

# POLICY BRIEF



July 2011

## Insuring Arizona Preserving AHCCCS Coverage in a Challenging Economy

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### Introduction

In recent years, Arizona policy makers have dealt with extensive budgetary challenges that are primarily a result of the economic downturn. Financing the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, continues to be particularly challenging. The purpose of this policy brief is to provide a basic structural overview of the AHCCCS program, describe the unique aspects of Arizona's version of Medicaid, and present a potential solution that would fill the funding gap, prevent job losses in the health care sector, and avoid further health care cost shifts to private sector employers.

### History

In 1965, Congress passed legislation that was designed to provide senior citizens and low income families with access to health care services. Medicare, enacted as Title XVIII of the Social Security Act, provides senior citizens over the age of 65 with health care coverage and is fully funded and administered at the federal level. Medicaid, enacted as Title XIX of the Social Security Act, is a collaborative program between the federal government and the states that provides low income families and the disabled with access to health care coverage, including long term care. State participation in Medicaid is optional but all states have chosen to participate. The federal government contributes no less than 50% of the program expense but has contributed as much as 85%.

Since 1965, there have been a number of notable reforms and expansions of Medicare and Medicaid, including the creation of the State Children's Health Insurance Program (CHIP) in 1997. Now referred to as CHIP, the program gives states the option to expand coverage to children from low-income families who are above the traditional Medicaid eligibility thresholds.

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In 2010, Medicare (47 million) and Medicaid (60 million) combined to cover over 100 million Americans. In Arizona, 890,000 individuals are enrolled in Medicare and another 1.3 million in Medicaid.<sup>1</sup>

### Medicaid Structure

All individuals who meet the established criteria are eligible to receive benefits through Medicaid.<sup>2</sup> Eligibility for Medicaid coverage depends on two main factors. An individual must be a member of a covered population and annual income cannot exceed certain levels. The federal government sets minimum coverage standards for each of these factors, but the states also have the option to expand eligibility beyond the federal minimums.

Income eligibility levels are expressed as a percentage of the Federal Poverty Level (FPL), a household income measurement that is set annually by the U.S. Department of Health and Human Services (HHS). The 2011 FPL for a single adult is \$10,890 and the income threshold increases by \$3,820 for each additional family member. For a family of four, this translates to annual income of \$22,350.

The mandatory covered populations and the associated income eligibility levels are presented below:

#### *Children (age 0-19)*

The federal government requires state Medicaid programs to cover children below the age of 6 up to 133% of FPL and children between 6 and 19 up to 100% of FPL. All 50 states have elected to expand coverage of children to some extent. Arizona has elected to expand coverage for infants, age 0-1, up to 140% of FPL.

In addition to children who are eligible for traditional Medicaid coverage, Arizona’s CHIP program, KidsCare, covers children from families with annual income up to 200% of FPL. However, since January 2010, enrollment in KidsCare has been frozen, meaning no new children are being accepted into the program even if they meet the income eligibility

requirements. As a result, enrollment has declined from nearly 46,000 in January 2010 to less than 19,000 in June 2011.<sup>3</sup>

#### *Pregnant Women*

The federal government requires state Medicaid programs to cover pregnant women up to 133% of FPL. Forty five states have expanded coverage for pregnant women. Arizona has elected to expand coverage for pregnant women up to 150% of FPL.

#### *Elderly or Disabled*

The federal government requires state Medicaid programs to cover certain elderly or disabled individuals up to 75% of FPL. Arizona has elected to expand coverage for elderly or disabled individuals up to 100% of FPL.

#### *Parents*

The coverage requirements for working parents vary by state. The federal requirement is 23% of FPL, but Arizona has elected to expand coverage for working parents up to 100% of FPL as a result of Proposition 204, a voter approved initiative discussed later in this brief.

Table #1 depicts the minimum federal coverage

**Table #1**  
*Medicaid Eligible Populations*

<b>Population</b>	<b>Federal Minimum</b>	<b>Arizona</b>
Children ages 0-1. Traditional Medicaid	133%	140%
Children ages 1-5. Traditional Medicaid	133%	133%
Children ages 6-19. Traditional Medicaid	100%	100%
Children ages 0-19. KidsCare (Enrollment Frozen)	N/A	200%
Pregnant Women	133%	150%
Elderly or Disabled	75%	100%
Parents	23%	100%

requirements for each population, as well as the coverage levels in Arizona.<sup>4</sup> Like many states, Arizona has chosen to expand coverage beyond the federal requirements in certain cases.

