ARIZONA HEALTH FUTURES

MARCH 2013

RE-KNITTING THE SAFETY NET

Part III: Arizona's Emerging Healthcare Landscape

SLHI

Re-Knitting the Safety Net: An Overview

Our goal is to develop a better understanding of how our health system is shifting so that we can inspire conversation on how to sustain and strengthen it in the future.

Arizona's healthcare safety net – its system of health care for those who are economically vulnerable – has been hit hard by the Great Recession.

State and federal funding for health care – especially care for those who are medically needy or low income – has eroded. Many Arizonans are finding it increasingly challenging to pay for their health care, either due to state policy changes or changes in the availability of employer-sponsored health insurance.

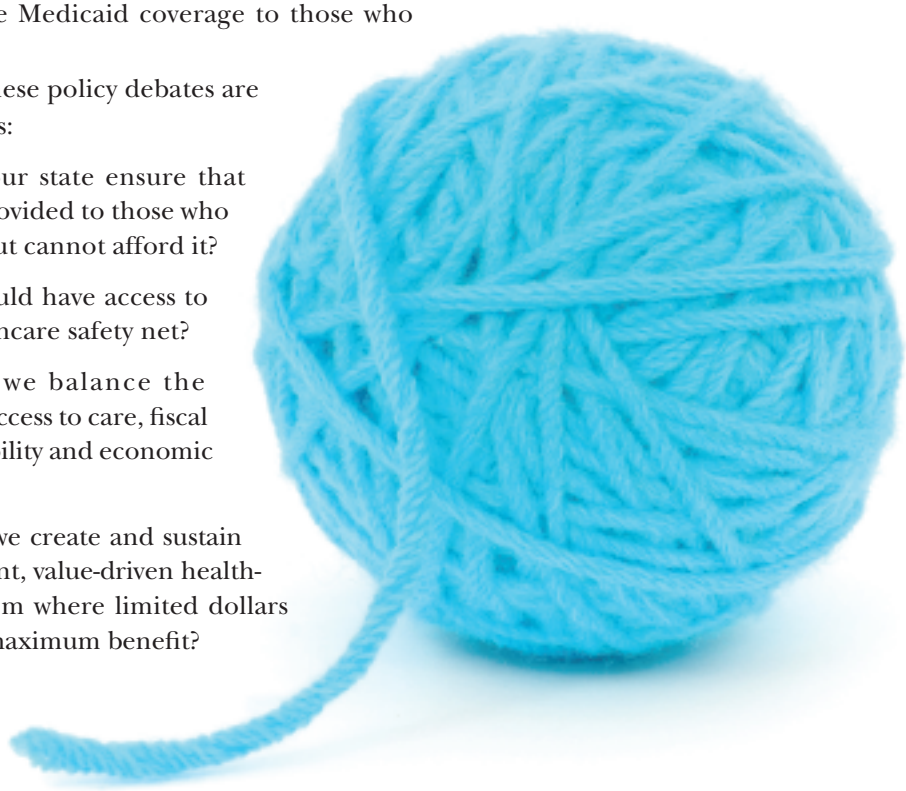
These changes have a ripple effect across the healthcare system, affecting not only access to care but also the strength and efficacy of the safety net. In some instances, people with profound health needs simply have to go without treatment, affecting their health, economic self-sufficiency and possibly their lives. In other instances, those who are unable to access health coverage or affordable health services receive treatment – but their care is often delivered in costly settings such as emergency rooms, and the costs many times go unpaid.

Safety-net providers are responding to these changes in a number of ways. In some cases, safety-net providers are limiting (when possible) care to those in need, or passing the costs of uncompensated care on to others with insurance, making healthcare coverage more expensive for everyone in the long run. In other instances, they are innovating to better control costs, or identifying short-term solutions to keep afloat and continue to provide care to those in need.

The viability, size and strength of Arizona's healthcare safety net is likely to be a hot topic in coming months as policy makers debate important policy issues such as whether or not to restore Medicaid coverage to those who once had it.

Central to these policy debates are questions such as:

- Should our state ensure that care is provided to those who need it but cannot afford it?
- Who should have access to the healthcare safety net?
- How do we balance the goals of access to care, fiscal responsibility and economic growth?
- How do we create and sustain an efficient, value-driven healthcare system where limited dollars achieve maximum benefit?



Final of Three Reports

This report, *Re-Knitting the Safety Net*, is the final in a series of three reports on Arizona's changing healthcare landscape.

In these reports, we consider how budget cuts, health reform and other changes are affecting Arizona's healthcare system and the people it serves. In all three reports, we consider the implications of these changes, and the opportunities and challenges ahead. Our goal is to develop a better understanding of how our health system is shifting so that we can inspire conversation on how to sustain and strengthen it in the future.

This report focuses on Arizona's formal and informal systems that provide health care to low-income Arizonans and those who incur catastrophic healthcare costs. The report considers the impact of state budget cuts on the individuals and healthcare providers who are respectively served by or comprise the safety net, and changes that are occurring in policy and practice as a result of these changes. We consider the factors that will have an impact on the safety net moving forward, looking at both the opportunities as well as the threats. Finally, we look at some of the important policy choices that are on the horizon and discuss some of the factors that policy makers may want to consider.

The two previous reports in this series, *After the Dust Settles: Our Most Vulnerable Citizens* (2011) and *Putting the Pieces (Back) Together: Public Health and Prevention* (2011) can be found at www.slhi.org.

Methodology

To examine recent changes to Arizona's safety net and best practices for improving its strength and sustainability, we:

- Conducted a literature review on issues related to the safety net, relying on recent reports from a wide array of organizations such as the National Academy of State Health Policy and past St. Luke's Health Initiatives' (SLHI) reports on the safety net
- Examined state budget documents from the Joint Legislative Budget Committee and the Governor's Office of Strategic Planning and Budgeting
- Reviewed AHCCCS enrollment data and other AHCCCS reports
- Interviewed 12 safety-net provider representatives
- Collected self-reported data on the rise in uncompensated care and increased demand for services among safety-net providers
- Reviewed polling data for the Pew Research Center and sponsored polling of 500 registered voters in February 2013 to gauge public sentiments on the safety net and various policy options
- Examined data from the Arizona Health Survey and Kaiser Health Facts to determine information on the number of uninsured and their characteristics
- Observed a series of charity care meetings at one local safety-net hospital in late 2011, where cases of those lacking coverage with large medical bills were discussed.

What Is the Healthcare Safety Net?

Examples of Safety-Net Providers

St. Joseph's Hospital and Medical Center

Maricopa Medical Center

El Rio Community Health Center

Holy Cross Hospital, Carondelet Health Network

Community Health Center of Yavapai

St. Vincent de Paul's Virginia G. Piper Medical and Dental Clinic

Scottsdale Health Center-Osborn

Desert Mission (John C. Lincoln Community Health Center)

Murphy School District/Phoenix Rotary 100 Education and Health Center

The Neighborhood Christian Clinic

Banner Good Samaritan Hospital

The healthcare safety net consists of providers who deliver care in a variety of settings to those who cannot otherwise afford or access care. Although many people think of public hospitals and health clinics as the safety net, the array of providers comprising the safety net is more varied and complex than is typically understood. For example, private physicians could be considered part of the safety net, since they often deliver uncompensated care to uninsured or underinsured. Indeed, 18 percent of office-based physicians were estimated to deliver care that was uncompensated in 2001.[1]

There are varying definitions of the safety net, and thus varying opinions about which providers are included in the definition. However, the Institute of Medicine (IOM) report, *American's Health Care Safety Net: Intact but Endangered*, published in 2000, provides a commonly used description of a safety-net provider. It has two distinguishing characteristics: 1) either by legal mandate or explicitly adopted mission, the provider offers care to patients regardless of their ability to pay for services; and 2) a substantial share of the provider's patient mix consists of uninsured, underinsured and Medicaid recipients.[2] Many different types of healthcare providers meet the IOM criteria, including public and teaching hospitals, community health centers, local health departments, free clinics, special service providers and, in some cases, physician networks and school-based clinics.

Who Uses the Safety Net?

Describing those who are served by the safety net also varies depending on how the safety net is defined. However, most agree that it does not include only those who lack any financial resources. Safety-net providers also serve low- and middle-income working families who lack access to affordable or quality health insurance, immigrants (documented or undocumented) who do not qualify for public benefits or have limited or no access to employer-based coverage and individuals across the income spectrum who experience catastrophic illness or injury – and whose insurance, savings or public benefits are inadequate to pay for their significant medical bills.

AHCCCS: Arizona's Nationally Recognized Medicaid Program

The Arizona Health Care Cost Containment System (AHCCCS) began operations in 1982 as the nation's first statewide Medicaid program designed to provide medical services to eligible persons through a managed care system. Today, the agency contracts with mostly private health plans to provide care to its 1.3 million members.

AHCCCS is one of only nine states that have 80 percent or more of its members enrolled in managed care. Other states are just now moving towards more fully implementing this model of care due to its effectiveness in managing costs.

Arizona's Medicaid program ranks 9th among states in lowest payments made per enrollee. It has been lauded for its use of market forces in controlling costs. At the same time, the quality of care delivered to its members is considered to be high.

Sources: Arizona Office of the Auditor General. (2012, September). Arizona Health Care Costs Containment System – Sunset Factors. Kaiser Health Facts, Medicaid Payments Per Enrollee, FY 2009. www.kaiserhealthfacts.org . GAO. (1995). Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs. AHCCCS. Acute Care Contractors and the Division of Developmental Disabilities, Quality Management Measures, September 30, 2010.

Nationally, racial and ethnic minorities make up nearly two-thirds of the population typically served by safety-net providers.[3] In Arizona, Hispanics are three times as likely to be uninsured as Anglos. However, it is also important to note that the safety net is not solely confined to one demographic group. For example, the 2010 Arizona Health Survey showed that one in every ten uninsured Arizonans were Anglo, and 27 percent of those with household incomes of $30,000 - $49,999 per year lacked insurance.[4]

How Is the Safety Net Funded?

