Payments to Hospitals
Arizona Health Care Cost Containment System
Program Summary

Key Points

1) AHCCCS has several programs that provide supplemental funding to hospitals over and above reimbursements for services provided to Medicaid enrollees.
2) The current state match cost of the program is $124.8 million, including $14.8 million from General Fund monies and $110.0 million from political subdivisions.
3) Most federal revenues from Disproportionate Share Hospital (DSH) payments serve as a General Fund revenue source to offset the General Fund costs of the AHCCCS program. The total DSH General Fund deposit was $83.3 million in FY 2020.
4) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act delayed nationwide DSH payment reductions until December 1, 2020, and reduced the scheduled FFY 2021 cut from $8.0 billion to $4.0 billion. Payments will then decline by $8.0 billion in fiscal years 2022-2025.
5) Graduate Medical Education (GME) funding has significantly expanded in recent years due to the option for local and tribal governments and universities to draw down Federal Funds through a voluntary match. At $357.6 million in FY 2021, it is the largest supplemental payment program.

Program Overview and Funding

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

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

On an annualized basis, hospital supplemental payment programs represent $488.5 million Total Funds.

Disproportionate Share (DSH)

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

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

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

The DSH program is funded by a combination of General Fund and Federal Fund monies, with the option for local governments or universities to provide additional state matching funds. The federal government provides the state with roughly a 2:1 match based on the Federal Matching Assistance Percentage (FMAP), which changes each year. The total amount of eligible funding is adjusted annually for changes in prices and the federal match rate. The FY 2020 eligible funding of $166,647,400 is 63.1% above the FY 2001 eligible funding (*See Table 1*).

Table 1

Disproportionate Share Funding History

	FY 2001	FY 2007	FY 2020	FY 2021
Eligible Funding				
County Hospitals	$ 59,149,000	$ 88,854,700	$95,696,000	$113,818,500
State Hospitals	28,474,900	28,474,900	28,474,900	28,474,900
Private Hospitals	15,150,000	26,147,700	884,800	884,800
Voluntary Match 1/	0	0	41,591,700	27,137,600
Total Funding	**$102,773,900**	**$143,477,300**	**$166,647,400**	**$170,315,800**

1/ Although the FY 2021 General Appropriation Act appropriated $27,137,600 for voluntary payments, a footnote appropriates any amount over that to the administration in FY 2021.

Publicly-Operated Hospitals

Since FY 2008, publicly-operated hospitals are required to document uncompensated care costs to the federal government through a Certified Public Expenditure (CPE) process. Those CPEs serve as the state match for the drawdown of Federal Funds. The publicly-operated hospitals of Maricopa Integrated Health System (MIHS) and DHS' Arizona State Hospital (ASH) is expected to receive eligible funding of $113,818,500 and $27,137,600 in FY 2021, respectively.

While the state retains most of the MIHS federal match as General Fund revenue, $4,202,300 of the federal drawdown is distributed to MIHS in FY 2021. This distribution to MIHS is appropriated in the Disproportionate Share Payments line. (The state match is part of the CPE and does not appear in the General Appropriation Act.)

In FY 2012 and FY 2013, legislation limited the DSH payment attributable to MIHS to $89,877,700, allowing MIHS to use uncompensated care monies as a match for the Safety Net Care Pool program (*see below*). This resulted in the diversion of some federal funding for DSH, which would have otherwise been distributed to the General Fund. Laws 2015, Chapter 14 increased payments attributable to MIHS to $105,945,500 in FY 2015 and $113,818,500 in FY 2016, thereby increasing the amount of Federal Funds transferred to the General Fund by $11,000,000 in FY 2015 and an additional $5,500,000 in FY 2016. While the FY 2020 Health Budget Reconciliation Bill (BRB) continued the $113,818,500 level of payments attributed to MIHS, actual certifiable uncompensated care from MIHS was $95,696,000 in FY 2020. The FY 2021 budget assumed no changes in uncompensated care levels from the $113.8 million appropriated level, projecting a total net General Fund deposit of $95,830,000 in FY 2021.

Private Hospitals

The state appropriates General Fund dollars, which receive a drawdown of federal dollars, for DSH payments to private hospitals. The FY 2021 budget includes an $884,800 total funds appropriation for this distribution in the Disproportionate Share Payments line. The appropriation includes $265,400 from the General Fund and $619,400 from the Federal Medicaid Authority. Prior to the FY 2016 budget, the state appropriated $9,284,800 of General Fund dollars to private hospitals each year. In FY 2018, 31 private hospitals received $884,800 in DSH payments.