### Medicaid Funding

Once a state establishes eligibility criteria, it is obligated to provide health care coverage to all individuals who meet the criteria. The expenses associated with providing that coverage are then divided between the state and federal government. The degree to which the federal government contributes toward the cost of each state's Medicaid expenses depends on each state's Federal Medical Assistance Percentage, or FMAP. This number, which varies by state between 50% and 85%, is determined annually by HHS. In Arizona the FMAP is 65.85%, meaning that the federal government pays for 65.85% of AHCCCS expenses and the state pays for the remaining 34.15%. The state contribution comes from a number of sources, including the state general fund, tobacco settlement fund, and tobacco tax revenues.

### Arizona Health Care Cost Containment System

As noted earlier, Medicaid is an optional program in which states choose to participate. In 1982, Arizona became the final state to join Medicaid when it established AHCCCS. AHCCCS uses a managed care model of Medicaid service delivery that is designed to both improve quality and reduce costs. Since the 1990s, states across the country have been transitioning away from the traditional fee-for-service Medicaid model and toward the managed care model pioneered by AHCCCS. Today, around 70% of Medicaid beneficiaries nationwide are enrolled in a managed care program and AHCCCS has been recognized by multiple organizations as the model for low cost and efficiency.<sup>5,6</sup>

Managed care models are designed to improve quality and reduce costs by facilitating coordination among providers and emphasizing the importance of primary care and prevention. Under the man-

aged care model, providers join together to form a "managed care organization" (MCO) that provides a certain combination of health care services. These organizations then receive a fixed payment per enrollee, known as a capitation payment. Because the capitation payment is fixed regardless of the service provided to a member, there is an incentive for the MCO to efficiently deliver high quality health care services.

### *Section 1115 Waiver*

Section 1115 of the Social Security Act enables the Secretary of HHS to grant waivers that "authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute."<sup>7</sup> These waivers, which are generally granted for five-year periods, allow states to structure their Medicaid program in ways that would not otherwise be allowed under federal statute. Additionally, programs operated under a waiver must be "budget neutral." Budget neutrality means that the cost to the federal government cannot exceed the cost that it would incur without the waiver program. Since its inception in 1982, AHCCCS has operated as a demonstration project under a Section 1115 waiver. Arizona's current waiver expires on September 30, 2011 and a revised waiver renewal application was submitted to CMS on March 31.

### Proposition 204

Arizona, Delaware, Hawaii, New York, Vermont, and the District of Columbia are the only six jurisdictions that have expanded Medicaid eligibility to at least 100% of the federal poverty level. The voters first approved such an expansion in 1996 when Proposition 203, Healthy Arizona I, received 72% of the vote. While this initiative expanded eligibility to 100% of FPL, the expansion was never funded. After the initiative was passed, AHCCCS twice submitted waiver applications to the Health Care Financing Administration (now CMS) that would have allowed Arizona to use federal matching funds to cover a portion of the costs associated with the expansion population. However, the federal gov-

ernment denied both requests because the waivers proposed a cap on the number of enrollees.<sup>8</sup> As a result, the cost of covering the expansion population would fall solely on the state of Arizona, and the legislature chose not to fund the expansion.

A new funding source for the Medicaid expansion became available when Arizona joined 46 states in signing the Master Settlement Agreement (MSA) with the tobacco industry in 1998. This \$246 billion agreement entitled Arizona to receive \$3.2 billion from the tobacco industry over 25 years.<sup>9</sup> In 2000, the voters again approved an expansion of health care coverage for low income Arizonans when Proposition 204 passed with nearly 63% of the vote. Unlike the 1996 expansion, Proposition 204 addressed the funding of the expansion directly:

“To ensure that sufficient monies are available to provide benefits to all persons who are eligible pursuant to this section, funding shall come from the Arizona Tobacco Litigation Settlement Fund...and shall be supplemented, as necessary, by any other available sources including legislative appropriations and federal monies.”<sup>10</sup>

After passage, AHCCCS again submitted a waiver application that would enable the states to use federal matching funds to cover a portion of the costs associated with coverage of the expansion population. This waiver application was initially approved in January of 2001 and the Proposition 204 expansion population is now part of the standard AHCCCS Section 1115 waiver that expires on September 30, 2011.