As noted above, safety-net providers – by definition – receive a lot of their funding from Medicaid (called AHCCCS in Arizona), the state/federal health insurance program for those living in poverty.[5] Another state/federally funded health insurance program called the Children's Health Insurance Program (CHIP) also pays to care for many low-income children who qualify.[6] For both of these programs, the state receives a match from the federal government. For Medicaid, the state receives $2 from the federal government for every dollar the state spends on health care. For CHIP (named KidsCare in Arizona), the state receives $3 for every state dollar spent.

Both Medicaid and CHIP play a significant role in funding the safety net. For example, Medicaid accounted for 50 percent of all charges by Arizona's 16 federally qualified health centers in 2010, paying for the care of more than 384,000 clients.[7] Similarly, safety-net hospitals such as St. Joseph's Hospital and Medical Center and Maricopa Integrated Health Systems rely on Medicaid to provide services for more than half of their clients.

Some of the funding for the safety net is also covered by private insurance. In some instances, this occurs indirectly through cost shifting that happens when providers pass along the costs of uncompensated care to those with insurance and their health insurance plans. Indeed, it is estimated that in Arizona, families with private health insurance pay $1,700 more each year for their health insurance due to this cost shifting.[8]

In addition, the federal government provides funding to help states and providers pay for uncompensated care through programs such as the federal disproportionate share hospital (DSH) program and grants to federally qualified health centers.

The Dish on DSH

Disproportionate Share Hospital (DSH – often pronounced as "dish") payments are disbursements made to hospitals under the Medicaid and Medicare public health insurance programs that "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs."*

The DSH program was established by Congress in the early 1980s. States were mandated to consider the needs of hospitals that serve a large portion of Medicaid and uninsured patients, recognizing that these hospitals often lost money as a result of low Medicaid reimbursement rates and high levels of uncompensated care. Hospitals with large caseloads of low-income patients frequently had low private payer caseloads and were unable to shift the cost of uncompensated care to privately insured patients.

To address this situation, states that chose to participate in the DSH program were allowed to draw down federal dollars – as long as matching funds were provided by the state. Over time, the federal government began to allow states to "count" revenue from non-state sources – including county taxes or donations – as the state contribution. Changes in law also allowed a labyrinth of intergovernmental transfers to occur, where public entities such as county hospitals or state psychiatric facilities were allowed to transfer their money to the state only to have those funds distributed to these and other public safety-net programs, allowing for the state to draw down federal matching funds in the process. In many instances, states used this mechanism to not only enhance payments to safety-net hospitals, but also provide additional revenue for state general funds.

In Arizona, DSH provides a significant source of income for many of Arizona's safety-net hospitals. In 2012, more than $9 million was received by 43 hospitals in DSH Medicaid distributions. However, a lot of DSH money has also gone to the state general fund over the year for purposes as varied as education to tax cuts. Indeed, for 2012 and 2013, Arizona's General Fund received over $147 million in DSH Federal Funds.

* Title XIX of the Social Security Act, Section 1923.

Sources: Deconstructing DSH (2003), St. Luke's Health Initiatives; Arizona JLBC 2013 Appropriations Report, AHCCCS, p. 21.

Foundations and the Safety Net

Arizona is home to more than 1,300 public and private foundations that provided more than $653 million in grants in 2008. Eight percent of foundation giving was dedicated to funding health-related efforts, amounting to approximately $52 million in spending. While these dollars are far from negligible, they are dwarfed by public expenditures for health care. For example, AHCCCS expenditures are expected to be over $8.3 billion during FY 2012 – nearly 160 times the amount that philanthropy is able to devote to healthcare spending in the state.

Source: Arizona Grantmakers Forum. (2010) Arizona Giving Report.

When funding is not available to cover the costs of care because the client is uninsured, has limited resources or the patient is ineligible for public funding, any care that is delivered is referred to as uncompensated care.

Furthermore, there has historically been an array of state and local funding streams that have supported care to the safety net, from primary care dollars that helped pay for uncompensated care at community health centers to funding for behavioral health services for the seriously mentally ill – some of whom do not qualify for Medicaid due to their household income. Such additional state and local resources play a small but important role in funding the safety net.

Beyond government funding, other monies also support the safety net. For example, some safety-net providers charge their uninsured or underinsured clients directly, especially if there is an indication that they have resources available to pay. The amount that is charged is often based on some type of sliding fee scale, especially in the case of providers such as federally-recognized community health centers, where such a sliding scale is required for those whose household income is at or below 200 percent of the federal poverty level (approximately $47,000 a year for a family of four).[9, 10] In other instances, those who are uninsured may be charged more for their care than those who have insurance, since insurers are able to negotiate deep discounts for the cost of care delivery, while the uninsured have no such bargaining power.[11]

When funding is not available to cover the costs of care because the client is uninsured, has limited resources or the patient is ineligible for public funding, any care that is delivered is referred to as uncompensated care. It is delivered either as an act of charity, where there is no expectation for compensation, or the provider charges the client for care, but the client does not pay their bill. Most uncompensated care is delivered by hospitals, where services are most costly.[12]

In addition, public or private charities, foundations and faith-based organizations also pay for the provision of care to uninsured or underinsured, either directly through nonprofit organizations, or by providing grants or funding to health providers such as free clinics.

Changes to the Safety Net

The economic downturn has taken its toll on the state, changing the healthcare safety net in a number of ways. Senate Bill 1070, high unemployment and housing foreclosures have caused many to leave the state, decreasing demand for care from some safety-net providers.[13] At the same time, the economic downturn has meant that many more Arizonans are uninsured or lack private health insurance. In addition, there have been substantial state funding cuts affecting safety-net providers and the services they deliver, often resulting in an additional loss in federal matching dollars.

Changing Demand

Overall, the need for safety-net services appears to be growing. Many Arizonans are having difficulty accessing health care. Nearly one-in-five Arizonans lack health coverage.[14] In addition, nearly 20 percent of Arizonans report delaying or not getting medical care when they need it, primarily due to the cost or lack of coverage.[15]

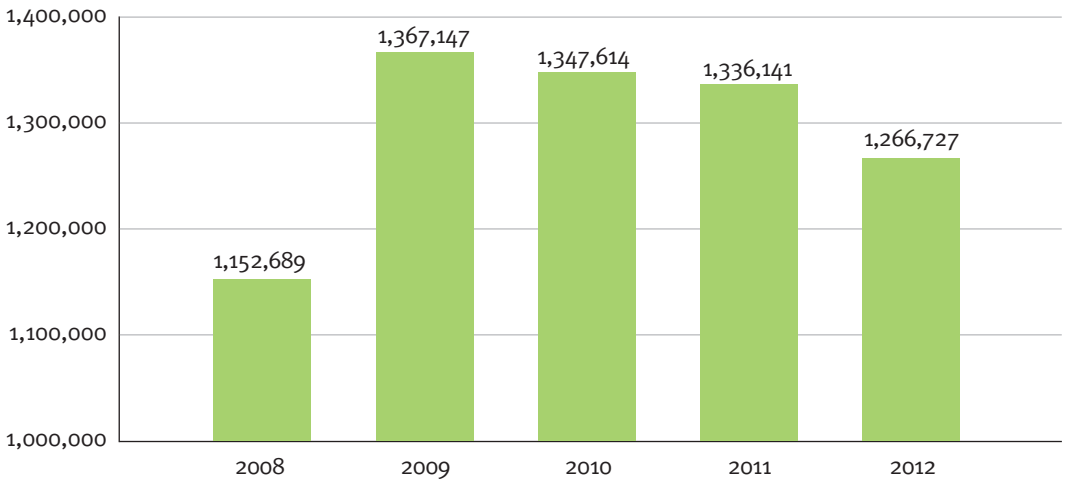
One-in-five Arizonans lack health insurance.

However, beneath those numbers, the changes in demand for safety-net services are more complex.

Many of those who are now seeking care from safety-net providers may be people who have been insured in the past – or people whose coverage is no longer adequate. From 2008 – 2010, the percentage of non-elderly Arizonans receiving coverage through an employer declined.[16] In addition, those who did have coverage (especially those working for small businesses) were increasingly likely to be covered by high-deductible health plans, and thus more exposed to out-of-pocket costs.[17] Our interviews with health providers suggest that these people – who may not have relied on safety-net providers in the past – may be seeking care through safety-net providers in increasing numbers.

Those who are now seeking care from safety-net providers may also be less likely to have any type of coverage, including AHCCCS coverage. While enrollment in AHCCCS steadily increased at the beginning of the economic downturn, state policy changes have resulted in reductions in AHCCCS coverage over the past year. Many of those who have lost coverage have significant health needs – needs that are greater than many safety-net providers such as health clinics are able to address. (See more on AHCCCS cuts in section on *State Budget Cuts* on page 9.)

AHCCCS Population 2008-2012



Source: AHCCCS Population Statistics Reports 2008-2012.

"People are forgoing their insurance premium to put food on the table.... A lot of people are now seeking (primary) care through the ED (emergency department)."

Hospital representative from Scottsdale

At the same time, some of those who have traditionally relied on the safety net may no longer be seeking care – or even living in the state. Some of the safety-net providers that we interviewed noted that there has been a change (and sometimes a decline) in their client base due to declining economic opportunities, foreclosures and the decrease in the number of undocumented immigrants living in our state. For example, the Pew Research Center estimates that 100,000 fewer undocumented immigrants lived in Arizona in 2010 than 2007.[18]

Because of these shifts, many of the safety-net providers we interviewed commented on the changing face of the uninsured. For example:

- One hospital representative said, "The uninsured that we used to care for were primarily Hispanic women. Now we are seeing Joan Smith."
- Another hospital representative we interviewed noted that they were having to provide a lot of education and assistance to those seeking health care in the community when they were discharged, since many of those who lack coverage have no idea how to access safety-net or other community-based services. Those seeking care are simply are unaccustomed to asking for help.
- A Maricopa County-based clinic that serves the uninsured noted that the majority of those seeking care from their clinics have complex health conditions. Those seeking care also increasingly have significant health problems such as a cancer diagnosis that they (as a primary care provider) simply cannot treat.

