Hoc Committee on the AHCCCS Budget. Your fellow committee members are:

Senator Carol Springer  
Senator Ann Day  
Senator Lela Alston

Representative Bob Burns  
Representative Susan Gerard  
Representative Herschella Horton

The committee is to review the JLBC Staff recommendations, the Executive Budget recommendations and alternative budget proposals, within the budget parameters established by the Appropriations Chairmen and reflected in the JLBC Staff recommendations. The committee shall take public testimony at two meetings to be held on January 21, 1993 and January 28, 1993.

The committee shall complete its work by Friday, January 29, 1993.



We appreciate your willingness to serve on this committee and to deal with these difficult issues in a timely fashion.

Sincerely,



John Greene  
President of the Senate



Mark Killian  
Speaker of the House

cc: Senator Springer  
Representative Bob Burns  
Senator Day  
Representative Gerard  
Senator Alston  
Representative Horton

1-27-93

ARIZONA HOUSE OF REPRESENTATIVES  
Forty-first Legislature - First Regular Session

AHCCCS AD HOC COMMITTEE

Minutes of Meeting  
Thursday, January 21, 1993  
House Hearing Room 3 - 5:00 p.m.

(Tape 1, Side A)

Chairman Edens called the meeting to order at 5:07 p.m. and the attendance was noted.

Members Present

Senator Day	Representative R. Burns
Senator Springer	Representative Gerard
Senator Huppenthal, Cochairman	Representative Horton
	Representative Edens, Cochairman

Members Absent

Senator Alston

Speakers Present

Peter Burns, Director, Governor's Office of Strategic Planning and Budgeting (OSPB)  
Ted Ferris, Director, Joint Legislative Budget Committee (JLBC)  
Linda Redman, Executive Administrator - Policy, Arizona Health Care Cost Containment System (AHCCCS)  
Monty Headley, Fiscal Analyst, Joint Legislative Budget Committee (JLBC)  
James D. Bruner, President, County Supervisors Association and Chairman, Board of Supervisors, Maricopa County  
Knox Kimberly, Inter-Governmental Relations, Maricopa County  
Anthony Rogers, Hospital Director, Maricopa County Hospital  
Richard Burnham, Attorney, St. Mary's Hospital and Tucson Carondelet Health Service, Tucson  
Margaret Snider, Valley Interfaith Project, Scottsdale  
Earl J. Baker, M.D., Arizona Medical Association (ARMA)  
Monsignor Edward J. Ryle, Executive Director, Arizona Catholic Conference  
Laurie Campbell, Vice President, Government Relations, Arizona Hospital Association  
Don Issacson, Legislative Counsel, St. Joseph's Hospital, Phoenix  
Barbara Hopkins, Arizona Consortium of Children With Chronic Illness

Guest List (Attachment 1)

## PRESENTATION

Cochairman Edens announced that he hoped the following parameters will be followed as testimony is taken:

1. Statements will concern long-term remedies to the health care situation in Arizona. He stated that "quick-fix" suggestions are not appropriate.
2. Assume that all proposals will use the same budget restraints.
3. The AHCCCS capitation process to remain in effect.

Peter Burns, Director, Governor's Office of Strategic Planning and Budgeting (OSPB), addressed the Committee concerning the Governor's budget proposals regarding the Arizona Health Care Cost Containment System (AHCCCS). He distributed a fact-sheet entitled "Controlling AHCCCS Expenditures of State General Fund (Attachment 2). Mr. Burns discussed the various suggested remedies on a time-frame basis as outlined in his handout. He noted his staff originally was working to find a way to save \$22 million, but now that figure has risen to \$82 million.

Mr. Burns referred to a "famous memo" (Attachment 3) delivered to the Governor's Office from AHCCCS that was widely distributed outlining the various items to be considered during deliberations on the budget proposals.

Representative Gerard referred Mr. Burns to the fact-sheet (see Attachment 2) and asked for clarification of Item 11 on Page 3. Mr. Burns stated the items listed were used to generate the proposals. There was a brief discussion regarding eligibility requirements and undocumented aliens.

Ted Ferris, Director, Joint Legislative Budget Committee (JLBC), distributed a handout entitled "Summary of Major Issues - AHCCCS" (Attachment 4). He stated both the Governor's and JLBC's budget projections used figures of \$135 million in new spendable revenues. However, unlike the Governor's budget, JLBC reserved three percent or \$111 million because of uncertainties in the budget. This will allow for a higher carry-forward to cover a reduction in the K-12 rollover and a tax cut; additionally, he said a commitment to fund K-12 average daily membership growth requires \$75 million. He said the goal of JLBC is to have a zero increase for the AHCCCS budget, but an additional \$80 million was found to be needed if nothing is done to change AHCCCS requirements.

He noted JLBC wanted to present a significant alternative to the Governor's budget because elimination of the Medically Needy - Medically Indigent (MN/MI) program may be too severe. JLBC used essentially the same parameters as OSPB.

Monty Headley, Fiscal Analyst, Joint Legislative Budget Committee (JLBC), addressed the Committee regarding the issues involved in the deliberation of the AHCCCS budget. Used the handout entitled "Summary of Major Issues - AHCCCS" (see Attachment 4).

Representative Gerard asked for clarification of the disproportionate share allocation to go the counties. Mr. Headley stated it is a legislative policy

decision that must be made regarding the amount to money to be sent to the counties, additionally, the counties will be able to collect additional sales tax revenue.

Senator Huppenthal asked if an analysis is available regarding the amount of sales tax revenues that might be available if additional monies are received from federal funds. Mr. Headley replied that to his knowledge a study of this issue is not presently available.

Senator Huppenthal asked if the proposed changes to the eligibility of SOBRA clients will make it more attractive for citizens with private insurance to cancel their medical coverage. Mr. P. Burns stated that 61 percent of the SOBRA population have inadequate or no medical coverage, and an assumption has been made that 50 percent of the 39 percent of those SOBRA clients involved in the increase of the poverty level may drop their insurance. He also noted it is very difficult to accurately measure the behavior of people.

There was a brief discussion regarding the possibility of State employees, with dependents, dropping state-offered medical insurance under proposed guidelines.

Mr. Edens asked for clarification of the undocumented alien issue.

(Tape 1, Side B)

Linda Redman, Executive Administrator - Policy, Arizona Health Care Cost Containment System (AHCCCS), stated the Quality Control group at AHCCCS conducted the study of undocumented aliens. She said that of 6200 people from the MN/MI group, 637 individuals were examined as to Title XIX eligibility. The case workers went to each individual to verify eligibility and found that 18 percent would qualify for full services and 23 percent will qualify for emergency services only, such as undocumented aliens.

Representative Gerard asked for a definition of emergency services. Ms. Redman read a definition of "emergency services" from federal statutes (Attachment 5).

Representative Gerard observed that hospitals under the proposed guidelines "hospitals will have to eat" the expenses of treating undocumented aliens. In response to a question from Representative Gerard, Mr. P. Burns stated an "emergency" will probably mean the time from the day admitted until the day discharged from a hospital. Representative Gerard asked if this issue may be settled by rule or if legislation is required. It was noted that this is a legislative policy decision, and under the JLBC proposals all MN/MI clients will continue to be covered, while under the Executive proposal the MN/MI patients will be left without medical coverage.

Ms. Horton asked if federal regulations allow coverage for delivery of babies. Ms. Redman replied in the affirmative.

Mr. P. Burns distributed a set of tables (Attachment 6) comparing the differences between the JLBC proposals and the Governor's proposals. He used several tables from the JLBC proposals and added the Governor's figures in comparison.

There was a brief discussion of Table No. 13 on Page 49 entitled "Comparison of the Impact on the Health Care System"; and Table 14 on Page 50 entitled "Comparison of the Impact on Hospitals" (see Attachment 4).

Senator Day asked for figures on the net impact to hospitals. Mrs. Day was referred to the bottom line of Table 14 showing a negative impact of \$47.6 million under Executive proposals as opposed to a \$37.9 million negative impact under JLBC proposals.

Mr. P. Burns referred the Committee to Table 16 entitled "Comparison of the Impact On Counties" (see Attachment 4). There was a brief discussion regarding county residual responsibility.

Mr. P. Burns discussed several of the JLBC proposals in comparison to the Executive proposals including acute care issues, the lack of adequate computer systems, and the proposed implementation date of April 1, 1993. Mr. Burns noted two elements were not addressed in the JLBC proposals which are "quick pay" to hospitals and the mental health waivers.

(Tape 2, Side A)

#### PUBLIC TESTIMONY

James D. Bruner, President, County Supervisors Association and Chairman, Board of Supervisors, Maricopa County, spoke in support of the Governor's proposals. Mr. Bruner spoke from a prepared text (Attachment 7) which included several charts, graphs and letters as attachments.

Representative Edens asked for more information regarding acute care and county responsibility. Knox Kimberly, Inter-Governmental Relations, Maricopa County, stated that the JLBC proposals are not consistent with county revenues. He said county health care expenditures must be "put on the table" and studied thoroughly because the counties cannot withstand JLBC proposals.

Senator Huppenthal asked for clarification of cost shifting under the Governor's proposals. Anthony Rogers, Hospital Director, Maricopa County Hospital, stated there will significant cost shifting and an analysis of this problem has not been done.

Senator Huppenthal suggested that efforts be made to minimize legal expenditures. Mr. Kimberly said that the County has been named as a defendant in several suits brought by private hospitals.

Richard Burnham, Attorney, representing St. Mary's Hospital and the Carondelet Health Service, Tucson, spoke in opposition to the Governor's proposal. He said the JLBC proposal may be "OK", but doing nothing is better. He said the proposals will amount to "a tax on hospitals". He noted adult males will be disenfranchised under the Governor's proposals. He suggested that the counties retain the residual provisions and are doing a good job in eligibility procedures. Mr. Burnham took strong exception to the figures regarding costs to be shifted to private hospitals. Mrs. Gerard observed that JLBC proposals protect hospitals and referred the Committee to Table 14, Page 50 of the JLBC handout (see Attachment 4.)

Margaret Snider, Valley Interfaith Project, spoke from a prepared text (Attachment 8). She spoke in support of those people that may be disenfranchised if the MN/MI population is eliminated from AHCCCS coverage.

Earl Baker, M.D., representing the Arizona Medical Association (ARMA), spoke in opposition to the elimination of MN/MI patients from AHCCCS coverage. He said he is the Director of a free medical and dental clinic in South Phoenix where 125,000 people are in need of medical help, he noted this number rises to 340,000 in Maricopa County and 600,000 in the State. He stated strongly that adding 35,000 additional people to this number is very wrong. He said his clinic had logged in 700 requests for dental care in two days. He urged that a way must be found to provide basic health care to the indigent population.

(Tape 2, Side B)

Monsignor Edward J. Ryle, Executive Director, Arizona Catholic Conference, stated he has worked with the AHCCCS program for several years, and has found it to be a bi-partisan program which has provided needed medical benefits to many citizens of the State. He noted AHCCCS is held up as a model for many other states across the nation. He spoke in support of health care for the MN/MI population and noted that undocumented aliens are in residence in the State and have rights to basic health care. He suggested that all parameters for establishing health care rules be revisited.

Laurie Campbell, Vice President, Government Relations, Arizona Hospital Association, spoke in opposition to the Governor's proposals. She noted the present MN/MI rules provide a safety net for the working poor. She said that premiums for health insurance will probably be increased significantly under the Governor's proposals. She expressed strong support for the JLBC proposal.

Don Issacson, Legislative Counsel, St. Joseph's Hospital, Phoenix, spoke in support of the JLBC proposals, and noted that one-third of services provided at St. Joseph's are funded through AHCCCS. He suggested that the \$48 million tax cut proposed by the Governor be used to fund needed health care. He stated the use of federal funds may not always provide the desired effect, and private hospitals are willing to study additional means of cost cutting. He agreed with the suggestions found on Page 13 of Mr. Bruner's testimony (see Attachment 5). He urged the third-party liability issue be studied.

Barbara Hopkins, Arizona Consortium of Children With Chronic Illness, spoke in support of retaining coverage of the MN/MI population. She described her son's illness and the problems involved in providing him with medication. She strongly urged the Committee to carefully consider the MN/MI population before eliminating them from AHCCCS coverage. She noted that every citizen is at risk of becoming a member of the MN/MI group because of the state of the economy. In response to a comment from Representative Edens asking for suggestions, Mrs. Hopkins said the Committee should address the issues of the availability of basic insurance and the problems of pre-existing conditions, sliding scales for the payment of services, more accountability from AHCCCS, and tort reform.

Representative Edens announced that the next meeting of the Committee will be held Thursday, January 28, 1993 convening at 5:00 p.m.

Without objection, the meeting adjourned at 8:10 p.m.

  
Barbara Williams, Secretary

(Attachments on file in the Office of the Chief Clerk and with the Committee Secretary. Tapes on file in the Office of the Chief Clerk).

ARIZONA HOUSE OF REPRESENTATIVES

GUESTS ATTENDING MEETING

HEARING ROOM 3

TIME 5:00

MEETING AHCCCS AD HOC Committee DATE 1-21-99

NAME AND TITLE (Please print)	REPRESENTING	BILL NO.
CHARLES TOMLINSON WELFARE DIR.	NAVAJO COUNTY	
DICK BURNHAM	ST MARY'S HOSPITAL	
JANIS GYANKER HELLMAN	TUCSON MEDICAL CTR	
Diane Pwodzi	Tucson Medical Center	
Martin Willett	Pima County	
FRANK KOENIG	INDIVIDUAL	
Edward Ryle	AZ CATH. CONF.	
Karen Brunson	County Super Assoc	
AUSTIN TURNER	Senate	
Bill CHAMBERLAIN	AQUA	
Pat Moore	ASU	
Rozie Blackwell	Health Care Arizona	
Marta Mee	AZ STATE AFF-10	
Linda Hanson	AZ Consortium for	
Linda Hanson	Widow of Chronic Illness	
David Landis	ArMA	
Richard Dwyer	Maricopa County	
JERRY ORRICK	Co SUPERVISORS ASSN	

# CONTROLLING AHCCCS EXPENDITURES OF STATE GENERAL FUND

- 1) The List - June, 1992
  - Emergency Services/Deliveries Partially Enacted
  - Co-Locate DES/County Rejected
  - Co-Pay MNMI Rejected
  - EAC Conversion Administration Pursued
  - Recoup Maricopa Hospital Reimbursement Rejected
  - Increase Quick-Pay Discount Rejected
  
- 2) Other Early Issues: May - July, 1992
  - Shifting Cost to Categorical
    - Eliminate Quick-Pay Discount to Categorical and Increase Quick-Pays to State-Only
  - Pursue Higher DSH Payments
  - Provider Taxes
  - Examine LTC Rates
  - Eligibility Consolidation
  - Uniform Purchasing of Health Care
  - 48-Hour Retroactive Repeal/Increased County Contributions
  - Limit MNMI to Six Months in One Year
  - Teaching Subsidy to University of Arizona Medical School
  - Limited by P&O Dollars Available to AHCCCS and Federal Funds Effort at OSPB
  
- 3) August 3, 1992
  - Rough OSPB Estimate of AHCCCS Increase at \$65.6 Million
  
- 4) August 4, 1992: "Options for the Governor" From AHCCCS
  - Discontinue Medicaid
  - Eliminate/Modify MNMI/Children's Programs
    - Eliminate
    - Retroactive 48-Hour
    - Asset Test 50,000 → 30,000
    - Eligibility Six Month → Three Month
    - Stricter State Residency Requirements
    - Family Membership
    - Service Package
    - Co-Payments
    - Eliminate Spend Down
  - Mandatory Eligibility Application for Title XIX
  - Reduce Eligibility Standards
    - or Eliminate Optional Groups (140-133) Resource Standards
  - Eliminate Optional Services Under XIX
  - Eliminate Waiving Parental Income for Children In ALTCS
  - Limit Amount or Level of Service (Hospitals)
  - Reduce ALTCS Income Level, 300 → 100 SSI
  - Provider Tax

- 5) August 19, 1992: FOIA Request - Arizona Hospital Association
  - 6) September 29, 1992: Revisit Federal Medically Needy Program
  - 7) October AHCCCS Analysis (See OSPB Memo Dated November 2, 1992)  
Turn MNMI Back to Counties, With Limited State Funding  
Eliminate County Residual, With Minimum Service Package
  - 8) November 2, 1992: OSPB Pool Funding  
Discount MNMI Reimbursements (Quarterly, Semi-Annual, Annually)  
Eliminate Quick-Pay on Categorical
- November 10, 1992: Lewin - Eliminate Hospital Payments (trend in other states),  
Increase Match \$10.0 Million
- November 13, 1992: AHCCCS Analysis of Budget Reduction Proposal → Block Grant

9) *Guiding Principles*: November 24, 1992

- Zero Growth in AHCCCS General Fund Appropriation
- Minimize Impact on External Entities (Providers, Counties, People),  
Recognizing Everyone Will Get Hurt
- Minimize Administrative Changes Necessary
- Preserve Managed Care for Title XIX
- Minimize Implementation Lead Time
- Convert As Many State-Only Eligible Persons to Title XIX

Block Grant Run by AHCCCS/County or Maricopa and Pima Counties  
and Bid or Continue Rural

Limit Population, Pregnant Women & Kids, Non-Medicare, and > \$20,000 Hospital  
Bills

- 10) December 4, 1992:
- Focus on Undocumented
  - Medicare Groups
  - EAC/ELIC
  - SOBRA Back to 133%
  - FY 1993 Proposal
  - Looking at Hospital Impacts Along With Occupancy Factors
- 11) December 9, 1992:
- Formulation of Executive Proposal
    - 14-18 Years to 100% FPL
    - <6 Years Increase From 133 to 140% FPL, 6-13 Years Increase From 100 to 140% FPL, 14-18 Years to 140% FPL
    - Same as Above at 185% FPL
  - SOBRA Women to 185% FPL
  - Quick-Pay
  - Emergency Services for Undocumented
  - Shift MNMI to Categorical
  - MNMI Eligibility Tail
  - MNMI Tail
  - Mental Health
  - Offset to CRS
  - Eligibility
  - County Savings

MEMORANDUM

TO: Charline Franz  
Special Assistant to the Governor

FROM: Leonard Kirschner, M.D., M.P.H., Director *LK*

SUBJECT: OPTION PAPERS FOR THE GOVERNOR

DATE: August 4, 1992

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As requested by the Governor's Office, AHCCCS developed a series of option papers that range from the elimination of Medicaid in Arizona to other modifications designed to save State funds in the current AHCCCS program. We have prepared the following summary that follows as well as more detailed analyses on the options. When readily available, a very preliminary and rough estimate of the fiscal impact has been provided. If you want more detail on any of the options, please advise me and we will do further research on your selections.

The legal implications of the options have not been discussed. In most cases, legislation or a rule change would be required to implement the changes. In addition, many of the changes will require amendments to the State Plan and approval by the Health Care Financing Administration.

One issue to keep in mind in that any change in services or eligibility groups will require amendments to the health plan contracts and capitation rates. Major restructuring may impact the economic viability of some of our plans and will need to be carefully weighed in the discussion of options.

**DISCONTINUE PARTICIPATION IN THE MEDICAID PROGRAM (Page 1)**

In FY 92-93, this option would eliminate the need for \$589 million in State and county matching funds for 364,000 Title XIX eligible people. However, the State would lose more than \$875 million in Title XIX federal funds for health care. Without the federal funding,

the State could not deliver the same level of services to the same population without additional State funding.

**ELIMINATE OR MODIFY THE STATE-FUNDED MEDICALLY NEEDED/MEDICALLY INDIGENT/CHILDREN'S PROGRAMS (PAGES 4 THROUGH 6)**

Under this option there are a number of approaches:

- 1) Discontinue the State-funded Medically Needy/Medically Indigent(MN/MI)/Eligible Assistance Children (EAC) and Eligible Low Income Children's (ELIC) programs. This option would eliminate the need for \$174 million in State and county funds for over 70,000 MN/MI/EAC/ELIC persons. There is no federal funding for this program.
- 2) After all possible conversions to the new AFDC-Medical Assistance Only (MAO) category, eliminate the ELIC and/or the EAC Program. This would discontinue State-funded health care to approximately 15,000 children who are 13 years of age or younger and do not qualify for a federal category.
- 3) Discontinue the two day retroactive payment to counties for MN/MI/ELIC eligibles.
- 4) Lower the asset test from \$50,000 to a lower amount. It was \$30,000 in 1986.
- 5) Reduce the six month eligibility period to a three month period.
- 6) Impose stricter standards for State residency before a person could qualify as MN/MI/ELIC.
- 7) Eliminate family household eligibility for MN/MI.
- 8) Reduce the service package for MN/MI/EAC/ELIC members. One example is the EPSDT program that, with the exception of some transplants, mental health services, and long term care, parallels the federal Medicaid EPSDT program.
- 9) Impose higher copayments for MN/MI/EAC/ELIC members.
- 10) Eliminate spend down as an option for MN/MI/ELIC status.

### **MANDATORY APPLICATIONS AT CONSOLIDATED ELIGIBILITY SITES (PAGE 8)**

The State could require potentially eligible persons to be determined eligible or ineligible for Medicaid at consolidated eligibility sites before the persons could qualify for a State-funded program. This will maximize federal funds, reduce administrative costs and streamline the eligibility process.

### **REDUCE ELIGIBILITY STANDARDS OR ELIMINATE OPTIONAL GROUPS (PAGE 10)**

Reduce the current income eligibility for SOBRA pregnant women and infants up to age one from the current 140 percent of federal poverty level (FPL) to the minimum allowable: 133 percent of FPL.

Eliminate optional eligibility coverage such as MAO. This will include the new eligibility group that AHCCCS will use to convert most of the 100 percent State-funded food stamp children up to age 13 into a federal program.

Increase resource requirements for SOBRA pregnant women and children. Currently, the resource requirement for these two eligibility categories is zero. Resource requirements could be increased and fewer pregnant women and children would qualify for the program.

### **ELIMINATE OPTIONAL SERVICES UNDER MEDICAID (PAGE 12 UNLESS OTHERWISE INDICATED)**

The State could elect to eliminate optional Medicaid services. By federal law, optional services do not include services determined as medically necessary by an EPSDT screen for children under the age of 21. The optional services for adults that Arizona covers that could be eliminated are:

- Respiratory Care
- Hospice
- Nurse-Midwife
- Private duty nursing
- Physical, occupational, speech, hearing and language disorder therapies
- Prosthetic devices
- Services in an Institution for Mental Disease for persons 65 years and older
- Dentures
- Emergency Hospital Services
- Adult transplants (kidney, cornea, heart, bone, bone marrow)
- Medical Supplies and Equipment

- Transportation
- Case management (Page 14)
- Home and Community Based Services (Page 16)
- Prescription drugs (Page 18)
- Mental health services: clinic/rehabilitative services; other practitioner services such as certified nurse anesthetists and non-physician mental health practitioners; services in an Institution for Mental Disease for persons 65 years and older (Page 20)
- Services in an Intermediate Care Facility for Mental Retardation (Page 22)

**ELIMINATE THE WAIVING OF PARENTAL INCOME FOR CHILDREN IN THE ARIZONA LONG TERM CARE SYSTEM (ALTCS) PROGRAM (PAGE 23)**

This will reduce the number of children with physical disabilities or developmental disabilities who qualify for ALTCS based on their own income and not based on a consideration of the parental income in the household.

**LIMIT THE AMOUNT OF SERVICES OR LEVEL OF SERVICES FUNDING (PAGE 26)**

The State could place limitations on various services, such as the number of inpatient hospital days, the number of outpatient visits, the amount that will be paid for physician visits or a limitation on the number of prescriptions that a member can receive.

**REDUCE THE ALTCS INCOME ELIGIBILITY LIMIT (PAGE 28)**

Arizona currently covers individuals in ALTCS with income up to 300 percent of SSI, or \$1266 per month income. Arizona could elect to set the income eligibility level anywhere from 100 percent of SSI to the 300 percent level. If income levels for ALTCS are reduced, fewer people will qualify for Title XIX long term care services.

**PROVIDER TAX**

Although technically not a modification of the existing AHCCCS program, a provider tax is one mechanism the State can pursue to infuse new federal funds into AHCCCS.

## DISCONTINUE PARTICIPATION IN THE MEDICAID PROGRAM

### ISSUE

Discontinue participation in the Medicaid program after notification to the Health Care Financing Administration (HCFA) and determine the scope of an indigent health care program that the State is willing to fund.

### DISCUSSION

In FY 92-93, Arizona could "save" up to \$589 million in State and county funds currently allocated as Title XIX matching funds for the AHCCCS program. Conversely, Arizona will lose over \$875 million in federal funding, which pays 65 cents on every dollar that Arizona spends for health care for Medicaid eligible persons.

In the Title XIX and state-funded programs over 440,000 people receive acute care and long term care services. Of these, 348,000 are Title XIX eligible for acute care services and 16,000 elderly/physically disabled/developmentally disabled persons receive long term care services under ALTCS. In the 100 percent State-funded Medically Needy/Medically Indigent (MN/MI), Eligible Assistance Children (EAC) and Eligible Low Income Children (ELIC) program, 76,000 persons receive acute care services. Approximately 15,000 of the EAC children should convert to a new federal eligibility option if HCFA approves Arizona's State Plan amendment to add this AFDC optional category.

Depending on the outcome of decisions for State funding of indigent health care coverage, several scenarios are possible. Two options are:

- 1) With the \$589 million in State and county funds that currently fund AHCCCS, the State, each of the 15 counties or a partnership of the State/counties could fund a limited indigent health care program for some of the individuals who currently receive acute care, mental health services and long term care. Without the federal funds, fewer individuals than currently receive services under AHCCCS would be served in a State-funded program with the available State dollars.
- 2) The State could decide not to fund any indigent health care or long term care services. This option would result in a significant cost shift to public and private hospitals as these facilities would become the only source of indigent health care for persons in life-threatening medical emergencies.

## PROS

- Arizona could tailor an indigent health care program free of federal mandates, such as the Boren Amendment and Medicaid mandated eligibility requirements.
- Depending on the scope of a new program, there may be some savings in overall State funds for the cost of limited health care and the administrative requirements for AHCCCS.
- Without the constraints of Medicaid law, Arizona could impose higher co-payments on persons who receive health care at State and county expense, thereby absorbing some of the general fund expense. However, this decision will be offset by the fact that there is a limit on how high a co-payment can be before it becomes a barrier to routine, preventive care and results in costly urgent care.

## CONS

- With the loss of federal funds, Arizona could not provide comparable health care coverage, mental health services, nursing facility or home and community-based care for the same amount of State funding.
- If the existing program is eliminated or seriously curtailed, pregnant women and children will be vulnerable. If prenatal care is not readily available, it is likely that the costs for delivery will increase as will premature babies and neonatal complications. Arizona currently ranks 40th in the nation in the provision of health care to children; scaling-back the AHCCCS program will further exacerbate health care problems for children.
- Unless the State or counties absorb the costs of nursing facilities or home and community based services (HCBS) currently paid for under ALTCS, elderly and physically disabled persons who do not have the resources to pay for their care in a nursing facility may be forced to move to cheaper settings where appropriate care is not provided. Medical conditions may worsen and hospitalization may be necessary. Persons in HCBS may be forced to move into institutional settings if the community-based supports are unavailable.
- For adult mental health services, Arizona is under the mandate of the Arnold v. Sarn lawsuit. Opting out of Medicaid will not obviate the terms of the lawsuit; rather, it will reduce available federal funds to pay for mental health services to persons who are covered by the terms of the settlement agreement.
- Unless the State absorbs the cost of care for persons with developmental disabilities currently funded by AHCCCS, many of these individuals will go without care or

request placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), such as Coolidge. Currently, 97 percent of this population is served in the community at a cheaper cost than an institutional setting. In 1988, county funding for this population was eliminated as part of the new long term care program. Prior to ALTCS, DES paid for care with 100 percent State funds, had a waiting list of over 10,000 people and significantly more people placed in ICFs/MR in the State.

- If health care funding is severely limited, serious repercussions will be felt by the health plans that contract with AHCCCS, Maricopa, Pima and Pinal counties as program contractors, DES, ADHS, AHCCCS, the provider community and their respective employees. This may result in health plans going out-of-business, forced private sector lay-offs and restructuring of State and county agencies, with possible reductions in force unless public employees can be reassigned to other areas.
- Many rural and urban hospitals are dependent on the revenues from AHCCCS to maintain economic viability and offset uncompensated care costs. If the AHCCCS program is significantly changed, many community hospitals may be vulnerable to this shift in their revenue stream.

## **POLITICAL REALITIES**

If a decision is made to opt out of the Medicaid program, legislative authorization will be required. Significant opposition will surface from people who believe that some form of indigent health care is a necessary public responsibility, especially when 65 percent of the funding comes from the federal government. Groups that will oppose this legislation include: the counties; hospitals; the tribes; the health plans; advocacy groups for all special interest groups whose constituency benefits from AHCCCS; many State legislators; and, probably some members of the Congressional delegation who have lobbied for AHCCCS before Congress.

The significant opposition and the loss of \$875 million in federal funds will make it difficult to pass authorizing legislation. Cost shifting to either the counties or public/private hospitals will fuel the opposition to any proposal to opt out of Medicaid unless a comparable health care delivery system is implemented with State funds and other entities are held harmless from increased expenditures.

## ELIMINATE OR MODIFY THE STATE-FUNDED MEDICALLY NEEDY/MEDICALLY INDIGENT/CHILDREN'S PROGRAMS

### ISSUE

The State could eliminate the Medically Needy/Medically Indigent (MN/MI), Eligible Assistance Children (EAC) and Eligible low income Children (ELIC) programs or modify these programs by changing the level of services, eligibility requirements, copayment requirements or the two day retroactive period for the counties.

### DISCUSSION

The following is a menu of options that can be considered. Since the principal benefit to the State will be some reduction in State funding, only the cons specific to each option are discussed below.

### ELIMINATE PROGRAMS

Two options are possible:

- 1) Discontinue the State-funded MN/MI/EAC/ELIC programs. This option would save approximately \$180 million in State and county funding for over 70,000 MN/MI/EAC/ELIC persons. It is assumed that the \$63 million county contribution would be returned to the respective counties and the counties would be required to provide some level of indigent health care; and/or,
- 2) Eliminate the ELIC and/or the EAC Program. After full conversion of approximately 15,000 EAC children to the new federally-funded AFDC-MAO category (if approved by HCFA), this would discontinue State-funded health care to a projected 15,000 children who are 13 years of age or younger.

In both cases, county residual for acute care services will increase. Even if the current county contribution is returned to the counties, it will be insufficient to cover the costs for a county-operated health care program and new county funds will be needed. Uncompensated care in public and private hospitals will increase.

## ELIMINATE COUNTY SUPPORTS

Discontinue the two day retroactive payment to counties for MN/MI/ELIC eligibles. Although this will save the State approximately \$14 to 15 million, it will result in a major cost shift of millions of dollars back to the counties or hospitals in the form of uncompensated care.

## ELIGIBILITY

Each of these eligibility-related options will mean that either one or all of the following will occur:

- 1) unless the county provides health care under the county residual program, fewer people who now qualify for the MN/MI/EAC/ELIC program will receive health care;
- 2) the counties could absorb the cost of care which will adversely impact county budgets; or,
- 3) uncompensated health care costs will increase for public and private hospitals. The adverse effects of implementing any of these options is discussed in the sections below.

The following are several eligibility options:

- ° By amending AHCCCS rules, reduce the six month eligibility period for MN/MI/ELIC members to a three month period. This will reduce the number of persons eligible for the program, make the eligibility process for members more cumbersome and increase administrative costs for eligibility. Health plan capitation rates may increase since the risk is not spread over a six month period and the cost to the plans may increase as members cycle in and out of the plans.
- ° Conform State residency to a federal citizenship standard before a person could qualify as MN/MI/ELIC. This option will directly impact individuals who are not citizens of the United States and will increase uncompensated care for public and private hospitals. It will be opposed vigorously by many interest groups and may be subject to legal challenge.
- ° By amending AHCCCS rules, eliminate family household eligibility for the MN/MI program. This will reduce the number of persons who qualify for the State-funded programs. However, some of the children in these households may still qualify for the State-funded EAC or ELIC programs. This may not be a cost-effective option

since the remainder of the household is generally healthy and this allows AHCCCS to negotiate lower capitation rates with the health plans.

- Eliminate the ability of an individual to spend down medical bills for MN and ELIC status. This will significantly impact the number of persons who qualify for the MN and ELIC programs and will result in more uncompensated care in public and private hospitals.
- Lower the asset test for eligibility for MN/MI/ELIC applicants from \$50,000 to a lower amount (it was \$30,000 in 1986). Fewer people will qualify for the program.

## **SERVICES**

Reduce the service package for MN/MI/EAC/ELIC members. One example is the EPSDT program that, with the exception of some transplants, long term care and mental health services, parallels the federal Medicaid EPSDT program. In 1987, Congress required all States to provide all medically necessary services to Medicaid children under the age of 21. Arizona provides this same level of care to children in the State-funded MN/MI/EAC/ELIC programs.

## **CO-PAYMENTS**

By amending AHCCCS rule, impose higher copayments on services for MN/MI/EAC/ELIC members. Currently, a copayment is imposed in the following instances: (1) \$1.00 for a doctor office visit, home visit and all diagnostic and rehabilitative x-ray and laboratory services; (2) \$5.00 for non-emergency surgery or non-emergency use of the emergency room. Excluded from the copayment requirements are: prenatal care, EPSDT/well-baby services and prescription drugs. Currently, members cannot be denied services because of their inability to pay. However, if the copayments are too high, this will be a barrier to preventive care and may lead to more costly emergency care. One problem with copayments is that many physicians do not want the administrative problems associated with the collection of copayments and do not collect them. If copayments are increased and the administrative costs for collection of the copayments are minimal, there will be additional dollars generated for the State.

