STEP BY STEP

PROPOSITION 204 – HEALTHY ARIZONA II

What it is, how it works, and what it means for the future of health care in Arizona

AN ARIZONA HEALTH FUTURES REPORT

Prepared for
St. Luke's Health Initiatives
by
Cannon and Gill, Inc.

St. Luke's Health Initiatives
A Catalyst for Community Health

Cannon & Gill, Inc. is a women owned and operated small business founded in 1993. The owners of the firm, Linda R. Cannon and Mary E. Gill, bring to each initiative a comprehensive range of management consulting experience from high-level planning to detailed project management and technical planning and writing. Cannon & Gill, Inc. professionals have a unique perspective as a result of actual participation in public sector organizations and through the provision of management consultant services to public and private organizations. They have worked with government agencies at federal, state and local levels; community providers, community-based organizations, private foundations, the Arizona State Legislature and the Arizona Office of the Governor.

ARIZONA HEALTH FUTURES is the health policy and education arm of SLHI. Its purpose is to conduct relevant and timely policy research; provide balanced, nonpartisan information and perspectives on health issues in Arizona; serve as a convener and forum for the critical discussion of those issues in an independent and policy-neutral setting; and translate good ideas into action through the support of community-based initiatives.

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Step by Step

Step by step, Arizona is emerging into the light of access to health care for its most vulnerable citizens. Before the passage of Proposition 204 in late 2000, Arizona ranked in the bottom one-fourth of states measured by Medicaid income threshold. By raising that threshold to 100 percent of poverty, Arizona is now close to the top quartile of states.

Step by step, issues of access, quality and cost in health care are beginning to get the attention and resources they need if Arizona is to successfully compete with other states on quality of life, workforce and development opportunities. Proposition 204 allocates all of Arizona's tobacco settlement funds to health care and health related services. That's not the case in many other states.

Step by step, Arizona's political and community leaders are getting in step with the collective will of the state's citizens and providing the imagination, courage and perseverance it takes to get things done. The difference between Healthy Arizona I and Healthy Arizona II is stronger leadership at all levels of the state.

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Why is Proposition 204 important?

St. Luke's Health Initiatives commissioned this report and analysis of Proposition 204 on our belief that its importance extends beyond providing health coverage for an additional 186,000 adults through the Arizona Health Care Cost Containment System (AHCCCS). As critical as that coverage is, the real story lies in the genesis of Proposition 204: How it started, why it was passed, how it is designed to work, and the stage it sets for a more productive and "Healthy Arizona" in the future.

We are optimistic because of these factors:

The Will of the People. Americans are generally less ideological and more pragmatic than their political leaders. Both Proposition 203 (which faced voters in 1996) and Proposition 204 were passed by a comfortable majority of voters. The difference the second time around was the availability of tobacco settlement dollars, solid leadership and support across the public and private sectors, and a clear message from Arizonans that access to basic, affordable health care is a core public good. The political debate over the means of access will continue, but Arizonans are out in front on this issue.

Emerging Leadership. It's fashionable to bemoan a lack of leadership in Arizona, but Proposition 204 never would have made it out of the gate – and won't be implemented successfully – without leadership. On the issue of health care, the most obvious example of inspired leadership is the late Senator Andy Nichols of Tucson, but we could point to many such examples at all levels of public and private life. The glass is no longer half empty. It's half full.

The Changing National Scene. President Bill Clinton's health plan failed in 1994, but health care problems didn't go away. The federal government's States Children's Health Insurance Program (SCHIP) for children's coverage, passed in 1997, gave states the ability to craft their own programs with significant federal support. Arizona's version, KidsCare, set the stage for Proposition 204 by strengthening the coalition of individuals and organizations working to provide health care access for all Arizona citizens, educating political and business leaders on ways to provide that access without breaking the state bank, and informing the general public about the magnitude of the problem. Health care reform at the national level has been fragmented and sporadic, but it's clear that we are faced with major systemic issues of access, cost and quality, and lawmakers on both sides of the aisle realize they have to deal with them.

The Business of Health Care. One silver lining in the dark cloud of limited access, increasing costs and quality concerns is the recognition that health care is a business, and is ripe for innovation and the adoption
of successful business practices. State health leaders are looking at ways of consolidating the eligibility process
for Proposition 204, streamlining the application process, improving information and tracking systems, and employing the powerful techniques of social marketing to insure that people who are eligible for health benefits both understand and have the opportunity to get them. Arizona has managed to attract strong internal leaders at key state agencies over the past several years, and they are starting to build an organizational culture based on best business practices and quality improvement. Necessity really is the mother of invention.

What we'll find is that you can describe the world from the ideological edges, but you can't live there.

The Changing Political and Economic Climate. Short term, we're not going to make any big changes in the financing and delivery of health care in America. That means we'll continue to tinker with the current system while we sort out the balance between federal and state power, and between public and private responsibility. What we'll find is that you can describe the world from the ideological edges, but you can't live there. The Arizona legislature that passed and set up the policies for the implementation of Proposition 204 worked across party and ideological lines; health care advocates who had supported a competing ballot initiative lined up in support of it. The heat of the political and social debate will continue, but a moderate and results-oriented group of leaders and their constituencies should continue to be successful.

The Culture of Inertia

The issue of uncompensated care alone has critical importance to providers, and Proposition 204 doesn't provide a solution.

Even with causes for optimism, it's easy to remain trapped in a culture of inertia. It's routine and predictable, safe and comfortable. We know the rules, even if we don't like them. We adapt and try to get along.

No one dismisses the difficult choices we face in deciding on competing claims for public resources, especially with rising health care costs and an aging population used to first-dollar coverage, the latest technology and subsidized services. The issue of uncompensated care alone has critical importance to providers, and Proposition 204 doesn't provide a solution. There's also the looming problem of stable funding. God forbid that people actually stop smoking – a public health problem if there ever was one – and we don't have another sin to tax or a group we can pass the buck to. In the culture of inertia, tobacco dollars are here now; when they run out, we'll deal with it then.

But that's old news. At SLHI, our goal is to look for and support ways to improve the health of all Arizonans, but especially our state's most vulnerable people. When we see signs of like-minded organizations and individuals breaking out of this culture of inertia, we try to encourage and extend their work. This Step by Step report was conceived and commissioned in response to many in the health care community who wanted policy makers, opinion leaders and concerned citizens to have an understandable, objective and thorough account of just what was proposed, the magnitude of what was achieved, and issues we face as we implement Proposition 204.

There should be enough here for both the generalist and specialist; as the plan rolls out we will continue to monitor and disseminate its progress, either through SLHI programs or those of our grantees. This report, as well as others, will be available on our website, www.slhi.com.

Finally, we want to recognize and celebrate the achievements and good will that result in sound social policy and better health in our communities. The process and energy that developed Proposition 204 need to be nurtured and extended through community work that one day will result in every Arizonan having regular access to affordable, high quality health care.

Step by step, it's doable.

Executive Director, St. Luke's Health Initiatives

IN 1998, the states' attorneys general and five major tobacco companies reached a settlement agreement that will direct $246 billion to the states as compensation for treating tobacco-related illnesses. Arizona's share of the "Tobacco Settlement Funding" is estimated to be $3.2 billion[1], and as a result of the passage of Proposition 204, it's all been targeted to improve health care for Arizonans. The Step by Step report provides a point-in-time review of Proposition 204, its corresponding legislation (Senate Bill 1577, Laws 2001, Chapter 344), and implementation plans and actions to date. Additionally, we've identified possible policy implications and
evaluation opportunities.

The Art of Policy Making

It is important to note that by many accounts, the art of public policy development was at its best throughout this process. From the Healthy Arizona II citizen-based initiative to Governor Jane Hull's establishment of parameters for legislative action, from development and passage of legislation to the beginning of the implementation process, this initiative has faithfully responded to the stated desires of the people, replete with pre-legislation communication, collaboration and compromise, and responsiveness to the potential impact of the legislation. Successful implementation will clearly require continuation of the partnerships and joint decision-making demonstrated throughout the process.

The 186,000 people who stand to gain health care coverage through this dedicated funding source will benefit the most from the implementation of Proposition 204. They will be able to access acute health care services as well as a full continuum of behavioral health services. Additionally, planned improvements in application and eligibility determination processes will benefit thousands of individuals and families attempting to obtain health coverage in the future. While not resolved through this specific process, the impact on hospitals of providing uncompensated care has been brought to the forefront and is clearly on the policy agenda.

This report is an account of what happened, why it happened and what's planned for the immediate future.

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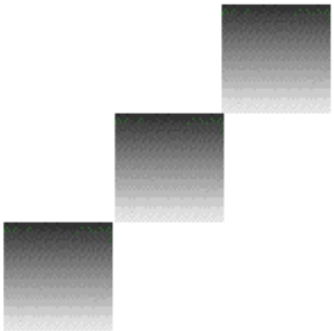

[1] Proposition 204 Analysis; Arizona Legislative Council

ON NOVEMBER 23, 1998, state attorneys general representing 46 states, five commonwealths and territories and the District of Columbia, reached the Master Settlement Agreement (MSA) with the five major tobacco companies to recoup medical costs of treating tobacco-related illnesses. Four states – Florida, Minnesota, Mississippi and Texas – settled prior to and separately from the MSA for a total of $40 billion over 25 years. Combined with the settlements from the four states, tobacco manufacturers essentially agreed to pay a total of $246 billion over 25 years.

The MSA provided an unprecedented financial opportunity for states to address their most pressing issues. Although the MSA did not restrict the use of the tobacco settlement funds, the top use of tobacco settlement monies, according to the National Governors' Association (NGA) Survey, has been to fund health initiatives (46 states) including tobacco prevention and control programs (42 states). The NGA report identified five broad categories of expenditures: Health, Education, Economic Development, Social Welfare and Natural Resources.

Of the 48 states and jurisdictions in the NGA survey, all reported some Tobacco Settlement Funding being directed toward health care initiatives. Only nine states indicated that all their Tobacco Settlement Funding would be directed to health initiatives: California, Connecticut, Indiana, Minnesota, Rhode Island, Texas, Washington, Wisconsin and Wyoming.

Arizona's Tobacco Settlement Funding, estimated to be $3.2 billion by the year 2025[2], has been directed to health care and health related social services. Arizona's planned expenditures were identified in the following NGA categories: Health (Health Research, Maternal and Child Health, Medicaid, Uninsured and Other Health issues) and Social Welfare (Welfare, Social Services and Early Care and Education).