Our analysis of service delivery at a variety of Maricopa County safety-net providers demonstrates these complexities. In 2006, St. Luke's Health Initiatives looked at the number of client visits that occurred at a number of safety-net providers. We looked at data from 2001 and 2004, noting the increase in service demand.

Client Visits to Safety-Net Providers

	Number of Clients (Visits Where Noted) 2001	Number of Clients (Visits Where Noted) 2004	Number of Clients (Visits Where Noted) 2010	Number of Clients (Visits Where Noted) 2011	Projected or Actual Clients (Visits) for 2012
Clinica Adelante	17,000	28,000	26,442	27,962	40,000
Las Fuentes Health Clinic	4,000 (visits)	4,932 (visits)	CLOSED	CLOSED	N/A
Maricopa Health Care for the Homeless	5,000	6,000	8,895	8,831	8,500
Maricopa Integrated Health System Primary Care	406,000 (visits)	332,607 (visits)	322,534 (visits)	331,666 (visits)	347,356 (visits)
Mission of Mercy	12,274 (visits)	8,566 (visits)	10,825 (visits)	13,021 (visits)	14,128 (visits)
Mountain Park Health Center	25,000	46,000	46,997	49,933	52,000
Neighborhood Christian Clinic	2,328 (visits)	3,572 (visits)	7,143 (visits)	7,768 (visits)	8,200 (visits)
St. Vincent de Paul Clinic	10,000 (visits)	13,000 (visits)	13,000 (visits)	13,316 (visits)	15,000 (visits)

For this report, we examined numbers reported since 2011, finding changes in safety-net service delivery to be more uneven. However, where more recent data is available, there appears to be an uptick in demand for services, with many of the providers interviewed noting that they are turning people away due to lack of capacity.

State Budget Cuts

At the same time that the need for safety-net services appears to be on the rise, state budget cuts have been taking a toll on public health insurance and safety-net providers.

Over the last five years, there have been substantial funding cuts to our state's AHCCCS program, affecting both safety-net providers and the people they serve. Funding for the program decreased by $2.5 billion. This 21.7 percent decline in AHCCCS funding represents the largest drop in funding for a Medicaid program in the country.[19] Such budget cuts were made to address the state's large budget deficit, which was otherwise projected to increase from $150 million in FY 2010 to a forecasted $1 billion in FY 2012.[20]

Funding reductions to AHCCCS have occurred through a number of policy changes.

CHANGES IN ELIGIBILITY Arizona has made a number of policy changes affecting eligibility for Medicaid:

- **Freeze on Childless Adults –** Beginning in July 2011, a permanent enrollment freeze was enacted for adults with children who do not live in the home (referred to as the "childless adult population") whose incomes fall below the federal poverty level (approximately $11,100 per year for an individual). These childless adults were originally made eligible for AHCCCS by the passage of a voter-approved initiative (Proposition 204) in 2000.

  With the enactment of the enrollment freeze, people who renew their coverage routinely are able to maintain their coverage, but those who are temporarily unable to qualify (perhaps due to a bonus or temporary rise in income) or who do not fulfill their legal requirement to periodically renew their coverage in a timely manner lose coverage and are no longer able to re-enroll. In addition, childless adults who would otherwise be eligible for coverage who were not enrolled before the freeze (such as middle-aged men or women with grown children and recent job losses) may no longer be able to enroll in AHCCCS.

  Since the enrollment freeze was implemented in July 2011, over 141,000 Arizonans have lost coverage.[21] While efforts have been made by many community groups to encourage people to renew their coverage so they would not lose their health insurance, such efforts have had limited success for a variety of reasons, including income fluctuations among AHCCCS recipients causing them to no longer be eligible, difficulties renewing coverage and lack of understanding among many

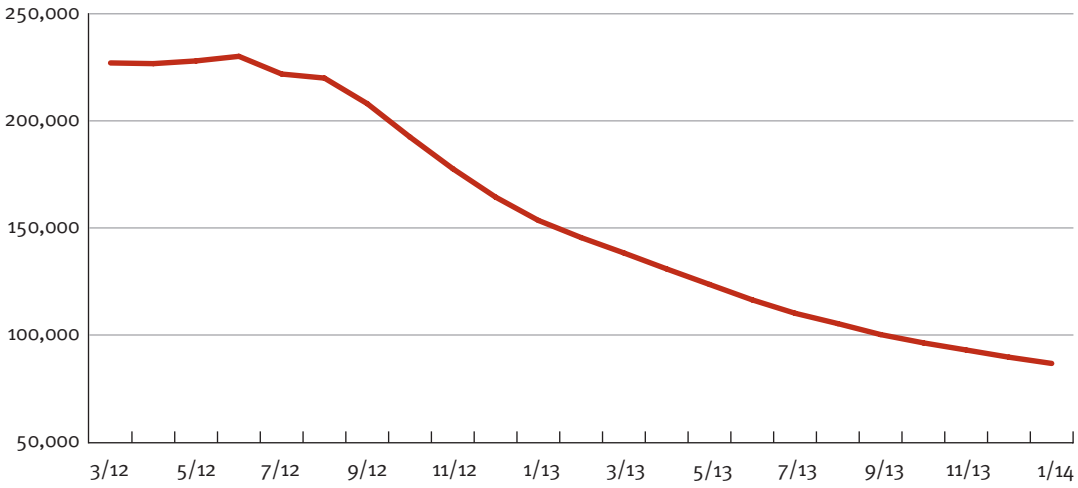
$2.5 Billion Cut from AHCCCCS

"It saddens me to believe people can be this callous."

Phoenix safety-net provider, referring to state budget cuts

recipients of the need to maintain health coverage. Many of those losing coverage have diagnoses associated with an ongoing need for costly medical services. (See "Diagnoses of Those Subject to Recent AHCCCS Coverage Changes," page12.)

Number of Childless Adults Enrolled In AHCCCS, March 2012-Projected to January 2014 (Estimate)



Source: AHCCCS. State Medicaid Advisory Committee presentation, February 1, 2013.

Funding for Arizona's Safety Net: A 149-Year History

1864

Arizona's first territorial laws (named the Howell Code) establish county-funded health care for "unemployables" without relatives capable of providing financial support.

1972

All of the states in the country, *except Arizona*, have established a Medicaid program – seven years after Congress authorized the program.

1981

Arizona counties face financial crisis due to escalating healthcare costs. An estimated 20-25 percent of county revenues are spent on indigent medical care. Governor Babbitt signs into law Arizona's Medicaid program called AHCCCS within the Department of Health Services, relieving counties of much of their healthcare burden.

1998

Arizona establishes its version of the federal State Children's Health Insurance Program called KidsCare, initially serving children under 150 percent of the federal poverty level. (Five years later, eligibility expanded to 200 percent.) Over the next 10 years, the percent of insured Arizona children increases from 74 percent to 84 percent of the state's population.

2000

Arizona voters pass Proposition 204, expanding eligibility for Medicaid up to 100 percent of the federal poverty level.

- **Elimination of Catastrophic Coverage** – Another change made in 2011 was the elimination of a program that has historically provided health coverage for Arizonans experiencing serious health problems and catastrophic healthcare costs. The state stopped taking applications for what is called its "spend down" program (part of AHCCCS) in April 2011. The program was eliminated in its entirety by October 2011.

  The state's "spend down" program has existed in one form or another since before Arizona became a state. Indeed, it existed long before Arizona began its AHCCCS program. (See "Funding for Arizona's Safety Net: A 149-Year History.") At the time the program was terminated, it provided temporary help to approximately 6,000 individuals (including approximately 1,000 children) whose incomes were too high for them to qualify for Medicaid under other eligibility categories, but whose medical bills from catastrophic illness or injury caused them to fall well below the federal poverty line. Those receiving "spend down" assistance received AHCCCS coverage for three to six months, enabling them to avoid bankruptcy and allowing health providers to avoid uncompensated care.[22]

  While the number of Arizonans receiving "spend down" coverage was limited, the medical costs for this group were enormous. In FY 2010, AHCCCS spending for those qualifying for the state "spend down" program who received care at Arizona hospitals was over $148 million.[23] Given the fact that those qualifying for "spend down" – by definition – had enormous, unpayable medical expenses, it is reasonable to assume that most of the costs for those who used to qualify for the "spend down" program are now uncompensated.

2005

AHCCCS and KidsCare enrollment surpasses 1 million Arizonans. The percent of uninsured Arizonans continues to grow as employer-sponsored insurance continues to decline.

2009

AHCCCS enrollment grows by one-third from February 2007 to December 2009 as the economic downturn deepens, adding an additional 342,500 enrollees.

2010

AHCCCS places a freeze on the state's KidsCare program. One year later, more than 33,000 children had lost coverage and 129,000 families were on the wait list.

2011

Governor Jan Brewer proposes and the Arizona Legislature approves policy changes affecting AHCCCS eligibility, including the elimination of health coverage for nearly 6,000 people facing catastrophic illnesses (the "spend down" population) and a permanent freeze on enrollment for the nearly 250,000 Arizonans who qualified for coverage under Proposition 204 beginning in July. Most of the cuts and changes to eligibility were approved by the federal government. Court challenges to the cuts were not successful. By the end of 2011, approximately 66,000 Arizonans had lost this coverage, with an additional 74,000 losing coverage by the end of 2012.