## **POLITICAL REALITIES**

Except as noted above, statutory changes will be required for these options. Eliminating or modifying the MN/MI/EAC/ELIC programs will raise a significant level of opposition from hospitals, counties, advocacy groups and those legislators who support an indigent health care program and realize that the counties do not have the resources to fully fund a

comprehensive program. Any changes to the residency requirements will be controversial and will be opposed by some legislators and may result in a legal challenge.

## MANDATORY APPLICATIONS AT CONSOLIDATED ELIGIBILITY SITES

### ISSUE

Arizona could maximize federal funding by requiring all persons who are potentially eligible for Medicaid programs to apply at consolidated eligibility sites and be determined eligible or ineligible for Medicaid before receiving services in the State-funded MN/MI/ELIC programs.

### DISCUSSION

This will further expand the mandatory application requirement made in the 1992 legislative session that all EAC and hospitalized individuals must apply for federal Medicaid programs before being determined eligible for State programs. A recent study done by AHCCCS indicated that 41 percent of the current state-funded population would qualify for a federal Medicaid program, either for all Title XIX services or emergency services only. Currently, there is no incentive for a person who has been determined eligible for a State-funded program to apply for a Medicaid program. Secondly, counties want to avoid county exposure for health care costs; therefore, the financial incentives for the counties are to make a person eligible for a State-funded program as quickly as possible. Two major issues must be addressed to successfully implement this option:

- 1) a streamlined eligibility process consolidated at DES should be implemented to maximize efficiency and timeliness while allowing one entity to screen for all public benefits. This will greatly increase the opportunity to enroll individuals in Medicaid; and,
- 2) the issue of county residual and uncompensated care for hospitals in the interim prior to an eligibility determination must be considered. A task force has been established to make recommendations on a comprehensive eligibility system with a plan due March 31, 1993 with a financial and statutory considerations report due January 1, 1994. However, the State could implement this option sooner and draw down increased federal funds.

### PROS

- The State will maximize federal funds by requiring individuals to apply for Medicaid programs, if appropriate.

- A streamlined, consolidated eligibility system will reduce administrative costs and make it easier for persons to apply for the federal or State programs.
- A State agency performing the eligibility process will be more accountable for errors since financial sanctions will be imposed if timeliness requirements are not met.

## CONS

- Any attempt to consolidate eligibility at the State level will be opposed by the counties unless the issue of county residual is resolved. Some hospitals will oppose a State eligibility process because they fear delays in eligibility determinations and the resulting uncompensated care.
- In order for DES to implement a responsive and timely consolidated eligibility process, additional resources must be allocated to the agency.
- If the counties no longer perform eligibility functions for AHCCCS, some county employees may be displaced. It is possible that county eligibility workers could be offered the opportunity to transfer to newly created DES eligibility positions.

## POLITICAL REALITIES

This has been a controversial option for several years, vigorously opposed by Maricopa County, in particular, other counties and some hospitals. Reasons vary from dismantling eligibility infrastructures to county residual and uncompensated care. This may be a difficult measure to pass at the legislature but one that will maximize federal funding, streamline a complicated system for the individuals who apply and greatly save administrative dollars.

## REDUCE ELIGIBILITY STANDARDS OR ELIMINATE OPTIONAL GROUPS

### ISSUE

Arizona could elect to decrease the income eligibility standards for pregnant women and infants up to age one, impose a resource test for pregnant women, infants and AFDC-Medical Assistance Only (MAO) children up to age 13 or discontinue optional eligibility coverage for MAO groups.

### DISCUSSION

The following are three options:

#### PREGNANT WOMEN AND INFANTS

- States are required to establish a minimum income eligibility standard for pregnant women and infants up to age one at 133 percent of federal poverty level (FPL) with an option to set a maximum of up to 185 percent of FPL. Arizona has chosen a 140 percent of FPL and could reduce it to 133 percent. This would result in the loss of federal funding for some of the women and children in the 134-140 percent income range. This may not be a cost effective approach since many of these women or children currently may be MN/MI eligible or will be once the prenatal care or hospitalization costs spend them down to the State-only levels. Secondly, early prenatal care has proven to be cost effective and limiting access to care may result in more expensive deliveries and neonatal care.

#### RESOURCE TEST

- Arizona does not have a resource test for the SOBRA pregnant women and children (now at age 9) or the newly created AFDC-MAO program that will convert State-funded EAC children up to age 13 to a new federal category. By federal law, the maximum allowable resource test that could be used is \$1000 for a pregnant woman (\$2000 couple) or \$1000 for a child. Imposing a resource test will mean that some pregnant women and children will not qualify for a Title XIX program. However, depending on medical costs, some of these individuals will qualify for the MN/MI/EAC/ELIC program at 100 percent State costs.

The decision not to impose a resource test was based on the administrative costs that would have been incurred to use a resource test for all pregnant women and children versus the limited number of persons that will not qualify due to excess

resources. Secondly, imposing a resource test will slow down the expedited eligibility process for pregnant women before they can qualify for prenatal care.

#### OPTIONAL ELIGIBILITY GROUPS

- Arizona has some optional eligibility groups, primarily MAO children groups. Eliminating this coverage could save State matching funds. However, unless 100 percent State-funded groups, such as EAC and ELIC are also eliminated, many of the federally funded children will convert to the State-only programs at significantly more State cost.

#### POLITICAL REALITIES

Discontinuing health care coverage for either pregnant women or children will generate significant opposition from advocates, health care professionals and some legislators who have supported health care coverage for this vulnerable population. Unless the State-only programs are significantly cut-back, many of these individuals will qualify for these programs at higher State cost. Public and private hospitals will oppose any measure that increases uncompensated care to their facilities.

## ELIMINATE OPTIONAL SERVICES UNDER MEDICAID

### ISSUE

A State may choose to select any one of 30 optional Medicaid services. Arizona has added 18 optional services to the program and, with notice to HCFA, may eliminate any or all of them.

### DISCUSSION

The following optional services are discussed separately in the issue papers that follow: case management, home and community-based services, prescription drugs, optional mental health services and services in an ICF/MR. The remaining optional services are discussed below.

### OPTIONAL SERVICES

The remaining optional services covered by AHCCCS are: adult transplants, private duty nursing, therapies, prosthetic devices, respiratory care, hospice, nurse-midwife, dentures, emergency hospital services, medical supplies/equipment and transportation. Many of these optional services were added to the program because it was a cost effective means for the health plans to manage a continuum of care in a coordinated care system. Others, such as adult transplants and dentures were added in response to quality of life issues and legislative initiatives.

Even if Arizona elects to eliminate optional services, EPSDT persons under the age of 21 must receive all mandatory or optional Medicaid service that are medically necessary. Therefore, all 30 of the optional services will be available to EPSDT persons no matter what action a State takes to streamline the Medicaid program.

The other variable that should be considered before a decision is made on the cost-effectiveness of eliminating optional services is the health plan bidding process. Risk is spread across all populations and the more cost-effective alternatives to institutional care lowers the capitation rates accordingly. Eliminating alternatives to institutional care, such as hospice, therapies and private duty nursing services, may increase the costs to the plans and increase bids accordingly.

## **PROS**

- The State may be able to save costs on some of the optional services to the adult Medicaid population.

## **CONS**

- Eliminating services that are alternatives to institutional care may keep a person in a hospital setting if there are no other options in the community.
- Health plan costs may actually increase depending on which optional service is eliminated.
- Managed care will be difficult without a full continuum of services.

## **POLITICAL REALITIES**

Legislation may be required to change some of these options. In other cases, a rule change may be sufficient but subject to legal challenge if the legislature does give specific authority to the Director of AHCCCS to cut services. Any attempt to eliminate services will lead to opposition from some forum. It is expected that advocates, professional groups that deliver or represent the various services, health plans and some legislators will oppose changes to the program.

## ELIMINATE OPTIONAL CASE MANAGEMENT SERVICES

### ISSUE

Optional case management services could be eliminated.

### DISCUSSION

AHCCCS has 130 case managers funded by federal and State funds to provide case management services to the elderly and physically disabled; DES/DDD has 160 case managers who provide case management to persons with developmental disabilities. Seven tribes provide case management to Title XIX long term care tribal members. Case management is also provided by the Regional Behavioral Health Authorities (RBHA's) to Title XIX eligible persons with mental health and substance abuse problems.

Case management services in the AHCCCS program were initiated as part of the long term care waiver. They were requested by the State to help defray the 100 percent State cost for existing case managers in DES/DDD and to contain costs in ALTCS with a gatekeeper determining the most appropriate and cost effective services for members in ALTCS. Due to the federal requirement to provide all medically necessary services to all EPSDT children, case management services were extended to children in the mental health program.

Although an optional service, 43 States have elected to provide case management services in an effort to control costs and coordinate care. Eliminating this service for AHCCCS members will require HCFA approval and assurances that long term care and mental health costs will not increase. However, many of the functions that case managers perform, such as cost-effectiveness analyses of home and community-based services versus institutional care and oversight of the appropriateness of the placements, will still be necessary and require employees to perform those functions.

### PROS

- The State may save some administrative funds for employees who provide case management services.

### CONS

- Unless the affected entities redeploy personnel into other positions, this option will require two agencies, seven tribes, and the RBHA's to lay off employees.

- Program costs may increase without the case manager acting as a gatekeeper to determine appropriate and cost effective services.
- The federal match for a targeted case management system ranges from 65 to 75 percent, depending on the qualifications of the personnel, making case management a cost effective service. Eliminating this option will still require State personnel to perform many of the activities; however, the available federal match will be 50 percent and not the enhanced amount that is available for case management.

## **POLITICAL REALITIES**

Eliminating this service will meet significant opposition from advocates who view case management as a necessary service for individuals who need assistance to coordinate the services necessary for quality care.

## ELIMINATE OPTIONAL HOME AND COMMUNITY-BASED SERVICES

### ISSUE

Arizona could elect to eliminate the optional home and community-based services (HCBS) currently provided under ALTCS.

### DISCUSSION

States have an option to operate a HCBS program if HCFA approves a waiver request. One of the key variables that must be demonstrated before HCFA will approve a waiver is whether the HCBS program will be cost effective when compared with care provided in an institution. When Arizona added long term care to AHCCCS, a joint decision was made by the legislature, Governor's Office, counties and various advocacy groups to push the federal government for a comprehensive HCBS program in Arizona. Two major factors drove this decision: the cost effectiveness of such a approach and quality of life considerations for persons who can remain in the community rather than an institution. Therefore, a request was submitted to HCFA and, after strenuous negotiations, HCFA approved an HCBS program with a cap of 5 percent on the program for 1988-89. Subsequently, AHCCCS convinced HCFA to raise that cap to 25 percent and then 30 percent of the total long term care population on October 1, 1992. As further validation of the cost-effectiveness of HCBS, Project SLIM has recommended that these services should be expanded beyond the present 30 percent cap.

AHCCCS currently provides HCBS to over 2,300 of the 10,500 ALTCS elderly/physically disabled persons. The HCBS program for persons with developmental disabilities administered by DES/DDD does not have any cap on their HCBS program, serving over 4100 (97 percent) members in the community.

Prior to the initiation of ALTCS, the counties were responsible for long term care services, including HCBS, for the elderly and physically disabled population and contributed over \$2 million for the care of persons with developmental disabilities. DES/DDD had the primary responsibility for persons with developmental disabilities. If the HCBS program is eliminated, it is assumed that the HCBS portion of the \$93 million county contribution would be returned to the counties and each county would be responsible for services to the elderly and physically disabled population. DES/DDD would assume the responsibility for HCBS services to persons with developmental disabilities but without federal Title XIX funds.

For persons with behavioral problems, ADHS has the statutory responsibility for the community care. The Arnold v. Sarn lawsuit further obligates ADHS to provide mental

health services to adults. Beginning February 1, 1993, the State will provide mental health services to persons 65 years and older who qualify for ALTCS. If the State eliminates HCBS, ADHS will need additional resources to provide the required mental health services to elderly persons who lose eligibility for ALTCS.

## **PROS**

- The State could cut back HCBS to persons with developmental disabilities and save State funds.

## **CONS**

- The counties could not provide the same level of services to the elderly and physically disabled with the current county contribution, absent the federal Title XIX funding. Therefore, either the counties would need to find new dollars or vulnerable populations will lose HCBS.
- If the only alternative for some or all of the current ALTCS members is institutional care in a nursing facility, ICF/MR or an Institution for Mental Disease, admissions to these facilities will increase and costs will go up dramatically when compared with the costs for HCBS.
- Both ADHS and DES/DDD will not be able to provide the same level of HCBS without additional State funds.
- Any reduction in HCBS will be contrary to the Project SLIM recommendation to expand these services.

## **POLITICAL REALITIES**

A legislative change is necessary to eliminate HCBS from statute. Strong and vocal opposition will surface from the counties, advocates and ALTCS members. Many members of the legislature will oppose any diminution of services to vulnerable populations.

## ELIMINATE OR RESTRICT THE USE OF PRESCRIPTION DRUGS

### ISSUE

AHCCCS could discontinue or restrict the use of prescription drugs.

### DISCUSSION

Although coverage of prescription drugs is an optional Medicaid covered service, all 50 states have elected this option. Arizona could elect to eliminate prescription drugs and save State matching funds and 100 percent State funds for the MN/MI/EAC/ELIC program. New Mexico has restricted prescriptions to no more than three per month, with exceptions for antibiotics, dialysis and other chronic conditions. The initial savings to the State would be significant; however, any savings will be offset by the increased cost of providing emergency medical care or follow-up care to individuals unable to afford the cost of prescription drugs. Costs to the counties under their residual responsibilities will increase for prescription drugs not covered by the State.

### PROS

- The State would save State funds and the administrative costs for monitoring prescription drug usage.

### CONS

- Quality of care will be seriously impacted if members cannot afford needed prescriptions and medical conditions worsen or result in death.
- Some AHCCCS members may not have sufficient funds to cover the cost of prescription drugs and forego needed medication. The impact of this may be that some members become sicker and will need emergency care for chronic health problems.
- AHCCCS health plans and program contractors will find it difficult to deliver quality managed care with an emphasis on prevention if members cannot purchase needed prescriptions. Accordingly, emergency room and long term care costs may increase.
- Costs to the counties will increase.

## POLITICAL REALITIES

A legislative change will be required before AHCCCS could eliminate prescription drugs as a Medicaid covered service. Restrictions on prescriptions will require a rule change. Strong opposition may come from a wide variety of interested parties: advocates; pharmacists; medical-related advocacy groups, such as AIDS, diabetes, or chronic disease organizations; family planning organizations; the health plans and program contractors who are concerned about their long-range costs; and, legislators who may receive pressure from their constituencies.

## ELIMINATE OPTIONAL MEDICAID MENTAL HEALTH SERVICES

### ISSUE

The State could eliminate optional Medicaid mental health services such as clinic/rehabilitative services delivered in the community, services in an Institution for Mental Disease for persons 65 years and older and non-physician mental health practitioners.

### DISCUSSION

The federal requirements for mental health services are minimal; individual States have great latitude to design a mental health program based on the available options. Arizona choose a mental health program that emphasizes community mental health services rather than institutional settings. In addition to covering members under the age of 21, the legislature passed enabling legislation in 1992 which authorized the phase-in of mental health services for Medicaid eligible adults who are seriously mentally ill and persons 65 years and older enrolled in ALTCS. Case management is the cornerstone of the mental health program and, coupled with capitated payments, both should contain costs when compared with an institutionally-based program. If Arizona eliminated the optional community placements, mental health services would only be available for adults in an acute care general hospital, the most expensive level of care. Costs would increase dramatically as would admissions to these facilities if they are the only source of care. The State must still provide all optional community mental health services to EPSDT children.

### PROS

- The State would save the State matching funds for the optional services.

### CONS

- The only available Medicaid service with federal participation would be inpatient hospitalization for persons over the age of 21 years. Institutional care is not cost effective and will cost the State more than care in community settings.
- Institutionally based services will build an incentive to place persons in restrictive settings since that will be the only source of federal funding. Quality of care will be an issue since the emphasis in this State has been to provide services in the least restrictive setting and use institutions as the last resort.

- ° Eliminating the optional mental health services would not relieve the State from the statutory requirements nor legal obligations under Arnold v. Sam for a community mental health program. The State would be required to pay for these services with 100 percent State funds.

## **POLITICAL REALITIES**

Legislation would not be required to eliminate the optional mental health services; however, rules would need to be amended. It will be difficult to scale back this program without encountering significant opposition from some legislators, advocates, consumers and the court monitor for the lawsuit.

## ELIMINATE SERVICES IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED

### ISSUE

The State could elect to drop the optional coverage of services in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

### DISCUSSION

Currently, the State has five ICF/MR facilities with a total of 250 Title XIX certified beds. Federal financial participation is approximately \$12 million for the costs in these facilities. If Arizona dropped this optional service, federal funds would be lost and the State would be forced to pay the costs of the facilities with 100 percent State funds for any persons residing in an ICF/MR. The State could elect to close one or more ICF/MR facilities, thereby saving significant State costs; however, this is a difficult political process with strong opposition coming from various advocates and family members of persons who reside in these facilities.

### PROS

- In the absence of federal funds, the State may have more leverage to move more individuals from the ICFs/MR into appropriate and less restrictive community placements at a cheaper cost.

### CONS

- The loss of federal funds would be significant for those individuals who are Title XIX eligible and reside in an ICF/MR.

### POLITICAL REALITIES

Any overt move to close the ICFs/MR or curtail funding to those institutions will lead to significant opposition from a small, but extremely vocal, group of parents and advocates. Therefore, the reality is that the State probably will need some institutional beds and losing federal funding for those beds does not make sense.

## ELIMINATE THE WAIVING OF PARENTAL INCOME FOR CHILDREN IN THE ALTCS PROGRAM

### ISSUE

The State could discontinue the federal option which allows parental income to be waived when determining the income level for long term care eligibility of disabled children.

### DISCUSSION

Persons may qualify for ALTCS if their income does not exceed 300 percent of SSI (\$1266 per month), resource limitations are met and the person is at risk of institutionalization in a nursing facility, an Institution for Mental Disease (IMD) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). AHCCCS waives the parental income for children who apply and qualify for ALTCS since Medicaid does not allow the imposition of a sliding fee scale on families who have excess income.

If this option is selected, many children will not qualify for ALTCS and will lose home and community-based services or residential placements unless parental income is sufficient to pay the cost of care. If these children do not qualify for ALTCS they will also lose their health care benefits under AHCCCS.

There are at least four options that should be considered to address the needs of children who lose ALTCS coverage:

- 1) DES/DDD could provide ICF/MR and the full range or limited home and community-based services to children with developmental disabilities at 100 percent State cost (ADHS for children with behavioral health problems);
- 2) the counties could provide services to children with physical disabilities with county funding or county/State funding;
- 3) a sliding fee scale can be imposed on the families with the difference made up in State funding; or,
- 4) neither the State or counties provide any services.

For children with developmental disabilities, the majority are now served in home and community-based settings, either living with their families or in group homes. If DES/DDD absorbs the cost of care, the impact to their State budget will be significant depending on whether individuals are served in an ICF/MR or community placement. Even with the

imposition of a sliding fee scale, the amount collected may not equal the current federal Title XIX funding for these individuals; therefore, more State funds would be required to serve the same number of children.

In 1988 with the passage of the ALTCS legislation, counties were held harmless for any funding of services for persons with developmental disabilities. Unless that provision is changed by statute, the counties do not share in these costs. If the counties are required to pay for placements in a nursing facility or provide home and community based services to children with physical disabilities or developmental disabilities in excess of the current ALTCS contribution to the State, this will have a significant impact on county budgets.

Unless legislation is enacted that will relieve ADHS and the counties of the responsibility to provide mental health services to children, they will continue to be responsible for funding these services, with or without Title XIX funding.

## **PROS**

- The State could save State matching funds depending on the level of services that would be available in lieu of ALTCS.
- A sliding fee scale could be imposed on persons who can afford to pay, and currently do not under ALTCS, and the State will recoup some of the costs from the families.
- The health care system will be more equitable and save limited resources if those that can afford to pay for services share in the cost of care.

## **CONS**

- Children who are seriously emotionally disturbed, physically disabled or developmentally disabled will lose health care services, which may worsen their medical conditions and lead to much higher emergency room costs.
- If emergency room costs increase and there is no alternative payor, hospitals will absorb these costs in uncompensated care.
- If parents or legal guardians are faced with the loss of services for their children, it may lead to a request for termination of parental rights. In that event, the State will be faced with providing services at 100 percent State cost if the child does not become eligible for Medicaid due to the dependency status.

- ° Requests for admission to ICFs/MR or IMD's may increase if the State curtails home and community-based services and parents do not have sufficient resources to keep their children at home. Any increase in institutional admissions due to children who had been served in the community will significantly increase costs to the State.

## **POLITICAL REALITIES**

AHCCCS' policy will need to be changed and legislation may be needed to implement this change under the following conditions:

- 1) the legislature requires the counties to share in the cost of services for persons with developmental disabilities or expands their responsibilities for the physically disabled;
- 2) the county funding formula for ALTCS is changed; or,
- 3) DES/DDD or ADHS require additional appropriations to absorb the cost of care.

Any move to curtail services or make eligibility requirements more stringent for disabled populations will meet with significant opposition from families, advocates and various legislators who have supported efforts to ensure a strong home and community-based program for disabled children. If the counties or the hospitals are required to absorb any additional cost for services, they will also oppose this option.

## LIMIT THE AMOUNT OF SERVICES OR FUNDING LEVEL OF SERVICES

### ISSUE

AHCCCS could set a limitation on various services: the number of annual inpatient hospital days, number of visits for outpatient services and federally qualified health centers, or a cap on the dollar amounts that the State will pay for services in accordance with federal law.

### DISCUSSION

AHCCCS could save State funds by limiting the amount of various services or setting a cap on services. Any decision to limit hospital reimbursement must adhere to the funding cap will be constrained by the requirements of the Boren Amendment that payments made to a hospital or nursing home are reasonable and adequate to meet the costs incurred by economically and efficiently operated facilities. If this option is adopted, either counties will absorb the cost of care once the individual reaches the limitation or there will be significant cost shifts to public and private hospitals. Capping the number of days for Title XIX reimbursement will undermine the agreements made in the new hospital reimbursement legislation which passed the legislature in 1992.

### PROS

- This will reduce State costs, including administrative costs for prior authorization that would no longer be necessary.

### CONS

- This approach is contrary to a managed care model. Individuals may go without necessary services, avoid preventive care so as not to use exhaust their benefits and emergency room costs will increase.
- A limitation on inpatient hospital stays may result in some individuals being discharged from an inpatient hospital setting prematurely.
- Providers may disagree with arbitrary stay limitations that could adversely affect continuity of care for members.
- Health plans may face difficulty in securing contractual arrangements with hospitals or nursing homes if these entities are at-risk for the period beyond the limitation.

- ° County residual costs will increase.
- ° If the new hospital reimbursement provisions passed in the 1992 legislative session are changed, the controversy about quick pay discounts and the sufficiency of reimbursement levels that surrounded this issue will resurface.

### **POLITICAL REALITIES**

To ensure that there is no legal challenge, it is recommended that a statutory change be done to implement these options. Strong opposition will come from the Arizona Hospital Association and the counties concerned about cost shifting to them. Advocacy groups will oppose any curtailment in services.

## REDUCE THE ALTCS INCOME ELIGIBILITY LIMIT

### ISSUE

The State could reduce the current ALTCS income eligibility limit.

### DISCUSSION

As part of the eligibility process for a long term care program, States may elect to establish the income eligibility limit at 100 percent of SSI or up to 300 percent of SSI. In order to maximize federal funding for the long term care services, Arizona chose to establish the income eligibility at the maximum level of 300 percent of SSI or \$1,266 per month. The income level allowed the State to convert the most number of people previously served in the county programs. Currently, 27 States have their income eligibility standard at 300 percent of SSI.

By reducing the income eligibility limit, fewer individuals will qualify for ALTCS and also will lose their acute care benefits under AHCCCS. Two variables that should be considered for this option are whether to:

- 1) impose a new income limit only on new applicants; thereby, reducing the growth of the program while grandfathering in all current members; or,
- 2) redetermine the eligibility for all current members based on the new eligibility level and reduce the current population accordingly.

Prior to the ALTCS program, the counties were responsible for long term care for the elderly and physically disabled. The counties could assume the responsibility for the individuals which no longer qualify for ALTCS; however, this will require additional county funds without the federal matching funds. If the county does not assume responsibility for the members, the persons who are no longer eligible for ALTCS will have to find residential placements or home and community-based services with their own resources. This may lead to inappropriate placements of vulnerable populations in the settings they can afford.

The only savings to the State will be in the state match for administrative funds to operate ALTCS since the \$93 million county contribution for long term care provides the programmatic state match for the program.

## **PROS**

- The State will be able to curb the growth of the long term care program and reduce the number of individuals eligible for the program.

## **CONS**

- If counties are required to assume responsibility for the individuals who lose ALTCS eligibility, it is unlikely that they can serve the same number of individuals without increased cost to the counties.
- There will be significant quality of care issues if persons in nursing facilities lose their ALTCS services and have insufficient funds to pay for appropriate services, either in a residential setting or in the community. Choices will be driven by financial considerations rather than medical conditions which may lead to serious health problems or death for some of these individuals.
- Individuals who lose health care benefits will increase indigent health care costs for the counties or uncompensated care to the public or private hospitals.
- DES/DDD and ADHS will have increased State costs in order to serve the same number of individuals without federal funding.

## **POLITICAL REALITIES**

A legislative change will be required to reduce the income eligibility limit. Many legislators, the counties, advocates, and hospitals will be strongly opposed to this proposal.

issue

**SUMMARY OF MAJOR ISSUES  
AHCCCS**

<b>MAJOR ISSUES</b>	<b>EXECUTIVE RECOMMENDATION</b>	<b>JLBC STAFF RECOMMENDATION</b>
Overall Size of Budget	<ul style="list-style-type: none"> <li>• \$1 million decrease in General Fund Budget from FY 1993.</li> </ul>	<ul style="list-style-type: none"> <li>• \$1.8 million decrease in General Fund Budget from FY 1993.</li> </ul>
Medically Needy/Medically Indigent (MN/MI) and Eligible Low Income Children (ELIC) Programs	<ul style="list-style-type: none"> <li>• Eliminates both programs; 35,000 lose coverage.</li> <li>• Assumes 18% (11,000) will convert to Federal groups.</li> <li>• Funds emergency services for federally-qualified undocumented aliens (14,000).</li> </ul>	<ul style="list-style-type: none"> <li>• Retains bulk of program.</li> <li>• Does not count on conversions, but would point out possible savings from transferring eligibility to the state.</li> <li>• Funds only emergency services for all undocumented aliens (18,000), including 25% not federally-reimbursed.</li> </ul>
Coverage for Pregnant Women and Children (Table 11, p. HW-46 and Table 11a, attached)	<ul style="list-style-type: none"> <li>• Expands coverage for 69,000 pregnant women and children under age 6 to 185% of the Federal Poverty Level.</li> </ul>	<ul style="list-style-type: none"> <li>• Rolls back SOBRA coverage for pregnant women and infants from 140% of FPL to the minimum level of 133%, affecting 1,500 women and infants.</li> </ul>
County Funding of AHCCCS Acute Care (Table 4, p. HW-36)	<ul style="list-style-type: none"> <li>• Maintains current \$65 million county contribution.</li> </ul>	<ul style="list-style-type: none"> <li>• Restores county acute care contribution to 1/3 of total state match; increases by \$34.5 million, saving General Fund a like amount.</li> </ul>
Disproportionate Share	<ul style="list-style-type: none"> <li>• Makes no change to allocation.</li> </ul>	<ul style="list-style-type: none"> <li>• Eliminates county in-lieu payments and restricts the number of private hospitals receiving payments; directs greater funds to counties where state can better recoup some portion.</li> </ul>

**SUMMARY OF MAJOR ISSUES**  
**AHCCCS**  
(Continued)

<b>MAJOR ISSUES</b>	<b>EXECUTIVE RECOMMENDATION</b>	<b>JLBC STAFF RECOMMENDATION</b>
General Fund Impact (Table 12, p. HW-48)	<ul style="list-style-type: none"> <li>• Net savings to the State of \$88 million in FY 1994 and \$190 million in FY 1995.</li> </ul>	<ul style="list-style-type: none"> <li>• Net savings to the State of \$81 million in FY 1994 and \$103 million in FY 1995.</li> </ul>
Impact on Health Care System (Table 13, p. HW-49)	<ul style="list-style-type: none"> <li>• Estimated health care system losses of \$16 million in FY 1994 and \$68 million in FY 1995.</li> </ul>	<ul style="list-style-type: none"> <li>• Estimated health care system losses of \$33 million in FY 1994 and \$61 million in FY 1995.</li> </ul>
Impact on Hospitals (Table 14, p. HW-50)	<ul style="list-style-type: none"> <li>• Estimated hospital losses of \$7 million in FY 1994 and \$47 million in FY 1995.</li> </ul>	<ul style="list-style-type: none"> <li>• Estimated hospital losses of \$20 million in FY 1994 and \$38 million in FY 1995.</li> </ul>
Impact on Counties (Table 16, Attached)	<ul style="list-style-type: none"> <li>• Eliminates county residual responsibility, but recommends that counties be held to some "maintenance of effort"; county MN/MI eligibility function no longer needed; counties could have \$27 million gain in FY 1994 and \$16 million gain in FY 1995.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintains county residual responsibility; eligibility stays with counties, but would again note potential savings from transferring eligibility to the state; counties could see \$40 million loss in FY 1994 and \$49 million loss in FY 1995, most of which is through the increased Acute Care contribution.</li> </ul>
Impact on AHCCCS Health Plans	<ul style="list-style-type: none"> <li>• Loss of MN/MI revenue may force some health plans out of the provider network, though difficult to predict how many; loss of plans hurts competition and could drive capitation rates up.</li> <li>• Loss of MN/MI revenue may induce health plans to bid higher for remaining groups to help recoup lost MN/MI revenue</li> </ul>	<ul style="list-style-type: none"> <li>• Could be a negative impact on health plans, but not as significant since JLBC proposal maintains most of MN/MI program.</li> </ul>

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

DEPARTMENT: Arizona Health Care Cost Containment System  
PROGRAM: Acute Care

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The JLBC Staff recommends a total General Fund appropriation of \$412,110,000 (GF) and \$1,195,040,800 (TF) -- a decrease of \$(3,190,100) (GF), or (0.8)%, and an increase of \$109,093,400 (TF), or 10.3%, to the FY 1993 appropriation.

### JLBC Staff Recommended Changes from FY 1993

#### *Introduction*

This section of the JLBC Staff recommendation provides estimates of FY 1994 expenditures for medical care in the AHCCCS Acute Care program, as well as JLBC Staff budget reduction proposals and our analysis of the Executive's recommendations for AHCCCS. The analysis begins with Staff estimates of FY 1994 funding needs based on current statutory requirements. This analysis will, in other words, look at how much the state would need to budget in FY 1994 for AHCCCS Acute Care if no program changes were made. Included in this discussion of FY 1994 is our assessment of a possible current year shortfall for AHCCCS.

Following our estimates for FY 1994 are JLBC Staff budget reduction proposals that are estimated to hold spending to an amount just below the FY 1993 General Fund appropriation. These proposals include conforming with the federal policy regarding undocumented aliens by funding emergency services only and restoring the county share of Acute Care funding to about one-third of the overall FY 1994 Acute Care and Long Term Care statewide funding requirement. Combined, these proposals yield an estimated \$82.1 million in General Fund savings in FY 1994. Included in this discussion is the Staff's assessment of the impact of these proposals on the statewide health care system and clients served by AHCCCS.

Following the discussion of the JLBC Staff proposals is an analysis of the Executive's proposals for AHCCCS. The Staff analysis includes an explanation of the Executive proposals, as well as Staff estimates of the impact of these proposals on the statewide health care system and AHCCCS clients. The Staff analysis attempts to estimate this impact beyond FY 1994 since certain one-time costs in FY 1994 tend to understate the impact as compared to later years.

#### *Index to JLBC Staff Acute Care Recommendation*

• Acute Care Increase Based on Current Law . . . . .	HW-28
Current Year Shortfall . . . . .	HW-28
FY 1994 Budget . . . . .	HW-28
• JLBC Budget Reduction Proposals . . . . .	HW-33
Undocumented Aliens Emergency Services . . . . .	HW-33
Restore County Acute Care Contribution to Earlier Share . . . . .	HW-35
"Roll Back" SOBRA Coverage . . . . .	HW-38
Revise Disproportionate Share Allocation . . . . .	HW-38
• Analysis of Executive Recommendation . . . . .	HW-41
• Comparison of Proposals . . . . .	HW-47
• Other Acute Care Changes . . . . .	HW-52

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

- Acute Care Increase Based on Current Law

\$78,928,300 GF  
142,330,600 TF

### *Current Year Shortfall*

The \$78.9 million General Fund increase represents spending growth over the original FY 1993 appropriation. However, using a revised FY 1993 estimate of AHCCCS General Fund expenditures as a base, the increase for FY 1994 is actually \$62.7 million, due to an estimated \$16.2 million shortfall in FY 1993. The Executive has estimated the shortfall at \$20 million.