Categories selected by states for funding ranged from a low of two categories in Rhode Island and Wyoming to a high of 17 categories in Alabama. Arizona has distributed funding among the eight categories identified which is slightly below the average of 8.25 categories for all states and jurisdictions.

Tobacco prevention, economic development, education and elderly services were target areas for many states. Education initiatives funded with Tobacco Settlement Funding are primarily directed to improve state school systems and to assist high school students in accessing university level education opportunities. Additionally, tobacco-producing states are targeting some funds to invest in crop diversification and alternatives to tobacco production for their farmers and farm communities.

It is important to note that with "health care" as the overall category for investment in Arizona, many of the funding categories identified in Chart 2 will also be impacted by use of Tobacco Settlement Funds in Arizona. For example, increasing Medicaid coverage will impact services for chronic disease, substance abuse, and primary health care.

CHART 1

Arizona Activity

Summary of Arizona Activity for Tobacco Settlement Funds & Number of States with the Same Target Areas

Arizona Funding Categories	Number of States Also Funding in These Categories
Health	46
Other Health Issues	33
Health Research	17
Medicaid	17
Welfare and Social Services	15
Maternal and Child Health	13
Uninsured	11
Early Care and Education	7

Source: National Governors Association, 2001 State Tobacco Settlement Spending Initiatives, April 11, 2001.

[2] Joint Legislative Budget committee, August 2000, Fiscal Notes regarding Proposition 204

CHART 2

Summary of Other Activities for Tobacco Settlement Funds & Number of States with these Target Areas

Funding Category	Number of States Per Category
Tobacco Prevention	42
Economic Development	27
Education	21
Elderly	20
SCHIP	14
Chronic Diseases	12
Substance Abuse	11
Other Education Issues	9
Cancer	9
Adolescent Health	7
Criminal Justice	5
Rural Economic Development	5
Primary Care	4
Rural Health	4
Child Welfare Foster Care and Adoption	4
Other Social Welfare Issues	3
Education Technology	3
University Scholarship	3
Natural Resources	3
Other Natural Resources Issues	3
Literacy	2
School Construction	2
Early Childhood Development	2
Tobacco Farmers Assistance	2
Economic Development Information Technology	2
Telecommunications	2
Tax Relief	2
Before/After School Learning Opportunities	1
Women's Health	1

Source: National Governors Association, 2001 State Tobacco Settlement Spending Initiatives, April 11, 2001.

Arizona voters have dedicated all their Tobacco Settlement Funds to health care and health related services. While many states have committed some funding to health care issues, at least 27 states felt that economic development was a priority, and 21 states identified education as a priority for at least part of their funding.

Description

Proposition 204, Healthy Arizona II, was approved by voters on November 7, 2001 with 903,134 yes votes (62.9 percent) and 532,317 no votes. In 1996, Proposition 203, Healthy Arizona I, was passed by the voters but was never funded by the Arizona Legislature. Proposition 204 reached the ballot via Initiative Petition, demonstrating a clear message from the voters that health care is the priority for Tobacco Settlement Funding.

The overarching action of the Proposition is to change the definition of who may be eligible for AHCCCS medical coverage. The Proposition defines an "eligible person" as any person who has a family income level between zero and 100 percent of the Federal Poverty Guidelines.

The descriptive title of the ballot for Proposition 204 read:

> "Funds the Healthy Arizona initiative passed in 1996; increases eligibility of working poor at federal poverty level for Health Care Coverage through AHCCCS (Arizona Health Care Cost Containment System); Funds Health Education, Nutrition and Prevention Programs; Funds Premium Sharing and Other health care programs with tobacco litigation settlement monies."[3]

The overarching action of the Proposition is to change the definition of who may be eligible for AHCCCS medical coverage. The Proposition defines an "eligible person" as any person who has a family income level between zero and 100 percent of the Federal Poverty Guidelines. The Proposition specifically limited modification to that definition with the following provisions:

- The people may through initiative or the Legislature change the eligibility threshold to a percentage of the federal poverty guidelines that is even more inclusive.
- The Executive Branch or the Legislature is prohibited from imposing a cap on the number of eligible persons who may enroll in the system.

Additionally, the Proposition designates funding from the Arizona Tobacco Litigation Settlement Fund, and as necessary any other available sources including legislative appropriations and federal monies, to provide the benefits to all persons who are eligible. It also allows an eligible or prospective eligible person to bring an action in the Superior Court against the Director of AHCCCS and the State to enforce this section.

The Proposition includes the following implementation authority and direction designed to preserve the integrity of the funding:

- Creates the Tobacco Litigation Settlement Fund and provides that all monies that the state receives pursuant to the Tobacco Litigation Master Settlement Agreement and interest earned on these monies shall be deposited in the Fund.
  - Requires monies in the Fund to be used to supplement – not supplant – existing and future appropriations to the AHCCCS for existing and future programs.
  - Requires that monies in the Fund not be reverted to the State General Fund and exempts the monies in the Fund from the provisions of Section 35-190 relating to lapsing of appropriations and indicates the monies are continuously appropriated.
- Authorizes the Director of AHCCCS to use the funds in the following order:
  - To fully implement and fund the programs and services required as a result of the expanded definition of an eligible person.
  - To fully fund and implement the programs listed in the November 5, 1996

[3] Proposition 204; Ballot Initiative Description

Healthy Arizona Initiative (Healthy Families, Arizona Health Education System, Teen Pregnancy Prevention, Disease Control Research, Health Start, Women, Infants and Children Food Program).

- To use remaining funds to expand coverage in the Arizona Health Care Cost Containment System, including the Premium Sharing Program and as approved by the voters or by the Legislature, and restricts appropriation of any remaining funds to programs that "benefit the health of the residents of this state."

l Provides that any provision of the measure that is not contrary to the provisions of a separate initiative that receives a higher total vote in the election cycle is valid.

- This provision was included to address differences between the Healthy Arizona II Proposition and a competing initiative – Healthy Children, Healthy Families. If the Healthy Children, Healthy Families initiative had received more votes than Healthy Arizona II, the provisions in Healthy Arizona II that were not contrary to Healthy Children, Healthy Families requirements would have been enacted. Since Proposition 204 received more votes, this provision became unnecessary.

The passage of Proposition 204 is especially important in light of the provisions in Proposition 105 passed by the voters in November 1998. Proposition 105 prohibits the legislature from diverting funds created or allocated to a specific purpose by an initiative measure, such as Proposition 204. In essence, this protects the provisions passed in propositions from being superseded by legislative action. Proposition 105 was not retroactive, but all initiatives passed by the voters from November 1998 on, are protected.

PRO

Ballot arguments for passage of Proposition 204 centered around Arizona's lack of health care coverage for the working poor population. Representatives of numerous health and social service organizations supported the provisions of the Initiative, including many of the same organizations and individuals who supported and worked for the passage of Proposition 203 (Healthy Arizona) in 1996. While Proposition 203 received 72 percent of the vote in 1996, the State Legislature never implemented the provisions of the Initiative.

CON

Arguments against the passage of Proposition 204 included the following:

- Proposition 204 would triple the AHCCCS program and require funding from other state revenue sources when tobacco settlement funds were expended.
- Private companies that provide insurance to their employees would see less reason to do so with the availability of government-provided insurance coverage.
- A tax increase or dramatic cuts in other government services like education or public safety would be needed for the ongoing funding of the provisions of Proposition 204.

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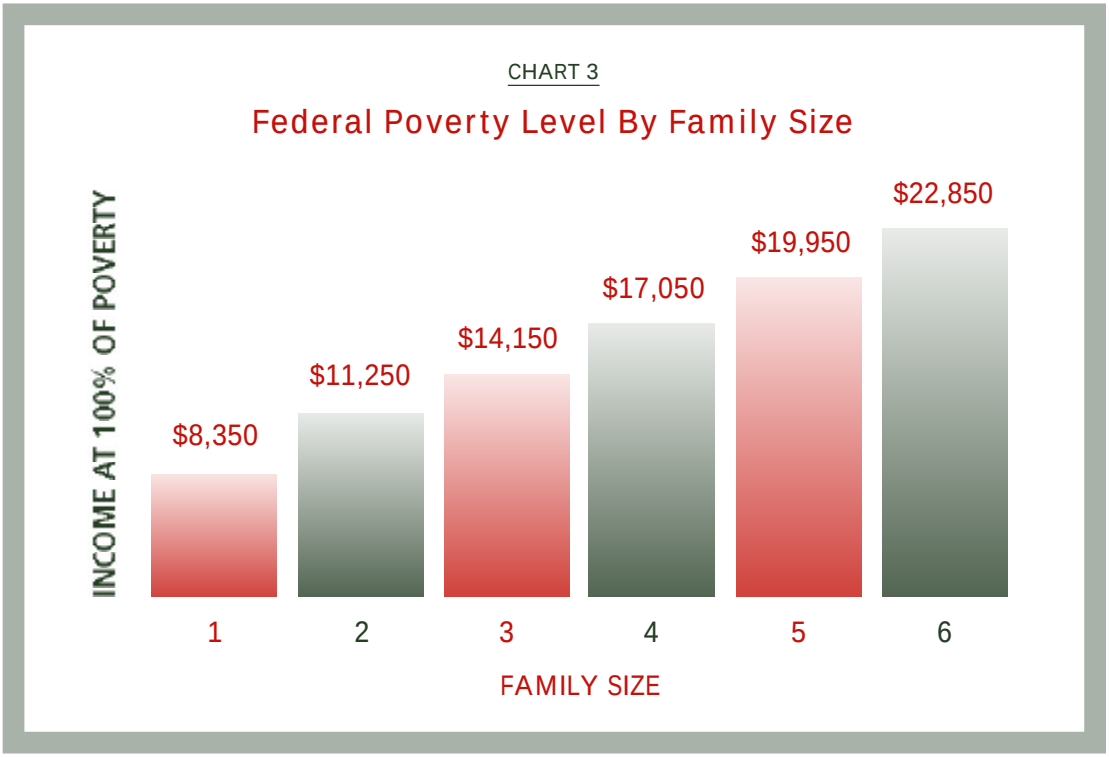
Impact of Proposition 204

AHCCCS Health Care Coverage for Individuals

Proposition 204 established a restricted funding source for health care in Arizona and raised the Medicaid
eligibility income level to 100 percent of the Federal Poverty Level (FPL). The increase in Medicaid coverage is estimated to provide health insurance coverage for an additional 186,000 currently uninsured adults by the year 2005. According to William M. Mercer, Inc., in 1999 there were 1.2 million people uninsured, which represents 21.2 percent of the Arizona population. Other studies have put this figure even higher.