Voluntary Match

Since FY 2010, the state has allowed local governments, tribal governments and universities to provide the state match in the form of voluntary payments to draw down federal dollars. Any eligible DSH funding remaining after the previously mentioned allocations is made available for voluntary match payments. The FY 2021 budget includes a $27,137,600 Total Funds appropriation for this distribution. In FY 2018, 10 hospitals contributed the voluntary state match for $19,690,700 in DSH payments.

Under the federal Affordable Care Act (ACA), DSH payments were expected to decline nationwide by $500 million in FFY 2014 and $600 million in FFY 2015, or about 5% of overall payments. Subsequent federal legislation has delayed the start of reductions. Per the federal CARES Act, DSH payments are now expected to decline nationwide by $4.0 billion beginning December 1, 2020 and by $8.0 billion in FY 2022 and each year thereafter.

Rural Hospital Payments

The Rural Hospital Payments program provides supplemental payments to small rural hospitals. The program began in FY 2003 with annual total payments of $1.7 million. Payments were originally provided only for Critical Access Hospitals (CAH). To qualify as a CAH, the federal government requires that the hospital:

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

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

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

Table 2

Funding History
Rural Hospital Payments

	FY 2003	FY 2007	FY 2021
Rural Hospital Reimbursement Program			
General Fund	$ 281,000	$ 4,092,400	$ 3,646,200
Federal	469,800	8,065,700	8,511,900
Subtotal	**$750,800**	**$12,158,100**	**$12,158,100**
Critical Access Hospital Program			
General Fund	$ 310,900	$ 567,800	$ 4,934,600
Federal	638,300	1,132,200	11,519,700
Subtotal	**$ 949,200**	**$1,700,000**	**$16,454,300**
Total Payments			
General Fund	$ 591,900	$ 4,660,200	$ 8,580,800
Federal	1,108,100	9,197,900	20,031,600
Total	**$1,700,000**	**$13,858,100**	**$28,612,400**

The Rural Hospital Reimbursement program and the Critical Access Hospital program are combined in the Rural Hospital Payments line item. The total annual appropriation for this line is $28,612,400 in FY 2021, which consists of $12,158,100 for the Rural Hospital Reimbursement program and $16,454,300 for Critical Access Hospitals (*see Table 2*). In SFY 2020, 21 hospitals received Rural Hospital payments totaling $12,158,100. Of these 21 hospitals, 12 also received Critical Access Hospital payments totaling $21,769,200.

Graduate Medical Education (GME)

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

Laws 2007, Chapter 263 allowed local, county, and tribal governments to increase federal funding for GME programs by providing additional voluntary state match monies. Laws 2010, Chapter 86 expanded this provision to public universities. In 2019, 19 hospitals received $335.7 million in total funds.

FY 2020 represented the first year since FY 2010 that the state appropriated monies for GME. The FY 2021 budget continues last year's appropriation and adds an additional $3.0 million. *Table 3* displays the historical data on funding levels for FY 2001, FY 2007, and FY 2021. The $6.0 million General Fund contribution is intended to supplement political subdivision funds for GME programs. Funding will be prioritized for hospitals located in federally-designated health professional shortage areas.

Table 3

Graduate Medical Education Funding History

Fund	FY 2001	FY 2007	FY 2021 1/
GF	$7,766,700	$11,519,800	$ 6,000,000
Federal	10,523,100	26,993,000	249,762,900
Voluntary	0	0	101,858,300
Total	**$18,289,800**	**$38,512,800**	**$357,621,200**

1/ Although the FY 2021 General Appropriation Act appropriated $357,621,200 for GME payments in FY 2021, it also included a footnote appropriating any amount above that to the Administration in FY 2021.

Safety Net Care Pool

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

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

Table 4

Safety Net Care Pool Funding History 1/

Fiscal Year	State Match	Federal Match	Total Funds
FY 2012	$49,050,000	$100,950,000	$150,000,000
FY 2013	122,296,100	239,658,800	361,954,900
FY 2014	160,865,600	327,087,700	487,953,300
FY 2015	56,429,500	118,705,000	175,134,500
FY 2016	41,396,800	77,187,800	118,584,700
FY 2017	29,946,800	66,810,000	96,756,800
FY 2018	16,668,200	37,965,100	54,633,300
FY 2019	0	0	0
FY 2020	0	0	0
FY 2021	0	0	0

1/ The General Appropriation Act includes a footnote appropriating any amount above the appropriation to the Administration in each fiscal year.

Proposition 202 – Trauma and Emergency Services

Proposition 202 (2002) allowed the Governor to enter tribal gaming compacts allowing tribes to operate certain gaming activities in exchange for a percentage of the gaming revenues. The proposition further specified that approximately 25.5% would fund trauma and emergency services. AHCCCS distributes 90% of these monies to the 8 hospitals with trauma departments. The remaining 10% is distributed to hospital emergency rooms. In FY 2019, this funding source provided $24.8 million to hospitals.

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