The shortfall appears to be largely the result of certain federal funds initiatives failing to materialize as expected. As a reminder, the AHCCCS FY 1993 General Fund appropriation was reduced by \$22.5 million in anticipation that several federal funds initiatives would be implemented, either through legislative changes, or by administrative means. Three such initiatives, the conversion of most Eligible Assistance Children (EAC) to federal eligibility, federal reimbursement for emergency deliveries by undocumented aliens, and required federal eligibility applications for hospitalized Medically Needy/Medically Indigent (MN/MI) applicants, are being implemented, with varying degrees of success. Combined, though, these three initiatives were estimated to produce only \$13 million in General Fund savings. A means to realize the remaining \$9.5 million of the \$22.5 million in expected savings was not provided through legislative changes.

While the conversions of EACs appears to be progressing well, determining eligibility for federal reimbursement of deliveries by undocumented aliens started off well below expectations. While experience from recent months has been encouraging, the early eligibility problems and the timing of the state's receipt of federal reimbursement for emergency deliveries will limit FY 1993 savings. Since the hospitalized MN/MI application change was implemented October 1, it is too early to estimate if significant FY 1993 savings will accrue.

Problems with the federal funds initiatives appear to explain much of the current year shortfall. However, population growth is still a factor. Enrollment in AHCCCS health plans overall is growing as expected, but expenditures in the areas of Fee for Service and Reinsurance have continued at levels nearly double that of two years ago. This growth has been largely the result of an unexpected surge in the MN/MI population that began in early FY 1992 and was the cause of a \$25 million FY 1992 shortfall.

In recent months, MN/MI growth appears to be slowing, but, as experience would show, future growth is difficult to predict. The Staff's current shortfall estimate of \$16.2 million will be refined in the coming months as more enrollment and expenditure data becomes available. We will be focusing on the implementation of the federal funds initiatives, as well as expenditures in Fee for Service and Reinsurance.

### *FY 1994 Budget*

#### *Overview*

The AHCCCS Acute Care budget contains the following elements: Capitation, Fee for Service, Reinsurance, Deferred Liability, Medicare Premiums, Qualified Medicare Beneficiaries, EPSDT Mental Health, Adult Mental Health, and Disproportionate Share Hospital Payments. This narrative section will address Capitation, Fee for Service, Reinsurance, and Deferred Liability, which together make up 95% of the Acute Care General Fund budget.

Capitation represents monthly payments made by AHCCCS to contracted health plans for the medical services of enrolled AHCCCS members. Different capitation rates are paid for different groups within the AHCCCS population, and that rate is generally based on an actuarial assessment of medical care utilization by people in the various groups. Current Capitation rates are displayed in Table 1, as well as the share of costs paid by the state and federal government. For federal groups, the state pays 34.1% of the cost, while state groups such as the MN/MI are funded entirely with state funds.

**Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations**

Table 1

**AHCCCS CAPITATION RATES AND  
STATE/FEDERAL SHARE OF COSTS**

<u>Federal Eligibility Groups</u>	<u>Current Capitation Rate</u>	<u>State Cost</u>	<u>Federal Cost</u>
Aid to Families with Dependent Children (AFDC)	\$111.91	\$38.16	\$73.75
Supplemental Security Income (SSI) with Medicare	118.99	40.58	78.41
SSI without Medicare	301.88	102.94	198.94
SOBRA Women	110.85	37.80	73.05
SOBRA Children	90.96	31.02	59.95
SOBRA Delivery Amount (one time payment only)	4,180.36	1,425.50	2,754.86
<u>State Funded Groups</u>			
Medically Needy\Medically Indigent (MN/MI) with Medicare	134.82	134.82	0
MN/MI without Medicare	255.55	255.55	0
Eligible Assistance Children	90.45	90.45	0
Eligible Low Income Children	91.63	91.63	0

Fee for Service includes payments made by AHCCCS for members' medical bills incurred in varying periods prior to enrollment in a health plan. Reinsurance and Deferred Liability represent payment programs that assist in limiting health plan liability in cases involving catastrophic medical costs or when the AHCCCS applicant is hospitalized at the time of enrollment.

The following sections explain the factors behind the growth in the Acute Care budget and includes the Executive's estimates as well.

***Demographic Growth***

The JLBC Staff estimates overall population growth of 9.8% over the FY 1993 appropriation. This level of growth accounts for \$50.2 million of the total General Fund increase for Acute Care. Table 2, on the following page, details the population estimates by the various groups within the AHCCCS population. Populations are expressed in member months instead of a headcount figure, since Capitation is based on monthly payments per member. SOBRA Deliveries is listed on the bottom because this amount represents actual deliveries, not member months. The last column in this table also indicates each group's share of the total AHCCCS population.

Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

Table 2

MEMBER MONTH ESTIMATES

AHCCCS Eligibility Groups	FY 1993	FY 1994	FY 1994	Exec. % Chg. From FY 93	JLBC % Chg. From FY 93	Share of Pop.
	Orig. Approp.	Executive Est.	JLBC Est.			
<u>Federal Eligibility Groups</u>						
AFDC	2,405,100	2,766,700	2,682,700	15.0%	11.5%	49.2%
SSI	534,100	562,500	597,600	5.3%	11.9%	11.0%
SOBRA Women	143,700	154,100	143,200	7.2%	(0.3)%	2.6%
SOBRA Children	980,700	1,354,300	1,303,900	38.1%	33.0%	23.9%
Federal Subtotal	4,063,600	4,837,600	4,727,400	19.0%	16.3%	86.7%
<u>State Funded Groups</u>						
MN/MI	606,500	637,100	634,400	5.0%	4.6%	11.6%
EAC	237,900	38,500	22,700	(83.8)%	(90.5)%	0.4%
ELJC	61,500	67,800	71,000	10.2%	15.4%	1.3%
State Subtotal	905,900	743,400	728,100	(17.9)%	(19.6)%	13.3%
Grand Total-All Groups	4,969,500	5,581,000	5,455,500	12.3%	9.8%	
SOBRA Deliveries	17,700	17,000	17,900	(4.0)%	1.1%	

*Capitation Rate Increase and Medical Inflation*

The JLBC Staff recommendation reflects a 5% Capitation rate increase and a 5% medical inflation increase in Fee for Service, Reinsurance, and Deferred Liability. Combined, these rate and inflation increases make up \$21.1 million of the total Acute Care increase. The Executive recommendation also includes these 5% increases.

*Change in Federal Matching Rate*

The JLBC Staff recommendation assumes that the federal matching rate, also called FMAP, will increase from 65.89% to 65.90% effective October 1, 1993, producing savings of \$60,700. For the FY 1993 budget, the FMAP change from 62.61% to 65.89% saved the state General Fund approximately \$17 million.

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

A state's federal matching rate is based on the relationship between state per capita income and national average per capita income. This almost negligible FY 1994 change in Arizona's matching rate apparently indicates that the gap between Arizona's per capita income growth rate and the national average is stabilizing.

### *State Legalization Impact Assistance Grants (SLIAG)*

This item represents federal reimbursement for state costs of providing services to individuals granted legal U.S. residency under the federal amnesty program. SLIAG funds have been used in FY 1992 and FY 1993 to offset the AHCCCS General Fund appropriation by \$5 million and \$7.8 million, respectively. The 5 year SLIAG program will near completion in FY 1994, thus lowering state reimbursement. The JLBC Staff recommendation for FY 1994 includes a SLIAG offset of \$3 million, thereby making \$4.8 of the Acute Care increase due to lower SLIAG funding. The Executive recommendation reflects \$2 million in SLIAG reimbursement.

### *Miscellaneous Funds Offset*

Interest earnings, third party collections, and sanctions against counties for eligibility errors have been used in the past as an offset to the Acute Care General Fund appropriation. For FY 1993, the total offset was assumed to be \$6.6 million, nearly half of which was interest earnings. Given that AHCCCS may no longer retain interest earnings in the AHCCCS Fund, the Staff believes the Miscellaneous Funds Offset should be adjusted accordingly. For FY 1994, the Staff has used an offset of \$3.6 million, which increases the General Fund requirement by \$3 million. The Executive has maintained a \$6.6 million offset.

### *Acute Care Summary*

The following summarizes the components of the JLBC Staff's estimated FY 1994 "current law" Acute Care increase:

• Demographics	\$50.2 million
• Capitation and Inflation Increases	21.1 million
• Lower SLIAG Reimbursement	4.8 million
• Lower Misc. Funds Offset	3.0 million
• Other Acute Care Changes	<u>(0.2) million</u>
Total	\$78.9 million

From this current law basis, the JLBC Staff recommendation would add **\$78.9 million** to the Acute Care General Fund budget. The Executive would add **\$86.6 million** to fund this program, aside from any changes contemplated for FY 1994. This difference is relatively minor as, in fact, the JLBC estimate is 98% of the Executive's FY 1994 Acute Care total. Table 3 summarizes the Executive and JLBC estimates for Capitation, Fee for Service, and Reinsurance, by Total Funds and State Matching Funds. As with the member month table, this table also displays each group's share of overall dollars.

These independently derived estimates indicate some consensus regarding expected FY 1994 growth in the AHCCCS program. With these growth estimates in mind, as well as other fiscal concerns such as slow revenue growth, the upward spiraling cost to the state of fully funding the K-12 Basic State Aid Formula, plus calls for tax reductions and larger carry forward balances, the JLBC Staff has developed a set of proposals that, together, produce General Fund reductions for AHCCCS equivalent to the estimated growth for FY 1994. The next section explains in detail the Staff's proposals.

**Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations**

Table 3

**ACUTE CARE SUMMARY**  
(Capitation, Fee for Service, Reinsurance, and Deferred Liability)

Federal Eligibility Groups	Total Funds		Share of Total Funds JLBC Est.	State Match Funds		Share of State Funds JLBC Est.
	Exec. Rec. Total	JLBC Rec. Total		Exec. Rec. Total	JLBC Rec. Total	
AFDC	\$376,752,800	\$363,967,400	33.3%	\$125,030,100	\$118,392,000	22.0%
SSI	172,146,700	182,630,900	16.7	56,816,700	58,883,300	10.9
SOBRA Women	31,873,000	29,473,000	2.7	10,381,400	9,879,900	1.8
SOBRA Children	177,728,400	168,185,600	15.4	59,466,100	55,667,800	10.3
SOBRA Deliveries	73,778,200	77,817,900	7.1	25,160,100	26,537,700	4.9
Federal Subtotal	\$832,279,100	\$822,074,800	75.3	\$276,854,400	\$269,360,700	50.0%
<b>State Funded Groups</b>						
MN/MI	259,552,400	259,139,200	23.7	259,552,400	259,139,200	48.1
EAC	3,730,100	2,205,600	0.2	3,730,100	2,205,600	0.4
ELIC	7,596,300	8,027,800	0.7	7,596,300	8,027,800	1.5
State Subtotal	\$270,878,800	\$269,372,600	24.7%	\$270,878,800	\$269,372,600	50.0%
Grand Total-All Groups	\$1,103,157,900	\$1,091,447,400		\$547,733,400	\$538,733,300	

**Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations**

• JLBC Budget Reduction Proposals

(82,118,400) GF  
(33,237,200) TF

*Overview*

The JLBC Staff budget reduction proposals are comprised of the following elements:

	<b>FY 1994 General Fund Savings</b>
• <b>Conform with Federal Policy by Funding Only Emergency Services for Undocumented Aliens</b>	<b>\$(43,575,800)</b>
• <b>Restore County Acute Care Contribution to One-Third of Overall State Matching Requirements</b>	<b>(34,565,000)</b>
• <b>"Roll Back" SOBRA Coverage to 133% of the Federal Poverty Level</b>	<b>(2,377,600)</b>
• <b>Revise Disproportionate Share Allocation</b>	<b><u>(1,600,000)</u></b>
<b>TOTAL REDUCTIONS</b>	<b><u>\$(82,118,400)</u></b>

The following explains each point, including assumptions that were made in producing the estimated savings amounts.

***Conform with Federal Policy by Funding Only Emergency Services for Undocumented Aliens***

This JLBC Staff proposal would restrict AHCCCS coverage for undocumented aliens to emergency services only. Undocumented aliens, also referred to as illegal aliens, are individuals residing in the United States but lacking proof of U.S. citizenship or legal U.S. residency. An estimated 18,000 undocumented aliens are currently served by AHCCCS in the MN/MI and ELIC programs. As enrolled members, these individuals now receive the full range of AHCCCS-covered services, just as any other AHCCCS member. Undocumented aliens are allowed to enroll in the state funded MN/MI and ELIC programs because U.S. citizenship or legal U.S. residency is not required for enrollment.

The JLBC Staff proposal is consistent with the federal policy of funding only emergency services costs for certain undocumented aliens. Federal Medicaid law requires states to provide matching funds for the emergency services costs of undocumented aliens who would otherwise qualify for a federal Medicaid group such as AFDC for SSI, if not for the lack of U.S. citizenship or legal U.S. residency. This is an important point to stress: states must pay the non-federal share of the cost (for Arizona, 35%) of emergency services received by federally-qualified undocumented aliens. The implication of this is that federal law will not allow the complete exclusion of undocumented aliens from Medicaid services.

According to AHCCCS, between 28% and 33% of the MN/MI and ELIC populations are undocumented aliens. Furthermore, an April 1992 AHCCCS study of the MN/MI and ELIC populations estimated that 23% of the MN/MI and ELIC populations could be eligible for federal reimbursement of emergency services, meaning implicitly that at least 23% of these populations are undocumented. For purposes of calculating a savings estimate, the Staff has assumed that 30% of MN/MIs and ELICs are undocumented. The Staff estimates the FY 1994 state matching cost of federally-reimbursed emergency services to be \$8,957,500. This amount represents funding for the 23% of the MN/MI and ELIC populations AHCCCS estimates would be eligible for federal reimbursement of emergency services.

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

The remaining undocumented aliens ineligible for federally-reimbursed emergency services would, under the JLBC Staff proposal, be eligible for 100% state-funded emergency services. Funds for these services have been included after consulting with legislative attorneys who have advised that if the state were to adopt an emergency services only program for undocumented aliens, the state should also fund emergency services for those undocumented aliens who would not qualify for federal reimbursement. The JLBC recommendation includes \$7,994,700 for this portion of the undocumented population.

Implementing this proposal will require a change in the current county MN/MI eligibility process. Individuals who apply at county offices for MN/MI or ELIC eligibility would need to provide proof of U.S. citizenship or legal U.S. residency before being accepted into AHCCCS. Persons not having proof of U.S. citizenship or legal U.S. residency would be referred to the Department of Economic Security (DES) for a determination of "emergency services only" eligibility. Again, this would be a person otherwise eligible for a federal group such as AFDC or SOBRA, if not for their lack of U.S. citizenship or legal U.S. residency.

Some undocumented aliens (about 25%) referred to DES would not qualify for federal emergency services reimbursement. The Staff proposes that for this segment of the undocumented applicants, DES would be responsible for determining eligibility for 100% state-funded emergency services based on current MN/MI and ELIC income and resource standards. Once eligibility is determined, either for federally reimbursed or state-funded emergency services, AHCCCS would begin paying claims on a Fee for Service basis.

The estimated FY 1994 savings from this proposal would not equal the total cost of the undocumented population in AHCCCS minus the state cost of emergency services. FY 1994 savings would be lowered by two factors: prior year bills, and the cost of guaranteed enrollment. Bills incurred by the undocumented population in FY 1993 and other years prior to FY 1994, but not yet paid, would amount to an estimated cost of \$12,116,200 in FY 1994. Current law guarantees new MN/MI enrollees 6 months of eligibility in AHCCCS, so even though full AHCCCS eligibility were to end at some point for undocumented aliens, those eligible at the "cut off" point would still be fully eligible for periods ranging from one to six months. The Staff has assumed the cost of guaranteed enrollment in FY 1994 to be \$7,432,700, based on a implementation date of April 1, 1993. The Staff is proposing that statutory changes needed to convert undocumented aliens to "emergency services only" status be made effective retroactively to April 1, 1993, if needed.

The net savings calculation from this proposal is summarized as follows:

• Est. FY 1994 Cost of Undocumented Aliens in AHCCCS (30% of MN/MI and ELIC populations)	\$(80,076,900)
• State Match for Emergency Services	8,957,500
• 100% State Funded Emergency Services	7,994,700
• Prior Year Bills ("Tail")	12,116,200
• Guaranteed Enrollment	<u>7,432,700</u>
 Total General Fund Savings	 <u>\$(43,575,800)</u>

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

### *Restore County Acute Care Contribution to One-Third of Overall State Matching Requirements*

The JLBC Staff recommends an increase in the amount counties currently contribute to the state for the AHCCCS Acute Care program. The increase represents an adjustment to bring the county share of program costs up to a level more in line with the counties' share in the earlier years of the AHCCCS program. The recommended county Acute Care contribution for FY 1994 would be \$99,641,100, or an increase of \$34,565,000 over the current contribution of \$65,076,100.

As Table 4 demonstrates, the counties' share of the overall state matching costs of both the Acute and Long Term Care programs has been declining. County support of Acute Care has been relatively fixed over the past 10 years, whereas state General Fund expenditures have grown over 450% since FY 1984. Further, even with the addition of Long Term Care, for which counties pay the entire state match, the counties' share of the overall state match requirement has dropped to 26.7% in FY 1993. The recommended increase would restore the county share of overall state match requirements to approximately one-third of the total state match for FY 1994. From FY 1985 to FY 1987, during the first 3 full years under AHCCCS, the county contribution averaged 33.3% of the total matching requirement.

Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

Table 4

**COUNTY SHARE OF THE AHCCCS ACUTE CARE AND LONG TERM CARE BUDGETS  
FY 1984 TO FY 1994**

Fiscal Years	State General Fund Acute Care Budget	County Acute Care Contribution	County Long Term Care Contribution	Subtotal County Acute and L.T.C.	State Match Total	County Share of State Match
1984	\$76,169,200	\$63,073,500	\$0	\$63,073,500	\$139,242,700	45.3%
1985	117,110,700	63,073,500	0	63,073,500	180,184,200	35.0%
1986	132,373,700	61,835,700	0	61,835,700	194,209,400	31.8%
1987	117,481,600	58,392,400	0	58,392,400	175,874,000	33.2%
1988	170,307,600	57,448,900	0	57,448,900	227,756,500	25.2%
1989	216,301,700	58,432,600	33,066,700	91,499,300	307,801,000	29.7%
1990	228,655,200	58,432,600	64,531,700	122,964,300	351,619,500	35.0%
1991	292,455,100	58,432,600	88,211,000	146,643,600	439,098,700	33.4%
1992	376,312,500	65,077,200	87,298,300	152,375,500	528,688,000	28.8%
1993 Est	431,510,100	65,076,100	92,297,600	157,373,700	588,688,000	26.7%
1994 Est	412,110,000	99,641,100	101,921,300	201,562,400	613,672,400	32.8%

	Cumulative Percent Change	Cumulative Percent Change	Cumulative Percent Change	Cumulative Percent Change
1985	53.8%	0.0%	0.0%	29.4%
1986	73.8%	(2.0)%	(2.0)%	39.5%
1987	54.2%	(7.4)%	(7.4)%	26.3%
1988	123.6%	(8.9)%	(8.9)%	63.6%
1989	184.0%	(7.4)%	45.1%	121.1%
1990	200.2%	(7.4)%	95.0%	152.5%
1991	284.0%	(7.4)%	132.5%	215.3%
1992	394.0%	3.2%	141.6%	279.7%
1993 Est	466.5%	3.2%	149.5%	322.9%
1994 Est	441.0%	58.0%	219.6%	340.7%

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The JLBC Staff would consider this increase an equitable means of allocating growth in the AHCCCS program across state and county government and also believes it to be reasonable that the counties would continue to fund a third of overall state matching costs in future years. The Staff proposes that the new contribution be spread among the counties according to the current formula. Table 5 provides the breakdown by county. In terms of the ability of the counties to fund this increase, the JLBC Staff estimates that counties will receive an additional \$25 million in sales tax distributions in FY 1994 above the amounts budgeted for in FY 1993. Should this increased Acute Care contribution violate county expenditure limitations, the Staff proposes that the \$34.6 million increase be reflected under the state appropriation limit, as are current county contributions, given that the state has an estimated \$600 million of excess appropriation limit capacity.

Table 5

**PROPOSED CHANGE IN COUNTY ACUTE CARE CONTRIBUTION**

	<u>Current Share</u>	<u>Current Contribution</u>	<u>Proposed Contribution</u>	<u>Increase From Current</u>
Apache	0.403%	\$262,257	\$401,554	\$139,297
Cochise	3.321%	2,161,177	3,309,081	1,147,904
Coconino	1.114%	724,948	1,110,002	385,054
Gila	2.119%	1,378,963	2,111,395	732,432
Graham	0.804%	523,212	801,114	277,903
Greenlee	0.286%	186,118	284,974	98,856
La Paz	0.318%	206,942	316,859	109,917
Maricopa	57.969%	37,723,964	57,760,949	20,036,985
Mohave	1.856%	1,207,812	1,849,339	641,526
Navajo	0.466%	303,255	464,328	161,073
Pima	22.420%	14,590,062	22,339,535	7,749,473
Pinal	4.072%	2,649,899	4,057,386	1,407,487
Santa Cruz	0.724%	471,151	721,402	250,251
Yavapai	2.141%	1,393,279	2,133,316	740,037
Yuma	1.987%	1,293,062	1,979,869	686,807
<b>Total</b>	<b>100.000%</b>	<b>\$65,076,100</b>	<b>\$99,641,100</b>	<b>\$34,565,000</b>

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### ***Roll Back SOBRA Coverage to 133% of the Federal Poverty Level***

This proposal would reduce the income eligibility level for SOBRA Women and Infants from the current 140% of the Federal Poverty Level (FPL) to 133% of FPL. States are required by the federal government to provide medical care to pregnant women and infants under age 1 with household incomes below 133% of FPL. As an option, states may also cover pregnant women and infants up to 185% of FPL. Arizona chose 3 years ago to increase the income eligibility limit to 140% of FPL. This "roll back" of SOBRA coverage would affect approximately 5% of the current SOBRA population, or 1,500 women and infants. Savings from this proposal are estimated to be \$2,377,600 GF and \$6,972,400 TF.

### ***Revise Disproportionate Share Allocation***

The JLBC Staff proposes that the methodology for allocating disproportionate share funding be revised to allow for the state to retain a greater share of that revenue. The Staff proposes the elimination of county in-lieu payments and changes to the methodology for allocating disproportionate share revenue to hospitals to reduce the number of private hospitals receiving payments. General Fund savings from this proposal would be \$1,600,000.

The FY 1993 disproportionate share legislation provides for county in-lieu payment totalling \$911,200, with payments to each county ranging from a minimum of \$54,300, to a maximum of \$108,600, with the actual payment depending on the level of payments to private hospitals in the respective counties. The original disproportionate share payment plan introduced by AHCCCS would have made payments to 16 private hospitals and two county-operated hospitals in Maricopa and Pima counties. During negotiations on the legislation, the number of private hospitals to be paid was expanded to 28. The JLBC Staff proposes that the number be restricted to the 16 designated in the AHCCCS plan. Such a reallocation of disproportionate share revenue would allow for a greater diversion of funding to the county-operated hospitals in Maricopa and Pima counties, thus providing the state with enhanced opportunities to recoup a portion of that revenue from the county governments.

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***Impact of JLBC Proposals***

This section attempts to quantify the impact of the JLBC Staff proposals on the statewide health care system, private hospitals and counties, and clients served by AHCCCS.

***Impact on the Health Care System***

This level of analysis looks at how the statewide health care system would fare if: 1) the AHCCCS program provided emergency services only to undocumented aliens, and 2) additional revenue was lost through the SOBRA "roll back". Table 6 provides the Staff's estimates of how these revenue losses might impact the health care system, lessened to some extent, however, by revenue added back to the health care system.

<b>Table 6</b>		
<b><u>IMPACT OF JLBC STAFF PROPOSALS ON HEALTH CARE SYSTEM</u></b>		
	<b>JLBC Est.</b>	<b>JLBC Est.</b>
<b><u>Health Care System Revenue Losses</u></b>	<b><u>Year 1</u></b>	<b><u>Year 2</u></b>
State Funding for Undocumented Aliens in the MN/MI & ELIC Programs	\$(80,076,900)	\$(92,088,400)
"Roll Back" SOBRA Coverage	<u>(6,972,400)</u>	<u>(8,018,300)</u>
Subtotal-Revenue Losses	<b>\$(87,049,300)</b>	<b>\$(100,106,700)</b>
<b><u>Revenue Added Back to System that Lessens Impact</u></b>		
Federally-Reimbursed Emergency Services	26,268,300	30,208,600
State Funded Emergency Services	7,994,700	9,193,900
6 Month Guaranteed Enrollment	7,432,700	0
Prior Year Bills ("Tail")	<u>12,116,200</u>	<u>0</u>
Subtotal-Revenue Added	<b>\$53,811,900</b>	<b>\$39,402,500</b>
<b><i>Net Impact on Health Care System</i></b>	<b>\$(33,237,400)</b>	<b>\$(60,704,200)</b>

In net terms, the health care system could see a loss of \$33.2 million in revenue in the first year of implementation of the JLBC Staff proposals. With the loss of additional state revenue in FY 1995 as the MN/MI program is phased out, the net FY 1995 revenue loss could grow to \$60.7 million.

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*Impact on Hospitals*

Undoubtedly, questions will arise regarding the impact of these proposals on hospitals alone. Table 7 summarizes the Staff's estimates of how revenue losses might affect just hospitals, including both county-operated and private hospitals.

<b>Table 7</b>		
<b><u>IMPACT OF JLBC STAFF PROPOSALS ON HOSPITALS</u></b>		
	<b>JLBC Est.</b>	<b>JLBC Est.</b>
	<b><u>Year 1</u></b>	<b><u>Year 2</u></b>
<b><u>Hospital Revenue Losses</u></b>		
State Funding for Undocumented Aliens in the MN/MI & ELIC Programs	\$(52,050,000)	\$(59,857,500)
"Roll Back" SOBRA Coverage	<u>(3,137,600)</u>	<u>(3,608,200)</u>
Subtotal-Revenue Losses	\$(55,187,600)	\$(63,465,700)
<b><u>Revenue Added Back to Hospitals that Lessens Impact</u></b>		
Federally-Reimbursed Emergency Services	17,074,400	19,635,600
State Funded Emergency Services	5,196,600	5,976,000
6 Month Guaranteed Enrollment	4,831,300	0
Prior Year Bills ("Tail")	<u>7,875,500</u>	<u>0</u>
Subtotal-Revenue Added	\$34,977,800	\$25,611,600
<b><i>Net Impact on Hospitals</i></b>	<b>\$(20,209,800)</b>	<b>\$(37,854,100)</b>
Share Private Hospitals (73%)	\$(14,753,200)	\$(27,633,500)
Share County Hospitals (27%)	(5,456,600)	(10,220,600)

These estimates are built upon a number of assumptions regarding the allocation of revenue losses to hospitals, either county-operated or private. Based on information from AHCCCS, the Staff has assumed that 65% of the costs currently incurred by the MN/MI population are for inpatient hospital care. Thus, 65% of the revenue loss from eliminating services for undocumented aliens would be absorbed by hospitals. The allocation of lost revenue between private and county-operated hospitals was based on AHCCCS data showing that Maricopa and Pima county hospitals (the only 2 county hospitals) account for 27% of Medicaid inpatient days.

While these represent out "best estimates," they must be viewed with considerable caution since we have no way of knowing where undocumented aliens will present themselves for emergency services, assuming that, under the Staff proposal, they would no longer be enrolled in AHCCCS health plans. The share of revenue loss borne by county hospitals may actually be higher because many undocumented aliens may be more inclined to utilize the local public health system instead of private hospitals. With these caveats in mind, hospitals could see \$20.2 million in revenue losses in FY 1994, and \$37.9 million lost in FY 1995.

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### *Impact on Counties*

The above analysis suggests that county hospitals may also see a net loss in revenue from the JLBC Staff proposals. The most significant impact will be, however, through an increased county contribution to the state for the Acute Care program. Estimates of expected sales tax distributions in FY 1994 indicate that an additional \$25 million in revenue will be available to counties to help fund such an increase. While counties may wish to direct this additional revenue to other priorities, the Staff would again note the declining share of county support for the AHCCCS program as justification for restoring that share to a level more in keeping with earlier county support of AHCCCS.

### *Impact on Clients*

The proposal to fund emergency services only for undocumented aliens will affect about 18,000 people now in the AHCCCS MN/MI and ELIC programs. Under the Staff proposal, these individuals would no longer be enrolled in AHCCCS health plans. Possible outcomes of this change would be that undocumented aliens may no longer have access to preventative care or other forms of routine care. These individuals may forego seeking medical attention until an illness reaches a more critical stage, thereby requiring possible emergency room care.

The outcome for pregnant women no longer covered under SOBRA could be much the same. Without AHCCCS coverage, pregnant women may forego prenatal care, resulting possibly in premature births or infants with low birth weights and related medical problems.

### Analysis of Executive Recommendation

#### *Summary of Executive Recommendation*

The Executive's AHCCCS Acute Care recommendation calls for the elimination of the state-funded MN/MI and ELIC programs and the expansion of federal coverage for pregnant women and children under age 6. The major points of the Executive recommendation are summarized below:

- Eliminate MN/MI and ELIC programs
- Expand SOBRA coverage for pregnant women and infants to those with incomes below 185% of the Federal Poverty Level
- Expand federal coverage for children under age 6 with incomes below 185% of FPL (uses same federal provision that is now allowing for the conversion of most EACs to federal eligibility)
- Eliminate county residual responsibility for providing indigent health care, but keep some "maintenance of effort" at county level
- Increase hospital reimbursement levels by eliminating the 10% quick pay discount from the AHCCCS hospital reimbursement system
- Fund the state match for the emergency services of undocumented aliens who qualify for federal reimbursement
- Fund prior year bills and a guaranteed enrollment period after the MN/MI program is terminated
- Provide state match funding for former MN/MIs and ELICs who could convert to federal eligibility

Table 8 provides the associated costs of each element of the Executive and JLBC proposals, which in turn lead to the total General Fund dollar change from the FY 1993 appropriation. An examination of this table demonstrates that both proposals would produce comparable "bottom line" results. Both essentially hold the AHCCCS General Fund budget to no growth in FY 1994. This point may appear incorrect given that the Executive has recommended the complete elimination of the MN/MI and ELIC programs, whereas the JLBC Staff limits undocumented aliens to emergency services only and increases the county acute care contribution, thus leaving most of the MN/MI and ELIC programs untouched. However, as our analysis attempts to show, the Executive's savings would grow by \$100 million in the second year as certain costs associated with phasing out the MN/MI program are eliminated.

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Table 8

COMPARISON OF EXECUTIVE'S AHCCCS PROPOSAL WITH JLBC PROPOSAL

	<u>Executive</u>	<u>JLBC Staff</u>
FY 1994 Estimated AHCCCS Acute Care Increase-Current Law	\$86,562,300	\$78,928,300
FY 1994 Cost of MN/MI and ELIC Programs	(267,148,900)	NA
FY 1994 Cost of Undocumented Aliens	NA	(80,076,900)
 <u>Proposed Federal Eligibility Expansion Costs and Other Costs</u>		
• SOBRA Expansion (Women, Infants, and Children Under 6 to 185% of the Federal Poverty Level)	23,047,900	NA
• Prior Year MN/MI & ELIC Bills ("Tail")	70,000,000	12,116,200
• 6 Month Guaranteed Enrollment for MN/MI & ELIC	39,270,000	7,432,700
• Categorical Conversions (18% should be categorical)	16,400,000	NA
• Eliminate Quick Pay Discount on Categorical Bills	16,300,000	NA
• State Match for Undocumented Aliens Emergency Services	<u>8,957,500</u>	<u>8,957,500</u>
Subtotal-Expansion Costs, Other Costs	\$173,975,400	\$28,506,400
 <u>Other Options/Administrative Changes</u>		
• 100% State Funded Emerg. Services for Undocumented Aliens	NA	7,994,700
• "Roll Back" SOBRA Coverage for Women & Infants to 133% of FPL Shift MN/MI Eligibility to the State	NA	(2,377,600)
• Revise Disproportionate Share Allocation	NA	(1,600,000)
• Non-SMI Adult Mental Health	4,000,000	0
• Administrative Changes/Other Misc.	1,611,200	1,410,200
• Increase County Acute Care Contribution so that Acute Combined with the Long Term Care Contribution will equal One Third of Overall State and County Funds for AHCCCS	<u>NA</u>	<u>(34,565,000)</u>
 <b>Net General Fund Change from the FY 1993 Appropriation</b>	 <b>\$(1,000,000)</b>	 <b>\$(1,779,900)</b>
 <i>FY 1994 Savings from Proposals</i>	 <i>\$87,562,300</i>	 <i>\$80,708,200</i>

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In the next section, the JLBC Staff provides estimates of possible outcomes of the Executive's recommendation. This analysis examines the Executive's proposals in the same way the impact of the JLBC Staff proposals was described: first, from the perspective of the statewide health care system, secondly, looking at the impact on hospitals and counties, and third, assessing the impact on AHCCCS clients.

***Analysis of Executive Recommendation***

***Impact on the Health Care System***

The Executive's AHCCCS proposal is indeed complex and carries with it fiscal impacts that could take 2-3 years to be fully realized. As noted earlier, both the Executive and JLBC proposals have similar bottom line first year General Fund impacts, but as our analysis will show, the second year reveals dramatic differences in savings and resulting impacts on the statewide health care system. Again, we define the statewide health care system to include both the public (mostly, county) and private health care networks currently in existence throughout the state.