Income maximums based on 100 percent of the FPL by Family Size are defined in Chart 3.

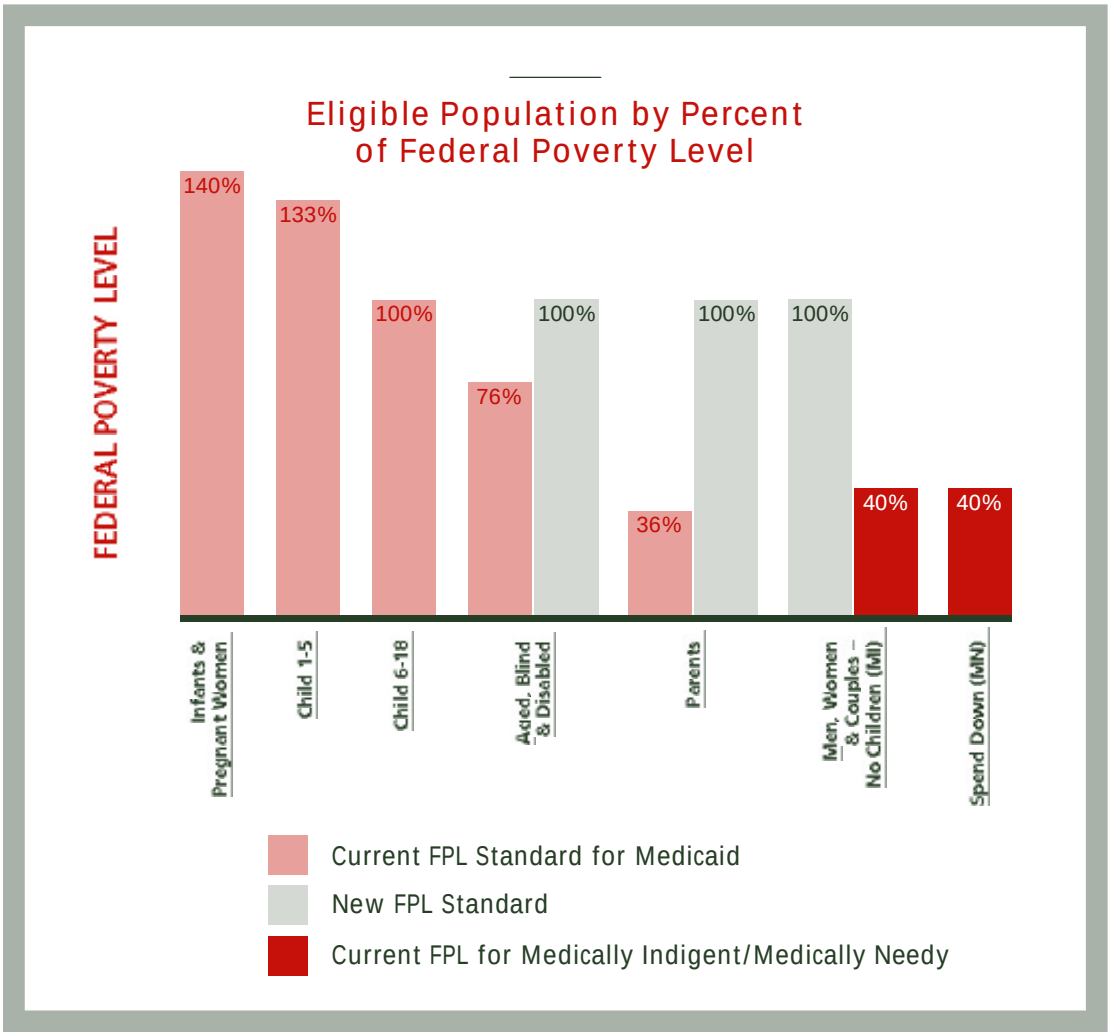
CHART 3



Source: Proposition 204: Expanding Health Care Coverage, AHCCCS, January 24, 2001, Page 3.

Prior to Proposition 204, Arizona Medicaid programs included eligibility at various levels of FPL. For adults, the income limits ranged from 36 percent of FPL for parents of eligible children ($5,094 for a family of three)
to 76 percent of the FPL for aged, blind and disabled persons ($6,346 for a family of one). Arizona already provided AHCCCS coverage for children of families with incomes at or below 100 percent of poverty.

The FPL requirements change to 100 percent for 1) aged, blind and disabled individuals, 2) parents of already eligible children, and 3) men, women & couples with no children (the current Medically Indigent population).



Source: Proposition 204: Expanding Health Care Coverage, AHCCCS, January 24, 2001, Page 4.

AHCCCS provides health care coverage to approximately 11 percent of the Arizona population. Following full implementation of Proposition 204, AHCCCS estimates that its programs will cover 15-16 percent of the population. For the three population groups of currently uninsured individuals, AHCCCS is projecting between 137,000 and 186,000 new eligible people by the year 2005:[4]

- Parents of already eligible children 65,000 to 87,000
- Aged, blind and disabled persons 27,000
  (An additional 47,000 aged, blind or disabled individuals currently receiving Medicare benefits may enroll)
- Men/women and couples without children 45,000 to 71,000

[4] Proposition 204, Expanding Health Care coverage, January 24, 2001, AHCCCS, Page 12

Public Health Program Impact

The second priority under Proposition 204 is the funding of six public health programs. Funding has been allocated for FY 2002 and FY 2003, but after that allocations to these programs will be dependent on the availability of Tobacco Settlement Funding. Based on current projections, Medicaid program growth will absorb the Tobacco Settlement Funding available to Arizona, and the public health programs will not receive future allocations from this funding source. This creates an obvious implementation challenge, since capacity will be increased with the Tobacco Settlement Funding only to be reduced in two years as funds are expended.

- **Healthy Families Program –** $5 million has been allocated to the Healthy Families Program administered by the Arizona Department of Economic Security (ADES). The program provides services to families with newborn children and is designed to reduce the incidence of abuse and neglect of newborn children. The additional funds will allow ADES to increase the number of families served from 8.8 percent of the eligible population to 12 percent of the eligible population.
- **Area Health Education System –** The Arizona Area Health Education System was created under ARS 15-1643 and requires the Board of Regents to establish the system within the University of Arizona College of Medicine. The system consists of five area health education centers, each representing a geographic area with specific populations that the system determines currently lack health care services. The $4 million in Tobacco Settlement Funding will allow the Area Health Education Centers to expand activities to reach their goals of providing medical education, recruiting medical personnel to rural and underserved areas of the state, and providing health promotion and disease prevention community health education for people who live and work in Arizona's rural and medically underserved communities.[5]
- **Teenage Pregnancy Prevention Programs –** $3 million has been allocated to the Arizona Department of Health Services (ADHS) Teenage Pregnancy Prevention Programs. The ADHS funds multiple programs to prevent pregnancies to unwed women (including teens) through community-based prevention programs that promote abstinence and decision making for healthy life choices. Tobacco Settlement Funding will allow the ADHS to specifically target funding and programs to areas where a direct impact can be made.[6]
- **Health Start Program –** The Health Start Program provides education and support to prenatal and postpartum women and their families by promoting optimal use of community-based family health and education services. Lay health workers, who live in and reflect the cultural and socio-economic characteristics of the community, provide services to 2,500 families through a program budget of $1,340,000. The additional $2 million in funding will allow targeted expansion to counties that do not have a program and to communities with poor perinatal outcomes.[7]
- **Disease Control Research Fund –** ADHS will receive $2 million for the Disease Control Research Fund. The Disease Control Research Commission is authorized "to contract with individuals, organizations, corporations and institutions, public or private, in this state for any projects or services that may advance research into the causes, the epidemiology and diagnosis, the formulation of cures, the medically accepted treatment or the prevention of diseases including new drug discovery and development."[8]

[5] Arizona Board of Regents, Board Meeting, May 24, 2001, Executive Summary, Item #1

[6] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, Senate Bill 1577, Teen Pregnancy Program, June 5, 2001

[7] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, SB 1577, Health Start Program

[8] ARS 36-273. Disease Control Research Commission, Powers and Duties

- The Federal Women, Infants and Children Food Program – The $1 million for the Federal Women, Infants and Children Food Program will be targeted to implement a Folic Acid Distribution and Education Program within the state. It will also provide match funding to establish a Farmer's Market Nutrition Program.[9]

Fiscal Impact

The implementation of Proposition 204 will result in an estimated increase in funding for health care in Arizona of $2.43 billion to $2.69 billion by the year 2005. This includes the increase in Federal Medicaid funding due to increasing the income level to 100 percent of FPL and converting the former state funded Medically Needy/Medically Indigent populations to Medicaid funding. Administrative costs for the various agencies involved may range from
$125 – $150 million over the next five years.[10]

The Joint Legislative Budget Committee (JLBC August 2000) Fiscal Notes regarding Proposition 204 estimated Arizona's Tobacco Settlement amount to be $3.2 billion by the year 2025.

The JLBC staff estimate projected that the six public health programs listed above will not receive funding after FY 2003 because Tobacco Settlement Funding will no longer be available. While the Proposition required that alternative funding sources be identified for the AHCCCS expansion, it did not provide a similar requirement for these programs.

~Based on current projections, Medicaid program growth will absorb the Tobacco Settlement Funding available to Arizona, and the public health programs will not receive future allocations from this funding source. This creates an obvious implementation challenge, since capacity will be increased with the Tobacco Settlement Funding only to be reduced in two years as funds are expended.~

[9] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, Senate Bill 1577, Women, Infants and Children

[10] Proposition 204, Expanding Health Care Coverage, AHCCCS, January 24, 2001, page 15

THE LEGISLATION TO SUPPORT the implementation of Proposition 204 was Senate Bill 1577 – the Senator Andrew Nichols Comprehensive Health Insurance Coverage Act. Governor Jane Hull signed this legislation into law on May 7, 2001.

Interestingly, the provisions of Proposition 204 could have been implemented without passage of SB 1577. The expansion to 100 percent of FPL and funding of the public health programs did not require additional legislative authority. However, the legislation was required to fully implement the provisions of the Centers for Medicare and Medicaid Services (CMS – formerly the Health Care Financing Administration, or HCFA) waiver to add new populations to the Medicaid funded programs, to create the pathway for making the system more accessible for individuals, and for streamlining the administrative responsibilities between ADES and the Counties. Additionally, the development and negotiation efforts involved in preparing the legislation created a forum for raising the visibility of the impact of uncompensated care on hospitals in Arizona.