Sources: AHCCCS overview October 1, 2004 through September 30, 2005. Fiscal year 2012 budget request. September 1, 2010 letter from Thomas J. Betlach to Janice K. Brewer; KidCare eligibility office activity, AHCCCS. Retrieved from http://www.azahcccs.gov/reporting/Downloads/KidsCareEnrollment/2011/Dec/KidsCareEligibilityOfficeActivity.pdf; AHCCCS Population by category, AHCCCS. Retrieved from http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2012/January/AHCCCS_Population_by_Category.pdf and http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2012/June/AHCCCS_Population_by_Category.pdf. Percent of children 18 and younger without health insurance, The Annie E. Casey Foundation, KidsCount Data Center.

Diagnoses of Those Subject to Recent AHCCCS Coverage Changes

During the 2011-2012 legislative session, AHCCCS provided policy makers with information describing the treatment needs of those who were covered under the "childless adult" and "spend down" coverage categories – both of which were affected by policy changes enacted by the FY 2012 legislative session. Many of those affected had one or more serious health conditions. As of January 1, 2010, the 205,012 who were covered under these two insurance categories had the following diagnoses:

DISEASE CATEGORY[1] MEDICAID COSTS	PATIENT NUMBERS	EXAMPLES
Heart and Circulatory $147,430,181	53,087	Heart attacks, heart dysrhythmia, high blood pressure, stroke
Musculoskeletal System $111,944,538	89,787	Joints, back, spine disorders including osteoarthritis and rheumatoid arthritis
Digestive System Diseases $112,484,434	52,921	Acute appendicitis, gall bladder, pancreas, and liver diseases
Respiratory Diseases $85,273,598	73,047	Asthma, emphysema, pneumonia, respiratory infections
Cancers $76,430,262	18,766	Breast, colon, lung, prostate, cervical, and other cancers
Genitourinary System Issues $47,359,369	50,894	Kidney stones, urethra and urinary tract disorders, kidney infections, endometriosis
Diabetes and Kidney Disease $49,029,611	28,981	Acute and chronic kidney failure and related costs
Nervous System and Senses $44,831,488	55,483	Cerebral palsy, epilepsy, seizures, Alzheimer's disease
Infectious and Parasitic Disease $49,331,792	28,522	Septicemia (infection in the blood), hepatitis, HIV, pulmonary tuberculosis, coccidioidomycosis
Skin and Subcutaneous Tissue $33,661,975	35,105	Cellulitis and abscess, chronic skin ulcers, psoriasis
Pregnancy/Newborn Related $14,214,315	6,887	Normal pregnancy and newborn care and complications
Other Physical Disorders $218,445,682	181,812	Physical disorders not classified above such as examination related to preventive health and treatment for conditions such as respiratory symptoms or abdominal symptoms
Behavioral Health $211,208,850	73,026	Cognitive disability, schizophrenic disorders, depression, mood disorders

1 For dates of service between 1/1/09-12/31/09.

Source: Profile of AHCCCS waiver population (2011, March 15). AHCCCS.

- **Freeze on KidsCare** – Beginning January 1, 2010, AHCCCS implemented an enrollment freeze on KidsCare, Arizona's version of the state/federal Children's Health Insurance Program (CHIP).

  Similar to the enrollment freeze on childless adults, this policy change led to a dramatic decline in children covered under KidsCare. Enrollment dropped from nearly 46,000 in January 2010 to under 11,000 in May 2012 – a drop of more than 76 percent.[24] As of February 2012, there were 136,843 children on the waiting list.[25] Recently, more than 19,000 children have been added again to KidsCare through a temporary program (ending in January 2014) funded by health providers and local governments. (See Safety-Net Care Pool, page 21.) However, as a result of this ongoing enrollment freeze, 15,000 fewer children are enrolled in KidsCare than three years ago.[26]

PROVIDER REDUCTIONS Another way in which Arizona cut its AHCCCS program is through reductions in how much providers are paid. Beginning in 2009, the state reduced the amount that AHCCCS healthcare providers are paid, resulting in health providers receiving $367 million less in 2010 than they did in 2009, and $413 million less in 2011 than they did in 2010.[27]

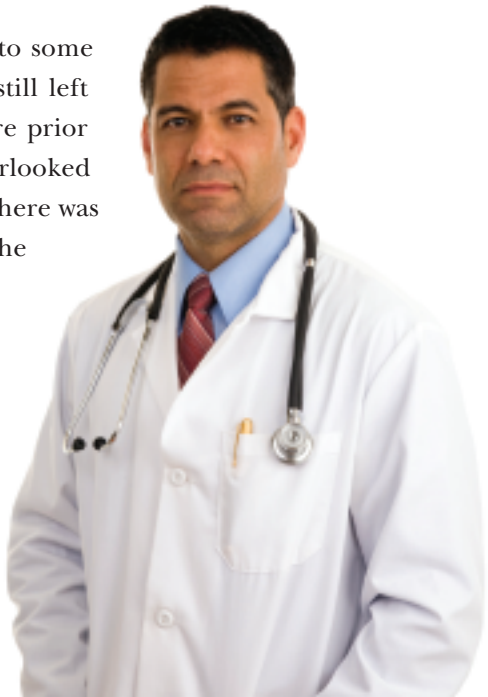
As of February 2012, there were 136,843 children on the KidsCare waiting list.

Provider Rate Reductions

PROVIDER GROUPS	PRIOR TO 4/1/2011	4/1/2011	10/1/2011
Hospitals	Rate freeze	5% rate cut	5% rate cut
Physicians	5% rate cut	5% rate cut	5% rate cut
Ambulance (Emergency Transport)	5% rate cut	5% rate cut	5% rate cut
Behavioral Health Services	5% rate cut	5% rate cut	5% rate cut
Nursing Facilities	Rate freeze	Rate freeze	5% rate cut

Source: Governor's Office of Strategic Planning and Budgeting. The executive budget recommendation, FY 2012 through FY 2014.

During the FY 2013 legislative session, rates to some providers increased. However, the increase still left most providers being paid less than they were prior to 2011. In addition, some providers were overlooked completely during the session. For example, there was no increase in rates paid to hospitals during the FY 2013 legislative session.



Currently, two federal dollars in state revenue are lost for every dollar cut from AHCCCS. Three federal dollars are lost for every dollar cut from KidsCare. Collectively, from 2008 through 2011, the state lost more than $1 billion in federal matching funds due to cuts in Medicaid and CHIP.

Source: azahcccs.gov/reporting/downloads/budget proposals/FY2011/Cumulative Budget Reduction Savings Summary.

BENEFIT CHANGES Another way that the state has cut funding for AHCCCS was by eliminating some types of services from being paid for by Medicaid. For example, services such as adult emergency dental care and podiatry are no longer covered under Medicaid. Such changes add up to $39 million in benefit reductions for 2011.[28] These costs – if they are not paid for by the individual or some other insurer – add to uncompensated care.

Loss of Federal Dollars

Any time that state dollars are cut from Medicaid or CHIP, there is a loss of significant federal matching dollars. Thus, state budget cuts are typically amplified two or threefold when state lawmakers make budget cuts. The elimination of services for the childless adult population was estimated to be a loss of federal funds of $1.1 billion.[29] The estimated loss of federal funds due to reductions in the CHIP (KidsCare) program is estimated at $51 million from 2010 through 2012.[30]

Loss of Other Safety-Net Dollars

In addition to reductions in Medicaid and CHIP, the state has cut other funding for safety-net providers. For example, the state eliminated more than $10 million in tobacco tax funding for community health centers between 2008 and 2011 – funding that supported the delivery of primary care to those who are uninsured but do not qualify for public benefits.[31] In 2011, Arizona was one of 17 states nationally that did not provide state dollars (other than dollars dedicated for state matching funds for Medicaid) to community health centers.[32]

Widening Holes *in the Safety Net*

Growing demand for services and cuts to eligibility, covered services and provider rates mean that the safety net is feeling increased financial strain.

In many ways, the impact of these changes is just beginning. However, we are beginning to see the effect on the healthcare system, its providers and Arizona citizens in a number of ways.

Uncompensated Care is Surging

Budget cuts are leading to significant increases in uncompensated care for many healthcare providers. This increase in uncompensated care has been most pronounced in the last 19 months after the most recent round of Medicaid coverage cuts were implemented. The freeze on coverage for the childless adult population the elimination of coverage for the "spend down" population, and the continual decline in KidsCare coverage has led to a surge in uncompensated care.

For example, the Arizona Hospital and Healthcare Association reports that while uncompensated care remained steady between 2008 and the second quarter of 2011, it increased from 3.8 percent to 4.7 percent of billed charges in the third quarter of 2011, and then spiked to 6 percent in October 2011 – a 71 percent increase in four months. By November 2011, uncompensated care flattened out to 5.7 percent, with 90 percent of hospitals reporting an increase in uncompensated care.[33]

For 2012, the Arizona Hospital and Healthcare Association reports that Arizona hospitals were on pace to provide $665 million in uncompensated care (billed charges) for the year.[34] (Final numbers are not yet available.) In September 2012, uncompensated care for hospitals was the highest that had ever been reported – 7.4 percent of billed charges. This represents over twice the level of uncompensated care costs that hospitals typically experience.[35]

Charity Write-offs & Bad Debt Expense (Millions) St. Joseph's Hospital and Medical Center, FY 2009-2012

	2009	2010	2011	2012
Arizona Bad Debt	$24,563	$20,993	$21,009	$33,806
Arizona Charity Care	$18,194	$17,809	$15,521	$31,345
Total	$42,757	$38,802	$36,530	$65,151

Source: Dignity Health Arizona.