Table 9 below quantifies the impact of the Executive's proposals by looking at the expected reduction in state expenditures for the MN/MI program and new or continued revenue sources that offset this reduction. The column titled "Governor's Plan OSPB EST Year 1" reflects estimates from the Governor's Office of Strategic Planning and Budgeting (OSPB). The remaining two columns represent JLBC estimates of the Executive's plan during the first and second years of implementation.

<b>Table 9</b>			
<b><u>IMPACT OF EXECUTIVE'S PROPOSALS ON THE HEALTH CARE SYSTEM</u></b>			
	<u>Executive's Plan OSPB Est Year 1</u>	<u>Executive's Plan JLBC Est Year 1</u>	<u>Executive's Plan JLBC Est Year 2</u>
<u>Health Care System Revenue Losses</u>			
Estimated Dollar Value of Care No Longer Provided by State for MN/MI & ELIC Programs	\$ (267,148,900)	\$ (266,923,100)	\$ (293,615,400)
<u>Revenue Added Back to System that Lessens Impact</u>			
Prior Year Bills ("Tail")	70,000,000	51,053,500	0
6 Month Guaranteed Enrollment	39,270,000	38,669,900	0
Conversion of MN/MI to Federal Groups	48,059,000	17,595,300	21,700,900
Eliminate Quick Pay Discount	47,900,000	49,540,500	56,971,500
Undocumented Aliens Emergency Services	26,268,400	26,268,300	30,208,600
SOBRA Expansion	<u>67,589,100</u>	<u>67,589,100</u>	<u>116,824,600</u>
<b><i>Net Impact on Health Care System</i></b>	<b><u>\$31,937,600</u></b>	<b><u>\$(16,206,500)</u></b>	<b><u>\$(67,909,800)</u></b>

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The OSPB estimate for the first year of implementation suggests that the health care system will actually experience a net gain in revenue, largely due to the expansion of eligibility for pregnant women and children. This expansion could bring an additional \$67.6 million in revenue into the statewide health care system in FY 1994. The JLBC Staff estimates, however, that the statewide health care system may actually experience a net loss of revenue in the first year. The Staff's estimate is lower due to differences in estimates of revenue from the payment of prior year bills and the conversion of MN/MIs to federal groups.

Apparently, the Executive's estimate for prior year bills builds in a considerable margin for error, while the Executive's estimate of conversions to federal, or "categorical" groups generally assumes that nearly all MN/MIs potentially eligible for federal groups will actually convert in the first year. The Staff's estimate for conversions assumes that the first year effect will be more limited.

The JLBC estimate for the second year shows that the revenue loss to the health care system could increase substantially. As prior year bills are paid off and MN/MI enrollment is completely eliminated in FY 1995, nearly \$90 million in state revenue would no longer flow into the health care system. Even with the revenue from eligibility expansions, the revenue loss could grow to \$67.9 million in FY 1995.

### *Impact on Hospitals*

This section isolates the impact of the Executive's proposals on hospitals alone. Table 10 follows the format of Table 9 but shows the share of costs or revenues directed at hospitals.

<u>Hospital Revenue Losses</u>	<u>Executive's Plan OSPB Est. Year 1</u>	<u>Executive's Plan JLBC Est. Year 1</u>	<u>Executive's Plan JLBC Est. Year 2</u>
Estimated Dollar Value of Care No Longer Provided by State for MN/MI & ELIC Programs	\$(173,646,800)	\$(173,500,000)	\$(190,850,000)
	@ 62% of Total	@65% of Total	@65% of Total
<u>Revenue Added Back to Hospitals that Lessens Impact:</u>			
Prior Year Bills ("Tail")	43,400,000	33,184,800	0
6 Month Guaranteed Enrollment	24,347,400	25,135,400	0
Conversion of MN/MI to Federal Groups	29,796,600	11,436,900	14,105,600
Eliminate Quick Pay Discount (100% goes to Hospitals)	47,900,000	49,540,500	56,971,500
Undocumented Aliens Emergency Services	16,286,400	17,074,400	19,635,600
SOBRA Expansion	<u>30,415,100</u>	<u>30,415,100</u>	<u>52,571,100</u>
<b>Net Impact on Hospitals</b>	<b><u>\$18,498,700</u></b>	<b><u>\$(6,712,900)</u></b>	<b><u>\$(47,566,200)</u></b>
Share Private (Exec. @ 83%, JLBC @ 73%)	\$15,353,900	\$(4,900,400)	\$(34,723,300)
Share County-Operated (Exec. @ 17%, JLBC @ 27%)	3,144,800	(1,812,500)	(12,842,900)

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The Executive has assumed that if costs were allocated between private and county hospitals, 83% would be borne by private hospitals, and 17% would be shifted to county hospitals. The JLBC Staff has assumed that a higher share, or 27%, of costs would be the responsibility of county hospitals. The Staff derived this percentage from AHCCCS data which indicated that Maricopa and Pima county hospitals account for 27% of hospital days utilized by Medicaid patients. As we mentioned in the analysis of the JLBC proposals, these, or any assumptions regarding the share of costs to be borne by either private or county hospitals must be viewed with considerable caution, since the location where those without MN/MI coverage choose to seek medical care is difficult to predict. Using the JLBC Staff estimates from Table 10 suggests that \$6.7 million in costs will be shifted to private hospitals in FY 1994, and by FY 1995, that number could grow to \$47.6 million. If private hospitals and providers are to bear the bulk of the shift in costs, then a portion of these costs will undoubtedly be passed on to patients who pay "out of pocket" or else have health insurance. The portion that is not absorbed by paying patients may show up as increased charity care or uncollectible debt.

### *Impact on Counties*

The analysis of the impact on hospitals shows that some costs may be shifted to the county-operated hospitals as charity care or uncollectible debt and may ultimately become the responsibility of county general revenue sources. The estimate of increased costs borne by county hospitals may in fact be low, and this point was made in the analysis of the JLBC Staff proposals. Not knowing where newly disenfranchised MN/MI and ELICs will present themselves for medical care is probably the greatest problem in producing an estimate. One might conclude that people no longer covered by the state would most likely seek care at the county level, either through county medical centers in Maricopa and Pima counties or county health clinics. However, there are undoubtedly limits on the ability of county facilities to physically handle sharp increases in patients.

To lessen the impact of ending the MN/MI program, the Executive has proposed to eliminate county residual responsibility. Counties are now required by state law (A.R.S. Title 11) to maintain indigent health care programs that were intact prior to the development of AHCCCS in 1983. Title 11 further designates counties as being ultimately responsible for medical care of the indigent sick. While the elimination of county residual responsibility may not affect people's decisions regarding where to seek medical care, it will shift some of the responsibility for funding indigent health care away from counties to, in all likelihood, private hospitals and providers.

The fiscal implications of Title 11 are that county governments must often pay for medical services of indigent persons incurred for some period prior to the commencement of AHCCCS coverage. These bills would be either incurred directly through the county-operated hospitals or received from private hospitals that have provided care to an indigent patient. Other costs are incurred by a few counties who have more generous eligibility standards or services than currently available in the AHCCCS MN/MI program. The Executive has estimated these county residual costs to be \$10-\$20 million annually. The JLBC Staff is aware that staff of the County Supervisor's Association is studying the residual issue and will make available to the Legislature estimated residual costs.

The Executive has, however, suggested that even though county residual responsibility should be eliminated, counties should still be held to some "maintenance of effort." The Staff would assume that the Executive is implying that counties should be required to maintain some form of public health system, such as county hospitals and clinics.

Another factor that could lessen the impact on counties would be savings achieved through the elimination of the MN/MI eligibility function. Counties now perform MN/MI and ELIC eligibility determinations for the AHCCCS program. According to information from the County Supervisors Association, counties as a whole now spend approximately \$13.8 million on MN/MI eligibility, employing about 600 people. With the proposed elimination of the MN/MI program, all AHCCCS Acute Care eligibility work would be performed by the Department of Economic Security (DES), with the exception of federal SSI coverage.

The Staff's estimate of the impact of the Executive's proposals on hospitals alone indicates that county hospitals could see a \$1.8 million loss in revenue, aside from changes resulting from the elimination of residual responsibility or the county eligibility function. Assuming, however, that county residual costs are \$15 million and county eligibility costs are \$13.8 million, the proposed elimination of these two costs could produce a net gain of \$27 million to counties in FY 1994. As state revenue declines in FY 1995 due to the final phase-out of the MN/MI program, that gain would be lowered to \$16 million.

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### *Expanded Federal Coverage for Pregnant Women and Children*

A portion of savings generated through the proposed elimination of the MN/MI program would be used to expand federally-supported coverage of pregnant women, infants, and children under age 6. The Executive has proposed to expand the income limit for these groups to 185% of the Federal Poverty Level. Currently, Arizona, under the federal SOBRA program, covers pregnant women and infants with incomes below 140% of FPL. States, as an option, may expand the income limit to 185% of FPL and still receive federal matching dollars. This proposed SOBRA expansion would extend AHCCCS coverage to an additional 9,000 pregnant women and infants in FY 1994.

The proposed expansion for children under age 6 to 185% of FPL would occur under a federal Medicaid eligibility provision that is currently allowing the state to convert most EACs to federal eligibility. The Executive has estimated that this expansion for children under 6 will extend coverage to 60,000 more children in FY 1994.

Questions often arise regarding MN/MI income eligibility levels, as well as other income eligibility levels that are related to certain percentages of the Federal Poverty Level. Table 11 provides current MN/MI income eligibility levels and income levels under the Executives' proposed expansion for pregnant women, infants, and children.

As this comparison demonstrates, the Executive's proposed expansion for pregnant women and children would encompass income levels considerably higher than those in the MN/MI program, a program the Executive would eliminate. The proposed expansion would cover individuals with incomes up to 85% over the Federal Poverty Level, whereas MN/MIs losing eligibility must have incomes that are 58% below the Federal Poverty Level (for a family of 3). (The MN/MI income limits allow applicants to deduct from their incomes medical expenses in order to "spend down" to the allowable income eligibility level. According to AHCCCS, approximately 25% of the MN/MI population become eligible through the spend-down provision.) While some MN/MI applicants may have higher gross incomes prior to deducting for medical expenses, the Executive's proposal essentially exchanges a lower income group (the MN/MI) for a higher income one in order to benefit from federal matching funds that can be brought into the state through expansions of federal eligibility.

Table 11

### COMPARISON OF MN/MI AND PROPOSED FEDERAL INCOME LIMITS

Family Size	MN/MI Income Limits	Proposed Income Limits @ 185% of FPL
1	\$ 3,200	\$ 12,599
2	4,266	17,002
3	4,810	21,405
4	5,354	25,808
5	5,898	30,211
6	6,442	34,614
7	6,986	39,017
8	7,530	43,420

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### *Summary of Analysis*

Conceptually, the Executive's proposal is relatively straightforward: eliminate the MN/MI program, expand coverage for pregnant women and children, eliminate county residual responsibility, and increase hospital payments by eliminating the quick pay discount. Sorting through a quantitative analysis is, however, a more daunting matter. In the Staff's view, substantial costs will ultimately be shifted to other sectors of the health care system. Exactly how those costs will be distributed is unclear, though.

While the health care system as a whole may not experience a net loss of revenue during FY 1994, further reductions in state revenues in FY 1995 could result in a net loss of \$68 million to the health care system. The proposed elimination of county residual responsibility, plus the fact that a majority of hospital capacity resides in the private sector suggests that most revenue losses will be felt by the private sector, including private hospitals, physicians, and other private practitioners. However, this impact on private providers may be ameliorated to some extent because many newly disenfranchised MN/MIs may instead seek care through the county public health system.

The allocation of lost revenues is highly speculative, but the impact on AHCCCS clients is somewhat clearer. An estimated 35,000 individuals will be left uncovered by the AHCCCS program, and another 14,000 will be covered for emergency services only. However, some 69,000 women, infants and children would now be eligible for AHCCCS services under proposed expansions of federal eligibility.

Those 35,000 left without any state-funded care will be left to find other sources of payment for their medical care. The lack of preventative care may result in many individuals foregoing medical attention for an illness until their condition becomes critical, thus increasing emergency room utilization and costs. In general, what many view as a state "safety net" for people with catastrophic medical expenses would no longer exist.

### *Other Concerns*

This analysis of the Executive's recommendation has attempted to address what we believe are the major issues and possible outcomes. Certainly, there are many others that could arise, either expectedly, or unexpectedly.

One other concern regarding the Executive's proposals, and to a lesser extent the JLBC Staff proposals, is the impact of lost revenue on AHCCCS health plans. According to AHCCCS, 25% of health plan revenue is derived from MN/MI enrollment. AHCCCS has suggested that the loss of that revenue could force some health plans out of the AHCCCS provider network. The loss of health plans could diminish competition among health plans for AHCCCS enrollment, thus resulting in higher rates paid by AHCCCS for members' care. Ultimately, the loss of contracting health plans presents considerable challenges to the managed care concept that is the basis of the AHCCCS program.

### *Comparison of Proposals - A Summary*

This section compares the Executive and JLBC Staff proposals, based first on the respective FY 1994 and FY 1995 General Fund impact of each, and second, looking at how the two proposals compare on such major points as the impact on the health care system, hospitals and counties, and AHCCCS clients.

Table 12 shows how the proposals compare based on the estimated impact on General Fund support of the Acute Care program. The amounts used in this table represent JLBC Staff estimates of the impact of the Executive's proposals. While estimated FY 1994 savings from both proposals are comparable, the Executive's proposals would produce an additional \$103 million in General Fund savings in FY 1994. The JLBC Staff proposals would save an additional \$21.8 million in FY 1995. Savings for both proposals would increase in FY 1995 due largely to the elimination of prior year bills and any continued enrollment. The difference in savings between the proposals is due to the fact that the Executive's proposals eliminates the entire MN/MI program, whereas the JLBC proposal restricts coverage for undocumented aliens only, or about 30% of the MN/MI population.

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Table 12

COMPARISON OF GENERAL FUND SAVINGS FROM EXECUTIVE  
AND JLBC STAFF PROPOSALS  
(Dollars in Millions)

<u>General Fund Savings</u>	<u>FY 1994</u>		<u>FY 1995</u>	
	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>
Eliminate MN/MI Program/Expand SOBRA Coverage	\$86.8	N/A	\$190.0	N/A
Emergency Services Only for Undocumented Aliens	NA	\$43.6	NA	\$59.9
Restore County Acute Care Contribution	NA	34.6	NA	38.3
"Roll Back" SOBRA Coverage	NA	2.4	NA	2.7
Revise Disproportionate Share Allocation	NA	1.6	NA	1.6
Other Changes	<u>0.8</u>	<u>(1.5)</u>	<u>0</u>	<u>0</u>
<i>Net General Fund Savings</i>	<u><u>\$87.6</u></u>	<u><u>\$80.7</u></u>	<u><u>\$190.0</u></u>	<u><u>\$102.5</u></u>

*Impact on the Health Care System - Comparison*

Table 13 provides a comparison between the Executive and JLBC Staff proposals regarding the estimated impact of these proposals on the statewide health care system. The JLBC proposal has a larger FY 1994 impact on the health care generally because the Staff has not recommended the expansion of eligibility for pregnant women and children, nor the elimination of the hospital quick pay discount. However, as state health care expenditures decline into FY 1995 with the elimination of prior year bills and guaranteed enrollment, the net loss to the health care system under the Executive's proposal would marginally exceed the loss produced by the JLBC Staff proposals. The estimated revenue loss under the Executive's proposals would grow from \$16.2 million in FY 1994, to \$67.9 million in FY 1995. This increase in revenue losses would not equal the gain in General Fund savings, though, in large part because of offsetting increases in revenue generated by the federal eligibility expansions. Once fully implemented, the proposed expansion of eligibility for pregnant women and children could bring an additional \$50 million in revenue into the health care system in FY 1995.

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Table 13

COMPARISON OF THE IMPACT ON THE HEALTH CARE SYSTEM  
(Dollars in Millions)

	FY 1994		FY 1995	
	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>
<u>Health Care System Revenue Losses</u>				
State Funding for the MN/MI Population	\$(266.9)	NA	\$(293.6)	NA
State Funding for Undocumented Aliens	NA	\$(80.1)	NA	\$(92.1)
"Roll Back" SOBRA Coverage	NA	(7.0)	NA	(8.0)
Subtotal-Revenue Losses	\$(266.9)	\$(87.1)	\$(293.6)	\$(100.1)
<u>Revenue Added Back to System that Lessens Impact</u>				
Prior Year Bills	51.0	12.1	0	0
6 Month Guaranteed Enrollment	38.7	7.4	0	0
Conversion of MN/MI to Federal Groups	17.6	NA	21.7	NA
Eliminate Quick Pay Discount	49.5	NA	57.0	NA
Undocumented Aliens Emergency Services	26.3	34.3	30.2	39.4
Federal Expansion for Pregnant Women and Children	67.6	NA	116.8	NA
Subtotal-Revenue Added Back	\$250.7	\$53.8	\$225.7	39.4
<i>Net Impact on the Health Care System</i>	<i>\$(16.2)</i>	<i>\$(33.3)</i>	<i>\$(67.9)</i>	<i>\$(60.7)</i>

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*Impact on Hospitals - Comparison*

Table 14 provides a comparison between the Executive and JLBC Staff proposals regarding the estimated impact on hospitals. As with our comparison of the impact on the health care system, the same concepts hold true for the impact on hospitals. The Executive's proposals yields a smaller first year revenue loss for hospitals, but as state funding is further restricted in FY 1995, the net revenue loss under the Executive's proposals would again marginally exceed that of the JLBC Staff proposals in FY 1995.

	<b>COMPARISON OF THE IMPACT ON HOSPITALS</b>			
	<b>(Dollars in Millions)</b>			
	<b>FY 1994</b>		<b>FY 1995</b>	
	<b>Exec. Proposals</b>	<b>JLBC Proposals</b>	<b>Exec. Proposals</b>	<b>JLBC Proposals</b>
<b><u>Hospital Revenue Losses</u></b>				
State Funding for the MN/MI Population	\$(173.5)	NA	\$(190.9)	NA
State Funding for Undocumented Aliens	NA	\$(52.1)	NA	\$(59.9)
"Roll Back" SOBRA Coverage	NA	(3.1)	NA	(3.6)
Subtotal-Revenue Losses	\$(173.5)	\$(55.2)	\$(190.9)	\$(63.5)
<b><u>Revenue Added Back to Hospitals that Lessens Impact</u></b>				
Prior Year Bills	33.2	7.9	0	0
6 Month Guaranteed Enrollment	25.1	4.8	0	0
Conversion of MN/MI to Federal Groups	11.4	NA	14.1	NA
Eliminate Quick Pay Discount	49.5	NA	57.0	NA
Undocumented Aliens Emergency Services	17.1	22.3	19.6	25.6
Federal Expansion for Pregnant Women and Children	30.4	NA	52.6	NA
Subtotal-Revenue Added Back	\$166.7	\$35.0	\$143.3	\$25.6
<b>Net Impact on Hospitals</b>	<b>\$(6.8)</b>	<b>\$(20.2)</b>	<b>\$(47.6)</b>	<b>\$(37.9)</b>

*Impact of Counties*

Under the Executive's proposal, county hospitals could see revenue losses totalling \$1.8 million in FY 1994, and \$12.8 million in FY 1995. If the JLBC Staff proposals were implemented, county hospitals may lose \$5.5 million in FY 1994, and \$10.2 million in FY 1995.

The Executive has proposed certain changes, however, that could produce net revenue gains for the counties in FY 1994 and FY 1995. The elimination of county residual responsibility could save counties \$15 million, while the elimination of the county MN/MI eligibility function could add \$13.8 million to county savings. The JLBC

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

Staff recommendation maintains county residual responsibility and leaves most of the MN/MI program intact, thus continuing the need for the county eligibility system. However, due to concerns over improper MN/MI eligibility determinations, the Staff recommends that the Legislature consider consolidating all AHCCCS eligibility work with the state. We made this recommendation last year based on information from AHCCCS indicating that 18% of the MN/MI population are in fact eligible for federally-reimbursed groups, but are not being correctly enrolled due to limitations in the current county eligibility system. Project SLIM has also made a similar recommendation. (See Other Issues for Legislative Consideration in the Agency Summary narrative for a discussion of SLIM proposals.)

### *Impact on Clients*

Under the Executive's proposal, of the existing 60,000 people in the MN/MI and ELIC programs, 35,000 would lose all AHCCCS coverage. The Executive estimates that 11,000 MN/MIs and ELICs will convert to federal eligibility groups, while another 14,000 undocumented aliens in the MN/MI and ELIC programs will receive emergency services only. The proposed expansion of federal eligibility would, however, extend AHCCCS coverage to an additional 69,000 pregnant women, infants, and children under age 6.

The JLBC Staff proposal regarding undocumented aliens would affect 30% of the MN/MI and ELIC populations, or about 18,000 people. In conformance with federal policy, these individuals would receive emergency services only coverage through AHCCCS. The proposed "roll back" SOBRA coverage would affect 1,500 women and infants, or about 5% of the current SOBRA women and infants population.

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Table 15 summarizes the major points of the Executive and JLBC Staff proposals.

Table 15	
<u>COMPARISON OF PROPOSALS</u>	
<ul style="list-style-type: none"><li>• Eliminates MN/MI and ELIC programs; 35,000 lose full coverage; 11,000 may convert to full federal eligibility; 14,000 undocumented aliens receive emergency services only.</li></ul>	<ul style="list-style-type: none"><li>• Restricts coverage for undocumented aliens to emergency services only; affects 18,000 undocumented aliens. Retains rest of MN/MI and ELIC programs.</li></ul>
<ul style="list-style-type: none"><li>• Maintains county acute care contribution at \$65 million.</li></ul>	<ul style="list-style-type: none"><li>• Increases county acute care contribution to \$99.6 million, or one-third of overall FY 1994 state match requirements.</li></ul>
<ul style="list-style-type: none"><li>• Expands federal SOBRA coverage; adds 9,000 women and infants; expands federal coverage for children under age 6; adds 60,000 children.</li></ul>	<ul style="list-style-type: none"><li>• Rolls back SOBRA coverage to 133% of FPL; takes out 5%, or 1,500 women and infants.</li></ul>
<ul style="list-style-type: none"><li>• Eliminates county residual responsibility; eliminates quick pay discount.</li></ul>	<ul style="list-style-type: none"><li>• Keeps county residual and quick pay discount.</li></ul>

### **Other Acute Care Changes**

#### *Medicare Part B Premiums*

This line item represents the payment of Medicare Part B Premiums for AHCCCS recipients also eligible for the federal Medicare program. The Part B "buy-in" lowers state costs of providing health care because a portion of the Medicare-eligible recipient's costs are paid for by Medicare. The Staff estimates an FY 1994 increase of \$490,700 GF associated with population growth and the higher cost of Part B premiums. The Total Funds amount is reduced \$438,200 to adjust for the appropriate matching rate.

#### *Qualified Medicare Beneficiaries (QMBs)*

This federally required expenditure represents the payment of Medicare Part A and B premiums, copayments and deductibles for qualified low income individuals who are Medicare-eligible. The JLBC Staff estimates an FY 1994 increase of \$333,700 GF and \$882,300 TF associated with population growth and increased premium, copayment, and deductible costs.

## Joint Legislative Budget Committee - Fiscal Year 1994 Budget - Analysis and Recommendations

### *EPSDT Mental Health*

The General Fund reduction of \$1,000,000 GF from this line item represents the transfer of funding to the Department of Health Services, which will now be capitated by AHCCCS for the Children's Title XIX Mental Health program. The General Fund appropriation has been used to pay Fee for Service drug and laboratory claims of children receiving mental health services through the DHS behavioral health system. These amounts will now be incorporated into monthly capitation payments, with AHCCCS providing the federal portion and DHS the state General Fund amounts. The Total Funds change include a \$16,000,000 reduction for a one-time federal appropriation in FY 1993 associated with the recovery of funds from certain behavioral health entities. The FY 1994 recommended amount reflects also an increase of \$11,231,900 in federal funding related to population growth and continued conversions of clients to Title XIX eligibility. For a more detailed discussion, please refer to the Staff's recommendation for DHS Behavioral Health.

### *Adult Mental Health*

The JLBC Staff recommends an increase of \$6,000,000 in federal expenditure authority for the Title XIX Adult Mental Health program. The General Fund appropriation for this program is reflected in the DHS Behavioral Health budget. Again, a more detailed discussion of behavioral health programs appears in the DHS Behavioral Health budget.

Table 11a

**SOBRA INCOME LEVELS**  
(Annual Income)

<u>Family Size</u>	<u>Income @ 133% of the Federal Poverty Level</u>	<u>Income @ 140% of the Federal Poverty Level</u>	<u>Income @ 185% of the Federal Poverty Level</u>
1	\$9,057	\$9,543	\$12,599
2	12,223	12,866	17,002
3	15,388	16,198	21,405
4	18,553	19,530	25,808
5	21,718	22,862	30,211
6	24,884	26,194	34,614
7	28,049	29,526	39,017
8	31,215	32,858	43,420

Table 16

**COMPARISON OF THE IMPACT ON COUNTIES**  
(Dollars in Millions)

	FY 1994		FY 1995	
	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>
<b><u>County Revenue Losses</u></b>				
County Hospital Losses	\$(1.8)	\$ (5.5)	\$(12.8)	\$(10.2)
Increased Acute Care Contribution	<u>NA</u>	<u>(34.6)</u>	<u>NA</u>	<u>(38.3)</u>
Subtotal - Revenue Losses	\$(1.8)	\$(40.1)	\$(12.8)	\$(48.5)
<b><u>Revenue Added Back to Counties that Lessens the Impact</u></b>				
Eliminate County Residual Responsibility	15.0	NA	15.0	NA
Eliminate County Eligibility Function	<u>13.8</u>	<u>NA</u>	<u>13.8</u>	<u>NA</u>
Subtotal - Revenue Added	\$28.8	\$ 0	\$ 28.8	\$ 0
<b><i>Net Impact on Counties</i></b>	<b>\$27.0</b>	<b>\$(40.1)</b>	<b>\$16.0</b>	<b>\$(48.5)</b>
<b>Other Revenue:</b>				
Additional Sales Tax	\$25.0	\$25.0	\$55.0	\$55.0

### Emergency Services Coverage

#### Health Care Financing Administration, HHS

§ 440.270

ments of the State plan (except for receipt of AFDC, SSI or a State Supplementary payment) must be furnished only those services necessary to treat an emergency medical condition of the alien as defined in § 440.255(c).

(o) [Reserved]

(p) A State may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid, under the following conditions:

(1) These services must be pregnancy-related or related to any other condition which may complicate pregnancy, as defined in § 440.210(a)(2) of this subpart; and

(2) These services must be provided in equal amount, duration, and scope to all pregnant women covered under the State plan.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48541, Oct. 1, 1981; 48 FR 5735, Jan. 8, 1983; 51 FR 22041, June 17, 1986; 55 FR 36822, Sept. 7, 1990; 56 FR 24011, May 28, 1991]

#### § 440.255 Limited services available to certain aliens.

(a) *FFP for services.* FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).

(b) *Legalized aliens eligible only for emergency services and services for pregnant women.* Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§ 435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—

(1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.

(c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—

(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part, and

(2) The alien otherwise meets the requirements in §§ 435.406(c) and 436.406(c) of this subpart.

[55 FR 36823, Sept. 7, 1990; 56 FR 10807, Mar. 14, 1991]

#### § 440.260 Methods and standards to assure quality of services.

The plan must include a description of methods and standards used to assure that services are of high quality.

#### § 440.270 Religious objections.

(a) Except as specified in paragraph (b) of this section, the agency may not require any individual to undergo any medical service, diagnosis, or treatment or to accept any other health service provided under the plan if the individual objects, or in the case of a child, a parent or guardian objects, on religious grounds.

OSPB ANALYSIS OF EXECUTIVE AND JLBC PROPOSALS

Table 8 - A

COMPARISON OF EXECUTIVE'S AHCCCS PROPOSAL WITH JLBC PROPOSAL

OSPB ANALYSIS

	<u>Executive FY 94</u>	<u>JLBC Staff FY 94</u>	<u>Executive FY 95</u>	<u>JLBC Staff FY 95</u>
Estimated AHCCCS Acute Care Increase	\$86,562,300	\$78,928,300	\$126,562,300	\$137,612,900
FY 1994 Cost of MN/MI and ELIC Programs	(267,148,900)	NA	(267,148,900)	NA
FY 1994 Cost of Undocumented Aliens	NA	(80,076,900)	NA	(80,076,900)
<u>Proposed Federal Eligibility Expansion Costs and Other Costs</u>				
• SOBRA Expansion (Women, Infants, and Children Under 6 to 185% of the Federal Poverty Level)	23,047,900	NA	47,618,200	NA
• Prior Year MN/MI & ELIC Bills ("Tail")	70,000,000	12,116,200	35,000,000	0
• 6 Month Guaranteed Enrollment for MN/MI & ELIC	39,270,000	7,432,700		0
• Categorical Conversions (18% should be categorical)	16,400,000	NA	16,400,000	NA
• Eliminate Quick Pay Discount on Categorical Bills	16,300,000	NA	20,600,000	NA
• State Match for Undocumented Aliens Emergency Services	<u>8,957,500</u>	<u>8,957,500</u>	<u>8,957,500</u>	<u>10,941,100</u>
Subtotal-Expansion Costs, Other Costs	\$173,975,400	\$28,506,400	\$128,575,700	\$10,941,100
<u>Other Options/Administrative Changes</u>				
• 100% State Funded Emerg. Services for Undocumented Aliens	NA	7,994,700	NA	9,193,900
• "Roll Back" SOBRA Coverage for Women & Infants to 133% of FPL Shift MN/MI Eligibility to the State	NA	(2,377,600)	NA	(2,700,000)
• Revise Disproportionate Share Allocation	NA	(1,600,000)	NA	(1,600,000)
• Non-SMI Adult Mental Health	4,000,000	0	4,000,000	0
• Administrative Changes/Other Misc.	1,611,200	1,410,200		0
• Increase County Acute Care Contribution so that Acute Combined with the Long Term Care Contribution will equal One Third of Overall State and County Funds for AHCCCS	<u>NA</u>	<u>(34,565,000)</u>	<u>NA</u>	<u>(38,300,000)</u>
<b>Net General Fund Change from the FY 1993 Appropriation</b>	<b><u>\$(1,000,000)</u></b>	<b><u>\$(1,779,900)</u></b>	<b><u>\$(8,010,900)</u></b>	<b><u>\$35,071,000</u></b>
<i>FY 1994 and FY 1995 Savings from Proposals</i>	<i>\$87,562,300</i>	<i>\$80,708,200</i>	<i>\$134,573,200</i>	<i>\$102,541,900</i>

Table 9A

IMPACT OF EXECUTIVE'S PROPOSALS ON THE HEALTH CARE SYSTEM

<u>Health Care System Revenue Losses</u>	<u>Executive's Plan OSPB Est Year 1</u>	<u>Executive's Plan JLBC Est Year 1</u>	<u>Executive's Plan OSPB Est Year 2</u>	<u>Executive's Plan JLBC Est Year 2</u>
Estimated Dollar Value of Care No Longer Provided by State for MN/MI & ELIC Programs	\$(267,148,900)	\$(266,923,100)	\$(293,615,400)	\$(293,615,400)
<u>Revenue Added Back to System that Lessens Impact</u>				
Prior Year Bills ("Tail")	70,000,000	51,053,500	35,000,000	0
6 Month Guaranteed Enrollment	39,270,000	38,669,900	0	0
Conversion of MN/MI to Federal Groups	48,059,000	17,595,300	48,059,000	21,700,900
Eliminate Quick Pay Discount	47,900,000	49,540,500	61,800,000	56,971,500
Undocumented Aliens Emergency Services	26,268,400	26,268,300	26,268,400	30,208,600
SOBRA Expansion	67,589,100	67,589,100	143,100,000	116,824,600
<i>Net Impact on Health Care System</i>	<u><i>\$31,937,600</i></u>	<u><i>\$(16,206,500)</i></u>	<u><i>\$20,611,900</i></u>	<u><i>\$(67,909,800)</i></u>
<b>JLBC IMPACT</b>		<b>\$(33,237,400)</b>		<b>\$(60,704,200)</b>

Table 10 - A

IMPACT OF EXECUTIVE'S PROPOSALS ON HOSPITALS

<u>Hospital Revenue Losses</u>	Executive's Plan <u>OSPB Est. Year 1</u>	Executive's Plan <u>JLBC Est. Year 1</u>	Executive's Plan <u>OSPB Est. Year 2</u>	Executive's Plan <u>JLBC Est. Year 2</u>
Estimated Dollar Value of Care No Longer Provided by State for MN/MI & ELIC Programs	\$(173,646,800) @ 62% of Total	\$(173,500,000) @65% of Total	\$(190,850,000) @65% of Total	\$(190,850,000) @65% of Total
<u>Revenue Added Back to Hospitals that Lessens Impact:</u>				
Prior Year Bills ("Tail")	43,400,000	33,184,800	22,800,000	0
6 Month Guaranteed Enrollment	24,347,400	25,135,400	0	0
Conversion of MN/MI to Federal Groups	29,796,600	11,436,900	31,238,400	14,105,600
Eliminate Quick Pay Discount (100% goes to Hospitals)	47,900,000	49,540,500	40,170,000	56,971,500
Undocumented Aliens Emergency Services	16,286,400	17,074,400	17,074,400	19,635,600
SOBRA Expansion	30,415,100	30,415,100	93,015,000	52,571,100
<b><i>Net Impact on Hospitals</i></b>	<b><u>\$18,498,700</u></b>	<b><u>\$(6,712,900)</u></b>	<b><u>\$ 13,447,800</u></b>	<b><u>\$(47,566,200)</u></b>
Share Private (Exec. @ 83%, JLBC @ 73%)	\$15,353,900	\$(4,900,400)	\$(34,723,300)	\$(34,723,300)
Share County-Operated (Exec. @ 17%, JLBC @ 27%)	3,144,800	(1,812,500)	(12,842,900)	(12,842,900)
<b>JLBC IMPACT</b>		<b>\$(20,209,800)</b>		<b>\$(37,854,100)</b>

Table 12 - A

COMPARISON OF GENERAL FUND SAVINGS FROM EXECUTIVE  
AND JLBC STAFF PROPOSALS  
(Dollars in Millions)

<u>General Fund Savings</u>	<u>FY 1994</u>		<u>FY 1995</u>	
	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>	<u>Exec. Proposals</u>	<u>JLBC Proposals</u>
Eliminate MN/MI Program/Expand SOBRA Coverage	\$86.8	N/A	\$190.0	N/A
Emergency Services Only for Undocumented Aliens	NA	\$43.6	NA	\$59.9
Restore County Acute Care Contribution	NA	34.6	NA	38.3
"Roll Back" SOBRA Coverage	NA	2.4	NA	2.7
Revise Disproportionate Share Allocation	NA	1.6	NA	1.6
Other Changes	<u>0.8</u>	<u>(1.5)</u>	<u>0</u>	<u>0</u>
<i>Net General Fund Savings</i>	<u>\$87.6</u>	<u>\$80.7</u>	<u>\$190.0</u>	<u>\$102.5</u>
NET GENERAL FUND COST GROWTH	\$(1.0)	\$(1.8)	\$(8.0)	\$35.0

**TESTIMONY BY**  
**THE HONORABLE JAMES D. BRUNER**

**PRESIDENT**  
**COUNTY SUPERVISORS ASSOCIATION**  
**CHAIRMAN, BOARD OF SUPERVISORS**  
**MARICOPA COUNTY**

**BEFORE THE**  
**JOINT AHCCCS AD HOC COMMITTEE**

**JANUARY 21, 1993**

TESTIMONY BY THE HONORABLE JAMES D. BRUNER, PRESIDENT, COUNTY SUPERVISORS ASSOCIATION OF ARIZONA, AND CHAIRMAN, BOARD OF SUPERVISORS, MARICOPA COUNTY, BEFORE THE JOINT AD HOC COMMITTEE ON AHCCCS, THURSDAY, JANUARY 21, 1993.