### AHCCCS Post Proposition 204

Since 2000, the AHCCCS population has grown from 509,000 to 1.36 million.<sup>11</sup> Of the 1.36 million AHCCCS enrollees, approximately 375,000 are eligible as a result of Proposition 204.<sup>12</sup> Of the 375,000 members of the expansion population, approximately 221,000 are childless adults. The tobacco settlement funds quickly proved insufficient to cover the full cost of the expansion population.

In 2002, voters created a new dedicated funding stream to help fund the coverage of the expansion population with the passage of Proposition 303, a \$0.60 per pack cigarette tax. Forty-two percent of the new tax revenue was allocated to covering the Proposition 204 population. Despite the tobacco tax revenue created by Proposition 303, the general fund commitment continued to increase. Additionally, Medicaid is a counter cyclical program, meaning that demand for Medicaid services increases during a weak economy and decreases during a strong economy. As a result, the growth in the eligible population has been especially dramatic during the Great Recession, expanding by 46% since FY 2007. This rapid population growth has resulted in rising general fund costs. Since 2007, general fund support for AHCCCS grew by 65% and AHCCCS now accounts for 29% of total general fund spending, up from 17% in 2007.<sup>13</sup>

Due in large part to the enactment of the federal Patient Protection and Affordable Care Act (ACA), growth in the AHCCCS population is expected to continue. Starting in 2014, state Medicaid programs will be required to cover all individuals at or below 133% of FPL. AHCCCS estimates that this expansion will increase the eligible population by 91,500 individuals. In addition, AHCCCS estimates that another 147,300 individuals who are currently eligible but not enrolled will join AHCCCS because of the new federal requirement that all Americans obtain health insurance. This is known as the “woodwork effect.”<sup>14</sup>

The costs associated with this coverage expansion will be shared between the federal government and the state as follows:

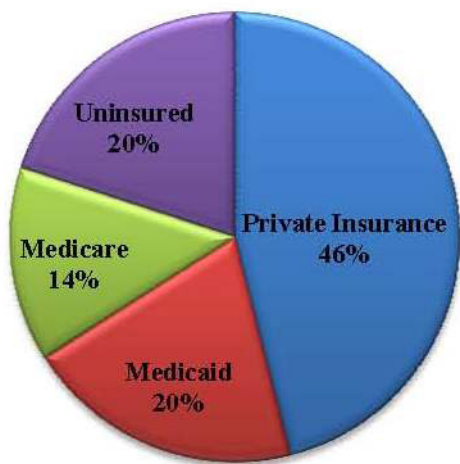
The FMAP for newly eligible enrollees will be 100% from 2014 through 2016, and will decline annually until it reaches 90% in 2020 and beyond.<sup>15</sup> Because Arizona expanded coverage to 100% of FPL in 2000, this enhanced FMAP will only apply to newly eligible enrollees between 100% and 133% of FPL. However, for the majority of states that did not elect to expand coverage, the enhanced FMAP

will apply to a much larger population. States that do not currently cover the childless adult population will receive the enhanced FMAP for all individuals that earn between 0% and 133% of FPL. AHCCCS estimates that this expansion will cost the state \$1.3 billion from 2014 through 2023.

To partially address this inequitable situation that penalizes Arizona for previously expanding Medicaid coverage, the ACA reconciliation bill includes a phased-in increase in the FMAP for childless adults. Starting in 2014, the childless adult FMAP increases to 83% and rises incrementally to 93% by 2019. For 2020 and beyond, the FMAP will be 90%. AHCCCS estimates that the “woodwork effect” will cost the state \$3.4 billion from 2014 through 2023.