Providers that serve a large percentage of Medicaid clients are most hard hit. For example, St. Joseph's Hospital and Medical Center (which serves the largest number of Medicaid clients statewide) reports a 55 percent increase in charity write-offs and bad debt expenses since 2009.[36] Similarly, Banner Good Samaritan has seen its charity care increase from $39.5 million in 2009 to a projected $90.6 million in 2012.[37]

The spike in uncompensated care is not confined to hospitals operating in the inner city. Indeed, the Arizona Hospital and Healthcare Association reports that 85 percent of the hospitals reporting data noted an increase in uncompensated care in 2012 compared to 2011.[38]

In September 2012, uncompensated care for hospitals was the highest that had ever been reported – 7.4 percent of billed charges.

It appears that the increase in uncompensated care is taking a hit on hospitals' operating margins. Of the 85 hospitals reporting data to Arizona Hospital and Healthcare Association, 42 percent reported an operating loss in November 2012. The overall operating margin for hospitals in Arizona was 2.1 percent.[39]

Game of Hot Potato

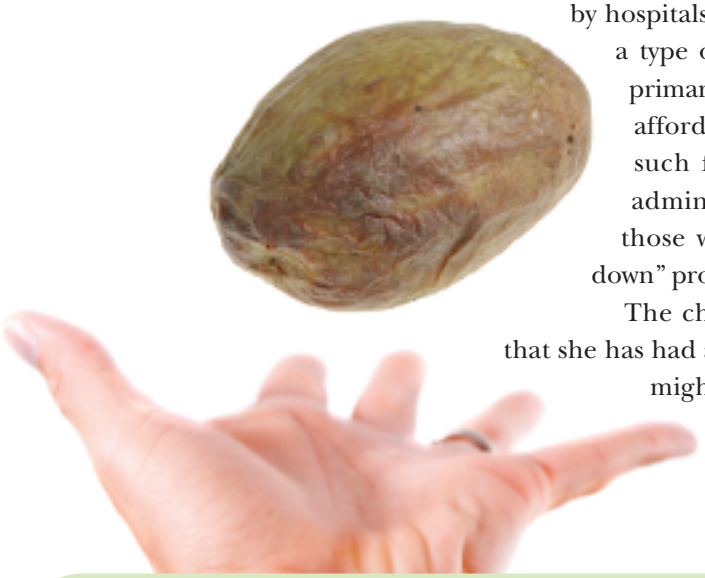
Another impact of cuts to public health coverage may be an increase in cost shifting among providers in an attempt to control their exposure to uncompensated care.

Several of those interviewed suggested that some hospitals are apparently making it a practice to transfer uninsured clients to other hospitals for "bogus" reasons, such as needing a type or level of care only available at another hospital when such care was not really needed.

Shifting Care Delivery

Another way that health providers such as hospitals and health clinics seem to be responding to the growing number of uninsured is by referring their clients to charity medical clinics.

According to the administrator of one large charity care clinic that we interviewed, her charity clinic is seeing more and more serious, complex medical cases referred to them by hospitals and community health centers. Those referred either need a type of care that the community health centers (which focus on primary care) are unable to provide, or those referred are unable to afford the fees charged by community health centers, even though such fees are charged on a sliding-fee-scale. According to the administrator we interviewed, many of those they are seeing are those who would have qualified in the past for the state's "spend down" program – those who are realizing catastrophic healthcare costs. The charity health clinic administrator that we interviewed noted that she has had a lot of sleepless nights recently, worrying about liability that might be borne by her clinic as they serve individuals who require a higher level of care than they are qualified or prepared to deliver. However, she said she knew that if they did



Do Hospitals Have to Care for Anyone Who Needs Care?

Since 1986, federal law (the Emergency Medical Treatment and Active Labor Act or EMTALA) has required nearly all hospitals to provide public access to emergency services regardless of ability to pay. For Medicare-participating hospitals, there are specific obligations to perform medical screening examinations and treatment of these emergency medical conditions.

It is important to understand that many life-threatening conditions are not considered emergencies under federal law and rules. Federal law defines an emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate treatment could be expected to result in 1) placing the health of the individual in serious jeopardy; 2) serious impairment of bodily functions; 3) serious dysfunction of any bodily organ; or 4) (in the case of a pregnant woman with contractions) pose a threat to the health and safety of the woman or unborn child. Thus, hospitals may not always be required to treat someone with cancer, for example, even though the condition may ultimately be life-threatening since there may not be an immediate threat to life or impairment of bodily functions or organs.

In other words, just because a condition is serious and life-threatening does not always mean it is an emergency.

Source: Title 42 US Code, Chapter 7, Subchapter XVIII, Part E, §1395dd.

not care for these individuals, nobody would, and these individuals would – in some cases – realize serious harm. That said, she also noted that her clinic had to turn some people away since they simply did not have enough resources to serve all of those who needed to be served.

Such charity care clinics are also responding to the increased demand for care by imposing more cost sharing on their clients. For example, a free clinic in Phoenix which normally does not charge for services has been more proactive in asking for patient donations – typically $10.[40]

Making Hard Choices on Care

With limited charity dollars available and increased exposure to patients lacking resources to pay for care, hospitals and other providers are sometimes giving patients less-than-optimal care options. For example, in a hospital breast cancer clinic we observed, we saw doctors choosing to prescribe an uninsured breast cancer patient in remission a less effective drug to ward off the prospect of reoccurrence due to the drug's lower cost. While these doctors – who treat cancer patients daily and confront difficult decisions routinely – were clearly uncomfortable and troubled with this decision, they appeared to be trying to preserve limited charity dollars to ensure that they could care for additional people needing care.

"These are horrible, ethical decisions that we have to make."

Representative from a Phoenix metropolitan hospital

In another instance, we witnessed a provider choosing whether to use scarce charity dollars to serve a patient at all. The patient – who had cancer – had limited prospect for being cured. Types of treatment such as chemotherapy were considered to help control her symptoms and improve her quality of life. In the end, the provider chose not to provide such treatment since charity care dollars were limited. The provider observed that serving this person might mean someone else with a more favorable prognosis might not be treated.

Rationing of care is certainly not new to our healthcare system. However, as the resources grow tighter and the demand grows larger for limited charity care dollars, these rationing decisions appear to be occurring more frequently. Sometimes, these decisions may help preserve limited resources and direct care to those who may most benefit. However, rationing decisions may also mean that decisions are made to treat the most immediate need and forgo preventive treatment. What is clear is that the ethical and psychological strains on many safety-net providers are growing.

Changing Charity Care Policies

Another result of recent budget cuts is that some hospitals are re-examining and changing their charity care policies. Two of the people we interviewed noted that when resources get tight, it is critical to develop criteria for who will or will not be given charity care so that people are treated equitably. These changes may also be resulting in tighter restrictions on charity care, since an increase in demand may mean that the standards for providing charity care have to grow tighter because there are limits in the amount of charity care that can be delivered. Said one hospital insider, "You have to go hard core or open up the door."

"Is anybody listening? Does anybody care?"

Phoenix safety-net provider

In a charity care meeting we observed at one hospital, we saw a hospital financial officer (CFO) asking hard and tough questions about available family resources before charity care would be considered. For example, for one patient, he asked whether the patient had any relatives who could pay for the cost of care. When staff answered that the patient only had a father who lived on social security, the CFO asked whether the father owned a home and could sell it to pay for the expensive treatment that was needed for his daughter who had cancer.

Depending on your perspective, the financial officer's questions could be viewed as a prudent and appropriate attempt for a family to take responsibility for care. For others,

this example can be viewed as a sad commentary on the desperate situation which families are facing.

What is clear from our interviews is that as more people become uninsured, families and individuals are being asked to take responsibility for payment – at tremendous personal and financial costs.

Erecting Barriers

In one of the charity care meetings we observed at a hospital, we saw a clinic doctor complain about what he was supposed to do with a patient he had seen who does not have insurance. A hospital administrator counseled the doctor to do what other doctors typically do – charge a high amount up front if the client lacks coverage. That way the uninsured person won't get in the door in the first place.

Another hospital administrator that we talked to noted that there is a sentiment at times that "if you touch a patient, you own them," meaning that you are obligated to treat them. Therefore, it is not surprising that more screening may be occurring before clients are ever seen these days by healthcare providers. This makes it difficult to assess how well people are accessing care, since some folks may not even be getting their foot in the door.

Community health centers also seem to be changing how they do business to address the growing number of uninsured. According to a community health association representative whom we talked to, some community health centers have stopped taking any more uninsured clients. They have received federal permission to do so, noting that HRSA (the federal agency charged with overseeing federal funding for federally funded clinics) has recognized that the sustainability of clinics may be otherwise jeopardized if too many uninsured clients seek care.

Silently Slipping through the Holes

Why were there not stories about this nightly in the news?

Why weren't hospitals pushing to have these stories covered in the press?

Why wasn't the press covering such stories more frequently?

One of the things we found quite puzzling as we prepared this report was why – when some hospitals and other providers are experiencing financial hardship and witnessing human calamity at an escalating rate – were there not stories about this nightly in the news? Why weren't hospitals pushing to have these stories covered in the press? Why wasn't the press covering such stories more frequently?

We received multiple answers to this question from industry insiders as well as some journalists to whom we spoke.

The journalists said that they were sometimes told by their bosses that Arizonans are experiencing "compassion fatigue." With so many bad stories occurring in the news for so long, the public had little appetite for more of the same.

A hospital insider whom we spoke to noted that hospitals don't like to talk about hits to their profit margin, because the public does not like to think about hospitals making profits in the first place. They also worry that discussion of increasing demands on charity care might drive even higher demand for such services. Finally, they fear that discussions about narrowing profit margins or impending layoffs might drive away patients, when they need to be expanding their business to commercially insured patients to stay in business.

What this means is that there is this disturbing, hidden reality that is playing out right now in our state's healthcare system. People with serious health conditions are being told that there are few options for them to receive care, or they are being

given choices that may result in substandard care. These limited options may result in people literally dying or experiencing a poorer quality of life. At the same time, providers are watching this happen, some of them feeling helpless to assist the very people they were trained to serve.