IT IS MY PLEASURE TO TESTIFY THIS EVENING IN MY CAPACITY AS CHAIRMAN OF THE MARICOPA COUNTY BOARD OF SUPERVISORS, AND AS PRESIDENT OF THE COUNTY SUPERVISORS ASSOCIATION. BOTH MARICOPA COUNTY AND THE COUNTY SUPERVISORS ASSOCIATION, REPRESENTING ALL OF ARIZONA'S FIFTEEN COUNTIES, ARE EXTREMELY CONCERNED WITH STATE BUDGET PROPOSALS IN THE AREA OF HEALTH CARE AND THEIR ENORMOUS POTENTIAL IMPACT ON ARIZONA COUNTIES. MY PRESENTATION WILL BE THE ONE AND ONLY COMPREHENSIVE PRESENTATION ON BEHALF OF ALL OF ARIZONA'S COUNTIES AT THIS HEARING.

IN HIS STATE-OF-THE-STATE MESSAGE, GOVERNOR SYMINGTON SAID:

"IN 1993, WE MUST CONTINUE TO SEND WASHINGTON SOME OTHER SIGNALS OF FIERCE WESTERN INDEPENDENCE. WE WILL CONTINUE TO PRESS OUR CASE THAT MANDATES FROM THE FEDERAL GOVERNMENT HAVE STRIPPED US OF OUR FISCAL SOVEREIGNTY. AND IN DOING SO THEY HAVE STRIPPED THE PEOPLE OF THEIR RIGHT TO REPRESENTATIVE GOVERNMENT AT THE STATE LEVEL, WHERE REPRESENTATIVE GOVERNMENT IS MOST IMPORTANT. WE WILL CHALLENGE THESE FEDERAL MANDATES UNDER THE TENTH AMENDMENT AND WE WILL DEFEND THE CONSTITUTIONAL RIGHT OF THIS STATE TO SELF-DETERMINATION."

MOST MEMBERS OF THE LEGISLATURE APPLAUDED THOSE WORDS. YET IN RECENT DAYS, THERE HAVE BEEN INDICATIONS THAT SOME MEMBERS OF THIS LEGISLATURE ARE POISED TO PASS THE LARGEST UNFUNDED MANDATE UPON COUNTIES IN ARIZONA HISTORY. TONIGHT, I ASK THAT YOU STOP AND EXAMINE MORE CAREFULLY THE CONSEQUENCES OF THAT PROSPECTIVE ACTION.

THERE ARE NOW TWO MAJOR PROPOSALS ON THE TABLE. ATTACHMENT 1 IS A CHART THAT SUMMARIZES THE IMPACT ON MARICOPA COUNTY OF THOSE TWO PROPOSALS. ATTACHMENT 2 SUMMARIZES THE IMPACT ON ALL 15 COUNTIES OF THE OVER \$44 MILLION IN JLBC - PROPOSED CONTRIBUTION INCREASES FOR ACUTE CARE AND LONG TERM CARE. I WOULD LIKE TO COMPLIMENT GOVERNOR SYMINGTON ON HIS STAND THAT SHIFTING COSTS TO LOCAL GOVERNMENT DOES NOT SOLVE PROBLEMS.

WHILE MANY OF YOU AND MANY OF US ARE CONCERNED ABOUT THE PROSPECT OF DISCONTINUING COVERAGE FOR THE MEDICALLY NEEDY/MEDICALLY INDIGENT POPULATION, HIS PROPOSAL DOES NOT SHIFT COSTS TO COUNTY GOVERNMENT AND RECOGNIZES THAT WHETHER THE EXPENSE RESTS WITH THE STATE OR THE COUNTY - THE SAME TAXPAYERS BEAR THE BURDEN.

UNFORTUNATELY, WE CANNOT FIND ANYTHING POSITIVE TO SAY ABOUT THE JLBC STAFF PROPOSAL. IN FACT, THE JLBC STAFF PROPOSAL MAY BE THE SINGLE MOST DAMAGING FISCAL PROPOSAL EVER INTRODUCED AS FAR AS

ARIZONA'S COUNTIES ARE CONCERNED. IN CONTRAST TO THE TRUTH IN BUDGETING PRINCIPLES ADHERED TO BY THE GOVERNOR IN ADDRESSING THE MAJOR ISSUES IN HEALTH CARE, THE JLBC PROPOSAL RESORTS TO THE OLDEST TRICK IN THE BOOK - SHIFTING COSTS TO THE LOWER LEVEL OF GOVERNMENT.

THIS APPROACH IS EXACTLY WHAT GOVERNOR SYMINGTON AND MANY MEMBERS OF THIS LEGISLATURE HAVE OPPOSED. THIS APPROACH DOES NOT SOLVE THE PROBLEM, IT ONLY PASSES THE PROBLEM ON TO THE COUNTIES.

PLEASE UNDERSTAND THIS SIMPLE FACT - NEITHER MARICOPA COUNTY NOR ANY OF ARIZONA'S COUNTIES HAVE THE ABILITY TO WITHSTAND THE COST-SHIFTING THAT IS PROPOSED IN THE JLBC STAFF PROPOSAL, AND WE VIGOROUSLY OPPOSE IT OR ANYTHING SIMILAR TO IT. PLEASE ALSO UNDERSTAND THAT THERE ARE SERIOUS CONSEQUENCES ASSOCIATED WITH SUCH COST-SHIFTING, AS WE WILL IDENTIFY TONIGHT AND IN THE DAYS AHEAD. AS I WILL OUTLINE FOR YOU TONIGHT, THIS IS NOT A MATTER OF SELFISH PROTECTION OF COUNTY RESOURCES. IT IS MATTER OF FINANCIAL SURVIVAL.

TONIGHT, I WOULD LIKE TO REVIEW WITH THIS AUDIENCE THE SCOPE OF THE COUNTY ROLE IN HEALTH CARE. THAT ROLE ENCOMPASSES MUCH MORE THAN JUST THE COUNTY CONTRIBUTION TO THE ACUTE CARE AND LONG TERM CARE PROGRAMS OF AHCCCS.

SECOND, I WOULD LIKE TO REVIEW WITH YOU THE COUNTY FINANCIAL STRUCTURE AND ITS CURRENT FINANCIAL CONDITION. AS I WILL OUTLINE FOR YOU, THAT CONDITION CURRENTLY IS MOST UNFAVORABLE, PARTICULARLY IN THE HEALTH CARE AREA.

THIRD, I WOULD LIKE TO DISCUSS AND REVIEW WITH YOU THE IMPACT OF THE TWO BUDGET PROPOSALS ON THE TABLE.

FINALLY, I WOULD LIKE TO RAISE SEVERAL ISSUES THAT I BELIEVE MERIT THE CONSIDERATION OF THIS GROUP IN CRAFTING A SOLUTION. LET ME ASSURE YOU THAT MARICOPA COUNTY, WHILE IT IS MOST STRONGLY OPPOSED TO THE JLBC PROPOSAL, IS COMMITTED TO PLAYING A CONSTRUCTIVE ROLE IN THESE DISCUSSIONS AND WISHES TO BE A PART OF THE SOLUTION, AS WE VIEW THE COUNTY TO HAVE A CONTINUING ROLE AS A REGIONAL LEADER IN THE AREA OF HEALTH CARE.

#### COUNTY ROLE IN HEALTH CARE

IN THE LATE 1970'S, COUNTIES WERE THE SOLE PUBLIC PROVIDERS OF CARE TO THE INDIGENT SICK IN ARIZONA. COUNTIES WERE EXPERIENCING SEVERE FINANCIAL DISTRESS, AND ARIZONA TAXPAYERS WERE NOT RECEIVING THEIR SHARE OF AVAILABLE FEDERAL DOLLARS.

FOR THESE REASONS, AND IN RESPONSE TO FEDERAL MANDATES, ARIZONA CREATED AHCCCS IN 1981 AS AN EXPERIMENTAL ALTERNATIVE SYSTEM TO MEDICAID.

COUNTIES PAY AN ANNUAL CONTRIBUTION ESTABLISHED BY THE LEGISLATURE TO THE ACUTE CARE PROGRAM OF AHCCCS, AND COUNTIES PAY 100 PERCENT OF THE NON-FEDERAL PORTION OF THE PROGRAM COST FOR THE LONG TERM CARE PROGRAM. SOME OF YOU MAY BE UNDER THE IMPRESSION THAT THIS IS WHERE THE COUNTY ROLE IN HEALTH CARE NOW BEGINS AND ENDS.

IN FACT, THE COUNTY ROLE IN HEALTH CARE IS MUCH BROADER THAN THAT. HEALTH CARE ACCOUNTS FOR 42 PERCENT OF MARICOPA COUNTY'S BUDGET AND OUR CONTRIBUTIONS TO THE ACUTE CARE AND LONG TERM CARE PROGRAMS OF AHCCCS ARE ONLY TWO COMPONENTS OF WHAT MARICOPA COUNTY EXPENDS ON HEALTH CARE OVERALL.

THESE EXPENDITURES ARISE FROM A VARIETY OF PROGRAMS AND AREAS OF LIABILITY. OF PARTICULAR NOTE IS THAT WE OPERATE WHAT IS BY FAR THE LARGER OF THE STATE'S ONLY TWO REMAINING COUNTY-OPERATED HOSPITALS.

ATTACHMENT 3 IS A CHART THAT DETAILS OUR ACTUAL EXPENDITURES IN THESE AREAS FOR THE LAST FISCAL YEAR AND PROJECTED EXPENDITURES FOR THE CURRENT FISCAL YEAR. AS YOU CAN SEE, THE HEALTH CARE

RESPONSIBILITIES OF THE COUNTY ARE QUITE BROAD AND INVOLVE A SUBSTANTIAL PORTION OF OUR COUNTY BUDGET.

AHCCCS DID NOT FULLY ASSUME RESPONSIBILITY FOR ALL POPULATION GROUPS AND TYPES OF SERVICES THAT THE COUNTY WAS SERVING PRIOR TO 1981. IN FACT, AS A PART OF THE AHCCCS LEGISLATION, COUNTIES WERE LEFT WITH A "MAINTENANCE OF EFFORT" STANDARD FOR PROVIDING HEALTH CARE TO INDIVIDUALS. UNDER THIS STANDARD, COUNTIES MUST CONTINUE TO PROVIDE, OR "MAINTAIN ITS EFFORT", WITH RESPECT TO BOTH THOSE POPULATION GROUPS, AND THE ARRAY OF COUNTY SERVICES, THAT EXISTED AT THE TIME AHCCCS WAS CREATED.

IN OTHER WORDS, IF AN INDIVIDUAL WAS ELIGIBLE FOR COUNTY HEALTH CARE COVERAGE OR A TYPE OF SERVICE WAS PROVIDED BY THE COUNTY UNDER THE LAWS, RULES AND REGULATIONS THAT EXISTED IN 1981, AND AHCCCS DOES NOT TODAY COVER THAT INDIVIDUAL OR PROVIDE THAT SERVICE, THEN THE COUNTY IS REQUIRED TO PAY THAT COST. THIS EXPENSE, WHICH CONSTITUTES OUR MAINTENANCE OF EFFORT OR RESIDUAL LIABILITY OBLIGATION, IS IN THE MANY MILLIONS OF DOLLARS EACH YEAR.

ATTACHMENT 4 CONTAINS A BRIEF EXPLANATION OF THE VARIOUS TYPES OF RESIDUAL LIABILITY AND SUMMARIES OF THE STATUTES GOVERNING SUCH LIABILITY. ATTACHMENT 5 SETS FORTH RESIDUAL LIABILITY AND ELIGIBILITY DETERMINATION COSTS FOR ALL 15 COUNTIES. OBVIOUSLY, OUR RESIDUAL

HEALTH CARE OBLIGATIONS REMAIN QUITE SIGNIFICANT OUTSIDE OF AHCCCS. PART OF THE JLBC PROPOSAL IS TO INCREASE THE COUNTY CONTRIBUTION TO THE ACUTE CARE PROGRAM TO RAISE THE LEVEL OF OUR FINANCIAL PARTICIPATION TO ONE THIRD OF TOTAL STATE-COUNTY COSTS, WHICH IS WHAT JLBC INDICATES IT WAS IN THE EARLY YEARS OF THE AHCCCS PROGRAM.

WE BELIEVE THIS ANALYSIS TO BE FLAWED FOR TWO REASONS. FIRST, THIS ANALYSIS DOES NOT TAKE INTO ACCOUNT THE FULL RANGE OF THE COUNTY'S COMMITMENT TO HEALTH CARE SPENDING - IT ONLY LOOKS IN ISOLATION AT THE ACUTE CARE CONTRIBUTION. ALTHOUGH LEGISLATIVE HISTORY IS FREQUENTLY LACKING, WE BELIEVE THAT THE INTENT OF THE LEGISLATURE WHEN AHCCCS WAS CREATED WAS TO FIX THE COUNTY CONTRIBUTION AT A SET AMOUNT IN EXCHANGE FOR THE COUNTY RETAINING RESIDUAL RESPONSIBILITY. THE JLBC PROPOSAL PROPOSES TO UNCAP THE COUNTY CONTRIBUTION AND TO SET IT AT A PERCENTAGE EACH YEAR WITHOUT RELIEVING THE COUNTIES OF RESIDUAL RESPONSIBILITY.

IF THE JLBC PROPOSAL IS TO BE SERIOUSLY CONSIDERED, THEN ELIMINATION OF RESIDUAL LIABILITY FOR COUNTIES DESERVES EQUALLY SERIOUS CONSIDERATION. THESE TWO ISSUES GO HAND IN HAND. RESIDUAL LIABILITY IS, IN FACT, THE FIRST MAJOR ISSUE WE WOULD IDENTIFY FOR THIS COMMITTEE TO CONSIDER IN ADDITION TO THE OSPB AND JLBC PROPOSALS.

THE SECOND REASON WHY THE JLBC ANALYSIS IS FLAWED IS THAT IT FAILS TO TAKE INTO ACCOUNT THE CAPACITY OF COUNTIES TO GENERATE REVENUE. AS I WILL OUTLINE FOR YOU IN A MOMENT, MOST COUNTIES HAVE NO ABILITY TO DO SO. THUS, THE STATE AND THE COUNTIES ARE NOT IN PARALLEL POSITIONS WHEN IT COMES TO ABSORBING COST INCREASES. IF THE STATE, WITH ITS GREATER FLEXIBILITY TO ABSORB COSTS, HAS CONCLUDED IT CANNOT AFFORD ANY MORE MONEY FOR AHCCCS - IT SHOULD NOT SEEK TO PAY FOR INCREASES WITH REVENUE FROM COUNTIES WHICH HAVE ESSENTIALLY NO FLEXIBILITY AS FAR AS REVENUE IS CONCERNED. WHATEVER IT IS THAT THE STATE CANNOT AFFORD - THE COUNTIES CANNOT AFFORD EITHER.

#### **COUNTY FINANCIAL STRUCTURE AND CONDITION**

NOW, I WOULD LIKE TO SAY A FEW WORDS ABOUT MARICOPA COUNTY'S FINANCIAL STRUCTURE AND CONDITION. MARICOPA COUNTY GOVERNMENT IS FINANCED PRIMARILY BY PROPERTY TAXES, SALES TAXES, FEES AND CHARGES, AND OTHER NON-TAX SOURCES OF REVENUE SUCH AS GRANTS. THE TWO MAJOR VARIABLES IN THIS MIX ARE PROPERTY TAXES AND SALES TAXES. THE FINANCIAL STRUCTURE OF ALL 15 COUNTIES IS ESSENTIALLY THE SAME.

ATTACHED AS ATTACHMENT 6 ARE TWO CHARTS OUTLINING THE CATEGORIES OF REVENUES AND EXPENDITURES FOR MARICOPA COUNTY FOR THE CURRENT FISCAL YEAR. MARICOPA COUNTY'S ONLY SOURCE OF SALES TAX REVENUE IS ITS PORTION OF THE SALES TAX REVENUE SHARED BY THE STATE OF ARIZONA WITH COUNTIES. MARICOPA COUNTY DOES NOT HAVE ANY AUTHORITY FOR A

COUNTYWIDE SALES TAX. WHILE OTHER COUNTIES DO HAVE THIS AUTHORITY, THE MOOD OF THE ELECTORATE IS CLEARLY IN OPPOSITION TO TAX INCREASES OF THIS NATURE.

IN THE AREA OF PROPERTY TAXES, COUNTIES ARE GOVERNED BY THE 1980 VOTER APPROVED CONSTITUTIONAL LEVY AND EXPENDITURE LIMITS. OUR TOTAL LEVY FOR PROPERTY TAX PURPOSES MAY NOT INCREASE IN ANY GIVEN YEAR BY MORE THAN THE SUM OF 2 PERCENT OF THE PRIOR YEAR'S LEVY PLUS NEW CONSTRUCTION. MARICOPA COUNTY DOES NOT OBJECT TO OR OPPOSE THIS LEVY LIMITATION, BUT WE MUST POINT OUT TO YOU THAT THE EXISTENCE OF THE LEVY LIMITATION PREVENTS MARICOPA COUNTY FROM RAISING THE PROPERTY TAX LEVY IN ORDER TO RAISE REVENUE TO PAY FOR PROGRAMS.

THIS IS ALSO TRUE FOR MOST OF THE OTHER COUNTIES. ATTACHMENT 7 OUTLINES THE CURRENT TAX RATES AND RATE LIMITS FOR ALL 15 COUNTIES. IT ALSO IDENTIFIES WHAT THE JLBC PROPOSAL WOULD MEAN IN TERMS OF TAX RATE INCREASES IF IT WERE POSSIBLE FOR COUNTIES TO PASS THEIR INCREASES ON TO PROPERTY TAX PAYERS.

HOWEVER, MARICOPA COUNTY AND MOST OF THE OTHER COUNTIES DO NOT HAVE THE ABILITY TO INCREASE PROPERTY TAXES OR SALES TAXES, OR ANY OTHER TAXES, TO RAISE REVENUE TO PAY FOR ADDITIONAL COSTS PASSED ON BY THE LEGISLATURE IN THE AREA OF AHCCCS, OR ANY OTHER AREA. WE CERTAINLY HAVE NO WAY OF RAISING THE REVENUE TO ABSORB THE TYPES OF

INCREASES THAT ARE PROPOSED BY JLBC. EVEN IF JLBC'S REVENUE ESTIMATES ARE CORRECT, OUR SHARE OF THE ADDITIONAL SHARED SALES TAX REVENUE WHICH MARICOPA COUNTY WOULD RECEIVE NEXT YEAR WOULD PAY FOR LESS THAN HALF OF THE COST SHIFTS THAT ARE PROPOSED UNDER THE JLBC PROPOSAL.

MANDATING THAT ALL NEW REVENUES PAY FOR HEALTH CARE ALSO LEAVES US WITH ABSOLUTELY NO NEW REVENUE TO DEAL WITH OTHER PROGRAMS WHERE WE ARE EXPERIENCING INCREASES DUE TO INFLATION IN COSTS, GROWTH IN SERVICE DEMANDS, OR BOTH. OUR JAILS WOULD BE AN EXAMPLE OF SUCH AN AREA. OUR JAIL EXPENSE IN 1983 WAS EQUAL TO \$17.8 MILLION - THAT AMOUNT HAS MUSHROOMED 267% TO THE CURRENT YEAR LEVEL OF \$47.5 MILLION. NEW REVENUES ARE NEEDED TO COPE IN MANY CRITICAL AREAS OF COUNTY RESPONSIBILITY BESIDES HEALTH CARE.

ON THE EXPENDITURE SIDE, OUR CURRENT FINANCIAL SITUATION IS MOST UNFAVORABLE. MARICOPA COUNTY HEALTH CARE CARRIED INTO THE CURRENT FISCAL YEAR A NEGATIVE BALANCE OF APPROXIMATELY \$15 MILLION DOLLARS. THIS NEGATIVE BALANCE RESULTED PRIMARILY FROM THE EVER GROWING AMOUNT OF UNCOMPENSATED CARE PROVIDED BY THE COUNTY HOSPITAL AND AMBULATORY CARE CLINICS.

YESTERDAY MORNING, THE BOARD OF SUPERVISORS RECEIVED A REPORT FROM A MANAGEMENT COUNCIL THAT HAS BEEN APPOINTED TO OVERSEE VARIOUS ACTIVITIES IN THE HEALTH CARE AREA WHERE COSTS ARE SIGNIFICANTLY EXCEEDING BUDGETED AMOUNTS. THE REPORT WE RECEIVED FROM THE MANAGEMENT COUNCIL INDICATES THAT MARICOPA COUNTY HEALTH CARE CAN EXPECT TO END THE YEAR WITH A NEGATIVE BALANCE OF APPROXIMATELY \$30 MILLION DOLLARS.

#### IMPACT OF JLBC PROPOSAL

AS WE LOOK AT THE JLBC PROPOSAL, OUR EXISTING \$30 MILLION PROBLEM WOULD BE INCREASED BY AT LEAST \$31 MILLION DOLLARS IN NEW STATE MANDATED COSTS, INCLUDING A \$20 MILLION DOLLAR INCREASE IN THE COUNTY ACUTE CARE CONTRIBUTION, AN OVER \$5 MILLION DOLLAR INCREASE IN THE COUNTY LONG TERM CARE CONTRIBUTION, AND A \$6 MILLION DOLLAR INCREASE IN UNCOMPENSATED CARE PROVIDED BY MARICOPA MEDICAL CENTER AND COUNTY CLINICS FOR UNCOMPENSATED CARE THAT WOULD ARISE FROM THE FACT THAT UNDOCUMENTED ALIENS WOULD NO LONGER BE COVERED FOR OTHER THAN EMERGENCY SERVICES, AND CUTS IN SOBRA COVERAGE FOR PREGNANT WOMEN AND CHILDREN.

TO SUMMARIZE, TAKING OUR EXISTING PROBLEM AND ADDING TO IT THE JLBC PROPOSAL LEAVES US WITH A \$60 MILLION DOLLAR PROBLEM IN THE HEALTH CARE AREA THAT WE HAVE ABSOLUTELY NO REVENUE TO COVER. THIS

SITUATION WILL HAVE DEVASTATING CONSEQUENCES FOR MARICOPA COUNTY GOVERNMENT AND CITIZENS. THESE DEVESTATING CONSEQUENCES WILL BE RELFECTED ACROSS THE ENTIRE SPECTRUM OF COUNTY SERVICES, INCLUDING COURTS, LAW ENFORCEMENT, JAILS, ELECTIONS, SOCIAL SERVICES, ASSESSOR, RECORDER, PUBLIC DEFENDER, MEDICAL EXAMINER, PARKS AND RECREATION AND MANY OTHER AREAS. ALL ARIZONA COUNTIES WILL SUFFER SIMILAR CONSEQUENCES.

WE HAVE NO ALTERNATIVE BUT TO OPPOSE THE JLBC STAFF PROPOSAL. THIS PROPOSAL DOES NOT ADDRESS THE PROBLEM - IT ONLY SHIFTS THE PROBLEM TO OTHER LEVELS OF GOVERNMENT AND WILL CREATE SEVERE PROBLEMS FOR LOCAL CITIZENS ON MANY OTHER ISSUES.

#### **ISSUES TO BE ADDRESSED**

THEREFORE, WE URGE THAT THIS AD-HOC GROUP SEEK REAL SOLUTIONS TO THE PROBLEM AND AVOID THE TEMPTATION TO SOLVE IT AT THE EXPENSE OF LOCAL TAXPAYERS BY SHIFTING COSTS TO COUNTY GOVERNMENT. GIVEN THE PRESENT ADVERSE FINANCIAL CONDITION OF THE COUNTIES, THE IMPACT OF THESE SOLUTIONS SHOULD BE NO WORSE THAN REVENUE NEUTRAL TO THE COUNTIES. AMONG THE ISSUES WE BELIEVE YOU SHOULD ADDRESS IN THIS REGARD IS THE ELIMINATION OF COUNTY RESIDUAL RESPONSIBILITY.

TO THE EXTENT THAT THE STATE HAS CONCLUDED THAT INDIGENT HEALTH CARE CAN BE PROVIDED ONLY TO CERTAIN POPULATION GROUPS, AND THAT ONLY CERTAIN SERVICES CAN BE PROVIDED, IT MAKES NO SENSE TO HAVE A SEPARATE DEFINITION OF INDIGENCY OR SEPARATE MANDATED ARRAY OF SERVICES IN EACH COUNTY BASED ON CIRCUMSTANCES THAT EXISTED TWELVE OR MORE YEARS AGO. IT IS TIME TO HAVE A STATEWIDE UNIFORM STANDARD FOR INDIGENCY AND SERVICES AND TO ELIMINATE COSTLY RESIDUAL RESPONSIBILITY THAT OUR TAXPAYERS SIMPLY CAN NO LONGER AFFORD.

I SHARE THE CONCERN OF MANY OF YOU ABOUT DISCONTINUING COVERAGE FOR THE MN/MI POPULATION. AS AN ALTERNATIVE TO EITHER DROPPING THAT POPULATION AS CALLED FOR IN THE EXECUTIVE PROPOSAL OR KEEPING THAT POPULATION AS CALLED FOR IN THE JLBC PROPOSAL, THIS AD-HOC GROUP SHOULD LOOK AT THE MIDDLE GROUND IN WHICH PERHAPS SOME OF THE RULES AND STANDARDS OF THE EXISTING MN/MI PROGRAM COULD BE MODIFIED TO REDUCE COSTS WHILE PROVIDING CARE TO THOSE WHO MOST DESPERATELY NEED IT. AMONG THE ASPECTS THAT MAY REQUIRE EXPLORATION ARE:

- THE LENGTH OF THE PERIOD OF ELIGIBILITY.
- AUTOMATIC COVERAGE OF ALL FAMILY MEMBERS.
- ASSET STANDARDS FOR ELIGIBILITY.
- CO-PAYMENTS AND DEDUCTIBLES.
- THE ARRAY OF SERVICES - SO LONG AS ANY LIMITATIONS ON SERVICES ARE MIRRORED IN THE COUNTY'S MAINTENANCE OF EFFORT.

FINALLY, THE CURRENT SYSTEM FOR ELIGIBILITY DETERMINATION NEEDS TO BE ASSESSED. MARICOPA COUNTY AND ALL 15 COUNTIES ARE PREPARED TO ADDRESS ALTERNATIVES TO THE CURRENT ELIGIBILITY DETERMINATION SYSTEM.

THANK YOU FOR HEARING MY TESTIMONY ON BEHALF OF ARIZONA'S 15 COUNTIES. AS CHAIRMAN OF THE MARICOPA COUNTY BOARD OF SUPERVISORS AND PRESIDENT OF THE COUNTY SUPERVISORS ASSOCIATION, I ASSURE YOU WE WILL FULLY PARTICIPATE IN THESE DISCUSSIONS WITH ALL INTERESTED PARTIES TO SEEK RESOLUTION. THAT RESOLUTION, HOWEVER, MUST BE SENSITIVE TO THE CONSIDERABLE RESOURCE LIMITATIONS OF THE COUNTIES. I WILL BE HAPPY TO RESPOND TO YOUR QUESTIONS.

## MARICOPA COUNTY - FY 1993-94 FINANCIAL IMPACT OF OSPB AND JLBC BUDGET PROPOSALS

### Joint Legislative Budget Committee Proposal

- Funding only Emergency Service for 18,000 undocumented aliens, eliminating MN/MI coverage for this population.

Estimated impact: < \$ 4.4 million >

Note: Impact estimate based on Maricopa County's share of the JLBC estimate. (Maricopa County will determine concurrence with this estimate when the assumptions made by JLBC in developing their estimate are known.) Future year impact significantly higher (\$10.2 million in FY 94-95), with multi-year increase undetermined. Uncompensated care provided by Maricopa Medical Center may increase if private hospitals refuse or transfer patients for whom they are no longer compensated.

- "Roll back" SOBRA coverage for pregnant women and infants from 140% to 133% of Federal Poverty Level.

Estimated impact: < \$ 1.3 million >

Note: Based on JLBC estimate. Actual negative impact may be higher as Maricopa County does not currently enroll all potentially eligible women. Indirect costs related to expensive high-risk pregnancies/complicated deliveries are not included in the estimate.

- Increase County Acute Care Contribution.

Estimated impact: < \$ 20 million >

Note: Estimated impact based on JLBC and CSA analysis.

- Increase County Long Term Care Contribution.

Estimated impact: < \$ 5.5 million >

Note: Estimated impact based on JLBC and CSA analysis.

**Net Impact All JLBC Proposals: < \$ 31.2 million >**

## Office of Strategic Planning and Budgeting Proposal

- Elimination of full MN/MI coverage for 35,000 recipients.

Estimated impact: < \$ 22.6 million >

Note: Impact based on increased uncompensated care provided by MMC to acutely ill/injured persons and loss of administrative revenue percentage for Maricopa Health Plan. This impact is expected to increase significantly if private hospitals refuse or transfer patients for whom they are no longer compensated.

- Extension of SOBRA to 69,000 pregnant women and children up to 185% of Federal Poverty Level.

Estimated impact: \$ 3.5 million

Note: This is the estimated net benefit from increase in revenue. Impact is based on additional coverage of only 2% of the population currently being served, of which up to 50% would be ineligible based on inability to meet citizenship requirement of SOBRA. (based on Ambulatory Care Prenatal Pilot Study data)

- Elimination of County Residuality.

Estimated impact: \$ 11 million

Note: This is the amount currently spent on payments to outside hospitals for indigent care. This estimate differs from the Maricopa County data included in the table developed by CSA for FY 1992 due to large settlements and write-offs made to expedite resolution of the Perez lawsuit and resulting backlog of claims during that year. It does not include the estimated "tail" for remaining claims (\$2.5 million) or chronic conditions (\$2.3 million).

- Elimination of MN/MI determination.

Estimated impact: \$ 7.6 million

Note: This impact is based upon the net cost of all eligibility functions currently performed by the County. The estimate assumes some eligibility functions will be retained by the County based on the OSPB statement that "Hospitals and other providers will probably invest more time making sure persons whose expenses are potentially reimbursable under Title XIX fill out applications with DES." It also assumes these funds will remain with the County as a partial offset to increased costs resulting from the implementation of other proposal components.

- Increase County Long Term Care contribution.

Estimated impact: < \$ 5 million >

**Net Impact All OSPB Proposals: < \$ 5.5 million >**

This analysis is intended as an *estimate* only since a significant additional increase in uncompensated care provided by both Maricopa Medical Center and the Ambulatory Care Primary Care Centers could occur as a result of the elimination of the MN/MI program. In addition, as noted in the JLBC analysis, the multi-year impacts are estimated to increase for many of the proposed changes.