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To summarize

- Proposition 204 defined the AHCCCS eligibility expansion to 100 percent of FPL and funding for public health programs.
- The CMS Waiver expanded AHCCCS Medicaid eligibility to the MN/MI populations. Prior to the waiver the MN/MI populations were eligible for state funded only services. This waiver allows Arizona to receive two dollars in Medicaid matching funds for every one dollar expended by Arizona for the current MN/MI population as well as the new income eligible MN/MI populations.
- SB 1577 specifically defines changes in these areas:
  - AHCCCS Expansion
  - Public Health Programs
  - ADES and County Eligibility Consolidation
  - County Responsibilities
  - Budget Neutrality Compliance Fund
  - Private Hospital Uncompensated Care Requirements
  - Joint Legislative Study Committee
  - Hospital Reimbursement Study
  - County Rights to Tobacco Settlement Funding

AHCCCS Expansion

To implement the expansion of AHCCCS programs because of increased funding and more favorable program eligibility rules, SB 1577 provides the following requirements for AHCCCS:

Streamlined Eligibility

Requires AHCCCS to adopt rules for a streamlined eligibility determination process for persons at or below 100 percent FPL and income that does not exceed 40 percent FPL after deducting allowable medical expenses (medical expense deduction or the MED category). Streamlined eligibility determination includes:

- Eligibility periods extended from 6 months to 12 months, except the MED program, which is six months.
- Establishment of the date of eligibility as the first day of the month of application.
- Elimination of prior quarter coverage for Medicaid-eligible persons.
- Inclusion of the ability to accept written applications signed by the applicant or the applicant's representative.
- Elimination of the requirement to conduct in-person interviews.

The administration and ADES are required to hold one public meeting in an urban county and one public meeting in a rural county before adopting the proposed rules.

Children's Health Insurance Program

Repeals the Direct Services Program under the Children's Health Insurance Program (CHIP). The original implementation of the Children's Health Insurance Program (KidsCare) included a provision that families could access health care under CHIP through community health clinics. Since the number of families selecting this option has been small (180 children[11]), the option has been deleted

[11] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, Senate Bill 1577.

and no funding is appropriated for FY 2002. The 180 children will be referred to the AHCCCS KidsCare program.

Medical Expense Deduction Program (MED)

Defines the provisions of the MED Program to allow an applicant to use medical expenses of a family member to reduce the income and to determine the spend down amount by using medical expenses beginning with the month before the month of application. The MED Program replaces the formerly state funded Medically Needy Program. The legislation specifies that eligibility for the MED program is the later of the date spend down is met or the first day of the month of application. Additionally, the legislation requires AHCCCS to enroll a MED eligible person with a health plan located in the geographic area of the member's residence.

IGA with Arizona Department of Economic Security (ADES)

Requires AHCCCS to enter into an Intergovern-mental Agreement (IGA) with ADES to implement the eligibility process and administrative requirements:

(a) Establish an expedited streamlined eligibility and enrollment process for hospitalized applicants.

(b) Establish performance measures and incentives for ADES.

(c) Establish a management evaluation review process.

(d) Establish eligibility quality control reviews.

(e) Develop rules for an appeal of eligibility determinations or re-determinations.

(f) Establish ADES' responsibility to place sufficient eligibility interviewers in health centers, hospitals and level one trauma centers.

(g) Withhold payments for errors in eligibility or performance measures.

The legislation allows the Director of AHCCCS to offset a sanction if ADES submits a corrective action plan and requires the Director to adopt rules for the appeal of eligibility determinations and discountenances.

Public Health Programs

The legislation appropriates, as required in Proposition 204, annual funding for the following programs for FY 2002 and 2003 and allows for an inflationary factor to be added:

(a) $5 million for the Healthy Families Program

(b) $4 million for the Area Health Education System

(c) $3 million for Teenage Pregnancy Prevention Programs

(d) $2 million for the Health Start Program

(e) $2 million for the Disease Control Research Fund

(f) $1 million for the Federal Women, Infants and Children Food Program

If AHCCCS expansion does not occur at the projected rate, funding could be available in subsequent years.

Arizona Department of Economic Security and County Eligibility Consolidation

The current system of eligibility includes ADES, AHCCCS and 15 counties performing eligibility for various categories of Medicaid and state-funded medical programs. While not a requirement of Proposition 204, the implementation provides an opportunity to consolidate the eligibility determination processes within two agencies, AHCCCS and ADES.

SB 1577 requires ADES and the county boards of supervisors to enter into intergovernmental agreements (IGAs) to transfer the counties' AHCCCS eligibility determination responsibility to ADES. ADES may enter into an IGA with a county to allow the county to perform eligibility determinations for ADES for up to one year.

Since SB 1577 eliminates the county residual responsibility (see County Responsibilities), there is no longer a direct county interest in completing medical eligibility determinations. Other than the public hospitals (Maricopa Medical Center and Kino Hospital), there is not a direct county responsibility for providing health care to the indigent.

Consolidation of eligibility in two agencies, rather than 17, is anticipated to streamline the process and focus on administrative efficiencies; e.g., the use of a single automation system at ADES, which is currently linked directly to the AHCCCS system.

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County Responsibilities

With the implementation of 100 percent of the FPL for Medicaid eligibility and the CMS waiver, which transfers responsibility for the MN/MI populations to Medicaid funding through AHCCCS, the counties will no longer have a residual responsibility. All persons who would have been covered by the county residual responsibility will now be Medicaid eligible under AHCCCS.

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- **County Residual Responsibility:** The legislation repeals the county residual responsibility for providing medical care to the indigent sick. When Medicaid was implemented in Arizona in 1982, each county had a maintenance of effort responsibility for indigent care services that was in effect on January 1, 1981.

  The legislation maintains the county responsibility for residual claims by a hospital or health care provider for medical care provided before October 1, 2001. Counties have until November 15, 2004, to adjudicate the residual claims. The legislation does permit a county board of supervisors to continue to provide hospital and medical care for the indigent sick in the county.

- **County Hospitals:** For counties that maintain a hospital or health care facility, the county board of supervisors or county board of health may enter into agreements with other entities to provide, maintain or manage the risk of health care services; to acquire and maintain property; to adopt rules to administer and operate the facility's programs and property; to establish or acquire foundations to solicit donations, financial contributions, property or services; and to disclose and make available public records, with exceptions.

  The legislature requires that a county that now operates a hospital to maintain that hospital until July 1, 2006 unless legislation is enacted to both (1) authorize counties with a population of two million or more (Maricopa and Pima counties) to establish a special district or nonprofit entity to operate a health system (Maricopa County), and (2) continue offset payments in FY 2003-2004 through FY 2005-2006 to a county (Pima County) that operates a hospital. The county is required to provide at least a 13-month notice to AHCCCS before closing a hospital.

  The legislation repeals the county hospital maintenance of effort on July 1, 2003 unless legislation is enacted to both (1) authorize counties with a population of two million (Maricopa and Pima counties) to establish a special district or nonprofit entity to operate a health system (Maricopa County), and (2) continue offset payments in FY 2003-2004 through FY 2005-2006 to a county (Pima County) that operates a hospital.

  Arizona has two county hospitals, Maricopa Medical Center (Maricopa County) and Kino Hospital (Pima County). Both hospitals have to resolve serious financial issues. Maricopa County has proposed the creation of a hospital district that would provide bonding authority to increase available funding. Pima County is seeking assurances that offset payments will continue through FY 2006. Each county intends to maintain their hospitals, but they still have to address the financial issues.

- **County Contribution to AHCCCS Expansion Administrative Costs:** SB 1577 requires in FY 2002-2003 and each fiscal year thereafter that the State Treasurer withhold $5 million from transaction privilege tax revenues for the county contribution for administrative costs related to the AHCCCS expansion ($3,750,000 will be withheld in 2001-2002). The funds are to be deposited in the Budget Neutrality Compliance Fund. The State Treasurer is to adjust the withholdings for inflation as calculated by the JLBC staff. Each county's annual contribution rate (portion of the total contribution) is defined in the legislation.

  Although $35 million in county eligibility and claims responsibilities is eliminated, counties lose $21 million in disproportionate share payments and contribute over $11 million to new program administration and private hospitals for uncompensated care. After a state offset payment to those counties that are adversely affected by these

losses, total net gains to counties are approximately $7 million in FY 2003.

- **Behavioral Health Services:** SB 1577 provides for the continuation of the following county responsibility regarding behavioral health services:
  - Requires a county with a population of less than 600,000 to provide behavioral health services to persons who are seriously mentally ill at the same benefit levels as required by statute on January 1, 2001.
  - Requires a county with a population between 600,000 and 2 million, and that has an Intergovernmental Agreement (IGA) with the ADHS, to provide behavioral health services on January 1, 2001, and to annually renew the IGA at the same benefit levels.
  - Requires a county with a population of more than two million and that has an IGA with ADHS to provide behavioral health services to persons with a serious mental illness on January 1, 2001 and to annually renew the IGA at the same benefit levels annually adjusted for inflation and population.
- **County Offset Loss:** The legislation eliminates public hospital eligibility for disproportionate share payments. However, it also appropriates $5,532,500 in FY 2001-2002 and $4,825,600 in FY 2002-2003 from the state general fund to AHCCCS to distribute to specified counties to offset the new loss in revenue from elimination of the counties' disproportionate share funding. The appropriation is non-lapsing, and the legislation requires the appropriations and any savings realized by the counties as a result of the AHCCCS expansion to be used for indigent health care costs.
- **Financial Impact on Counties:** A review of the FY 2002-2003 Financial Analysis provided by the County Board of Supervisors Association demonstrates the impact of the various fund shifts during the first full year of implementation[12] with regard to the counties. See Chart 5.
  - Eligibility & Medical Liability Costs – represents the costs to counties to provide the eligibility services. This amount represents the savings to the Counties when eligibility determination functions are transferred to the ADES.
  - Disproportionate Share Reduction – represents the loss of revenue to the counties from discontinuation of this revenue source.
  - Population Percentage – represents the population percentage by county for purposes of determining how much each county would contribute to the Proposition 204 Administrative Pool.
  - Proposition 204 – Administrative Pool Contribution – represents the amount of each county's transaction privilege tax revenues that will be contributed to the Proposition 204 Administrative Pool. This goes in the loss column.
  - Uncompensated Care Pool Contribution – represents each county's share of contribution to the Uncompensated Care Pool. This goes in the loss column.
  - Net – represents the net gain or loss of funds to the county.
  - Offset Payments to the Counties – represents the amount counties with a net loss of funding will receive from the offset funds. The agreement is that counties could not experience a net loss in funding; therefore, offset payments equal the projected loss plus $100,000.
  - Gains in FY 2003 – represents the amount each county will gain when all adjustments have been made.