Laying Off Staff, Closing Their Doors

Hospitals and other providers generally seem to be responding to budget cuts by reducing their exposure to the uninsured, reducing their profits or shifting their costs onto those who are insured. However, there are instances where cuts have resulted in layoffs or providers closing their doors. For example, the Arizona Council of Human Services Providers (whose members include many of the state's behavioral health providers) reports that its members have laid off more than 1,100 staff as a result of budget cuts.[41]

Hospitals have also not been immune to layoffs. For example, hospitals reporting layoffs include:

- Maricopa Integrated Health Systems – 145 positions eliminated, 87 people affected[42]
- Carondelet Health Network – 225 positions were eliminated[43]
- Yuma Regional Medical Center – 135 positions[44]
- Dignity Health eliminated more than 500 positions[45]
- Havasu Regional Medical Center eliminated seven employees and 33 positions.[46]

Some providers have also closed their doors or filed for bankruptcy. For example:

- Southeast Arizona Medical Center in Douglas filed for reorganization bankruptcy in February 2013.[47]
- Holy Cross Nursing Home in Nogales closed in February 2011. While Medicaid reimbursements were not the sole reason for the facility closing, it was reported to be a factor.[48]
- Tucson-Based Corondelet Health Network closed an 11-bed hospice in Tucson and a 31-bed long-term care facility in Nogales. This was the only long-term care facility serving Nogales.[49]
- A rural substance-abuse transitional facility closed in Page as a result of the behavioral health cuts.[50]

Charity health clinics have also been hard-hit by both the increased demand for care and the economic downturn. For example, the Wellcare Foundation, a non-profit organization that operated five Phoenix-area clinics serving single working mothers ineligible for state assistance, closed its doors in June 2012.[51]

City of Phoenix Initiative

The City of Phoenix's recent effort to adopt a provider assessment on hospitals is one example of how localities are using the safety-net care pool to address uncompensated care in the short term.

The Phoenix City Council adopted a 6 percent hospital assessment on net patient revenue to be used as a state match under provisions of the Safety Net Care Pool. By doing so, they hope to draw down federal funds to make special payments back to Phoenix hospitals to offset uncompensated care costs. The assessment would be matched at about 2-to-1 with federal funds, and Phoenix estimates that the entire program would provide about $400 million to these hospitals for five quarters until the tax expires on December 31, 2013. The initiative is currently awaiting federal approval.

Source: Arizona Office of the Governor.

Patches to the Safety Net

Actions (to date) have prevented more dire consequences, but are – in essence – short-term solutions to an unraveling safety net.

Healthcare providers and advocates have been reacting to state budget cuts in a number of ways. In many instances, their efforts have not been successful. In other instances, their actions have prevented more dire consequences, but are – in essence – short-term solutions to an unraveling safety net.

Filing Lawsuits

On May 23, 2011, the Arizona Center for Law in the Public Interest and the William E. Morris Institute for Justice filed a lawsuit against the state, claiming that the Governor and legislature's decision to implement a Medicaid enrollment freeze on the childless adult population was illegal since eligibility for coverage was established and protected by a voter-passed initiative (Proposition 204) approved by voters in 2000.[52] In December 2011, the Arizona Court of Appeals rejected the plaintiffs' claim.[53]

In late 2011, the Arizona Hospital and Healthcare Association filed a lawsuit in U.S. District Court in response to several years of provider rate freezes and provider rate cuts. The suit claimed that provider rates were "so low that they violated the mandate of federal law that Medicaid rates be consistent with quality and assure that Medicaid beneficiaries have equal access to services." The lawsuit sought permanent injunctive relief barring the cuts, and a declaration that the rate cuts were invalid. It also claimed that hospitals were being reimbursed at roughly 70 percent of the costs they incurred treating AHCCCS patients.[54]

The lawsuit was ultimately unsuccessful, and it created schisms in the healthcare community. As of March 2012, three of the state's largest hospital systems – Banner Health, Abrazo Health Care and Dignity Health – pulled out of the Arizona Hospital and Healthcare Association, an industry trade association that formerly represented 95 percent of the hospitals in Arizona. Scottsdale Healthcare has since followed suit. As a result, a significant healthcare advocate has been compromised in their ability to advocate on behalf of the safety net.[55]

High-Risk Insurance Pool

Many hospitals and other safety-net providers have connected patients needing treatment to a temporary federal insurance program that helps patients pay for treatment and providers avoid uncompensated care.

The Pre-existing Condition Insurance Program (PCIP) provides insurance coverage to those who have been uninsured for six months or longer and who have a pre-existing health condition. Individuals who meet these requirements pay monthly premiums and co-pays for coverage based on their age. While the cost for the premiums alone can be more than $4,100 annually (making it unaffordable to those with very low incomes), the coverage nonetheless provides a lifeline to the uninsured who have significant health needs.[56]

Currently, nearly 4,000[57] Arizonans are taking advantage of this temporary insurance program. However, the federal government recently announced that the program will be accepting no new applicants, and coverage for existing recipients is scheduled to end in January 2014. The program – which is part of the Affordable Care Act (ACA)[58] – is scheduled to end, since other provisions in the ACA (such as the prohibition from using health

status in determining insurance rates and the opportunity for states to increase Medicaid eligibility) allow for improved access to care beginning in 2014.

Safety-Net Care Pool

In 2011, the Arizona Legislature passed a law (SB1357) creating the Safety-Net Care Pool – an opportunity for political subdivisions to help defray the costs of uncompensated care provided to Medicaid recipients and the uninsured. The local dollars contributed are matched by the federal government. To date, more than $150 million has been provided to safety-net hospitals through such efforts, and another $13 million has been paid in emergency department funding.[59] Additional hospitals (in collaboration with the City of Phoenix) are currently working towards securing such a funding arrangement for Phoenix-area hospitals.[60] However, the arrangement needs the approval of the federal Centers for Medicare and Medicaid Services.

All such Safety-Net Care Pool funding arrangements will end as of January 2014, when the state will no longer be able to draw down federal matching dollars for such efforts. The program's temporary nature is due to the fact that the federal government contemplates states being able to provide care for low-income individuals through Medicaid beginning in 2014, as allowed under the Affordable Care Act.

Cutting Costs, Focusing on Quality

In response to budget cuts, healthcare providers are also taking advantage of opportunities included in the federal healthcare reform law to change the way that they do business to better control their costs.

Realizing that they are being hit from all sides to cut costs, some providers are building and strengthening networks to ensure that primary care is delivered in community-based settings rather than the emergency room. Such efforts are aimed at minimizing their financial exposure to uncompensated care and serving Medicaid clients (from whom they receive less cost reimbursement than privately insured patients) more cost-effectively. The efforts are also aimed at responding to some of the new provisions contained in the health reform law that encourage the provision of community-based services, such as the new penalty that hospitals began experiencing late last year when patients with specific health conditions are inappropriately readmitted to the hospital within 30 days of hospital release.

For example:

> *One large suburban hospital system is strengthening its network of community-based providers, leveraging federal dollars in the process. Over the past 15 years, the hospital has established a network of four community-based clinics using dollars the federal law requires it to spend for the benefit of the broader community. Since the budget cuts and passage of healthcare reform, it transitioned these clinics to private not-for-profits[61] and the clinics have applied to be deemed as federally recognized health clinics (federally qualified health centers look-alike status). This designation will allow the clinics to draw down additional federal dollars, blunting some of the cost of serving the uninsured. In addition, these primary care clinics are connecting with and expanding the number of school-based clinics in the area, further allowing the hospital system to serve people in the community and leverage federal dollars.*

Some providers are building and strengthening networks to ensure that primary care is delivered in community-based settings rather than the emergency room.

Possibilities *and Peril* Ahead

By allowing more Arizonans to be covered by Medicaid in 2014, state policy could once again reflect the will of the voters and allow more than 290,000 low-income Arizonans access to health care.

The safety net has undergone many tribulations and changes in recent years. Looking forward, the future contains both opportunities and challenges.

Leveraging Medicaid

One issue that will have tremendous consequences for the safety net moving forward is whether the state chooses to change eligibility for Medicaid so that more low-income Arizonans can be insured.

Beginning in January 2014, the Affordable Care Act allows a state such as Arizona to receive an enhanced federal match if it expands the eligibility of its Medicaid program, allowing all qualified Arizonans with household incomes of up to 133 percent of the federal poverty level – approximately $31,000 per year for a family of four – to qualify for coverage.[62, 63] Instead of paying approximately 66 cents on every dollar for coverage, the federal government will pay approximately 90 cents of every dollar, with the state paying the remainder.[64] If a state such as Arizona expands eligibility beginning in 2014, the federal government will pay the entire cost of coverage for those who are newly eligible for a period of three years.

When the Affordable Care Act was passed into law, it was believed that all states would expand their Medicaid programs in 2014. If not, they would lose ALL federal matching dollars for Medicaid – a poison pill that most thought few states would swallow. However, when the Supreme Court rendered its decision on the ACA in June 2012, it gave states far more flexibility to decide whether or not to expand the program. The Court said that states could decide whether or not to expand coverage for new programs, essentially giving state discretion on whether or not they want to expand eligibility for adults up to 133 percent of the federal poverty level.[65]

Governor Jan Brewer recently surprised many by recommending that such coverage restoration and expansion occur. If Arizona were to increase eligibility for AHCCCS to 133 percent of the federal poverty level, more than 290,000 low income Arizonans would likely benefit.[66] By taking advantage of the enhanced Medicaid matching dollars from the federal government, the state could restore coverage to the 141,000 adults who have recently lost coverage due to the enrollment freeze.[67] In doing so, state policy would once again reflect the will of the voters who passed Proposition 204 more than a decade ago, promising health coverage for Arizonans living in poverty.[68]

Safety-net providers would benefit tremendously by allowing more Arizonans to be eligible for AHCCCS. For example, the expansion of Medicaid would likely allow many more community health center patients to be insured. Nationally, it is estimated that the percentage of Medicaid patients served by health centers will rise from 38.5 percent in 2010 to 43.9 percent in 2019 if Medicaid eligibility changes to 133 of the federal poverty level.[69]

"The web of our life
is of a mingled yarn,
good and ill together."