### Long Term Care Payments (ALTCS)

	A	B	C	D
County	County Percent Of Total	ALTCS Payment FY 92-93	ALTCS Increase FY 93/94	ALTCS Payment FY 93-94 (JLBC)
Apache	0.22%	\$203,064	\$21,323	\$224,387
Cochise	2.53%	\$2,335,924	\$245,291	\$2,581,215
Coconino	0.66%	\$609,117	\$63,962	\$673,079
Gila	2.53%	\$2,330,914	\$244,785	\$2,575,679
Graham	0.64%	\$590,654	\$62,023	\$652,677
Greenlee	0.34%	\$313,789	\$32,950	\$346,739
La Paz	0.34%	\$313,789	\$32,950	\$346,739
Maricopa	56.55%	\$52,190,057	\$5,480,381	\$57,670,438
Mohave	2.73%	\$2,519,514	\$264,570	\$2,784,084
Navajo	0.91%	\$839,842	\$88,190	\$928,032
Pima	20.55%	\$18,965,618	\$1,991,544	\$20,957,162
Pinal	5.09%	\$4,697,564	\$493,282	\$5,190,846
Santa Cruz	1.05%	\$969,151	\$101,769	\$1,070,920
Yavapai	3.12%	\$2,879,453	\$302,366	\$3,181,819
Yuma	2.75%	\$2,539,151	\$268,632	\$2,805,783
Totals:	100.00%	\$92,297,600	\$9,692,000	\$101,989,600
	Percent Increase	5.43%		10.50%

OSP increase -- \$101,242,559

### Acute Care AHCCCS Payments

	A	B	C	D	E	F
County	AHCCCS FY 89/90	Percent Of Total	AHCCCS <sup>1</sup> FY 92/93	Percent Of Total FY 92/93	AHCCCS Increase FY 93/94 (JLBC Only)	AHCCCS Payment FY 93/94
Apache	\$262,488	0.45%	\$262,257	0.403%	\$139,438	\$401,695
Cochise	\$2,169,587	3.70%	\$2,161,177	3.321%	\$1,149,066	\$3,310,243
Coconino	\$725,384	1.24%	\$724,948	1.114%	\$385,444	\$1,110,392
Gila	\$1,379,280	2.35%	\$1,378,963	2.119%	\$733,174	\$2,112,137
Graham	\$523,038	0.89%	\$523,212	0.804%	\$278,184	\$801,396
Greenlee	\$186,108	0.32%	\$186,118	0.286%	\$98,956	\$285,074
La Paz	\$211,447	0.36%	\$206,942	0.318%	\$110,028	\$316,970
Maricopa	\$33,144,215	56.46%	\$37,723,963	57.969%	\$20,057,274	\$57,781,237
Mohave	\$1,218,011	2.07%	\$1,207,812	1.856%	\$642,176	\$1,849,988
Navajo	\$302,964	0.52%	\$303,255	0.466%	\$161,236	\$464,491
Pima	\$12,748,275	21.72%	\$14,590,061	22.420%	\$7,757,320	\$22,347,381
Pinal	\$2,670,357	4.55%	\$2,649,899	4.072%	\$1,408,912	\$4,058,811
Santa Cruz	\$472,179	0.80%	\$471,151	0.724%	\$250,504	\$721,655
Yavapai	\$1,393,263	2.37%	\$1,393,279	2.141%	\$740,786	\$2,134,065
Yuma	\$1,300,631	2.22%	\$1,293,062	1.987%	\$687,502	\$1,980,564
Totals:	\$58,707,227	100.00%	\$65,076,099	100.000%	\$34,600,000	\$99,676,099
					Percent Increase --	53.17%

<sup>1</sup>In 1991, the Legislature increased Pima and Maricopa counties' AHCCCS contribution by \$6.6 million while keeping other counties' amount constant. The JLBC proposed increase of \$34.6 million is distributed to all counties according to the revised percentages and would accentuate Pima and Maricopa's proportional contributions in the future.

**MARICOPA COUNTY  
HEALTH CARE COSTS  
FY1991-92 AND 1992/93**

	<b>FY91/92 Actual Costs</b>	<b>FY92/93 Projected Costs</b>
<b>COUNTY CONTRIBUTION TO AHCCCS ACUTE CARE</b>	<b>*\$37,733,080</b>	<b>\$37,733,080</b>
<p>Acute Care includes AFDC, SSI, MAO, and MN/MI. There is no federal reimbursement for MN/MI.</p>		
<b>COUNTY CONTRIBUTION TO ALTCS LONG TERM CARE</b>	<b>\$49,505,623</b>	<b>\$52,350,000</b>
<p>Includes elderly and physically disabled. Counties pay 100% of non-federal share.</p>		
<b>LONG TERM CARE RESIDUAL</b>	<b>\$ 5,000,000</b>	<b>\$ 4,300,000</b>
<p>Costs associated with County Maintenance of Effort statutes. Counties cannot reduce medical benefits and categories of services for persons who meet county indigent standards which were in place as of January 1, 1981.</p>		

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\*Includes \$4.8 million increase over FY90/91 enacted by the Legislature.

**FY91/92  
Actual Costs**

**FY92/93  
Projected Costs**

**HOSPITAL**

Maricopa County Medical Center is a \$172.4 million hospital with 106 departments, 194 attending physicians, and 311 visiting physicians.

<b>REVENUE</b>	\$120,800,000	\$162,200,000
<b>EXPENSE</b>	\$161,400,000	\$124,600,000
<b>NET COUNTY COST</b>	(\$ 40,600,000)	(\$ 37,600,000)

**AMBULATORY CARE**

Ambulatory care consists primary care centers providing direct primary health-care services as well as dental, counseling, education, pharmacy and laboratory services to eligible clients; county homeless alternative psychiatric services; day treatment for seriously mentally ill; corrections health care, and LARC.

<b>REVENUE</b>	\$22,500,000	\$30,100,000
<b>EXPENSE</b>	\$34,500,000	\$17,200,000
<b>NET COUNTY COST</b>	(\$12,000,000)	(\$12,900,000)

**OUTSIDE HOSPITALS**

	\$11,100,000	\$11,000,000
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Amount paid to various area hospitals for residual populations including amounts resulting from the 48-hour rule.

	<b>FY91/92 Actual Costs</b>	<b>FY92/93 Projected Costs</b>
<b>ELIGIBILITY</b>	<b>\$ 8,300,000</b>	<b>\$ 8,600,000</b>
<p>Eligibility determinations for AHCCCS and other medical assistance programs are available in various offices throughout the county, including the Maricopa Medical Center and some other primary care centers.</p>		
<b>PUBLIC HEALTH</b>	<b>\$ 6,400,000</b>	<b>\$ 6,300,000</b>
<p>Consists of community health, disease control, epidemiology, vital statistics, rabies/animal control, environmental health.</p>		

STATE MANDATED RESIDUAL RESPONSIBILITIES  
MARICOPA COUNTY -- FISCAL YEAR 91/92

A. Eligibility Determination

The County presently provides administration and eligibility workers for determining patient eligibility for MN/MI applicants and pre-screening of applicants for Federal categoricals.

\$7,191,284.00

B. Medical Pre-AHCCCS Cost

The County remains responsible for paying medical costs for indigents until 48 hours prior to the time the County can notify AHCCCS of eligibility. Example: An MN/MI eligible patient arrives at a hospital on a Friday night and is processed for eligibility. Final determination of eligibility can not be made until Wednesday. The County is liable for services provided on Friday, Saturday and Sunday.

\$14,272,233.00

C. County Medical Residual Services

The County remains responsible for providing additional services which are not covered by AHCCCS. Example: Patients in Federal categories do not receive dental care, the County must provide it.

\$1,040,727.00

D. County Law Suits

The County is required to pay for the cost of care for individuals whose income levels met indigency standards of the County in 1981. Also if an applicant for AHCCCS fails to provide sufficient information to establish eligibility but is later determined to be indigent, the County is liable for the cost of all services.

\$3,180,485.00



OFFICE OF THE  
Pima County Attorney  
Civil Division  
32 N. STONE  
SUITE 1500

STEPHEN D. NEELY  
PIMA COUNTY ATTORNEY

Tucson, Arizona 85701-1412  
(602) 740-5750  
FAX (602) 620-6556

September 10, 1992

TO: Fat Franck, Director, Medical Assistance Department  
FROM: Suzanne Hodges, Deputy County Attorney *SH*  
SUBJECT: "County Residual Liability" for Indigent Health Care

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To assist you and the other members of the County/State Task Force in developing a definition of "County Residual Liability", I submit the following discussion of the statutes involved:

§11-251(5):

Grants the counties the power to provide for the care and maintenance of the indigent sick of the county and to maintain hospitals therefor. This is the "grand daddy" enabling statute and the basis of the counties' residual indigent health care liability in its broadest sense.

§11-291:

§11-291(A) makes the counties responsible for providing hospitalization and medical care (excluding long term care but including home health services as defined in §36-131) to indigent persons, including those under the supervision of the county corrections agency, to the extent that the care is not the responsibility of AHCCCS.

Under §11-291(B), AHCCCS does not become responsible for providing care to an indigent until such time as a county has made a final eligibility determination and provided notice to AHCCCS of the person's eligibility. Counties are residually liable for the costs of services provided to a person who is "in fact eligible" up to the point at which the county gives proper notification of the person's eligibility to AHCCCS. For non-emergency care the counties' liability is limited to those persons who actually complete the AHCCCS application process, but the counties are responsible for

emergency services, subject to the hospital notification requirements of §11-297.01(C), regardless of whether an application is completed.

§11-291(G) makes counties responsible for the cost of emergency transportation of persons whose medical care is a county responsibility.

#### §11-291.01

By the terms of this statute, a county may not reduce the eligibility standards, benefit levels and categories of service for the hospitalization and medical care of the indigent sick in effect in the county on January 1, 1981. These requirements create four areas of county residual liability:

- (1) The cost of care provided to persons whose income and resources meet the higher levels that were in effect in a number of counties in January 1981 but fail to reach the current AHCCCS levels.
- (2) The cost of emergency care provided to persons during the period between spend down to the 1981 county level and spend down to the current AHCCCS level. This liability is extended by §11-291(B) and §11-297(E) to include the cost of services provided between spend down to the 1981 county level and notification to AHCCCS of the person's AHCCCS eligibility.
- (3) The cost of care provided to persons who would have qualified under the more lenient eligibility rules in effect in counties in 1981, i.e. Pima County disregarded the equity a person over sixty had in his or her home when determining resources.
- (4) The cost of services not covered by AHCCCS but provided by the counties in 1981, i.e. dental, eyeglasses, non-prescription medications and mental health services.

#### §11-297

§11-297(E) makes a county residually liable to AHCCCS providers and non-providers as well as to applicants if the county fails to complete an AHCCCS application within the time frame prescribed by AHCCCS rule. The county becomes liable for the cost of potentially AHCCCS covered services from the latest date that the person should have been determined eligible until the date that the county notifies AHCCCS of the person's eligibility.

§11-297.01

In general, this statute makes counties liable for the costs of emergency medical treatment provided by private hospitals to persons who are "in fact eligible" for care subject to notification by the hospital to the county. This statute reinforces the residual liability created under §11-291 and §11-291.01.

§11-297.01(C) extends a county's residual liability to a private hospital to a point prior to that hospital's notifying the county of a potential indigent's emergency hospitalization if the patient submitted evidence of insurance which was later determined to be invalid for the purpose for which the patient was admitted.

§36-2905.01 and § 36-2905.02

These statutes create indirect residual liability for the counties in that they provide for sanctions by the AHCCCS Administration and reimbursement by the counties to AHCCCS for the cost of medical services provided by AHCCCS to persons erroneously determined eligible for AHCCCS by the counties.

In conclusion, the counties currently have a broad and multi-faceted residual liability for indigent health care which provides a "safety net" and satisfies federal maintenance of effort requirements. That residual liability includes responsibility for the costs of emergency care provided to a person from the point he or she meets the 1981 county eligibility standards up to the point that the county notifies AHCCCS of the person's AHCCCS eligibility regardless of whether the person ever completes the application process. It covers non-emergency services for these same people if they complete the application process. It includes AHCCCS non-covered services that were provided by the counties in January 1981, emergency transportation for persons who qualify for county care, home health care services and medical care provided to indigent county prisoners. It includes liability to an applicant for eligibility if he or she incurs expenses at a point after which the county should have made an eligibility determination, and liability to AHCCCS for reimbursement of expenses incurred for erroneous eligibility determinations.

cc: Martin Willett  
Michael Callahan

COUNTY MEDICAL ASSISTANCE BUDGETS, FY 91 - 92  
 CSA SURVEY 10/16/92, ELIGIBILITY DETERMINATION AND MEDICAL LIABILITY COSTS BY COUNTY

FISCAL YEAR 1991 - 1992

COUNTY:	A. MED. ASSISTANCE PERSONNEL ON 10/01/92	B. COUNTY ELIG. DETERM. NET COST	C. MEDICAL* PREAMHCCCS COST	D. COUNTY MEDICAL RESIDUAL SERVICES	E. COUNTY LAWSUITS \$ PAID IN FY 91 - 92	F. TOTAL (B..E) ADM COST PLUS MED. LIABILITY FY 91 - 92
APACHE	4	\$133,795	NR	NR	NR	\$133,795
COCHISE	20	371,478	\$5,939	\$27,400	\$9,000	413,817
COCONINO	14	295,942	62,258	38,938	0	397,138
GILA	6	221,474	152,049	67,444	65,678	506,645
GRAHAM	3.5	90,294	15,905	0	0	106,199
GREENLEE	3	78,749	NR	0	0	78,749
LA PAZ	4	103,324	NR	0	150,000	253,324
MARICOPA	288	7,191,284	14,272,233	2,040,727	3,180,485	26,684,729
MOHAVE	25	372,714	632,015	48,836	15,000	1,068,565
NAVAJO	20	607,333	88,535	NR	0	695,868
PIMA	144	2,989,426	793,295	2,268,324	120,500	6,171,545
PINAL	35	404,378	1,670,208	34,083	230,710	2,339,378
SANTA CRUZ	7	145,175	43,948	0	0	189,123
YAVAPAI	16	373,850	60,981	37,907	41,299	514,037
YUMA	17	381,870	507,617	23,759	158,806	1,072,052
<b>TOTAL</b>	<b>606.5</b>	<b>\$13,761,086</b>	<b>\$18,304,984</b>	<b>\$4,587,417</b>	<b>\$3,971,478</b>	<b>\$40,624,965</b>

\*NOTE: MEDICAL LIABILITY COSTS REPORTED IN THIS TABLE DO NOT INCLUDE COSTS FOR MENTAL HEALTH, INCLUDING INVOLUNTARY COMMITMENTS, LONG TERM CARE RESIDUAL, PUBLIC HEALTH, OR JAIL HEALTH. ALSO THE EXPENDITURES REPORTED FOR MARICOPA UNDER COLUMNS C AND E ARE UNUSUALLY HIGH IN FY 92 DUE TO PEREZ LAWSUIT SETTLEMENT.

A. PERSONNEL INCLUDES ELIGIBILITY WORKERS, SUPERVISORS, QUALITY ASSURANCE, AND SUPPORT PERSONNEL ON THE DATE INDICATED.

B. COUNTY ADMINISTRATIVE COSTS FOR THE FISCAL YEAR ARE NET OF FEDERAL REIMBURSEMENTS FOR THE SAME TIME PERIOD.

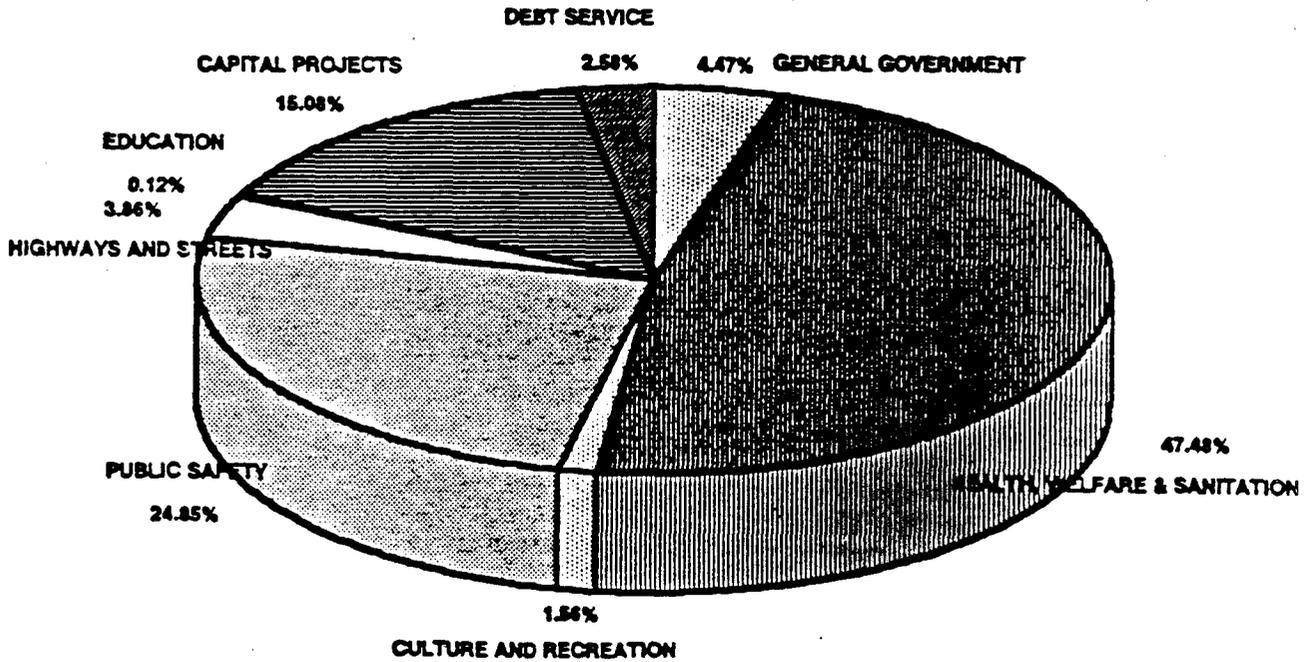
C. MEDICAL PRE - AHCCCS COSTS INDICATE COUNTY MEDICAL RESIDUAL LIABILITY ASSOCIATED WITH CONDUCTING AHCCCS ELIGIBILITY, NOT INCLUDING LAWSUITS PAID IN FY 1991 - 1992. AMOUNTS PAID ON LAWSUITS ARE INDICATED IN COLUMN "E".

D. COUNTY MEDICAL RESIDUAL MEANS ONLY A COUNTY'S MAINTENANCE OF EFFORT FOR SERVICES PROVIDED TO PERSONS WHO MET A HIGHER COUNTY INCOME STANDARD AND DID NOT QUALIFY FOR AHCCCS OR QUALIFIED FOR COUNTY RESIDUAL SERVICES.

# 1992-93 ADOPTED BUDGET

The 1992-93 Budget of \$1.225 billion was adopted by the Maricopa County Board of Supervisors on July 20, 1992. Of this total budget, approximately \$967 million, or 79%, is the operating budget. The Capital Improvement budget (CIP) totals \$175 million, or 14%. Debt Service amounts to \$30 million (3%), and contingency and reserve accounts represent the remaining \$52 million (4%).

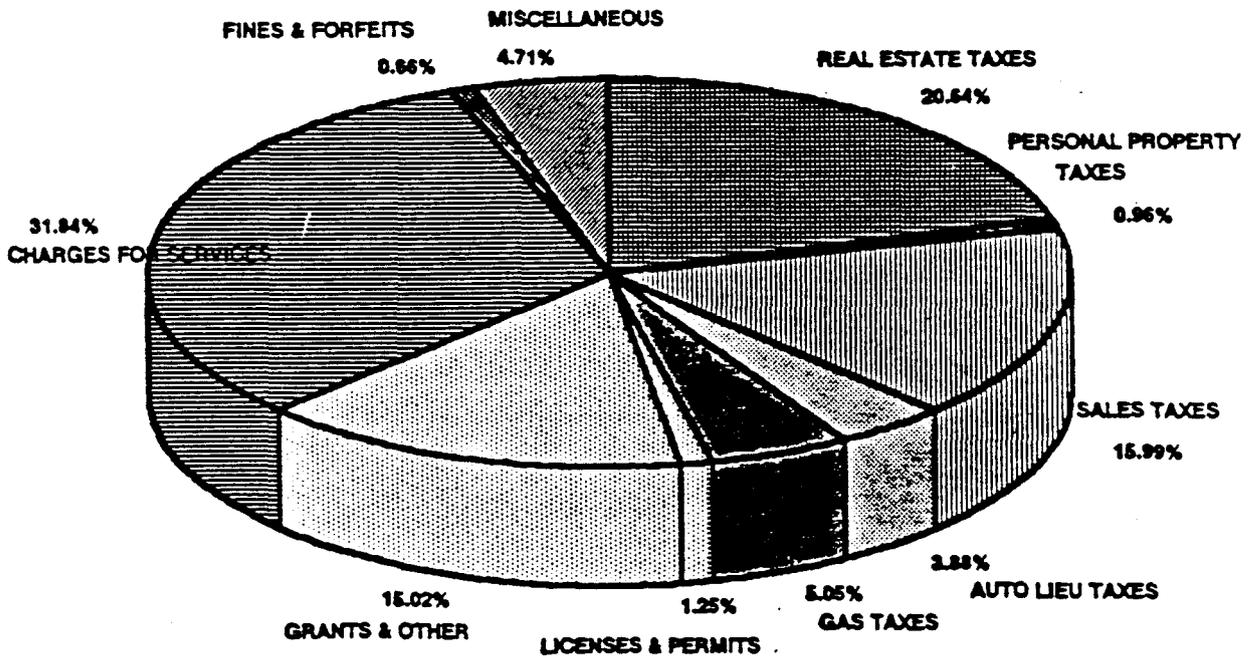
## ADOPTED EXPENDITURE BUDGET FY 1992-93



MARICOPA COUNTY  
1992-93 ADOPTED BUDGET

Total resources available for 1992-93 expenditures include estimated fund balances of \$132 million and revenues of approximately \$1.094 billion. All revenue figures included in the budget are estimates; the result of a complex forecasting process. The pages that follow offer a more detailed description of major revenue sources by giving historical reference points, highlights of revenue fluctuations and the basis for current year estimate. The concluding page of this section combines budgeted expenditures and estimated revenues to present a projection of Maricopa County's financial condition at fiscal year end.

ADOPTED REVENUE BUDGET  
FY 1992-93



**JLBC Proposed County Increase in AHCCCS  
Property Tax**

	B	C	D	E	F	G	H
County	Tax Rate	Tax Rate Limit	Status	Proposed AHCCCS Increase	Equivalent Tax Rate Increase	Status	Percent of Increase
Apache	0.2146	0.2146	At Limit	\$139,438	.0351	Over Limit	16.36%
Cochise	3.2108	3.2108	At Limit	1,149,066	.2959	Over Limit	9.22%
Coconino	0.4485	0.4485	At Limit	385,444	.0616	Over Limit	13.74%
Gila	3.4000	3.8859		733,174	.2828		8.32%
Graham	2.5484	2.8879		278,184	.4661	Over Limit	18.29%
Greenlee	0.1783	0.1783	At Limit	98,956	.0545	Over Limit	30.55%
La Paz	2.7229	2.7229	At Limit	110,028	.1127	Over Limit	4.14%
Maricopa	1.0692	1.0692	At Limit	20,057,274	.1474	Over Limit	13.79%
Mohave	1.8318	1.8318	At Limit	642,176	.1072	Over Limit	5.85%
Navajo	0.4246	0.4246	At Limit	161,236	.0322	Over Limit	7.60%
Pima	3.6949	4.3166		7,757,320	.2629		7.11%
Pinal	4.5476	5.2024		1,408,912	.2520		5.54%
Santa Cruz	2.1035	3.1236		250,504	.1759		8.36%
Yavapai	2.1418	2.1728		740,786	.1087	Over Limit	5.07%
Yuma	1.9200	2.1691		687,502	.1777		9.25%
				\$34,600,000			

C:\KEN\WK1\92PLEVYB.WK3

Margaret Swider  
Valley Interfaith Project

~~Member~~, MA Chairman, Member of the Committee

I am M.S. from V.I.P. V.I.P. is a grant based organization made up of 30 member organizations from across the metro Phoenix area. V.I.P. is multi-denominational and multi-racial. My own congregation is FRC in Scottsdale.

In V.I.P. we believe that health care is a basic human right and carries with it a corresponding obligation of responsibility. We find precedent in this belief in the Declaration of Independence whose authors recognized our inalienable right to life, liberty and happiness and in our faith traditions which recognize the innate dignity of every human person.

V.I.P. understands that Arizona is faced with a very tight budget with limited resources but we have grave concerns about the current proposals of Gov. Symington + the AZ legislature to balance the budget by excluding medically needy persons from health care in the AHCCCS System. We believe that these proposals imperil the lives of those vulnerable persons in our congregations and in our state who cannot afford health care ins. and who are stricken by catastrophic illness or trauma. There are people caught in job loss, pre-existing conditions, low-income jobs without benefits, or change in job or marital status. The number of people in the MN/MS population has been publicized at 35,000 but V.I.P. learned this week that <sup>as many as</sup> the number is 35,000 it may be more, 125,000 people cycle through the program each year.

Involved in  
Churches +  
Synagogues +  
Civil groups  
with  
CD elected  
participants

VIP has studied the proposals to drop MHI/MI and we are concerned that the effect of this action would be to greatly raise the amount of uncompensated care costs to hospitals and ultimately would raise health care costs to all AZ citizens and to corporations which do provide health benefits to their employees. Members, there is no free lunch and someone will have to pick up the costs, most probably in increased insurance premiums. We think that this penalizes unfairly those good corporate citizens who do the responsible thing and care for their employees. We think that this sends a contrary message to corporations being recruited by economic development and job-training proposals. We are also concerned that targeting residents who are not U.S. citizens could be interpreted as contrary to the spirit of the No-Am Free Trade Treaty. These effects could present AZ as being closed to and non-cooperative in the global economy.

Because we believe health care is a right, we also recognize a corresponding responsibility to share in the costs and obligations of good health care. We think that innovative cost-cutting programs like Maricopa County's proposal for a Health Maint. Org. <sup>for NATCH GROUP participants</sup> should be considered as an alternative to dropping health care to already ~~at-risk~~ <sup>injured or</sup> all people. Programs that provide preventive primary care could help people from reaching a stage of costly acute illness. We endorse the Maricopa County proposal for an HMO for the Natch group because participants would share

in the cost of their own care. We would like to help this kind of a program succeed by helping train people to be responsible health care consumers.

VIP recognizes the many critical issues of AZ and the hard decision which the legislators and Gov. must make to meet those needs. However, the price of criticism is a constructive solution. VIP ~~would be willing~~ <sup>hopes</sup> to work for a solution which includes consideration of all the stakeholders in this debate — the medically needy, <sup>the notch group,</sup> pregnant women and young children, good corporate citizens, <sup>countries,</sup> hospitals and trauma centers of free trade and economic development.

Thank you for your attention and consideration.

ARIZONA HOUSE OF REPRESENTATIVES  
Forty-first Legislature - First Regular Session

**AHCCCS AD HOC COMMITTEE**

Minutes of Meeting  
Thursday, January 28, 1993  
House Hearing Room 3 - 5:00 P.M.

(Tape 1, Side A)

Cochairman Edens called the meeting to order at 5:10 p.m. and the attendance was noted.

Members Present

Senator Alston	Representative R. Burns
Senator Day	Representative Gerard
Senator Springer	Representative Horton
Senator Huppenthal, Cochairman	Representative Edens, Cochairman

Members Absent

None

Speakers Present

James D. Bruner, President, County Supervisors Association and Chairman, Maricopa County Board of Supervisors  
Larry Layton, Supervisor, Navajo County  
Bill Feldmeier, Supervisor, District 2, Yavapai County  
Tony Gabaldon, Supervisor, Coconino County  
Robert Gomez, Arizona Association of Community Health Centers  
Michael S. Clement, M.D., representing himself  
Jim Lemmon, Arizona Public Health Association  
Frank Koenig, representing himself  
Carol Lockhart, representing herself  
Mike Shea, COPE Director, Arizona State AFL-CIO  
Leslie K. Paulus, M.D., Ph.D., representing herself  
Carol Cotera, Immigration Attorney, representing herself and Catholic Social Services Immigration Program  
Elvera Anselmo, Director, Arizona Statewide Legal Services  
Roberta Latham, R.N., Rural Physican Relations Coordinator, Tucson Medical Center  
William Tye, M.D., President, Interfaith AIDS Network  
Laurie Campbell, Vice President, Government Relations, Arizona Hospital Association  
Richard Burnham, Attorney, Carondelet Health Care System, Tucson  
Monty Headley, Fiscal Analyst, Joint Legislative Budget Committee (JLBC)  
Leonard Kirschner, M.D., Director, Arizona Health Care Cost Containment System (AHCCCS)

Peter Burns, Director, Governor's Office of Strategic Planning and Budgeting  
(OSPB)  
Knox Kimberly, Director, Inter-Governmental Relations, Maricopa County

Guest List (Attachment 1)

### PRESENTATIONS

James D. Bruner, President, County Supervisors Association of Arizona and Chairman, Board of Supervisors, Maricopa County, addressed the Committee regarding some suggestions his organizations have compiled regarding the Governor's and the JLBC budget proposals for AHCCCS. Mr. Bruner spoke from a prepared text (Attachment 2).

Larry Layton, Supervisor, Navajo County, spoke very briefly regarding the budget proposals. He stated the Navajo County Supervisors agree with the suggestions as presented by Mr. Bruner, and he did not have any additional suggestions to offer.

Bill Feldmeier, Supervisor, District 2, Yavapai County, endorsed the statement of Mr. Bruner; additionally, he stated long-term care projections and the Medically Needy/Medically Indigent (MN/MI) issue will adversely affect Yavapai County at least \$1,080 million. He said Yavapai County is not prepared to meet this challenge now or in the future. He urged a compromise since "yesterday's solution will no longer work."

Senator Alston commented on the issue of counties picking up more acute care costs. She urged the Committee be provided with more up-to-date revenue projections so as to be able to make fair assessments; she stated a compromise "somewhere in the middle to be fair" is needed, and some safety nets must be built in.

Tony Gabaldon, Supervisor, Coconino County, spoke briefly regarding the Coconino County position on the issue. He stated nine of the counties are already at their spending limits, and funding must be taken from other sources if the counties must assume the MN/NI problem.

Robert Gomez, Arizona Association of Community Health Centers, Phoenix, stated his organization is a group of private, nonprofit health centers that provide health care to the underserved; he said the centers are located in rural areas in the State and serve approximately 35,000 people of which 6,000 are classified MN/MI. He said decisions regarding AHCCCS funding will have major significance for the centers. He stated his organization is in opposition to the proposed changes to the MN/NI and undocumented alien matter. He noted on the other hand if no new funding will be added to the AHCCCS budget, he encouraged the Committee to adopt the Governor's budget because it covers more people; but he urged the Committee to debate a new model of care for the MN/MI population. Mr. Gomez suggested that providers be involved in the debate. He observed that if the JLBC budget proposals are adopted, it will be a "quick fix" that will need to be revisited each year.

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In response to a question from Senator Alston, Mr. Gomez stated his organization could lose \$750,000 or seven percent of their total income. He expressed concern regarding the undocumented alien problem and primary care for children.

Senator Day observed that when Massachusetts went to 185 percent of poverty coverage for pregnant women it did not noticeably improve prenatal care or birth outcomes. Mr. Gomez stated that financing alone will not solve the problem.

Representative Gerard commented that both proposals have merit and the Governor's budget will cover more people, but some concessions must come from health care providers.

Ms. Horton asked if the Committee must select one of the budget proposals on an either/or basis. Cochairman Edens stated the suggestions from the AS HOC Committee will go the Subcommittee of Appropriations dealing with the AHCCCS budget and from there to the Appropriations Committee.

Michael S. Clement, M.D., representing himself, stated he is strongly opposed to any cuts in funding to prenatal care programs. He said he is a pediatrician working with children who have major medical problems because many of their mothers did not receive adequate prenatal care.

Jim Lemmon, Arizona Public Health Association, spoke in support of a tobacco excise tax to help fund services to the MN/MI population. He spoke from a prepared text (Attachment 3).

Senator Huppenthal observed that a tax increase is "not on the table" for discussion as there are many other worthy causes that are in need of additional tax revenues.

Frank Koenig, representing himself, spoke in opposition to the Governor's proposals. He stated he is a contractor and carpenter, and he in need of total hip replacement because of an injury on the job. He said his business has been ruined because of his inability to work, and if acute care for MN/MI people is eliminated he will not be able to receive the medical help he needs.

(Tape 1, Side B)

Carol Lockhart, representing herself, spoke from a prepared text (Attachment 4) in opposition to the removal of the MN/MI population from AHCCCS coverage. She said she was the first Acting Director of AHCCCS. Representative Gerard requested that copies of her testimony be distributed to all Members of the Committee because of the historical content of her comments.

Mike Shea, COPE Director, Arizona State AFL-CIO, stated his organization opposes dropping the MN/MI population from coverage. He spoke from a prepared text (Attachment 5).

Leslie K. Paulus, M.D., Ph.D., representing herself, spoke in opposition to the Governor's recommendations. She suggested the Committee consider the following

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changes:

1. Discuss why SSI recipients are automatically assigned to AHCCCS
2. Implementing a tobacco tax
3. Contacting the Mexican government regarding reimbursement for undocumented alien care.

Carol Cotera, Immigration Attorney, representing herself and the Catholic Social Services Immigration Program, spoke from a prepared text (Attachment 6) regarding the undocumented alien issue. In response to a question from Representative Gerard regarding the ability of the State to deal directly with the Mexican Government on this issue, Ms. Cotera said she believes California is involved in a like program, and suggested that lines of communication be opened.