{as a result of Proposition 204} total net gains to counties are approximately $7 million in FY 2003.

[12] While these fund shifts will begin in October of FY 2001-2002, Chart 5 represents the first full year of implementation, FY 2002-2003.

CHART 5

Fiscal Impact on the Counties for FY 2002 – FY 2003

County	Eligibility & Medical Liability Costs[13]	Dispro Share Reduction	Population Percentage	Prop 204 Admin Pool Contribution	Uncompen-sated Care Pool Contribution	Net	Offset Payments to Counties	Gains in FY 03
Apache	660,964	185,957	1.320	67,100	87,300	320,607		320,607
Cochise	499,064	98,220	2.503	125,150	162,700	112,994		112,994
Coconino	646,953	98,220	2.469	123,450	160,500	264,783		264,783
Gila	592,463	196,321	1.014	50,700	65,900	279,542		279,542
Graham	144,902	196,321	0.721	36,050	46,800	-134,269	234,200	99,931
Greenlee	83,211	196,321	0.185	9,250	12,000	-134,361	234,400	100,040
La Paz	180,700	196,321	0.384	19,200	24,900	-59,721	159,700	99,979
Maricopa	23,114,799	13,140,300	59.289	2,964,450	3,853,800	3,156,249		3,156,249
Mohave	985,943	196,321	2.882	144,100	187,400	458,122		458,122
Navajo	925,265	98,221	1.889	94,450	122,800	609,794		609,794
Pima	4,358,491	6,102,000	17.167	858,350	1,115,900	-3,717,759	3,817,800	100,041
Pinal	1,642,070	98,220	3.359	167,950	218,300	1,157,600		1,157,600
Santa Cruz	136,834	160,315	0.794	39,700	51,600	-114,781	214,800	100,019
Yavapai	496,476	196,321	3.173	158,650	206,200	-64,696	164,700	100,005
Yuma	690,781	98,221	2.829	141,450	183,900	267,210		267,210
TOTAL	$35,158,914	$21,257,600	100%	$5,000,000	$6,500,000	$2,401,314	4,825,600[14]	7,226,914

Source: County Supervisors Association; Final Proposition 204 Bill Numbers.

[13] Based on average of FY 99 and FY 2000 county eligibility expenses

[14] Offset Payments to the Counties – this represents a two year commitment to the Counties.

Budget Neutrality Compliance Fund

In order to obtain approval from CMS for the waiver that adds new eligibility categories to Arizona's Medicaid program, Arizona had to demonstrate "budget neutrality" with regard to the new populations being added; specifically, the MN/MI population. From a Federal perspective, the waiver could not cost the Federal Government any more than coverage for the existing categorically eligible populations (excluding program growth). As part of the negotiation to obtain the waiver, Arizona will no longer receive Disproportionate Share Funds for the counties and the Arizona State Hospital, approximately $76 million for FY 2002 and FY 2003. This $76 million dollars is considered a savings to the Federal Government and becomes a factor in determining overall budget neutrality.

The non-lapsing Budget Neutrality Compliance Fund was established in AHCCCS. The fund will consist of third party liability recoveries, county contributions and appropriations. State funds formerly expended for the MN/MI populations will be transferred to the Budget Neutrality Compliance Fund. MN/MI savings are estimated to be $169,283,700 in FY 2002 and $178,085,600 in FY 2003. AHCCCS will be required to use approximately $53,700,000 of these funds in FY 2002 as a maintenance of effort for the state match for the MN/MI populations. The remaining funds will be deposited in the Budget Neutrality Compliance Fund.

Additionally, counties are required to contribute a specific amount of monies to the fund if in a fiscal year the state's total initial payment, annual payment and strategic contribution payment are less than 66 percent of the original amount, as defined in the Master Settlement Agreement. The state is required to use these monies to provide indigent health care services. The State Treasurer is required to invest the Budget Neutrality Compliance Fund monies and credit the interest to the Tobacco Litigation Settlement Fund to pay for the expanded coverage if monies in the fund are insufficient to cover the costs of the expanded coverage.

The legislation:

- Specifies the annual county withholding for administrative costs to be used for direct and indirect eligibility costs associated with the AHCCCS expansion.
- Requires the administration to transfer monies from the Tobacco Litigation Settlement Fund to the Budget Neutrality Compliance Fund to cover the expansion of persons who have income at or below 100 percent FPL.
- Requires the Administration to use $53,700,000 from the Fund in FY 2001-2002 for the maintenance of effort for the state match for non-categorical populations covered by the state before November 7, 2000.
- Appropriates $118,569,500 in FY 2001-2002 and $124,397,000 in FY 2002-2003 from the State General Fund to AHCCCS to deposit in the Budget Neutrality Compliance Fund and exempts the appropriations from lapsing.

AHCCCS will be required to use approximately $53,700,000 of these funds in FY 2002 as a maintenance of effort for the state match for the MN/MI populations.

Private Hospital Uncompensated Care Requirements

SB 1577 requires the State Treasurer to withhold a total of $3,502,000 from the counties' distribution of the state transaction privilege tax revenues and deposit the monies into the AHCCCS fund for hospital uncompensated care. It requires an additional $6,500,000 million to be withheld and deposited in the fund in FY 2002-2003.

The counties have been the payer of last resort for indigent health care provided by private and public hospitals. Hospitals submit their claims to the counties, after which they are either paid or become part of litigation by the hospitals. Currently, claims that are resolved through the resolution or litigation process are usually settled between 9 and 15 cents on the dollar.[15] In the past, since counties completed the eligibility determinations for the indigent populations, there was an incentive to ensure timely determinations. Once determined eligible, AHCCCS

[15] Alan Stevens, Executive Director, County Supervisors Association

would be responsible for the cost rather than the county being responsible. With the removal of the counties' residual responsibility and the transfer of eligibility determination to ADES, counties no longer have a responsibility for these costs.

In spite of several efforts to actually quantify the cost of uncompensated care, estimates acceptable to all involved were not identified. During negotiations regarding SB 1577, a compromise was reached, wherein counties would contribute $10 million ($3.5 million in FY 2002 and $6.5 million in FY 2003) to an uncompensated care fund, which AHCCCS will then distribute to each private hospital based on its non-obstetric adult hospital emergency care covered by AHCCCS.

Over the next two years, the Joint Legislative Study Committee will review the actual impact Proposition 204 has on uncompensated care. It is anticipated that the streamlined eligibility process will result in a reduction in uncompensated care, but this remains to be seen.

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Joint Legislative Study Committee on the Implementation of Proposition 204

SB 1577 establishes a 12-member Joint Legislative Study Committee[16] on the Implementation of Proposition 204. Its charge is to review the legislation's implementation. The Committee is to be comprised of six members of the House of Represen-tatives (not more than three of the members of the same political party) appointed by the Speaker of the House, and six members of the Senate (not more than three of the members of the same political party) appointed by the President of the Senate. The Speaker and the President will each designate one of these members to co-chair the Committee. The specific requirements of the Study Committee are to:

- Develop a uniform process for data collection required and in a format determined by the Committee.
- Review the number of persons who are enrolled in the AHCCCS as a result of the expansion of eligibility.
- Review the number, location and hours of operation of eligibility offices operated by the county and by the ADES before and after the transfer of county responsibility to the ADES.
- Review the average time it takes the AHCCCS and the ADES to process applications as a result of the expansion of eligibility.
- Review the number of persons who were denied eligibility by AHCCCS and ADES and the most common reasons for the denial.
- Review data provided by AHCCCS that show the income received by each hospital based on the expanded hospital population as a result of the expansion of eligibility of the AHCCCS.
- Review data provided by hospitals that show the number of persons the hospital served who would have been eligible for AHCCCS services if they would have submitted an application, and the dollar amount of the uncompensated care based on the AHCCCS fee schedule.
- Consider the expenditures for the new eligibility groups and the budget neutrality agreement with the CMS.
- Identify the amount received by each private hospital from AHCCCS for any disproportionate share payment to each hospital.
- Recommend whether the appropriations to counties required by this act should continue after Fiscal Year 2002–2003.
- Review the expenditures and the balance and projected future deposits from Tobacco Settlement Funds.
- Consider the financial and operational status of county hospitals and health systems and recommend measures to assure their continuing operation.
- Submit a report of the Committee's findings regarding county hospitals and health care systems to the Governor, President of the Senate and Speaker of the House of Representatives on or before December 15, 2001.

[16] SB 1577

- Submit a report of its findings to the Governor, the President of the Senate and the Speaker of the House of Representatives on or before August 15, 2002 and August 15, 2003. The reports shall include any recommendations for legislative or administrative changes as well as a recommendation whether the state shall continue to pay hospitals for uncompensated care. The report shall also include a recommendation regarding the continuation of payments to hospitals made by the Uncompensated Care Pool established by this act.

Hospital Reimbursement Study

The Director of AHCCCS, in cooperation with two urban hospitals, one rural hospital and a nonprofit trade association representing hospitals, will complete the Hospital Reimbursement Study to evaluate the inpatient hospital reimbursement system. The Director is to submit a report to the Joint Legislative Study Committee by November 15, 2002. The Study will include the following components:

- A methodology that will enable AHCCCS to compare reimbursement levels paid by AHCCCS contractors with the reimbursement levels of other categories of payers, including Medicare and insurers licensed pursuant to Title 20 ARS.
- Evaluation of the relationship between the inpatient hospital reimbursement rates and payments provided pursuant to Title 36 ARS, the actual costs hospitals incur in treating patients who are enrolled in AHCCCS.
- Review of the reimbursement methodologies used by selected states for Medicaid eligible persons.
- Review of the inflationary indicators that other states use to increase hospital reimbursement.
- Review of the federal requirements for Title XIX reimbursement of emergency services provided to non-documented clients, including any services that do not meet the definition of an emergency service and that may jeopardize Title XIX funding.
- Review of the impact of the Inpatient Hospital Reimbursement Pilot Program established by Laws 1996, Chapter 288, Section 20 on the reimbursement levels and the number of contracts that were signed between AHCCCS contractors and the hospitals before, during and after the pilot program.
- Recommendations that encourage contractual arrangements between AHCCCS and the hospitals to reduce the reliance on the fee-for-service schedule established by the system.