William Shakespeare

Beyond restoring and expanding access to health insurance, covering more Arizonans through Medicaid may result in lower mortality and better health for many Arizonans. In a widely cited study by the *New England Journal of Medicine* published in September 2011, researchers found that Medicaid expansions are associated with a significant reduction in adjusted all-cause mortality. These reductions were greatest among older adults, nonwhites and residents of poorer counties, often living in rural areas. Covering more people under Medicaid also resulted in decreased rates of delayed care and better self-reported health.[70]

As noted in earlier sections of this report, many of the efforts to address recent cuts to the safety net are short-term in nature. The efforts and opportunities were seen by many as a "bridge" to 2014 since the Affordable Care Act assumed that Medicaid would be expanded to 133 percent of the federal poverty level at that time. However, the Supreme Court's decision on the ACA in June 2012 gave states more flexibility in deciding whether or not they want to expand coverage. As a result, the short-term efforts may be seen as a bridge to nowhere if Medicaid eligibility is not afforded to more Arizonans in 2014.

Short-term efforts may be seen as a bridge to nowhere if Medicaid eligibility is not afforded to more Arizonans in 2014.

The Health Insurance Exchange

Beginning in 2014, many more Arizonans will also have access to more affordable health coverage through what is called a health insurance exchange. The exchange is a virtual, online marketplace where individuals and small businesses can shop for and compare private health insurance options. For people living in households with incomes between 100 and 400 percent of the federal poverty level, a federal subsidy will help defray the cost of such coverage.

It is estimated that more than 1.3 million Arizonans may eventually receive their coverage through the exchange.[71] Such an increase in coverage should reduce the number of uninsured receiving care at safety-net providers. For example, it is estimated that 9.2 percent of health center patients nationally will be covered by exchange plans by 2019.[72]

That said, the promise that a health insurance exchange holds for safety-net providers and the people they serve is far from reality at this point. The Governor recently announced that Arizona will be deferring to the federal government to run its health insurance exchange, and plans for a federally-run health insurance exchange are still vague. Critical elements for exchange success such as community outreach and assistance have not yet been planned in our state – let alone implemented. With open enrollment for the exchange targeted for October 2013, it appears that the state has a long way to go before the potential of an exchange to expand access to care is fully realized.

In addition, the health insurance exchange will not be a source of affordable health coverage for low-income individuals – those whose incomes fall below 100 percent of the federal poverty level. Federal subsidies will not be available to this group, since the Affordable Care Act, as it was written, envisioned this group receiving coverage through Medicaid. As noted earlier, this premise is now in question since the Supreme Court ruling on the ACA gave states more discretion on whether or not they wish to increase eligibility.

The health insurance exchange will not be a source of affordable health coverage for low-income individuals – those whose incomes fall below 100 percent of the federal poverty level ($11,170 a year for an individual).

Changing Demand?

If more Arizonans gain health insurance coverage through Medicaid and/or the health insurance exchange, it is easy to assume that some of those who currently seek care through safety-net providers might change where they access care. Low-income people with health insurance might seek care through a private doctor's office rather than a community clinic, for example.

While increased access to health coverage may result in a drop in demand over the long term, the experience of Massachusetts in enacting major coverage expansions suggests that demand for safety-net services are likely to increase – at least in the short run.

A study of Massachusetts's safety-net system showed rising volume after the state's health reform. The number of patients receiving care from community health centers jumped 31 percent from 2005 to 2009, while safety-net hospitals experienced a 9.2 percent increase in nonemergency ambulatory care visits from 2006 to 2009, according to researchers from George Washington University and the University of Minnesota.[73] Such an increase in demand for services may be due to people seeking care that they delayed when they were uninsured.

Demand for safety-net services are likely to increase – at least in the short run.

Disproportionate Share Payments

While the Affordable Care Act may result in more Arizonans having access to health coverage and more clients with coverage seeking care from safety-net providers, the federal law's overall impact on safety-net providers is murky moving forward.

One area of concern is the reduction in federal disproportionate share (DSH) payments beginning in 2014. The federal health reform law is premised on the idea that since more people will have health insurance in the future, fewer federal dollars are needed to compensate hospitals for providing care to the uninsured. Indeed, the ACA decreases Medicaid's disproportionate share hospital program by $18 billion over a seven-year period beginning in 2014.[74]

For several reasons, it is unclear that gains in health coverage will cover reductions in DSH payments for Arizona safety-net hospitals. First, it is not known how many additional people will be covered by Medicaid since legislative decisions related to eligibility have not yet been made. Second, it is possible that a greater proportion of uninsured will remain without coverage in Arizona compared to other states since Arizona has a relatively high number of immigrants (documented and undocumented) who will not typically qualify for Medicaid or health insurance exchange subsidies.[75]

It is also not known how cuts to DSH will be implemented in light of the Supreme Court's decision on the Affordable Care Act in June 2012. Since the Court ruled that Medicaid expansions are discretionary for states, some have argued that the federal government's methodology for implementing DSH cuts might take into consideration varying levels of Medicaid eligibility among states.[76] However, there have also been several reports suggesting that some Centers for Medicare and Medicaid Services (CMS) officials may not want to "reward" states for refusing to take up expansion.[77]

Health Reform's Quality and Cost Provisions

As noted earlier, many safety-net providers are taking advantage of provisions in the Affordable Care Act to help reduce costs while simultaneously improving quality.

Under the Affordable Care Act, there are opportunities to change how hospitals, community health centers and other providers are paid. If providers are able to achieve cost savings while simultaneously improving quality, they can keep part of the savings realized, thus incentivizing their efforts to bend the cost curve and improve health outcomes.

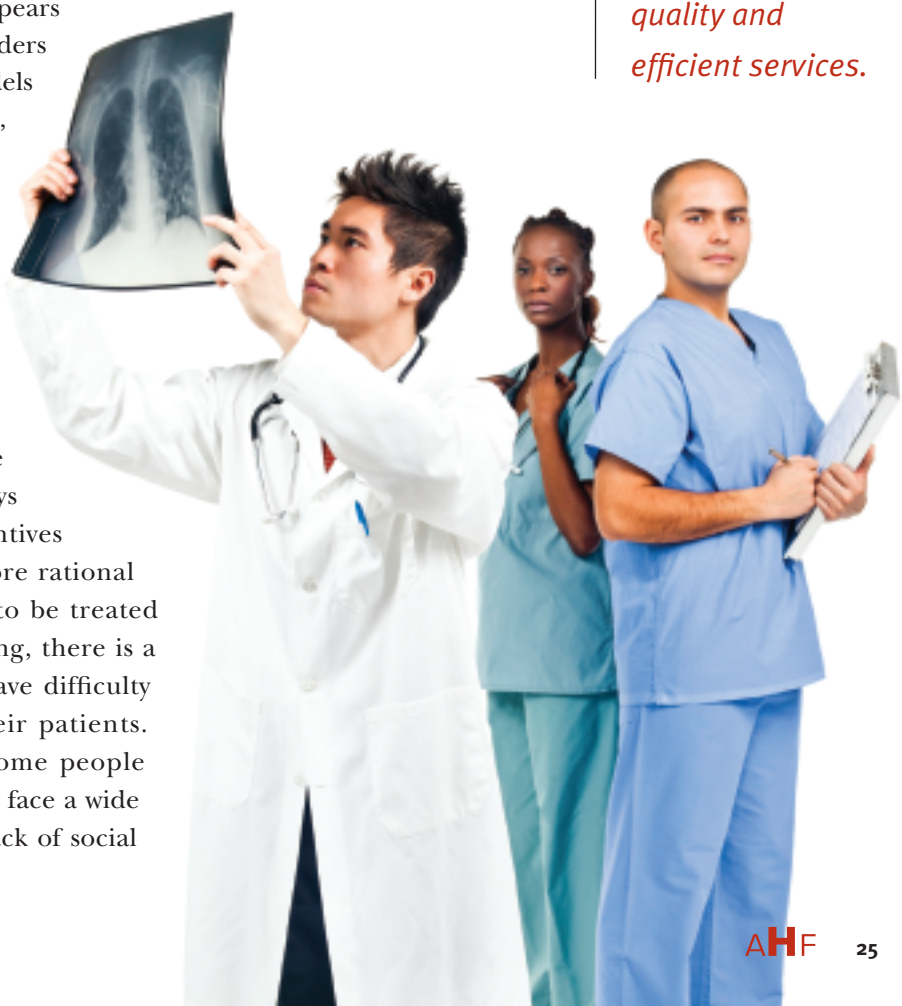
Many of Arizona's hospitals, health plans and community health centers are taking advantage of these new opportunities. For example, large hospital systems such as Banner Health Network, Dignity Health, Abrazo Health Care and John C. Lincoln have formed or are in the process of forming new relationships with community-based providers including health clinics and primary care physician networks to form accountable care organizations (ACOs) in Arizona.[78, 79, 80]

Efforts by healthcare providers such as these to better control costs would likely be occurring whether or not the Affordable Care Act existed or not. However, it is likely, according to provider representatives that we interviewed, that both the ACA and recent cuts to Medicaid have accelerated these efforts.