Elvera Anselmo, Director, Arizona Statewide Legal Services, spoke from a prepared text (Attachment 7) in opposition to dropping the MN/MI group from AHCCCS coverage.

Roberta Latham, R.N., Rural Physician Relations Coordinator, Tucson Medical Center, spoke regarding rural health care, and the possibility that some rural hospitals may be forced to close if there are drastic changes in MN/MI AHCCCS coverage. She expressed support for an additional tobacco tax, and urged that a state income tax cut be eliminated to allow that revenue to be used for health care. She urged support for family planning, and suggested that nurse practitioners and physician assistants be allowed to provide more primary care.

William Tye, President, Interfaith AIDS Network, stated that AIDS patients use all available health care resources, and if these resources are eliminated these people will die. He expressed admiration for the present AHCCCS program because it offers "unbiased" care. He indicated support for an additional tobacco tax and suggested the Committee study any new federal proposals from the new Administration.

Laurie Campbell, Vice President, Government Relations, Arizona Hospital Association, spoke from a prepared text (Attachment 8) regarding her organization's suggestions for the AHCCCS budget proposals. In response to a question from Representative Gerard, Ms. Campbell stated the Arizona Hospital Association is willing to accept the shift of undocumented alien emergency care. She stated the "quick pay" question is an illegal issue because of the Boren Amendment. Representative Gerard asked Ms. Campbell if the Hospital Association is going to sue if "quick pay" is eliminated. Ms. Campbell replied that the avenue of litigation is available .

There was a brief discussion regarding the offer of the Arizona Hospital Association to treat undocumented aliens on an emergency basis. Ms. Campbell stated this offer is the Hospital Association's response "to share the pain".

Richard Burnham, Attorney, Carondelet Health Care System, Tucson, spoke from a prepared text (Attachment 9) regarding maximizing savings and retaining the MN/MI program. He suggested that county eligibility workers be deputized to take federal applications. In response to a question from Representative Edens, Mr.

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Burnham stated the forms for eligibility are very complex and should be simplified.

(Tape 2, Side A)

Monty Headley, Fiscal Analyst, Joint Legislative Budget Committee (JLBC) presented a comparison of cost savings of the Governor's budget proposals and the JLBC proposals (Attachment 10).

There was a brief discussion regarding the legality of the proposals regarding undocumented aliens. Mr. Headley stated JLBC had received legal advice from the House Staff attorney regarding this issue. It was suggested that more specific legal advice on immigration law might be needed, and Leonard Kirschner, M.D., Director, AHCCCS, stated he will do a survey to see what other states are doing regarding the undocumented alien issue.

Mr. Headley referred the Committee to Attachment A of his presentation (See Attachment 10) regarding the list of optional services that receive federal reimbursement. Senator Alston asked if Arizona provides all the optional services. Dr. Kirschner replied in the affirmative, and stated the optional services amount to four percent of capitation. Dr. Kirschner provided a copy of a graph showing optional services provided in the various states (Attachment 11).

There was a discussion regarding SOBRA eligibility and the Governor's proposals to expand coverage to 185 percent of the federal poverty level for pregnant women. Senator Alston stated it is very difficult to get women into services even if they are eligible. Dr. Kirschner stated AHCCCS has not done a very good job with outreach. Mr. Peter Burns, Director, Governor's Office of Strategic Planning and Budgeting (OSPB) stated the Governor's proposals assume 100 percent of women will participate. Senator Alston stated very strongly that she feels outreach services should be included.

Mr. P. Burns briefly described how OSPB calculated the number (4,500) of women and children (60,000) to be served under the Governor's proposals. He stated it is proposed that these people be phased in over a nine-month period. He stated it is felt these numbers are quite accurate. He stated outreach programs were not included in the proposal.

Ted Ferris, Director, Joint Legislative Budget Committee (JLBC) presented the county contribution part of the discussion (see Attachment 10 - No. 3). There was a brief discussion regarding the disproportionate share funds, and Mr. Ferris pointed out that Arizona is the only state to receive an increase and Arizona also received a one-year extension on the AHCCCS waiver.

In response to a question from Representative Gerard, Mr. Ferris stated he does not believe the various proposals will come under Proposition 108 limitations.

(Tape 2, Side B)

Mr. Ferris referred the Committee to No. 4 - Eligibility Determination (see Attachment 10). Ms. Horton asked if the State has authority to authorize the county eligibility workers to take federal applications. Mr. Ferris replied in the affirmative, and said the State must empower the counties and make provisions to train the workers. He noted the figures for savings "are crude estimates."

There was a general discussion regarding the funding needed to effect a change in eligibility determination. Mr. Ferris stated there will be a significant expense to computerize and will require at least a year to implement. Mr. Burnham suggested if statutory changes were made, the switch could be implemented manually with minimal cost. Dr. Kirschner stated, very strongly, that a single eligibility system is needed throughout the 15 counties, and Department of Economic Security eligibility workers should do the work.

Representative Gerard stated a "short-term fix" is needed for this year, and work should continue to make permanent changes to the system. Several Members stated the AHCCCS Oversight Committee should continue work to help find solutions to the complex problems of AHCCCS funding.

Knox Kimberly, Intergovernmental Relations Director, Maricopa County, stated a study committee was organized to analyze eligibility determination with eight members, four from the counties, two from AHCCCS and two from DES. However, he noted a Chairman has not been appointed and the Committee has not functioned properly.

Mr. Headley referred the Committee to Number 5 - Miscellaneous Cost Reduction Measures (see Attachment 10). Dr. Kirschner noted there could be a significant increase in the capitation rate if MN/MI eligibility is limited to two or three months.

Ms. Horton asked what impact the limitation of MN/MI eligibility to individuals might have. Dr. Kirschner stated there would be a significant change in cash flow, and problems could result if providers ask to renegotiate their bids because of utilization rates. Representative Gerard stated these kinds of questions should be part of long-range policy decisions.

Senator Day stated efforts to detect fraud should be examined, and suggested the fingerprint system utilized by California be investigated.

Mr. Headley referred the Committee to Number 4, Item 5.3 and stated asset standards is currently being done; Item 5.5 - recovery from third parties will require a change in lien statutes; Item 5.4 - mandated copayments will require plans to implement; Item 5.7 - regarding fraud will require an automated fingerprint system and Item 5.8 - is a federal issue regarding AFDC regulations. Representative Gerard suggested that rules regarding foreign students be "tightened up."

AHCCCS AD HOC  
1-28-93

The Committee was referred to No. 6 - Other Options (see Attachment 10). Mr. Headley offered the following suggestions:

- 6.1 - will require moving to a fee-for-service setup
- 6.2 - a proposal from the counties
- 6.3 - a problem of who will assume the residual responsibility
- 6.4 - must be a "bare-bone" policy with a deductible

There was a general discussion among all Members of the Committee regarding the future focus of the Committee. Several Members expressed the desire to continue the meetings to formulate suggestions and solutions to AHCCCS budget proposals. Cochairman Edens stated that staff will take the suggestions proposed by those speaking to the Committee and report to the Subcommittee on the AHCCCS budget. Representative R. Burns read a letter (Attachment 12) regarding the organization of the AHCCCS AD HOC Committee.

Without objection, the meeting adjourned at 8:45 p.m.

Barbara Williams, Secretary

(Attachments are on file in the Office of the Chief Clerk and with the Committee Secretary. Tapes are on file in the Office of the Chief Clerk).

ARIZONA HOUSE OF REPRESENTATIVES

GUESTS ATTENDING MEETING

HEARING ROOM 5

TIME 5:00

MEETING A HCCCS HADHCC Committee

DATE 1-28-93

NAME AND TITLE (Please print)	REPRESENTING	BILL NO.
<del>SPILL STALLERGER, SUPERVISOR</del>	<del>WETMORE COUNTY</del>	
Karen Nelson	County Supervisor/Asst	
Michael S. Plouffe MD	Self	
DICK BURNTAM	CAKOND FLET	
Liane George	Self	
Robert Latham	Zucchi Park Center	
CHARLES W. Tomlinson	NAVAJO COUNTY	
Seri Carter	Navajo County	
FRANK KOENIG	AN INDIVIDUAL/MYSELF	
Edward Ryle	AZ. CATH. CONF	
Kim Pearson	RIDGE & ISABELLA ST. LA	
Raena Honan	ACC I	
Linos Casillas	EOFC	
Lynn Padberg	Self	
Mark May	AZ AFL-CIO	
Carol Packard	Self	
RICK POTTER	SELF	
Rev Dr William Tye	INTERFAITH AIDS NETWORK	
John Tye	Self	
Ruthi Cantrell	Arizona Social Work Directors	



TESTIMONY BY THE HONORABLE JAMES D. BRUNER, PRESIDENT, COUNTY SUPERVISORS ASSOCIATION OF ARIZONA, AND CHAIRMAN, BOARD OF SUPERVISORS, MARICOPA COUNTY, BEFORE THE JOINT AD HOC COMMITTEE ON AHCCCS, THURSDAY, JANUARY 28, 1993.

THANK YOU FOR PERMITTING ME TO SPEAK AT THIS HEARING. I AM HERE TO PRESENT A NUMBER OF SUGGESTIONS THAT WE BELIEVE WILL BE HELPFUL IN ADDRESSING THESE ISSUES.

BEFORE DOING SO, I WISH TO AGAIN EMPHASIZE MY BELIEF, WHICH I BELIEVE IS SHARED BY ALL 15 COUNTIES, THAT THE LEGISLATURE SHOULD RECOGNIZE THAT THE BOTTOM LINE IS NOT JUST THE STATE'S BOTTOM LINE, NOR IS IT THE COUNTY'S BOTTOM LINE. IT'S THE TAXPAYERS' BOTTOM LINE. SHIFTING COSTS FROM THE STATE TO THE COUNTY DOES NOTHING TO HELP THE TAXPAYERS.

AT THE SAME TIME, THE NEEDS OF ALL ARIZONANS - INCLUDING THOSE IN THE MN/MI PROGRAM - MUST BE ADDRESSED WITH CARE AND COMPASSION. I WISH TO MAKE IT CLEAR THAT I CARE DEEPLY ABOUT THE HEALTH CARE NEEDS OF THE WORKING POOR AND OTHERS IN THE MN/MI POPULATION. BALANCING THEIR NEEDS AND THE TAXPAYERS' BOTTOM LINE IS YOUR CHALLENGE.

WITH THAT BACKGROUND, LET ME OFFER A NUMBER OF SUGGESTIONS THAT I UNDERSTAND HAVE BEEN PRESENTED BY OUR STAFF TO THE CO-CHAIRMEN OF THIS GROUP AND JLBC STAFF.

- TO THE EXTENT THAT ONLY EMERGENCY SERVICES WILL BE FUNDED FOR UNDOCUMENTED ALIENS, WE SUGGEST THAT:
  - DISPROPORTIONATE SHARE DOLLARS BE REALLOCATED TO COMPENSATE THOSE PUBLIC AND PRIVATE HOSPITALS WHICH JLBC HAS PROJECTED WILL EXPERIENCE AN INCREASE IN UNCOMPENSATED CARE DUE TO THIS POLICY CHANGE; AND
  - COUNTY RESIDUAL RESPONSIBILITY SHOULD BE MODIFIED TO PARALLEL THIS STATE POLICY CHANGE. (I.E. EXCLUDE NON-EMERGENCY SERVICES FOR UNDOCUMENTED ALIENS).
  
- AS AN ALTERNATIVE TO THE TWO PROPOSALS NOW ON THE TABLE, WE SUGGEST THAT THE POSSIBILITY OF SERVING THE MORE CRITICAL NEEDS OF THE MN/MI POPULATION BE EXAMINED. THIS COULD BE ACCOMPLISHED BY RECASTING THE MN/MI PROGRAM TO SERVE CATASTROPHIC CARE NEEDS, INCLUDING:
  - EMERGENCY SERVICES - SITUATIONS WHERE UNLESS IMMEDIATE CARE IS GIVEN, THE LIFE OR LIMB OF THE INDIVIDUAL IS IN JEOPARDY; AND
  - CHRONIC CONDITION SERVICES - SITUATIONS WHERE ONGOING CARE IS REQUIRED FOR LIFE-THREATENING ILLNESSES SUCH AS CANCER.

UNDER THIS APPROACH, COUNTY RESIDUAL RESPONSIBILITY SHOULD BE MODIFIED TO PARALLEL THIS STATE POLICY CHANGE.

- WE WOULD ALSO AGAIN SUGGEST EXAMINATION OF THE ELIGIBILITY RULES FOR THE MN/MI PROGRAM. AMONG THE RULES WE BELIEVE SHOULD BE EXAMINED ARE:
  - REDUCING THE LENGTH OF THE PERIOD OF ELIGIBILITY
  - ELIMINATING AUTOMATIC COVERAGE OF ALL FAMILY MEMBERS OF AN MN/MI ELIGIBLE INDIVIDUAL.
  - TIGHTENING ASSET STANDARDS FOR ELIGIBILITY PURPOSES.
  
- WE ALSO ASK THAT YOU STUDY THE FOLLOWING OPPORTUNITIES TO ENHANCE OUR ABILITY TO MANAGE THE COUNTY HEALTH CARE SYSTEM. MARICOPA COUNTY HAS IDENTIFIED FIVE AREAS TO BE ADDRESSED:
  - ENHANCING OPPORTUNITIES FOR RECOVERING FEDERAL MATCHING FUNDS FOR COUNTY ACTIVITIES.
  - REDEFINING RESIDUALITY ACCORDING TO AN OBJECTIVE UNIFORM STATEWIDE STANDARD OF INDIGENCY.
  - REQUIRING USE OF ALTERNATIVE DISPUTE RESOLUTION TECHNIQUES TO RESOLVE HOSPITAL CLAIMS AGAINST COUNTIES.

- AUTHORIZING ESTABLISHMENT OF A COUNTY MEDICAL EVALUATION CENTER AS A SINGLE POINT OF CONTACT FOR EMERGENCY/TRAUMA TRANSFER CASES TO ADDRESS THE POTENTIAL CONCERNS WITH RESPECT TO REFUSALS/TRANSFERS.
- AUTHORIZING THE COUNTY TO ESTABLISH A SEPARATE HOSPITAL AUTHORITY TO ENTER INTO JOINT AGREEMENTS WITH OTHER GOVERNMENTAL ENTITIES FOR THE PURPOSE OF FINANCING CAPITAL IMPROVEMENTS OR TO COLLATERALIZE ASSETS FOR HEALTH SERVICES CAPITAL PROJECTS.

I CANNOT TELL YOU THAT EVERY COUNTY WILL SUPPORT EVERY ONE OF THESE IDEAS, OR THAT OTHERS WON'T BRING FORWARD OTHER ADDITIONAL OR BETTER IDEAS. WE LOOK FORWARD TO CONTINUING TO WORK WITH YOU CONSTRUCTIVELY TO ADDRESSING THESE ISSUES. THANK YOU.

STATEMENT IN SUPPORT OF TOBACCO EXCISE TAX

TO SUPPORT AHCCCS MN/MI PROGRAM

Arizona Public Health Association -- January 28, 1993

The Governor estimates that the elimination of the MN/MI program in AHCCCS would save the state of Arizona approximately \$82 million.

The Arizona Department of Health Services has published a report, "Economic Costs and Deaths Attributable to Smoking in Arizona -- 1989," which documents that in that year alone, tobacco related costs in Arizona totaled over \$725 million. This includes both direct health care costs of \$249 million and indirect costs such as lost productivity.

This amounted to over \$200 for every Arizonan, and equates to approximately \$2.40 per pack of cigarettes sold in Arizona.

All of society pays this bill on behalf of smokers, both publicly via tax-supported services such as public health care, and privately via higher insurance premiums, cost-shifted medical expenses, and so forth. As long as smokers are not paying society back, this constitutes a public subsidy of smoking, to the tune of \$2.40 per pack.

Arizonans are not generally of the temperament to knowingly subsidize the use of an addicting and deadly drug. A recent poll sponsored by the Arizona Hospital Association found that 81% of Arizonans surveyed supported increases in health care funding from higher taxes on alcohol and tobacco. Asking smokers to reimburse only 11% of the subsidy we provide to them, by paying the 27 cents per pack that would provide the needed \$82 million for the MN/MI program, seems the least that we should require.

My name is Carol Lockhart - I speak again the removal of the med. no. from AIDS I speak as a private citizen (under the name of AIDS) about a knowledgeable of AIDS. I was the first acting director of AIDS in 1981 & early 82 when it was created and

after while studying for my Ph.D. at Brandeis U. I wrote my doctoral dissertation on the AIDS; a case study in political involvement.

AIDS was created to provide a state wide system of care with one set of eligibility criteria & services across all 15 counties - for the indigent & med. indigent.

The state legislature & gov. approved the creation of a "safety net" for working people without ins. <sup>for those</sup> or who had white ins. who were hit by catastrophic medical events. They made the promise that people in AZ would not have to lose everything in order to get medical care. They would be treated & return to work as quick as their health allowed

NOW ~~WE~~ ARE DISCUSSING WHETHER WE SHOULD PULL AWAY THE NET, IF WE DO - <sup>WORKING</sup> PEOPLE WHO GET SERIOUS ILL MAY OR MAY NOT GET CARE, EVERY CO. - NO MATTER WHAT IS SAID ABOUT THEIR RESIDUAL RESPONSIBILITY WILL ~~BE~~ TO DO OR NOT DO DIFFERENT THINGS FOR THE MED. IND. - ONCE MORE IT WILL DEPEND ON WHO YOU KNOW & WHERE YOU LIVE TO DETERMINE WHEN OR IF YOU GET CARE, THERE WILL BE 15 APPROACHES AGAIN - WE WILL CANCEL OUT THE MAJOR STEP TAKEN WHEN WE MADE IT POSSIBLE FOR ALL ALL CITIZENS TO BE TREATED CONSISTENTLY & FAIRLY.

I ASK THAT YOU NOT REMOVE THE MED. IND FROM AHCCCS BUT RATHER THAT YOU CHARGE THE COV. & THE AHCCCS ADM. TO DEV. ADM. & PROGRAM OPTIONS WHICH ~~FOSTER~~ BUDGETARY & COST CONTROLS

(3) 1/28/93

AND THAT YOU YOURSELVES SUPPORT  
H. INSURANCE REFORMS THAT MAKE  
IT POSSIBLE FOR PEOPLE TO  
PURCHASE ADEQUATE INS SO  
THEY HAVE NO NEED FOR  
ANACAS SERVICES.

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Community Rating

limitations on dropping employees  
switching jobs

MN/MI - Fed Part

Changes in underwriting operations  
- Limitations on ins. cos.  
& unincorporated

ARIZONA CURRENTLY HAS MORE THAN 10% OF THE POPULATION WHO ARE  
MEDICALLY UNINSURED. THIS WAS BASED ON THE FLINN FOUNDATION  
STUDY A COUPLE OF YEARS AGO. WITH THE ECONOMIC DOWNTURN OF THE  
LAST TWO YEARS AND THE FEDERAL GOVERNMENT PROVIDING TAX INCENTIVES  
TO BRING OUR FLEET SOUTH TO THE BORDER, THOUSANDS MORE ARIZONA WORKERS  
HAVE LOST THEIR EMPLOYER BASED INSURANCE AND DEPEND ON AHDCOS  
TO PROVIDE FOR THEIR NEEDS UNTIL THEY BECOME EMPLOYED AGAIN.  
WE BELIEVE THAT TO THROW ~~DISPLACED WORKERS~~ <sup>Medical Needy and Medical Indigent</sup> INTO THE  
ROLLS OF THE UNINSURED UNDERMINES THE QUALITY OF LIFE FOR ALL  
OUR CITIZENS.

FROM AN ECONOMIC DEVELOPMENT POINT OF VIEW, THIS POLICY RUNS COUNTER  
WHAT OUR ELECTED OFFICIALS AND LEADERS FROM THE BUSINESS COMMUNITY  
ARE TRYING TO DO TO EXPAND EXISTING COMPANIES AND ATTRACT OUT OF  
STATE INDUSTRIES TO PROVIDE MEANINGFUL JOBS FOR OUR ARIZONA CITIZENS.  
WHEN ANY OF OUR CITIZENS ARE MEDICALLY UNINSURED WE VIEW THIS AS  
A TAX ON OUR EMPLOYERS AND OUR WORKERS. ULTIMATELY THE UNINSURED  
CITIZEN WILL RECEIVE HEALTH CARE, USUALLY IN AN EMERGENCY ROOM OR  
INTENSIVE CARE SETTING, THE MOST EXPENSIVE OF MEDICAL APPLICATIONS. THE  
MEDICAL PROVIDER WILL PASS THIS OFF AS A BAD DEBT EXPENSE. THESE EX-  
PENSES ARE PASSED BACK TO THE HEALTH INSURANCE INDUSTRY WHO THEN  
RAISE THE PREMIUMS FOR OUR EMPLOYERS AND THE WORKERS. ~~THE~~ COMPETITIVE  
EDGE FOR ARIZONA INDUSTRY, JOB SECURITY FOR ITS WORKERS AND THE  
ECONOMIC CLIMATE FOR THE STATE OF ARIZONA FURTHER ERODES. WE URGE  
THE ~~GUBERNATOR'S~~ <sup>Executive</sup> BUDGET OFFICE <sup>and the JLBC</sup> TO RECONSIDER THIS POLICY. WE BELIEVE  
THAT EFFORTS SHOULD BE MADE TO MEDICALLY INSURE ALL OUR CITIZENS AS  
IT IS THE MORALLY CORRECT THING TO DO AND DRAMATICALLY IMPROVES THE  
COMPETITIVE EDGE FOR ARIZONA INDUSTRIES!! Like the Counties

& VIP We wish to be part of the solution. Re work  
closely with the Chambers and small business  
associations as well as the insurance companies  
to pass the small group insurance bill two years ago  
to provide affordable insurance for small employers  
and to help close the gap of the uninsured. ATTACHMENT 5

we will be working hard this  
year to try and pass legislation for managing  
Risks.

This year we have committed to work with  
WFB on continuing legislation to assist small  
business.

The health care problem ~~is~~  
and costs associated with it is a problem  
that requires input by all of us.

Hopefully we will solve that  
problem.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS CAROL COTERA. I AM THE MANAGING ATTORNEY FOR CATHOLIC SOCIAL SERVICES IMMIGRATION PROGRAM. FOR THE PAST FIVE YEARS I HAVE WORKED FOR THREE NON-PROFIT ORGANIZATIONS IN MARICOPA COUNTY. MY SPECIALTY IS IMMIGRATION LAW. AT PRESENT, I AM ONE OF TWO ATTORNEYS IN MARICOPA COUNTY WHOSE PRACTICE IS DEDICATED TO ASSISTING LOW-INCOME IMMIGRANTS IN LEGALIZING. I HAVE A ROTATING CASE-LOAD OF 150 ACTIVE CASES AND I ESTIMATE THAT I HAVE PERSONAL INTERVIEWS WITH BETWEEN 500 - 700 PERSONS PER YEAR.

I WAS PRESENT LAST THURSDAY NIGHT WHEN BOTH THE GOVERNOR'S AND THE JLBC PROPOSALS TO CUT AHCCCS WERE PRESENTED. ALTHOUGH I DO NOT PROFESS TO BE AN EXPERT ON AHCCCS, ONE ISSUE WAS CLEAR WITH REGARD TO BOTH PROPOSALS. UNDOCUMENTED ALIENS ARE EITHER DISENFRANCHISED COMPLETELY OR LIMITED TO RECEIPT OF NARROWLY DEFINED EMERGENCY SERVICES. BOTH PLANS TOUT THE FACT THAT MILLIONS OF DOLLARS OF SAVINGS WILL BE REALIZED BY ELIMINATING THIS POPULATION FROM COVERAGE. THE GOVERNOR'S PLAN DID NOT CITE AN EXACT FIGURE, BUT THE JLBC PROPOSAL SAID THAT \$44 MILLION DOLLARS (MORE THAN HALF OF THE SHORTFALL \$82 MILLION NEEDED) COULD BE RECOVERED BY CUTTING-OUT UNDOCUMENTED ALIENS.

I HAVE SERIOUS CONCERN REGARDING TWO ISSUES. FIRST, THE FACT THAT HEALTH CARE FOR ONE OF THE MOST VULNERABLE SEGMENT OF OUR STATE'S POPULATION IS BEING ELIMINATED; AND SECOND, I SUSPECT THE STUDY PERFORMED TO ASCERTAIN THE NUMBERS OF UNDOCUMENTED ALIENS, THEIR ELIGIBILITY, AND THE BASIS FOR PROJECTION OF MILLIONS OF DOLLARS OF



Catholic Social Service of Phoenix  
Family Reunification and Immigration Services  
5623 WEST GLENDALE AVENUE  
GLENDALE, ARIZONA 85303

CAROL COTERA

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Arizona Immigration Attorney

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SAVINGS WAS FLAWED BY THE FACT THAT THE STAFF DOES NOT UNDERSTAND THE DEFINITION OF THE TERM "UNDOCUMENTED ALIEN."

MEMBERS OF THIS COMMITTEE ASKED FOR THIS TERM TO BE DEFINED BY THE GOVERNOR'S REPRESENTATIVE, THE JLBC STAFF MEMBER, AND MS. LINDA REDMAN OF DES. THE GOVERNOR'S REPRESENTATIVE SAID HE THOUGHT IT MEANT "ILLEGAL ALIENS." THE JLBC STAFF MEMBER SAID THAT HE WOULD HAVE TO CONSULT WITH THE HOUSE ATTORNEY MR. JANSEN. MS. REDMAN WAS THE MOST RESPONSIVE AND SHE LISTED THREE CATEGORIES OF PEOPLE: BORDER CROSSERS, NON-IMMIGRANTS, AND ALIEN CREWMAN. FOR THE COMMITTEE'S INFORMATION, A BORDER CROSSER HAS A LIMITED PERMIT THAT ALLOWS ENTRY WITHIN 50 MILES OF THE BORDER FOR THE PURPOSE OF SHOPPING OR VISITING, BUT IT DOES NOT AUTHORIZE WORK; A NON-IMMIGRANT IS A FOREIGN STUDENT, FOREIGN BUSINESSMAN, OR TEMPORARY VISITOR FOR PLEASURE ALL OF WHOM ARE REQUIRED TO SHOW SUFFICIENT ASSETS TO COVER COSTS OF THEIR VISIT BEFORE THEY ARE ISSUED A VISA; AND AN ALIEN CREWMAN IS A PERSON EMPLOYED ON A SHIP THAT TRADES AT AMERICAN PORTS WHO JUMPS OVERBOARD TO SWIM FOR THE U.S. IN MY FIVE YEARS OF WORK WITH ALIENS, I HAVE ONLY SEEN A BOARDER CROSSING CARD ONCE OR TWICE. MY NON-IMMIGRANT CASES COME FROM ALL OVER THE WORLD, BUT I WOULD ESTIMATE THAT LESS THAN TEN MEXICAN NATIONALS HAVE SHOWN ME A NON-IMMIGRANT VISA, AND I HAVE NEVER SEEN AN ALIEN CREWMAN. ALL THREE OF THESE CATEGORIES ARE VERY SPECIFIC AND I DOUBT THERE ARE ANY ALIEN CREWMAN IN OUR STATE UNLESS ARIZONA SUDDENLY HAS A SEA PORT I'M UNAWARE OF!

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MY POINT IS THAT WITHOUT A TRUE UNDERSTANDING OF THE DEFINITION OF UNDOCUMENTED ALIENS, THE STUDY PERFORMED AND THE FIGURES GENERATED CANNOT BE RELIABLE. YOU MAY WANT TO ASK ME HOW I WOULD DEFINE THIS TERM. MY ANSWER IS NOT SIMPLE. ONE NEEDS A THOROUGH KNOWLEDGE OF THREE THINGS: FEDERAL IMMIGRATION LAW; IMMIGRATION AND NATURALIZATION SERVICE REGULATIONS AND PROCEDURES; AND CURRENT WORLD POLITICAL EVENTS. BECAUSE OF THIS COMPLEXITY, FEDERAL LAW VESTS THE INS (IMMIGRATION AND NATURALIZATION SERVICE) WITH THE LEGAL AUTHORITY TO MAKE SUCH A DETERMINATION.

CONGRESS CONSIDERED THE VULNERABILITY OF THE ALIEN POPULATION AND CONTAINED WITHIN THE IMMIGRATION REFORM AND CONTROL ACT OF 1986 IS A PROCESS CALLED "S.A.V.E." MEANING "SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS". THE S.A.V.E. LAW IS A PROCEDURE WHEREBY STATE AGENCIES CHECK THE ELIGIBILITY OF AN ALIEN REQUESTING BENEFITS THROUGH THE INS. THERE ARE SIX FEDERALLY FUNDED PROGRAMS FOR WHICH USE OF THE S.A.V.E. PROCESS IS REQUIRED BY LAW. THEY ARE: AFDC, FOOD STAMPS, MEDICAID, UNEMPLOYMENT INSURANCE, HOUSING ASSISTANCE, AND EDUCATION. A SAFEGUARD TO THE INDIVIDUAL UNDER THE S.A.V.E. PROCESS IS THAT BENEFITS ARE NOT DENIED DURING THE PERIOD IN WHICH THE STATUS CHECK IS OCCURRING. I SPOKE WITH THE ASSISTANT DISTRICT DIRECTOR FOR OUR LOCAL INS OFFICE HERE IN PHOENIX LAST WEEK AND HE TOLD ME THAT PRESENTLY, THEY RECEIVE ABOUT 500 S.A.V.E. REQUESTS PER MONTH AND THEY HAVE ONE FULL-TIME STAFF MEMBER DOING THE STATUS VERIFICATION. OF THE 500, ONLY 50 WERE MEDICAID CHECKS.

I DO NOT MEAN TO CONFUSE YOU WITH INFORMATION, BUT WISH TO INFORM YOU THAT THERE ARE FEDERAL LAWS IN PLACE TO PROTECT ALIENS AND THEIR ENTITLEMENT TO CERTAIN GOVERNMENT BENEFITS. I WOULD CERTAINLY EXPECT THAT A PROPOSAL BY THE GOVERNOR TO COST-SHIFT HEALTH CARE TO FEDERAL DOLLARS WOULD HAVE CONSIDERED THIS FACT AND INFORMED THE COMMITTEE OF POTENTIAL COSTS INVOLVED AND LIABILITY IF FEDERAL LAW IS NOT OBSERVED.

EVEN WITH MY YEARS OF EXPERIENCE, I WILL TELL YOU THAT I CANNOT DETERMINE WHETHER AN INDIVIDUAL IS UNDOCUMENTED OR NOT UNTIL I INTERVIEW THE PERSON, SEE ANY PHYSICAL DOCUMENTATION HE/SHE HAS IN THEIR POSSESSION, AND TALK WITH THE INS OFFICE TO VERIFY THAT I AM NOT MISSING SOMETHING. AN UNDOCUMENTED ALIEN CAN BE A LAWFUL RESIDENT ALIEN WHO LOST THEIR WALLET, FAILED TO FILE NECESSARY PAPERWORK, WHOSE COUNTRY'S POLITICAL CLIMATE HAS CHANGED DURING THEIR STAY IN THE U.S., OR WHOSE APPLICATION IS "PENDING" SOMEWHERE IN THE INS SYSTEM.

I AM AWARE THAT THERE ARE PEOPLE WHO HAVE NO HOPE OF BECOMMING LEGAL RESIDENTS AND WHO ARE RECEIVING MEDICAL BENEFITS COVERED BY AHCCCS. AS A BORDER STATE WE HAVE A HIGHER PERCENTAGE OF MEXICAN NATIONALS IN THIS SITUATION THAN PERSONS FROM ANY OTHER COUNTRY. MR. CHAIRMAN YOU ASKED FOR SOLUTIONS. I PROPOSE ONE SUGGESTION. THE STATE SHOULD USE DIPLOMATIC CHANNELS WITH THE MEXICAN GOVERNMENT TO DEVELOP A PLAN THAT COULD SMOOTHLY TRANSFER A PATIENT TO A MEXICAN HEALTH CARE FACILITY AFTER THE PERSON'S CONDITION IS STABILIZED AND THE "EMERGENCY" NEEDS HAVE BEEN MET. THIS IS THE

ONLY HUMANE WAY TO DEAL WITH THIS ISSUE. THE ALTERNATIVE IS TO EITHER REFUSE SERVICES UP-FRONT OR FORCE HOSPITALS TO PICK UP THE COSTS AFTER AHCCCS REFUSES TO REIMBURSE.

IN CLOSING, I WOULD LIKE TO URGE THE COMMITTEE TO SCRUTINIZE THE METHODS USED TO CALCULATE THIS SIZE OF THIS POPULATION AND THE MONEY SAVED BY ITS ELIMINATION. ALSO, LET US BE SENSITIVE WITH OUR TERMINOLOGY AND REMEMBER THAT ALTHOUGH A PERSON'S PRESENCE IN THE U.S. MAY BE DETERMINED TO BE "ILLEGAL" A PERSON'S EXISTANCE IS AN INALIENABLE RIGHT AND A REALITY THAT WE CANNOT IGNORE.

I WOULD BE HAPPY TO ANSWER ANY QUESTIONS.