County Rights to Tobacco Settlement Funding

SB 1577 contains a September 30, 2001 delayed effective date that is conditional on each county relinquishing all rights and interest to the tobacco litigation settlement monies.

Arizona Counties formed a County Trust with the purpose of ensuring that Tobacco Settlement Funds would be made available to the counties and to ensure that the majority of the funding be directed to providing health care in Arizona. The counties' contention was that the cost data used in the tobacco litigation was data from when the counties were covering the care. The counties were not recognized for the costs they covered in providing health care, and they were concerned the results would not direct funding to health care. The Maricopa County Superior Court, in a Summary Judgment, ordered Maricopa County to work out the issues through Proposition 204. At this point, it is anticipated that counties will relinquish all claims to the Tobacco Settlement Funds.

AHCCCS Title XIX Expansion

AHCCCS filed a waiver request with the Federal Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA) to expand the populations that would be Medicaid eligible. On January 18, 2001, CMS approved the waiver through September 30, 2006 for the purpose of expanding eligibility to provide Medicaid coverage to individuals with income at or below 100 percent FPL and individuals who have incurred medical bills sufficient to reduce their income to 40 percent FPL. In effect, this approval allows single men and single women, couples without children and the "spend down" population to become Medicaid eligible. Additionally, AHCCCS filed a State Plan Amendment with CMS increasing the FPL to 100 percent for the Aged, Blind and Disabled population and for the Parents of Currently Eligible Children. The Aged, Blind and Disabled population and the Parent population are Medicaid eligible populations for which the state may establish the FPL limits through amendment to their State Plan.

On January 18, 2001, CMS approved the waiver through September 30, 2006 for the purpose of expanding eligibility to provide Medicaid coverage to individuals with income at or below 100 percent FPL and individuals who have incurred medical bills sufficient to reduce their income to 40 percent FPL.

In effect, this approval allows single men and single women, couples without children and the "spend down" population to become Medicaid eligible.

Since January 2001, AHCCCS has made numerous presentations regarding the upcoming changes in eligibility and the implementation plan. AHCCCS established the following principles to guide their implementation of Proposition 204:

- Implement at the earliest possible date
- Phase-in implementation to ensure services can be provided
- Improve and streamline the eligibility system for members
- Promote administrative efficiencies
- Maximize federal funding
- Maintain sensitivity to stakeholders

The phase-in schedule adopted by AHCCCS is:

- Phase I – April 1, 2001

  Add the Qualified Medicare Beneficiaries (QMB – Aged, Blind and Disabled) and the MN/MI populations. Phase I implementation includes an automatic conversion within the AHCCCS system of persons who were previously eligible for the Aged, Blind and Disabled population and the MN/MI population. On April 1, 2001, 18,867 individuals who were eligible under the MN/MI category were transferred to Medicaid eligibility, and 7,285 QMB individuals were added as Medicaid. Counties will continue to accept MN/MI applications until October 1, 2001 at their current income eligibility limits. All individuals qualifying through that process become automatically Medicaid eligible.

- Phase II – July 1, 2001

  Add individuals with serious mental illness currently served by the ADHS, Division of Behavioral Health Services (DBHS) and who have income less than 100 percent of the FPL (estimated to be between 6,161 and 9,242 individuals) and add the parents of some currently eligible children. Phase II implementation will include extensive outreach activities by AHCCCS and by ADHS/DBHS. ADHS/DBHS has developed, in coordination with AHCCCS, an outreach process to assist individuals with completion and submittal of the application. AHCCCS is providing written notices to parents of already eligible children. If parents do not respond to these notices, AHCCCS health plans will continue the outreach activities.

- Phase III – October 2001

  All remaining eligibility categories become effective. This phase includes the major changes in eligibility determination; the shift in eligibility determination processes from the 15 Arizona counties to ADES and continued outreach through AHCCCS, their health plans and the ADHS/DBHS.

Outreach

AHCCCS has contracted with seven Community-Based Organizations (CBOs) to inform the general public about Medicaid and KidsCare. The CBOs are to identify potentially eligible families and assist them in applying for AHCCCS health insurance. ADHS/DBHS has required the Regional Behavioral Health Authorities (RBHAs) to contract with or employ outreach workers specifically to assist behavioral health consumers with the application process. The efforts of the AHCCCS CBOs and the RBHAs have been coordinated by AHCCCS and ADHS through training and specific guidelines for eliminating duplication in the effort. As a general rule, whoever contacts the person first and begins assisting the individual will continue to follow through on the application process. If the behavioral health consumer reports that a CBO has completed an application for them, the behavioral health outreach workers will contact the CBO to ensure the application has been submitted.

Service Capacity

The AHCCCS/Medicaid benefit package available to the newly eligible populations includes all Medicaid eligible acute care and behavioral health services. The changes resulting from Proposition 204 do not impact the populations or services provided by the Arizona Long Term Care System (ALTEC).

AHCCCS anticipates that its health plans currently have or can develop the capacity to absorb the additional populations envisioned by Proposition 204. The AHCCCS health plans currently cover 11 percent of the Arizona population and include 60 percent of the licensed providers in the state.

Each Regional Behavioral Health Authority is currently assessing the service capacity within the Behavioral Health System. While some additional capacity may be needed to serve the April 1 – July 1 transition populations, the greatest impact will begin October 1, 2001 to accommodate the newly eligible population. See Behavioral Health Implementation for more detailed information.

Streamlined Eligibility Process

AHCCCS has developed a streamlined application process and a Universal Application form to be used when individuals or families apply for any of the health products offered by AHCCCS including Premium Sharing. ADES and AHCCCS will use the Universal Application regardless of the program for which application is being made. The Universal Application includes two pages to be completed by the applicant, an instruction/information page, a signature page with rights and responsibilities and a contact sheet.

The CMS Medicaid waiver permits Arizona to waive the requirement for face-to-face recertification interviews, which will allow ADES and AHCCCS to conduct recertifications via the telephone. This should improve administrative efficiency.

Arizona Department of Health Services, Behavioral Health Services

The ADHS is responsible for the State's publicly funded behavioral health services system. The system provides services to both Federally eligible populations (Title XIX and Title XXI) and state-only populations (those not eligible for Federal programs). The expanded coverage encompassed in Proposition 204 will result in the following changes in coverage for behavioral health services:

- New Medicaid eligible members, as a result of the change in income limits to 100% of poverty, will be eligible for Medicaid funded acute care services and behavioral health services. On average, approximately 5-10 percent of the total AHCCCS acute care population receive behavioral health services through the ADHS/DBHS. Of the estimated 186,000 new AHCCCS eligible members, an additional 9,000 to 18,000 individuals could receive behavioral health services.
- The general mental health and substance abuse populations served by ADHS with state funds will be eligible for the full continuum of acute care as well as behavioral health services if they meet the income criteria established by Proposition 204.

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Currently, behavioral health services for these populations are limited based on the availability of state appropriated funds.

- Persons with a serious mental illness currently receive the full continuum of behavioral health services through ADHS. If these individuals meet the income criteria, the full continuum of behavioral health services as well as acute care services will be available to this population.

ADHS/DBHS, in coordination with the Regional Behavioral Health Authorities (RHBAs), is implementing an extensive outreach effort to state-only behavioral health consumers to assist them in establishing AHCCCS eligibility. Those efforts began in May 2001, and are focused on the specific populations that are being phased into AHCCCS on April 1, July 1, and October 1, 2001.

ADHS/DBHS estimates that between 50-75 percent of the current state-only behavioral health population could become AHCCCS eligible due to the outreach efforts. This shift to Medicaid funding will make available state funds for non-Medicaid services and for individuals who are not Medicaid eligible.

In preparation for the phased-in implementation schedule, AHCCCS and ADHS compared their eligibility files to determine the potential number of persons with serious mental illness and general mental health needs receiving state-funded behavioral health services to the AHCCCS eligibility files for Aged, Blind and Disabled (QMB) and for the MN/MI populations. A total of 1,582 persons with serious mental illness and 3,155 persons with general mental health needs were projected to become Medicaid eligible based on a computer conversion from state-only eligibility to Medicaid eligibility on April 1, 2001.

CHART 6

Projected State-Only Behavioral Health Population to be Converted to Medicaid Funding – November 2000

Population	Number of State-Only Consumers	Estimated Number to Convert to Medicaid Eligibility
Adult – General Mental Health	8,178	4,089 to 6,133
Adult – Substance Abuse	14,491	7,245 to 10,868
Adult – Serious Mental Illness	12,323	6,161 to 9,242
TOTAL	34,992	17,495 to 26,243

Source: The Impact of Proposition 204 on the Public Behavioral Health System, ADHS, April 13, 2001.

The Phase II implementation process includes parents of already eligible children and individuals with a serious mental illness (SMI) who are determined disabled or who are elderly. AHCCCS is completing the outreach process for parents of already eligible children, while ADHS is completing the outreach for persons who are eligible for SMI services. Each RBHA has assigned individuals to follow the process described below to contact and assist individuals in completing the necessary application for Medicaid eligibility.

SMI Determination

AHCCCS and ADHS/DBHS are working to establish Medicaid eligibility for individuals with serious mental illness whose behavioral health services have been funded by state funds. AHCCCS requested and received approval from CMS to base the disability determination on the SMI Determination processed by DBHS. Individuals who are receiving Social Security Disability Insurance (SSDI) or who are aged will be Medicaid eligible as long as they meet the financial eligibility criteria (100 percent of FPL). For individuals who are not currently SSDI eligible or aged, the SMI Determination will be used as the basis for establishing categorical eligibility. (It is important to note that the cost of service for individuals who are categorically eligible does not count toward the budget neutrality requirement.) The Universal Application and documentation will be sent to the DES Disability Determination Services Administration for a decision regarding Medicaid eligibility. This does not determine a federal cash benefit, but it does establish categorical eligibility based on disability for Medicaid purposes.

Behavioral Health Outreach Process for Persons with Serious Mental Illnesses

STEP 1 RBHA – Informs the outreach worker which behavioral health consumers to contact.