While these new networks may help safety-net providers better manage their resources while simultaneously improving care, the resulting changes to the healthcare landscape are likely to increase competition among providers as they compete not only for patients but for partners. As providers compete to gain market share, many providers will likely consolidate and networks will likely become larger. While these growing networks may result in efficiencies being achieved as integrated systems, there is the threat that consolidation will occur to such a degree that health prices might rise as pricing becomes more concentrated.[81] In addition, there appears to be some disadvantages to safety-net providers as they transition to ACOs and similar models of care since they often lack the capital, capacity and payer support necessary to transform to these new models of care delivery.[82]

Other provisions in the Affordable Care Act also attempt to incentivize changes in care delivery as a means of bending the cost curve. For example, hospitals are now being penalized if patients with specific types of medical conditions are inappropriately readmitted within 30 days of discharge from a hospital. While incentives such as these are aimed at creating a more rational healthcare system, encouraging people to be treated in the least costly, community-based setting, there is a risk that many safety-net providers will have difficulty appropriately managing the care of their patients. Safety-net providers often serve low-income people with complex medical conditions who also face a wide array of other challenges, ranging from lack of social supports to inadequate housing.

Accountable Care Organizations are groups of providers that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services.



There may be a need to target quality-improvement efforts for safety-net providers and adjust how safety-net providers are paid moving forward.

A recent analysis from the Commonwealth Fund found that safety-net hospitals are 30 percent more likely to have 30-day hospital rates above the national average. The report recommends a variety of policy solutions to mitigate this increased risk exposure, including targeting quality improvement initiatives for safety-net hospitals and adjusting payments made to safety-net providers to account for socioeconomic risk factors.[83]

Potential Need for Safety Net Monitoring and Support

As health delivery, access to health coverage and funding for safety-net providers changes, it may be necessary for the state to monitor the financial stability of safety-net providers and respond to changing circumstances. Rapid changes in the financing of care may leave some providers at risk financially, especially if they care for many individuals who remain uncovered through insurance reimbursement.

Again, Massachusetts' experience implementing its health reform changes is informative. After Massachusetts enacted its health reform law in 2006, it continued to provide reimbursement for providers that care for low-income residents who are uninsured or underinsured through its Health Safety Net (formerly the Uncompensated Care Pool). The pool is funded through a combination of hospital assessments, payer surcharges and government payments. Nonetheless, hospitals that traditionally provided a high level of free care to uninsured patients, especially Boston Medical Center and Cambridge Health Alliance, struggled financially. Three years of supplemental payments were needed, averaging $250 million per year to bolster the two hospital systems during the transition. In addition, federal stimulus funds through Medicaid were used to further shore up these systems.[84]

The Federal Front

Potential changes to financing of federal entitlement programs – including funding for Medicare and Medicaid – also pose a threat to the safety net moving forward.

Federal deficits and debt have reached historic highs in recent years. One of the key drivers to fiscal imbalance is by rising federal outlays for health care, mostly attributable to the growth in overall healthcare costs and the aging population. While the Affordable Care Act (if implemented as originally designed) is projected to decrease the gap between federal revenues and expenditures over the next decade, it does not eliminate it.[85] The continued increase in federal debt means that many federal policy makers are looking to make significant changes to federal entitlement programs such as Medicare and Medicaid.

The recent fiscal cliff negotiations suggest that both of these programs are not likely to be on the chopping block any time soon. Still, the growing federal debt makes discussions on how to balance concerns about access to care and fiscal responsibility challenging.

"You can't ignore politics, no matter how much you'd like to."

Molly Ivins,
American Humorist

In a poll conducted of 500 likely Arizona voters in February 2013, nearly 60 percent reported wanting Medicaid to be restored or expanded.

Public Support

The safety net's future will very much depend on the commitment of policy makers and the general public to its sustainability. Unfortunately, there are conflicting signs of whether support for the safety net is waxing or waning.

Many of the advocates we talked to for this report noted that a philosophical shift appears to have occurred among policy makers in recent years. Many essentially described a swing in the pendulum from a focus on our obligation to help those in need to a focus on personal responsibility.

Questioning the role of government in creating and sustaining the safety net is not new. It has been a legitimate and important debate that has existed for years. However, it appears that the debate between these conflicting values – caring for others versus personal responsibility – is growing louder and more vitriolic, perhaps reflecting the tough years we have lived through in recent times.

These disagreements are also not confined to our state. They are part of a larger, national re-examination of the government's role in providing a safety net for its citizens.

According to the Pew Research Center, support for a government social safety net is declining. While the majority (59 percent) of Americans still say that is it the responsibility of government to take care of those who cannot care for themselves, support for this viewpoint is down 10 points from 2007. Moreover, popular support for government programs to aid the poor now nears a 25-year low.[86]

That said, recent polling sponsored by St. Luke's Health Initiatives shows that overall support for the safety net remains strong in Arizona. In a poll conducted of 500 likely Arizona voters in February 2013, nearly 60 percent reported wanting Medicaid to be restored or expanded. Such public support mirrors years of demonstrated voter support for paying for the health care of low-income people in this state. For example, nearly 63 percent of Arizona voters approved Proposition 204 (which expanded eligibility for AHCCCS to 100 percent of the federal poverty level) in 2000.[87]

"A thousand fibers connect us with our fellow men."

Herman Melville,
Novelist, Poet
and Essayist

Re-Knitting the Safety Net

Arizona could be well on its way towards creating a two-tiered healthcare system, one in which some people get high quality, accessible health care and others do not.

Recent budget cuts have put the safety net in jeopardy. While possibilities and perils exist moving forward, it is in the hands of Arizonans – policy makers, health providers and the citizenry – to decide its strength moving forward.

If Arizona does not make wise choices to sustain or re-knit a viable safety net, it is quite possible that our state will move towards becoming a place where many citizens are simply unable to get the care they need. Indeed, at a recent meeting of Arizona business leaders, a hospital CEO warned that Arizona could be well on its way towards creating a two-tiered healthcare system, one in which some people get high quality, accessible health care and others do not.

To re-knit and strengthen Arizona's safety net, Arizonans need to:

- **REAFFIRM OUR COMMITMENT TO THE SAFETY NET** Arizona has a long history of providing health care for those who cannot afford it, dating back to the Howell Code nearly 150 years ago. Voters have continued to show their support for the safety net through ballot initiatives and polling. While there may be differences of opinion on how wide the safety net should be, the basic premise that there should be a health-care safety net needs to be reaffirmed both by policy makers and the public.
- **RECOGNIZE THAT WE ARE ALL IN THIS TOGETHER** The idea that we can each pay for our own health care without any regard to those lacking health coverage is naïve public policy. The reality is that we each end up paying for the health of those who lack health insurance one way or another – either through higher insurance premiums or escalating health care costs. While individuals should have some skin in the game paying for health care, it is unrealistic to believe that those who are very low income or who have extraordinary health care costs can simply pull themselves up by the bootstraps and pay for all of their health coverage or healthcare needs.
- **ARTICULATE STRATEGIES FOR COVERING THE UNINSURED** Given the impact that the uninsured has on the healthcare system as a whole, it is important for each policy maker to articulate a position on how our state intends to ensure access to health care. Simply saying no to policy proposals should not be an option.
- **LEVERAGE AVAILABLE DOLLARS** It is unlikely that the state of Arizona will be able to go-it-alone to ensure adequate access to care for Arizonans. Arizona tried this approach for many years, and finally relented by choosing to become part of the federal Medicaid program in 1982 – the last state in the union to join. Before that time, local governments ended up paying the price of uncompensated care.
- **MONITOR THE HEALTH OF THE SAFETY NET** Our healthcare system is changing dramatically as a result of budget cuts, health reform and new efforts aimed at controlling the growth of healthcare costs. Our state needs to monitor how the safety net is faring as a part of these changes, and adapt our public policy accordingly.
- **REFORM HEALTH CARE** The challenges that our healthcare system is facing are not merely a reflection of the conflicting values of shared responsibility and individualism. Recent budget cuts also mirror the reality that as healthcare costs grow, policy makers at the state and national level face real pressures to control healthcare spending.

Polling sponsored by St. Luke's Health Initiatives in February 2013 shows that Arizonans are divided in their support of the Affordable Care Act. That said, we believe that federal health reform contains opportunities to move our state forward on a lot of the issues Arizonans care about. This includes not only opportunities for more Arizonans to have health insurance, but also opportunities to innovate how healthcare is delivered so that it is ultimately more cost-effective and of consistently high quality.

Contrary to the public discourse that is fixated on decisions being made in Washington D.C., real reform of our healthcare system will ultimately depend on better health prevention and promotion, as well as innovation and experimentation in health delivery and payment reform occurring at the local level.

Arizona is fortunate in that it has been a national forerunner in controlling healthcare costs and innovating in health delivery. Our state's AHCCCS program is seen as a national leader. However, like any leader, we cannot rest on our laurels. We must continue to create a more cost-efficient, value-driven healthcare system that emphasizes prevention, integrates and coordinates health delivery, rewards health outcomes and cost-effectiveness, and focuses on how to keep people healthy in the communities in which they live. While AHCCCS can and should continue to play a vital role in making this happen, the ultimate strength of our state's healthcare system depends on us all – from individuals making healthy behavior choices to health providers changing the way they do business to community leaders creating the conditions in which we can stay healthy and thrive.

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St. Luke's Health Initiatives
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2929 N Central Ave
Suite 1550
Phoenix Arizona 85012

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info@slhi.org

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Our Mission

To inform, connect and support efforts to improve the health of individuals and communities in Arizona. In all that we do, St. Luke's Health Initiatives seeks to be a catalyst for community health.

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic, tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at **www.slhi.org**. If you would like to receive extra copies or be added to the list, please call 602.385.6500 or email us at info@slhi.org.

ARIZONA HEALTH FUTURES

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially those in need.

Editor:
Kim VanPelt

Analysts:
Linda Cannon
Kim VanPelt

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Chalk Design

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