# MEDICAID

## *MEDICAL ASSISTANCE FOR FAMILIES, THE ELDERLY, AND DISABLED*

### *Medicaid provides...*

- reimbursement to participating providers for medical care to low-income persons
- doctors' services, hospital care, and (depending upon the state) prescription drugs and other services

### *Individuals qualify who are low-income and...*

- a child (maximum age 18-21, depending on the state), *or*
- 65 or older, *or*
- blind or disabled (as defined for SSI eligibility), *or*
- pregnant, *or*
- receiving or eligible for AFDC
- **NOTE:** AFDC and (in most states) SSI recipients are automatically eligible for Medicaid

### *Whether a person is financially eligible for Medicaid depends on...*

- income guidelines that follow AFDC and SSI levels, except that pregnant women and children can have higher incomes
- the income of all household members
- **NOTE:** In some areas, persons ineligible for AFDC or SSI because they exceed the income or resources limit may still qualify for state programs for the medically needy

### *If some members of the household are not U.S. citizens...*

- only those who are *lawful permanent residents* or *permanently residing in the U.S. under color of law* (PRUCOL) are eligible to receive full Medicaid services
- an ineligible parent can apply on behalf of an eligible child
- tourists, students, and other "nonimmigrants" are *not* eligible
- **IMPORTANT:** Regardless of immigration status, any alien can receive "emergency" services, provided he or she is otherwise eligible for Medicaid
  - An "emergency" is a medical condition (including labor and delivery) with acute symptoms that could place the patient's health in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part

### *To apply, a person should...*

- gather documents to prove *identity, residence, age, income, resources, and any disability*
- apply in person at the local hospital, welfare or social services office, or Social Security office
- **NOTE:** If approved, the person will be able to receive reimbursement for qualifying expenses dating back 3 months before the application was submitted

### *The law governing Medicaid appears at...*

Social Security Act, title XIX, 42 U.S.C. §§ 1396, *et seq.*, 42 C.F.R. Part 430, *et seq.*; alien eligibility at 42 U.S.C. § 1396b(v), 42 C.F.R. § 435.408.

## ALIEN ELIGIBILITY FOR MEDICAID

<i>ALIENS ELIGIBLE FOR FULL MEDICAID SERVICES</i>	<i>DOCUMENTS</i>
<p><b>Lawful Permanent Residents</b></p> <p><i>EXCEPT:</i></p> <ul style="list-style-type: none"> <li>• amnesty aliens subject to the 5-year disqualification (aliens who legalized under the general amnesty or farmworker programs are ineligible for Medicaid for 5 years unless they are under 18, 65 or older, blind, or disabled, or only seeking pregnancy-related care or emergency services)</li> </ul> <p><b>PRUCOL Aliens:</b></p> <p><b>Lawful Temporary Residents</b> under the amnesty programs who are exempt from 5-year disqualification</p> <p><b>Persons fleeing persecution:</b> refugees, aliens granted asylum, aliens granted withholding of deportation, parolees, Cuban/Haitian Entrants, conditional entrants</p> <p><b>Aliens granted permission to remain in the U.S.:</b> granted indefinite voluntary departure, stay of deportation, suspension of deportation, order of supervision</p> <p><b>Aliens who have applied for immigration benefits and whose departure the INS does not contemplate enforcing:</b> granted voluntary departure for definite period, applicant for adjustment of status, U.S. citizen's relative with approved I-130 petition</p> <p><b>Resided in the U.S. since before January 1, 1972</b></p> <p><b>Aliens residing in the U.S. with INS knowledge and permission and whose departure the INS does not contemplate enforcing</b></p>	<p>I-151, I-551, reentry permit, stamp in passport, I-94 stamped "temporary I-551"</p> <p>I-688</p> <p>I-571, I-94, decision of immigration judge, I-688B</p> <p>I-94, I-210, I-797, decision of immigration judge</p> <p>I-94, I-485 filing receipt, I-171</p>
<b><i>ALIENS INELIGIBLE FOR MEDICAID (EXCEPT EMERGENCY)</i></b>	
<p><b>Aliens granted Temporary Protected Status</b></p> <p><b>Aliens granted Family Unity</b> — for same length of time and in same manner as legalized spouse or parent</p> <p><b>Nonimmigrants</b></p> <p><b>Undocumented aliens who are not PRUCOL</b></p>	<p>I-688B</p> <p>I-797, I-688B</p> <p>I-94</p>
<b><i>ALIENS ARGUABLY ELIGIBLE FOR FULL MEDICAID</i></b>	
<p><b>Applicants for legalization, asylum, or suspension of deportation</b></p>	<p>I-688A, I-94, I-589 or I-256A on file</p>

**IMPORTANT:** All aliens, regardless of immigration status (including undocumented aliens), are eligible for Medicaid if they are only seeking *emergency care*.

# PRUCOL

## *PERMANENTLY RESIDING IN THE U.S. UNDER COLOR OF LAW*

*"Permanently residing in the U.S. under color of law," or PRUCOL, means...*

- something a little different depending on the federal benefit program defining it
- **NOTE:** "PRUCOL" is not defined in immigration law. It is not a separate immigration classification, like "refugee" or "lawful permanent resident."

*The four federal programs that use PRUCOL as a basis for eligibility are...*

- Aid to Families with Dependent Children (AFDC)
- Supplemental Security Income (SSI)
- Medicaid
- unemployment insurance (UI)

*Aliens who are PRUCOL include...*

- *refugees, aliens granted asylum, parolees, and Cuban / Haitian Entrants*
- certain other aliens, depending on how each benefit program defines PRUCOL

*SSI and Medicaid define PRUCOL in a broad way...*

- regulations list 15 specific immigration categories that qualify as PRUCOL, including such categories as *applicants for adjustment of status, aliens granted suspension of deportation, aliens granted withholding of deportation, and aliens residing in the U.S. since before January 1, 1972*
- they also define a *catch-all category* of PRUCOL that includes aliens residing in the U.S. with INS knowledge and whose departure the INS does not contemplate enforcing. This can include aliens who have applied for *deferred action*

*AFDC regulations define PRUCOL more narrowly...*

- but administrative and judicial cases may be expanding that definition (one state has found that asylum *applicants* are PRUCOL for AFDC eligibility)

*Who is PRUCOL for unemployment insurance depends on...*

- both federal and state law definitions and interpretations of PRUCOL
- case law, which has given the PRUCOL term a broad meaning for UI
- **IMPORTANT:** In *most* states, the alien is eligible for UI if during the "base period," he or she was working with INS work authorization. In *all* states, the alien must also have current work authorization to receive UI.

*When in doubt about whether an alien is PRUCOL...*

*...consider whether the INS knows of the alien's presence and is allowing him or her to reside here. Because PRUCOL has no one specific definition, it may be possible to advocate that an alien qualifies as PRUCOL based on the particular facts or equities in his or her case.*

*Important case law concerning PRUCOL appears at...*

Holley v. Lavine, 553 F.2d 845 (2d Cir. 1977), *cert. denied*, 435 U.S. 947 (1978), and Berger v. Heckler, 771 F.2d 1556 (2d Cir. 1985).

## PRUCOL ELIGIBILITY FOR SSI, AFDC, MEDICAID, AND UI

<i>IMMIGRATION CATEGORY</i>	<i>SSI</i>	<i>AFDC</i>	<i>MEDI-CAID</i>	<i>UI</i>
<b>Lawful Temporary Residents</b> under the amnesty programs who are not subject to 5-year disqualification	Yes	Yes	Yes	Yes
<b>Persons Fleeing Persecution:</b> refugees, aliens granted asylum, aliens granted withholding of deportation, parolees, Cuban/Haitian Entrants, conditional entrants	Yes	Yes	Yes	Yes
<b>Aliens Granted Permission to Remain in the U.S.:</b> granted indefinite voluntary departure, stay of deportation, suspension of deportation, order of supervision, Family Unity	Yes	Unclear	Yes	Yes
<b>Aliens Who Have Applied for Immigration and Whose Departure the INS Does not Contemplate Enforcing:</b> granted voluntary departure for definite period, applicant for adjustment of status, U.S. citizen's relative with approved I-130 petition	Yes	Unclear	Yes	Yes
<b>Resided in the U.S. Since Before January 1, 1972</b>	Yes	No	Yes	No
<b>Aliens Residing in the U.S. with INS Knowledge and Permission and Whose Departure the INS Does Not Contemplate Enforcing</b>	Yes	Unclear	Yes	Yes
<b>Temporary Protected Status</b>	No	No	No	No

# **ALIEN VERIFICATION**

## ***VERIFYING AN APPLICANT'S IMMIGRATION STATUS***

### ***Immigration status must usually be verified when...***

- an applicant for certain federal or state benefits admits to being an alien
- an eligibility worker has reason to doubt an applicant's claim to U.S. citizenship

### ***Agencies can verify an applicant's immigration status by...***

- checking INS records through a computer hook-up or sending documents to the INS
- examining documents submitted by the alien
- accepting sworn statements by the applicant

### ***The Systematic Alien Verification for Entitlements (SAVE) process...***

- is required for six federal benefit programs
- verifies an alien's immigration status through an INS computer database
- also relies on manual verification of records not located in the computer

### ***The federal benefit programs that use SAVE are...***

- Aid to Families with Dependent Children
- Medicaid
- Unemployment Insurance
- Food Stamps
- Housing Assistance
- Education
- **NOTE:** Agencies can get a waiver from having to participate in SAVE if they can show either (1) that they have an equally effective way of verifying an alien's status, or (2) that the costs of using SAVE will be more than the amount they would save by using it

### ***Under SAVE, if applicants do not have immigration documents when they apply ...***

- they must be given a "reasonable opportunity" to provide the documents
- if the applicant is otherwise eligible, benefits must not be delayed, denied, reduced, or terminated while he or she is gathering documents or, after they are submitted, while the INS is verifying status
- the agency may accept a receipt from the INS showing that the alien has applied for replacement of a lost document

### ***The INS cannot use information gained through the SAVE process...***

- to begin deportation proceedings
- for any other purpose other than verifying the alien's immigration status
- **NOTE:** The INS or other officials *are* allowed to prosecute aliens discovered through SAVE for criminal violations, such as use of forged or counterfeit documents

### ***The law governing SAVE appears at...***

Immigration Reform and Control Act § 121, Pub. L. No. 99-603; 42 U.S.C. § 1320b-7; 42 U.S.C. § 1436a; 42 U.S.C. § 1437, *et seq.*; 20 U.S.C. § 1091; 7 U.S.C. § 2025.

## VERIFICATION OF ALIEN STATUS

Benefit Program	Is Status Verified?	Verification Method
<i>Cash Programs</i>		
AFDC	Yes	SAVE
SSI	Yes	Examine documents — contact INS
Refugee Assistance Programs	Yes	Examine documents — contact INS
<i>Medical Programs</i>		
Medicaid	Yes	SAVE — some states have waivers
Medicare	Yes	Examine documents — contact INS
<i>Food Programs</i>		
Food Stamps	Yes	SAVE — some states have waivers
Child Nutrition Programs	No	—
WIC	No	—
<i>Employment-Related Programs</i>		
Job Training Partnership Act	No, but...	Must show work authorization
Social Security Benefits	No, but...	Must have social security card
Unemployment Insurance	Yes	SAVE — some states have waivers
<i>Other Federal Programs</i>		
Education Loans and Grants	Yes	SAVE — some waivers granted
Housing Programs	Not yet	SAVE not yet implemented
Legal Services	Yes	Examine documents — do not contact the INS

Good Evening Mr Chairperson, Members of the Committee

Thank you for opportunity to speak. I am Elvera...

The MN/MI program must continue. The Gallup poll shows that 72%...<sup>of Arizonans</sup> oppose <sup>cuts to reduce availability of health services to the medically indigent</sup> ~~insurance~~

The public understands health care has become a right and no matter how much money you have or if you are employed there may be a point in time that one can't afford the cost of needed medical care.

Not only is there public support for the program, there are two other reasons for continuing it. 1) WE haven't come to any resolution as to how to create opportunities for the underinsured and uninsured to obtain coverage. There has to be a safety net for those who have preexisting conditions, those who are high risk, those who want to pay but can't afford insurance, those who are working and don't receive coverage, those who ran out of coverage.

2) we don't understand who is on MN/MI and for what reasons. There have been many policy alternatives offered in the past two years as Mr Burns documented but no real discussion. This legislature created an AHCCCS <sup>oversight</sup> committee to wrestle with the problems but it never met. We seemed to be doomed in this state to constantly meet in appropriation meetings to superficially explore alternatives. When there are discussions the counties and hospitals <sup>DES & AHCCCS</sup> are usually the only one invited even though the employer community, unions, insurers and consumer advocates <sup>consumer advocates</sup> are affected and can add to the deliberations.

Until there really is some deliberation and hard negotiating along with alternative health care coverage MN/MI must continue.

In the Short Term  
Who pays.

There have been few alternatives offered because the Executive budget and JLBC have set the parameters on a policy of no tax increases, unless they are hidden or disguised as cost shifting.

This is dishonest policy making and ~~for little reason~~ <sup>for SA - needed</sup>. In the Gallup poll ~~68%~~ <sup>60% said they would support it</sup> of the respondents ~~supported~~ <sup>supported</sup> a tax on cigarettes. The governor and the legislature should take more seriously residents concerns about the availability of health care and less concern about image and proposition 108.

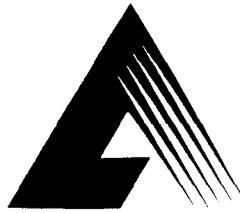
If this alternative is ignored, then cost must be distributed more evenly across the Board. Many states have relied on provider taxes; hospitals and nursing homes to create uncompensated pools which are then used to match federal funds. The federal government has made it more difficult for states to use this procedure with the passage of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. However ~~other suggestions have been offered~~ <sup>provider taxes ~~and~~ must be</sup> such as only qualifying the person needing medical care and not the household to hold down costs. Is there

possible ways to add state workers to the pool <sup>→ bring more revenue into the pool</sup> and negotiate a lower rate for the MN/MI population, <sup>additional participation of small business participation</sup> ~~Really none~~

If the providers bear more costs and ~~the counties are assessed~~ <sup>the counties have been assessing</sup> a higher contribution rate but ~~not as high as suggested by JLBC~~ <sup>being</sup>, what will the state offer? Once again I refer to the Gallup study. In it ~~68%~~ <sup>up to 33 month</sup> % said they would pay higher taxes. Well the Governor is asking that the legislature cut taxes. This state could easily continue MN/MI not by raising taxes but keeping those that are now in effect. The Governor's proposal is minimal tax relief for those we would like to help; the low and middle income tax payers. With this move, not only are we saving the MN/MI program, but we are stopping the erosion of one tax, personal income tax, that is growing because personal income and the population is growing. I think every tax decrease or tax expenditure decrease is suspect.

I know that Peter Burns in explaining the executive budget has ....

*Some states have used uncompensated care pools*



ARIZONA HOSPITAL ASSOCIATION

**Recommendation on Proposed  
Arizona Health Care Cost Containment System Budget**

The Arizona Hospital Association recommends that the Legislature adopt a modified version of the Joint Legislative Budget Committee (JLBC) staff's proposal concerning the Arizona Health Care Cost Containment System (AHCCCS) budget. The elements of the Association's recommendation are summarized below:

**Policy Issue**

**Fiscal Impact**

- |   |   |
|---|---|
| 1. Conform to federal Title XIX policy by funding only emergency services for 18,000 undocumented aliens and eliminate non-emergency MN/MI services to that population  | Saves the state general fund an estimated \$43.6 million in FY 1994.*   |
| 2. Defer proposed tax reduction until revenue projections improve sufficiently enough that cuts in health care services would not be required to fund the tax decrease. | Makes available at least \$48 million for needed services.**  |
| 3. Continue coverage of pregnant women and children with incomes at 140 percent of the federal poverty level.   | State would forgo estimated savings to the state general fund for reducing eligibility to 133 percent of federal poverty level of \$2.4 million for FY 1994.* |
| 4. Continue current level of county contribution to AHCCCS acute care program.  | State would forgo increased funding for AHCCCS from counties of \$34.5 million.*  |

\*Based upon JLBC staff projections

\*\*Office of Strategic Planning and Budget (OSPB) proposes to reduce taxes by \$48 million; JLBC staff defers to the Legislature as to the amount of a tax decrease

# MEMORANDUM

GAMMAGE & BURNHAM

TO: Parties Interested in AHCCCS

DATE: 1/28/93

FROM: Richard B. Burnham  
John R. Dacey

RE: AHCCCS Legislation--Maximizing Savings and  
Retaining the MN/MI Program

The following analysis is an attempt to pick from the various MN/MI proposals a combination of changes that maximizes state savings while insuring continued coverage of the MN/MI populations and dealing equitably with the involved parties.

To simplify the analysis, all annual costs associated with "tails" or "guaranteed enrollments" for involved populations are disregarded. These numbers confuse the analysis and can be somewhat offset by delay of payment of some percentage of each into the following fiscal year. If a consensus emerges on specific changes, these can be factored back in. Thus, we use annualized savings/cost numbers.

Our analysis of the most desirable blend of the various proposals together with an action plan and a discussion of other suggestions is as follows:

I. Recommended Savings Proposals:

[NOTE: THESE ARE FULL YEAR SAVINGS PROPOSALS WHICH CANNOT BE ACHIEVED UNTIL FISCAL 1995, IF THEN. THE JLBC STAFF WILL PRESENT THE FY '94 NUMBERS WHICH ARE SIGNIFICANTLY LOWER.]

<u>FY '94</u> <u>State \$ Saved</u>	<u>FY '95</u> <u>State \$ Saved</u>	<u>Category</u>	<u>Source of</u> <u>Recommendation</u>	<u>Discussion</u>
?	\$32.8 M	MN/MI Conversions	OSPB	These are the net State savings from converting 11,000 MN/MI's to federal categories. See Section II "Action Plan" for means of securing.

?	\$18.0/\$63.0 M	Emergency Services Only -- Undocumented Aliens	OSPB/JLBC	OSPB's number of \$18.0 M is a projection of federal match available for emergency services to undocumented aliens leaving the current program in place.
				\$63.M is JLBC's net annual savings from enrolling all possible undocumented under federal coverage and eliminating all non- emergency care to undocumented. (See, JLBC-FY94 Budget -- Analysis & Recommen- dations, p. 34, excluding "tail" and "guaranteed enrollment").
				See Section II "Action Plan" for means of obtaining either of these goals.
?	?	Enhance Third Party Recoveries		It is thought that with law changes these collections can be increased.
?	<u>\$50.8/</u> <u>\$95.8M</u>	Net Savings		

II. Action Plan -- Maximizing Federal Enrollment.

The majority of the savings described above will come from the maximum successful completion of federal applications by current MN/MI's. We believe this can only be achieved by using the existing county eligibility staffs and facilitating their work and

incentivizing them to identify federal eligibles. To facilitate their work we propose deputizing them to take and complete federal applications, or as a second alternative, co-location of DES workers who can certify applications in county offices. The incentive would be a penalty equal to the total cost of care for a federal eligible missed by the counties as determined by AHCCCS eligibility quality control analysis.

III. Discussion of Other Proposals.

Reduce the Governor's  
Proposed Tax Cut

Hospitals

Given the fundamental importance of the MN/MI program, the hospitals believe the Governor's proposed tax cut should be reduced or eliminated, if necessary, to retain MN/MI coverage after the changes outlined in Section I.

Increase County Funding of  
AHCCCS acute care

JLBC

Noting that County contributions to MN/MI costs have remained constant for many years, JLBC recommends a major increase from the counties. The counties role as a residual provider of services is a major cornerstone of the program and the counties assert they have very limited funds.

Expansion of SOBRA  
eligibility/Reduction of  
SOBRA Eligibility

OSPBJLBC

Given the tight budget and critical importance of saving MN/MI programs, we do not see further expansion of SOBRA as possible this year. Conversely, for the small amount of money involved, we do not see any

reason to cut back on  
SOBRA eligibility as  
recommended by JLBC.

Elimination of County  
Residuality and Eligibility  
Determinations

OSPB/Counties

County residuality is vitally important in keeping the counties in the delivery system for certain types of services and particularly for the continued operation of county hospitals by Maricopa and Pima counties. The duty to pay providers for pre-determination care of MN/MI's is an important source of hospital reimbursement and provides the incentive for counties to quickly determine eligibility. We further believe the county eligibility staffs are critical to performing MN/MI determinations and converting persons to federal categories.

Eliminate Quick Pay  
Discount on Hospital Bills

OSPB

The current quick pay discount of 10% will clearly violate the federal law Boren Amendment when the new reimbursement system kicks in March 1. This change would cost the State \$16.3M. It would moot a potential lawsuit and bring 32.6 in enhanced federal funds for hospital reimbursement which will

help bring hospitals closer to "cost" reimbursement on AHCCCS patients.

End Automatic Coverage of  
all Family Members      Counties

We do not believe this change is wise given the financial devastation caused to an MN/MI family by the acute need and expense of one family member.

Lower Asset Standards      Counties

The AHCCCS standards are so low that this would have little fiscal impact. It would be perverse on a case by case basis.

Co-Payments and  
Deductibles      Counties

These already exist in the spend down requirement. Other co-payments and deductibles would raise minimal revenue and not discourage utilization. These were found unmeaningful early in the AHCCCS experiment.

Limit Services      Counties

While this is worthy of examination, we do not see a great savings here. This could be looked at in future years.

RBB/lm

**AD HOC COMMITTEE ON AHCCCS  
DISCUSSION POINTS**

	Cost/(Savings) in Millions of Dollars	
	<u>1994</u>	<u>1995</u>
<b>1. <u>MN/MI - ELIC POPULATIONS</u></b>		
1.1 Governor's proposal to eliminate MN/MI & ELIC programs (Net of "Tail", 6-month guarantee, "Quick Pay" discount, emergency services for undocumented aliens and conversion of up to 18% of former MN/MI's to federal categorically-eligible groups).	\$(145.2)	\$(228.6)
1.2 JLBC Staff proposal on undocumented aliens - conform to federal policy of providing only emergency services (Net of "Tail" and 6 month guarantee).	(37.5)	(59.9)
1.3 Eliminate optional services (see Attachment A) - would apply to JLBC recommendation only.	(2.0)*	(4.0)*
* If applied to all AHCCCS groups, would save \$10 million when fully implemented.		
<b>2. <u>SOBRA Eligibility</u></b>		
2.1 Governor's proposal to expand coverage to 185% of FPL for pregnant women and infants (now 140%) and children under age 6 (now 133%).	23.0	47.6
2.2 JLBC Staff proposal to reduce coverage from 140% to 133% of FPL for pregnant women and infants up to 1 year of age (would remain at 133% for children under age 6).	(2.4)	(2.7)
<b>3. <u>County Contribution</u></b>		
3.1 JLBC Staff recommendation to set county acute care contribution at a level which, when combined with LTC contribution, equals 32.8% of total statewide match (see Attachment B).	(34.6)	(38.3)
Offsets:		
• Increase AHCCCS disproportionate share payments to counties to reflect higher level of federal funding; provides additional \$10.5 million in FY '93 and '94, \$5.2 million in FY '95.	--	--
• Higher county sales tax distributions; \$24.7 million in FY '94, \$55 million in FY '95.		

4. Eligibility Determination

- |     |   |                      |                                  |
|-----|---|----------------------|----------------------------------|
| 4.1 | Shift MN/MI and ELIC eligibility determination to state (DES), effective FY 1995.<br>Offset: Would provide \$15 million savings to counties in FY 1995.<br>Offset: Net state savings from conversions   | \$2 to 3<br>--<br>-- | \$10 to 15<br>--<br>Up to \$(23) |
| 4.2 | Authorize county eligibility workers to determine federal categorical coverage with sanctions for excessive error rates.  |                      |                                  |
| 4.3 | Same as 4.2 above, except reward counties for decreased error rates (currently 18%) by lowering county acute care contribution based upon a formula that considers resultant increase in federal funds (for example: a 1% decrease for each 1% decrease in the error rate - equals \$1 million in FY 1994). |                      |                                  |
| 4.4 | Have private sector (Hospitals) assist in training and financing of eligibility workers.  |                      |                                  |

5. Miscellaneous Cost Reduction Measures

- 5.1 Limit MN/MI eligibility to 2-3 months
- 5.2 Limit MN/MI eligibility to individuals only
- 5.3 Tighten asset standards
- 5.4 Mandate Co-pay (ER only?)
- 5.5 Enhance recoveries from both first and third parties
- 5.6 Require pay-back of MN/MI costs (on a sliding scale?)
- 5.7 Enhance efforts to detect fraud
- 5.8 Eliminate or modify parental income disregard

6. Other Options

- 6.1 Limit MN/MI services to only emergencies for entire population
- 6.2 Limit MN/MI services to only emergencies and chronic care (Cancer, Aids, etc.)
- 6.3 Restructure, standardize, possibly reduce county residual liability
- 6.4 State-subsidized catastrophic health insurance policy

### OPTIONAL SERVICES

In addition to extending services to certain optional groups, states may also choose to offer optional services and receive federal reimbursement for these services. The federal government has defined 31 such optional services. The table below indicates the optional services covered by Arizona and the number of states and territories that also cover the service.

Optional Service Covered In Arizona	# of States and Territories
Podiatry services	46
Optometry services	51
Other practitioner's services	44
Private duty nursing	27
Clinic services	55
Dental services	48
Physical therapy	41
Occupational therapy	30
Speech, hearing, and language disorders	37
Prescribed drugs	54
Dentures	40
Prosthetic devices	51
Eyeglasses	50
ICF services for the mentally retarded	51
Nursing facility services for under age 21	50
Emergency hospital services	43
Personal care services	28
Transportation services	52
Hospice care	32
Respiratory care services	12

	FY 1994 Acute Care and ALTCS Increases			Additional FY 1994 Revenue			
	Increased Acute Care Contrib.	Increased ALTCS Contrib.	Total FY 94 Increase	Additional Sales Tax Rev	Potential FY 93/94 Dispro Share Gain	Total Addtl. County Revenue	Surplus/ (Deficit)
<i>Apache</i>	\$139,297	\$21,322	\$160,619	\$291,680	\$66,326	\$358,006	\$197,387
<i>Cochise</i>	1,147,904	241,331	1,389,234	425,871	100,314	526,185	(863,049)
<i>Coconino</i>	385,054	63,967	449,021	764,002	60,004	824,006	374,985
<i>Gila</i>	732,432	248,115	980,548	352,784	120,010	472,794	(507,754)
<i>Graham</i>	277,903	62,029	339,931	84,282	60,004	144,286	(195,645)
<i>Greenlee</i>	98,856	32,953	131,809	254,932	120,010	374,942	243,133
<i>La Paz</i>	109,917	32,953	142,870	109,797	120,010	229,807	86,937
<i>Maricopa</i>	20,036,985	5,480,826	25,517,811	14,038,769	5,971,800	20,010,569	(5,507,242)
<i>Mohave</i>	641,526	264,592	906,118	785,677	60,004	845,681	(60,437)
<i>Navajo</i>	161,073	88,197	249,270	520,375	60,004	580,379	331,109
<i>Pima</i>	7,749,473	1,991,706	9,741,179	4,889,672	3,485,000	8,374,672	(1,366,507)
<i>Pinal</i>	1,407,487	493,323	1,900,810	712,889	60,004	772,893	(1,127,917)
<i>Santa Cruz</i>	250,251	101,766	352,017	198,728	60,004	258,732	(93,285)
<i>Yavapai</i>	740,037	302,390	1,042,427	733,941	60,004	793,945	(248,482)
<i>Yuma</i>	686,807	266,530	953,337	535,056	60,004	595,060	(358,277)
<b>Total</b>	<b>\$34,565,000</b>	<b>\$9,692,000</b>	<b>\$44,257,000</b>	<b>\$24,698,455</b>	<b>\$10,463,502</b>	<b>\$35,161,957</b>	<b>(\$9,095,043)</b>
	<b>FY 95 Increases Over FY 93</b>			<b>FY 95 Additional Revenue Over FY 93</b>			
<b>All Counties</b>	<b>\$38,300,000</b>	<b>\$20,400,900</b>	<b>\$58,700,900</b>	<b>\$55,000,000</b>	<b>\$5,231,751</b>	<b>\$60,231,751</b>	<b>\$1,530,851</b>

## Revised FY 1993 Disproportionate Share Allocation

I. Disproportionate Share Payments to Hospitals and County In-Lieu Payments		FY 1993	FY 1993 Rev	Option 1 Chg	FY 1993 Rev	Option 2 Chg
		Original	Option 1	From Orig	Option 2	From Orig
Maricopa and Pima County Hospitals	(S)	\$20,518,800	\$25,724,000	\$5,205,200	\$24,448,400	\$3,929,600
	(F)	39,635,900	49,690,900	10,055,000	47,226,700	7,590,800
	(T)	60,154,700	75,414,900	15,260,200	71,675,100	11,520,400
28 Private Hospitals	(S)	2,328,700	2,919,400	590,700	3,615,000	1,286,300
	(F)	4,498,200	5,639,400	1,141,200	6,983,000	2,484,800
	(T)	6,826,900	8,558,800	1,731,900	10,598,000	3,771,100
Arizona State Hospital	(S)	1,942,000	2,434,700	492,700	3,014,700	1,072,700
	(F)	3,751,400	4,703,000	951,600	5,823,600	2,072,200
	(T)	5,693,400	7,137,700	1,444,300	8,838,300	3,144,900
Total Payments to Hospitals	(S)	24,789,500	31,078,100	6,288,600	31,078,100	6,288,600
	(F)	47,885,500	60,033,300	12,147,800	60,033,300	12,147,800
	(T)	72,675,000	91,111,400	18,436,400	91,111,400	18,436,400
County In-Lieu Payments	(S)	911,200	1,142,400	231,200	1,414,600	503,400
Total Disproportionate Share Payments	(S)	25,700,700	32,220,500	6,519,800	32,492,700	6,792,000
	(F)	47,885,500	60,033,300	12,147,800	60,033,300	12,147,800
	(T)	73,586,200	92,253,800	18,667,600	92,526,000	18,939,800
II. Distribution of Dispro Funds Before Adjustments						
Maricopa County Medical Center		48,551,500	60,868,200	12,316,700	57,849,700	9,298,200
Kino Community Hospital (Pima County)		11,603,200	14,546,700	2,943,500	13,825,400	2,222,200
28 Private Hospitals		6,826,900	8,558,800	1,731,900	10,598,000	3,771,100
Arizona State Hospital		5,693,400	7,137,700	1,444,300	8,838,300	3,144,900
County Governments (In-Lieu)		911,200	1,142,400	231,200	1,414,600	503,400
Total Distribution (Gross)		73,586,200	92,253,800	18,667,600	92,526,000	18,939,800
III. Revenue-Related Adjustments						
Maricopa County						
Withhold Sales Tax Distributions		(43,145,900)	(54,091,300)	(10,945,400)	(49,458,200)	(6,312,300)
Pima County						
Withhold Sales Tax Distributions		(8,448,700)	(10,592,000)	(2,143,300)	(8,928,400)	(479,700)
Total Revenue Adjustments		(51,594,600)	(64,683,300)	(13,088,700)	(58,386,600)	(6,792,000)
IV. Net Distribution of Dispro Funds						
Maricopa County Medical Center		5,405,600	6,776,900	1,371,300	8,391,500	2,985,900
Kino Community Hospital (Pima County)		3,154,500	3,954,700	800,200	4,897,000	1,742,500
28 Private Hospitals		6,826,900	8,558,800	1,731,900	10,598,000	3,771,100
Arizona State Hospital		5,693,400	7,137,700	1,444,300	8,838,300	3,144,900
County Governments (In-Lieu)		911,200	1,142,400	231,200	1,414,600	503,400
Total Net Distribution		21,991,600	27,570,500	5,578,900	34,139,400	12,147,800
V. Net Gain to the General Fund						
Total Funds Appropriation		73,586,200	92,253,800	18,667,600	92,526,000	18,939,800
Less: General Fund Appropriation		(25,700,700)	(32,220,500)	(6,519,800)	(32,492,700)	(6,792,000)
Less: Net Distributions		(21,991,600)	(27,570,500)	(5,578,900)	(34,139,400)	(12,147,800)
Net Gain to the General Fund		\$25,893,900	\$32,462,800	\$6,568,900	\$25,893,900	\$0

JLBC Staff

28-Jan-93

Option 1 = All entities share equally in increased allocation

Option 2 = State gain is \$0, all other entities share equally in gain





JOHN GREENE  
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COMMITTEES  
APPROPRIATIONS  
COMMERCE & LABOR  
JUDICIARY

## Arizona State Senate

Phoenix, Arizona

January 15, 1993

Senator John Huppenthal  
Arizona State Senate  
1700 West Washington  
Phoenix, AZ 85007

Representative Bob Edens  
Arizona House of Representatives  
1700 West Washington  
Phoenix, AZ 85007

Re: Appointment to Joint Ad Hoc Committee on the AHCCCS Budget

Dear Senator Huppenthal and Representative Edens:

You are hereby appointed to Co-Chair the Joint Ad Hoc Committee on the AHCCCS Budget. Your fellow committee members are:

Senator Carol Springer  
Senator Ann Day  
Senator Lela Alston

Representative Bob Burns  
Representative Susan Gerard  
Representative Herschella Horton

The committee is to review the JLBC Staff recommendations, the Executive Budget recommendations and alternative budget proposals, within the budget parameters established by the Appropriations Chairmen and reflected in the JLBC Staff recommendations. The committee shall take public testimony at two meetings to be held on January 21, 1993 and January 28, 1993.

The committee shall complete its work by Friday, January 29, 1993.



Attachment 12

We appreciate your willingness to serve on this committee and to deal with these difficult issues in a timely fashion.

Sincerely,



John Greene  
President of the Senate



Mark Killian  
Speaker of the House

cc: Senator Springer  
Representative Bob Burns  
Senator Day  
Representative Gerard  
Senator Alston  
Representative Horton