STEP 2 The Outreach Worker – Contacts the consumer, assists the consumer in filling out the Universal Application and obtaining the necessary documentation, advises the consumer of what to expect next, and forwards the application packet to AHCCCS. Consumers who are not SSDI eligible or who are not elderly may be required to submit additional medical documentation.

STEP 3 AHCCCS – Makes the Title XIX eligibility determination, refers the family for screening (if appropriate), informs the health plan of the new enrollee by electronic process, communicates approvals/denials of Title XIX eligibility to the outreach worker, sends a letter to the consumer regarding approval/denial. For those approved, an AHCCCS insurance card will be sent to the consumer.

STEP 4 Health Plan – Sends a letter and member handbook to new members and requests the member to select a Primary Care Physician (PCP).

STEP 5 Outreach Worker – Contacts the consumer and assists with the PCP choice, assists the consumer in making their first appointment with the PCP, communicates approvals/denials of Title XIX eligibility and PCP information to the behavioral health service provider.

Capacity/Infrastructure Development for Behavioral Health Services

As a result of the addition of people and eligible services, ADHS/DBHS, along with the RBHAs, is conducting an assessment of the scope of needed services based on the projected service population increases. ADHS/DBHS anticipates a need to expand capacity, particularly in the areas of psychiatric hospital services and pharmacy and substance abuse treatment services, but will confirm this need based on each geographic service area. For persons with serious mental illness, the service package will be basically unchanged with regard to behavioral health services; i.e. persons with serious mental illness are eligible for the full continuum of behavioral health services whether they are state-only funded or federally funded services. This conversion will provide eligibility for acute care that is not currently available to this population, and will result in the change of fund source from state funding to federal Medicaid funding.

For persons who are receiving state-only funded or federal Mental Health Block Grant general mental health services and/or substance abuse treatment services, the current array of services is based on the availability of funds. These are not entitlement services. With the conversion to Medicaid eligibility, the full continuum of both acute care and general mental health/substance abuse treatment services must be made available to eligible persons.

Expansion of the behavioral health service continuum of care to accommodate the changes in benefit package and the increase in the number of eligible persons is being addressed by each of the RBHAs. The RBHAs can, within their current risk-based financial structures, invest in infrastructure development to a limited degree. The future enrollment of eligible persons and processing of claims for services provided must support not only the infrastructure development but the ongoing cost of direct services as well.

For persons who are receiving state-only funded or federal Mental Health Block Grant general mental health services and/or substance abuse treatment services, the current array of services is based on the availability of funds. These are not entitlement services.

Arizona Department of Economic Security

AHCCCS and ADES will amend their current IGA to further define the changes in the eligibility process provided by ADES. The IGA will define (1) the streamlined eligibility process to be used by ADES, (2) the expedited eligibility and enrollment for hospitalized applicants, (3) performance measures and incentives, (4) management evaluation review process, (5) quality control reviews, (6) rules for appeal and (7) methods to ensure that a sufficient number of eligibility workers are available in health centers, hospitals and level one trauma centers.

This expanded responsibility represents one of the largest operational implementation projects since the formation of ADES. The primary components of ADES implementation involve (1) assumption of the eligibility functions of the 15 Arizona counties and (2) the negotiation of IGAs with each of the county boards of supervisors to assume those functions or negotiation of IGAs with counties to maintain the eligibility functions for up to one year.

ADES is currently in the process of conducting a detailed county-by-county review of human resources, facilities, information technology and telecommunications, and fiscal issues; and discussing with representatives of the counties the possible conversion plans. The implementation schedule is as follows:

- June 2001 – complete preliminary assessment of the counties
- July 2001 – meet with each of the counties to negotiate transfers and timeframes
- August 2001 – complete an IGA with each county
- September 2001 – process IGAs through ADES and the County Board of Supervisors

By October 1, 2001 ADES must have completed:

- The IGAs to assume responsibility for the eligibility operation. (ADES may also enter into an IGA to allow a county to continue to perform eligibility for up to one year. The IGA would specify reimbursement levels and amount of fiscal sanctions for errors).

- Conversion of county staff employed in the eligibility process to the state personnel system. The estimated 500 to 700 county staff will have the option of converting to state employment with ADES. The State has agreed to convert county staff at their current level where it is higher than state level positions and provide state benefits effective the first day of state employment.
- Transition of county facilities and equipment as appropriate to ADES. There are currently approximately 100 county- and hospital-based eligibility sites, and many additional sites served on an itinerant basis.
- Training of staff in the revised eligibility requirements, the streamlined eligibility process and the use of information system technology.
- Establishment of processes which will allow 24 hour, 7 day-a-week processing of applications from hospital sites. ADES envisions this function operating in the same way Baby Arizona applications are processed, e.g. hospital administrative staff takes the initial application (which may be no more than a signed application), and ADES determines the eligibility at a later time. Once the initial application is taken, the effective date can be established retroactively to the first of the month of application. This is a significant improvement and critical implementation component from the hospital perspective, since it impacts directly the amount of uncompensated care provided.

Public Health Programs

Proposition 204 requires the Public Health Program Funding be adjusted annually for inflation. An Attorney General's opinion specified that the inflation calculation should include inflation since 1996, and that the amounts could not be prorated for partial year funding. In May 2001 the JLBC approved the following inflation adjustments for the FY 2001:[17]

CHART 7

Public Health Program Funding

Program	FY 2001 Funding
Healthy Families	$ 5,427,260
Arizona Health Education System	$ 4,341,808
Teen Pregnancy Prevention	$ 3,256,356
Disease Control Research	$ 2,170,904
Health Start	$ 2,170,904
WIC Food Program	$ 1,085,452
TOTAL	$18,454,684

HEALTHY FAMILIES PROGRAM

ADES will receive $5.4 million (including an inflationary factor) of Tobacco Settlement Funds for the Healthy Families Program. This is "a community-based multidisciplinary program serving families of newborns; and is designed to reduce stress, enhance parent-child interaction, promote child development and minimize the incidence of abuse and neglect within a multicultural environment."[18] As of April 3, 2000, the Healthy Families Arizona Program became the first in the nation to receive a four-year multisite credential from Prevent Child Abuse America and the Council on Accreditation.

FY 2001 funding for the Healthy Families Program was $6,497,917 with the majority of the funding ($4,334,732) from the State General Fund. The Child

[17] Fiscal Year 2002 and 2003 Appropriations Report

[18] Healthy Families Program Fact Sheet, Arizona Department of Economic Security, October 20, 2000

Abuse Prevention Fund, the Governor's Office of Drug Policy and a Community-Based Family Resource and Support Grant provide the additional funding. The Tobacco Settlement Funding of $5.4 million is a major increase for the program and could allow expansion of the program from 8.8 percent to 12 percent of the eligible families.

Since the Tobacco Settlement allocation is one time funding, the Healthy Families Steering Committee has provided recommendations to the ADES regarding expansion and expenditures. These recommendations specifically address the need to plan the expansion and potential reduction when Tobacco Settlement Funds are exhausted in a manner that allows all families that enter the 2 1/2-year program in the defined timeframe to actually complete it.

The ADHS will receive $3,256,356 for Arizona teen pregnancy prevention. Currently, ADHS's initiative includes a media campaign and 17 local projects in 12 counties directed toward reducing the number of births to single women through abstinence only education.

AREA HEALTH EDUCATION SYSTEM

The Arizona Area Health Education System (AzHEC), established under ARS 15-1643, is part of the University of Arizona College of Medicine. The system consists of five area health education centers, each representing a geographic area with specific populations that the system determines currently lack health care services. The goals of the centers are:

1. To provide health professions educational programs that recruit rural, minority and socio-economically disadvantaged students, and that encourage graduates to serve in Arizona's rural and medically underserved communities.
2. To provide continuing education programs for health professionals and practice site educational support services that enhance the retention of health professionals serving in Arizona's rural and medically underserved communities.
3. To provide health promotion and disease prevention community health education programs for people who live and work in Arizona's rural and medically underserved communities.

AzHEC currently operates several community-based projects and programs in order to meet its goals. Projects include rural and minority recruitment, clinical sites and residency rotations, retention strategies and continuing adult education and community health education programs. Tobacco Settlement Funding will support the implementation of projects and programs that are consistent with the AzHEC's.[19]

TEEN PREGNANCY PREVENTION PROGRAMS

The ADHS will receive $3,256,356 for Arizona teen pregnancy prevention. Currently, ADHS's initiative includes a media campaign and 17 local projects in 12 counties directed toward reducing the number of births to single women through abstinence only education. Most of these local projects are short term, focused on teens and implemented through schools. There is an evaluation component that will determine the efficacy of each of the strategies.

FY 2001 funding was $4,314,333 to support current efforts with the majority of the funding from a combination of federal funds ($2,501,000 in federal TANF dollars and $893,333 from the Bureau of Maternal and Child Health). The balance includes $670,000 in Tobacco Tax Funds and $250,000 from a general state appropriation specifically directed for teen pregnancy prevention. The ADHS is planning to use the new funding to develop three-year collaborative, comprehensive, community-based projects in target communities with particularly high rates of teen births. A request for proposals is being developed, and program implementation is anticipated to begin within five months of receipt of the Tobacco Settlement Funding. The ADHS goal is to allocate the $3.2 million funding to programs at a level that will make a demonstrable impact on the problem.[20]

[19] Arizona Board of Regents, Board Meeting May 24, 2001, Executive Summary, Item #1

[20] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, Senate Bill 1577, Teen Pregnancy Prevention Programs, June 5, 2001.

HEALTH START PROGRAM

The ADHS will receive $2,170,904 million for the Health Start Program. Health Start is a community health outreach program that assists families in vulnerable communities to access community-based health services. It is implemented through contracts with local agencies that employ lay health workers who live and reflect the ethnic, cultural and socioeconomic makeup of the communities. The program is in place in 15 communities and serves approximately 2,500 families. The ADHS will use the new funding to expand the number of women/families served through existing and new sites. Priority will
be given to the three counties that do not have a program and communities that have poor perinatal outcomes.[21]

DISEASE CONTROL RESEARCH FUND

The ADHS will receive $1 million from the Disease Control Research Fund in FY 2002 and FY 2003 for distribution to universities, hospitals and research centers in this state for Alzheimer's research, recruitment and retention efforts. Additionally, the Disease Control Research Commission shall receive $800,000 in each of the fiscal years to contract for research on Parkinson's Disease, $200,000 in each fiscal year for research on diseases of the brain and $100,000 in each fiscal year for research on Parkinson's Disease.

WOMEN, INFANTS AND CHILDREN

The ADHS will receive $1,085,000 million for the Women, Infants and Children Food Program (WIC). Implemented through local agencies and participating grocery stores, this program provides nutrition education, food and access to other health services for pregnant women, infants and young children. The program provides services to approximately 122,000 participants per month.

The program is entirely federally funded through a grant from the U.S. Department of Agriculture. The $1.085 million new funding will be used to implement a Folic Acid Distribution and Education Program within the state. It will also provide match funding to establish a Farmer's Market Nutrition Program. Folic acid has been determined to significantly reduce the incidence of neural tube birth defects.

[21] Arizona Department of Health Services, 2001 Legislative Implementation Action Plan, Senate Bill 1577, Health Start, June 4, 2001.

Tobacco Settlement Funding Revenue Schedule

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Balance Forward	$ 2,314,100					
Payments	$86,556,700	$108,498,200	$109,789,900	$96,175,200	$97,307,100	$98,470,200

Source: Fiscal Year 2002 and 2003 Appropriations Report, AHCCCS, p. 55.

Expenditure Estimates – Tobacco Settlement Funding

The JLBC Fiscal Year 2002 and 2003 Appropriations Report provides low end and high end estimates for
the expenditure of Tobacco Settlement Funds based on the number of individuals who become eligible for AHCCCS coverage.

Low End Estimate

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Balance Forward	$ 2,314,100	$ 70,416,100	$ 39,748,200	$ 3,473,500		
Payments	$86,556,700	$108,498,200	$109,789,900	$96,175,200	$97,307,100	$98,470,200
Total Available	$88,870,800	$178,914,300	$149,538,100	$99,648,700	$97,307,100	$98,470,200
Prop 204 AHCCCS		$100,351,500	$126,881,200	$99,648,700	$97,307,100	$98,470,200
Prop 204 Public Health	$18,454,700	$ 18,814,600	$ 19,183,400			
Prior Approp. ASH		$ 20,000,000				
Total Expenditures	$18,454,700	$139,166,100	$146,064,600	$99,648,700	$97,307,100	$98,470,200
Balance Forward	$70,416,100	$ 39,748,200	$ 3,473,500			

Source: Fiscal Year 2002 and 2003 Appropriations Report, AHCCCS, p. 55.

High End Estimate

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Balance Forward	$ 2,314,100	$ 70,416,100	$ 16,314,400			
Payments	$86,556,700	$108,498,200	$109,789,900	$96,175,200	$97,307,100	$98,470,200
Total Available	$88,870,800	$178,914,300	$126,104,300	$96,175,200	$97,307,100	$98,470,200
Prop 204 AHCCCS		$123,785,300	$126,104,300	$96,175,200	$97,307,100	$98,470,200
Prop 204 Public Health	$18,454,700	$ 18,814,600				
Prior Approp. ASH		$ 20,000,000				
Total Expenditures	$18,454,700	$162,599,900	$126,104,300	$96,175,200	$97,307,100	$98,470,200
Balance Forward	$70,416,100	$ 16,314,400				

Source: Fiscal Year 2002 and 2003 Appropriations Report, AHCCCS, p. 55.

Budget Neutrality Fund Estimates

The CMS Waiver allowing Arizona to include the 100 percent FPL population under Arizona's Medicaid program provides approximately two-thirds Federal matching money for the cost of this population. The waiver approval also limits the amount of Federal Medicaid funding (Budget Neutrality) the state can receive over the five and one-half years of the waiver. The Budget Neutrality Fund has been created to ensure AHCCCS has a source of funding to meet this required limitation. Based on projected growth in the AHCCCS program, the JLBC has provided Low End and High End Estimates regarding the use of the monies held in the Budget Neutrality Fund.

- Low End – The Budget Neutrality Fund will contain $83,768,400 at the end of the waiver (FY 2006).
- High End – The Budget Neutrality Fund will contain $135,762,700 to meet the CMS requirement. In the high-end scenario, it also becomes necessary to begin supporting Proposition 204 expenditures from the Budget Neutrality Fund during FY 2003.[22]

[22] Fiscal Year 2002 and 2003 Appropriations Report, AHCCCS, p. 55

Long-Term Financial Impact

The JLBC staff has estimated that Tobacco Settlement Funding will no longer be adequate to fund the Proposition 204 expansion after FY 2003. Since the Proposition clearly prohibits the Legislature or AHCCCS from capping or reducing the eligibility levels, it will be necessary for the state to identify the ongoing funds necessary to support this expansion. Obviously, this is going to generate a great deal of discussion and probably no small amount of controversy in the years ahead.

Uncompensated Care

Proposition 204 will not resolve the issues surrounding uncompensated care. Adequate documentation was not available to effectively estimate the impact Proposition 204 will have on uncompensated care, nor does anyone know the actual uncompensated care amount currently provided in Arizona. Timely processing of applications for eligibility by ADES at the hospitals can have a tremendous impact of reducing the uncompensated care provided by hospitals, and the Hospital Reimbursement Study included in SB 1577 is going to address this issue. Nevertheless, Proposition 204 underscores not only the need to develop better integrated communications, tracking and information systems to accurately assess uncompensated care so we know what we're talking about, but also the importance of continuing to explore ways of providing timely access to affordable health care for all Arizonans.

Woodwork Effect

All parties have identified the potential for "woodwork effect" impacts – the potential for additional persons to be added to the Medicaid, Food Stamps and TANF programs as a result of the publicity and outreach surrounding Proposition 204 implementation. Although Proposition 204 does not directly expand the number of children who would be eligible for Medicaid, part of the "woodwork" effect will include additional children becoming eligible for both acute care and behavioral health care services.

Implementation of Arizona's KidsCare program resulted in 50,000 children being determined KidsCare eligible. In addition to those 50,000 children, an additional 56,000 individuals were added
to other medical programs, primarily Title XIX, as a result of the KidsCare outreach effort. The woodwork was real in KidsCare, and it should be real this time as well. It will bring in not only additional people
eligible for health care, but people eligible for food stamps and cash assistance benefits.

AHCCCS acute care coverage (not including long term care or emergency services) has increased significantly since the beginning of the 2001 calendar year – some 30,156 additional people. Part of this growth can be attributed to Proposition 204 implementation. In April, Proposition 204 conversions resulted in over 7,000 QMB individuals being added to the eligible population, and individuals who would have been MN/MI are being added each month. The policy issue, of course, is the state's financial and organizational capacity to deal with those who come out of the "woodwork" for additional services.

~ Proposition 204 will not resolve the issues surrounding uncompensated care. Adequate documentation was not available to effectively estimate the impact Proposition 204 will have on uncompensated care, nor does anyone know the actual uncompensated care amount currently provided in Arizona.~

CHART 8

AHCCCS Program Growth

Month	Total Number of People with AHCCCS Coverage	Increase in the Number of People from the Prior Month
January 2001	513,319	XXXXXXXXXX
February 2001	515,024	1,705 people
March 2001	516,930	1,906 people
April 2001	534,405	18,381 people
May 2001	543,475	9,070 people
June 2001	551,334	7,859 people
July 2001 (as of 7/17/01)	568,578	17,244 people

Source: AHCCCS, BMcNeal, June 5, 2001 and July 16, 2001.

Dual Eligibility

Depending upon their income, people who are Medicare eligible may also be eligible for Medicaid. With the change in FPL, additional persons in this category may access Medicaid benefits especially to take advantage of pharmacy benefits. While this is not a new program component, only 70,000 people currently access this option. The Area Agency on Aging and the American Association of Retired People (AARP) are conducting outreach activities to notify people of this coverage. The policy issue, as with everything else, is finding the right match between fiscal and organizational capacity and the demand and need for services.

AHCCCS WILL EVALUATE the actual impact of Proposition 204 by answering these questions:

- Did the projected number of eligible people access the system?
- What effect did the outreach activities have on access to services?
- How can access information be used to inform future outreach and marketing activities?

Additional opportunities for evaluation identified by AHCCCS include:

1. What was the impact on the cost of health care in Arizona? With the addition of potentially thousands of additional people with health coverage, was the cost of care reduced and/or were other types of insurance premiums reduced?
2. Have utilization patterns shifted? With up to 186,000 additional people covered by AHCCCS, did the number of emergency room visits decline?
3. Did commercial insurance companies cover less people as a result of this change? Since many of the working poor will be covered by the implementation of Proposition 204, did commercial insurance companies discontinue basic coverage policies? Did employers reduce health options for their employees?
4. What is the real impact of Proposition 204 on the number of uninsured in Arizona? Proposition 204 has been described as a good step in addressing the uninsured population, but exactly what will that mean? Senator Carruthers' Committee and the Health Coverage Task Force is looking at other options for increasing coverage, supported in part by a technical assistance grant from St. Luke's Health Initiatives and a federal grant received by AHCCCS.
5. Proposition 204 has been described as a "budget buster" for Arizona. Once projected expenditures equal the Tobacco Settlement Funds, what are the options for the state to provide continued funding? What, if any, other state-funded programs might be reduced to compensate for the funds needed to support the policy commitment made with Proposition 204?
6. With more people able to access health care through Proposition 204, will the state see a demonstrable improvement in the overall health of Arizonans? Officials will continue to review established health status indicators to help answer this question, but the issue is complicated by the fact that health outcomes are affected by more than just access to care.

All manner of interest groups, consumer and family advocates, providers and professional associations plan to follow the legislative implementation closely and will no doubt be part of a lively debate on what's been promised, what's been achieved, and how we can continue to provide timely access to health care for all Arizona citizens in a prudent and responsible manner.

Other Evaluation Considerations

Finally, the evaluation of the impact of Proposition 204 on Arizona will be the province of more than just state activities. All manner of interest groups, consumer and family advocates, providers and professional associations plan to follow the legislative implementation closely and will no doubt be part of a lively debate on what's been promised, what's been achieved, and how we can continue to provide timely access to health care for all Arizona citizens in a prudent and responsible manner.

St. Luke's Health Initiatives' intent is to continue to support selected evaluation and dissemination activities, both in the public and private sectors, to insure that all relevant and defensible information is brought forward, and all voices have an opportunity to be heard in civil discussion.

The following individuals provided significant background and implementation information regarding Proposition 204 and Senate Bill 1577. Their thoughts and insight into the complexities of implementing an initiative of this magnitude are sincerely appreciated.

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