**Health Insurance Coverage in Arizona**

**Chart #1**  
*Health Insurance Coverage in Arizona*



Nearly 1.3 million Arizonans were uninsured in 2009 - the fourth highest percentage of uninsured in the country.<sup>16</sup> Large populations of uninsured individuals create a major challenge for any health care system because the uninsured still receive treatment for many conditions. Rather than being treated by a primary care physician for a relatively minor ailment, the uninsured individual is more likely to wait until the condition worsens prior to seeking treatment. The result of the delay is often an expen-

sive hospital emergency room visit that could have been avoided with earlier treatment. Furthermore, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 which requires hospitals to examine any individual who requests an examination and treat any individual who is found to have an emergency medical condition, regardless of the person’s ability to pay. This requirement exposes health care providers to significant and substantial amounts of uncompensated care when uninsured individuals receive emergency medical services but are unable to pay. Providers respond to uncompensated care by charging higher prices to those who are able to pay. This cost shift, which drives up insurance premiums for employers and individuals who purchase coverage in the private insurance market, is known as the hidden health care tax.

In addition to uncompensated care, the hidden health care tax also includes Medicare and Medicaid reimbursements that fail to cover a provider’s full cost of treatment. In total, \$1.3 billion in underpayments and uncompensated care were shifted to employers and individuals during 2007. Uncompensated care accounted for \$390 million of that cost shift.<sup>17</sup>

Employers and individuals have a limited capacity to absorb the cost shift. As premiums rise, employers and individuals are priced out of the insurance market, which increases the uninsured population and further reduces the population of patients to which providers can shift costs. In response, providers are forced to absorb more of the losses internally. Eventually, these losses can lead to staffing reductions or even facility closures. The implications for reductions in health care employment and facility closures are serious, as hospitals alone directly employ nearly 80,000 Arizonans and account for 5.2% of the state’s gross domestic product (GDP).<sup>18</sup> In many communities across the state, hospitals are the largest private employer in those communities.<sup>19</sup>

## AHCCCS Budget

In response to chronic budget deficits since 2008, Arizona lawmakers have made repeated cuts to AHCCCS. In total, nearly \$1.2 billion of state and federal funding has been cut from the AHCCCS program, as illustrated in table #2.<sup>20</sup>

**Table #2**  
*AHCCCS Funding Cuts, 2008-2011*

Provider Rate Reductions	\$713 million
Institutional Rate Freezes	\$241 million
Eligibility Reductions (KidsCare & KidsCare Parents)	\$121 million
Benefit Changes	\$39 million
Administrative Reductions	\$29 million
Increased Member Cost Sharing	\$28 million
<b>TOTAL</b>	<b>\$1.17 billion</b>

The enacted FY 2012 budget includes additional changes to the AHCCCS program, particularly the Proposition 204 population. This budget is intended to reduce the Proposition 204 population to a level that can be supported by the revenue from the tobacco settlement and tobacco taxes. In order to achieve this, enrollment will be frozen for two population categories. On May 1, AHCCCS froze enrollment for the 6,035 member Medical Expense Deduction (MED) population. These individuals do not otherwise qualify for AHCCCS, but medical expenses reduce their income to less than 40% of FPL. The program will be fully phased out by October 1, 2011. On July 8, AHCCCS froze enrollment for the 221,952 member childless adult portion of the Proposition 204 population. Over time, this population will be reduced to a level that can be supported by the tobacco settlement and tobacco tax revenues.<sup>21</sup>

The constitutionality of the childless adult enrollment freeze has been called into question. On May 23, the Arizona Center for Law in the Public Interest, the William E. Morrison Institute for Justice, and the Arizona Center for Disability Law filed a lawsuit challenging the elimination of Medicaid coverage for the Proposition 204 population. The plaintiffs argue that the legislature cannot reduce coverage eligibility because the expansion was voter approved, and therefore subject to Proposi-

tion 105 protections that prohibit the legislature from overturning a law that is passed through the initiative or referendum process. The plaintiffs argue that the Medicaid eligibility issue related to the Proposition 204 expansion can only be changed by the voters, not the legislature. Both the Maricopa County Superior Court and the Arizona State Supreme Court have so far denied issuing an injunction that would have prevented the state from freezing enrollment.

The outcome of the lawsuit is unclear, but in the event that it is successful, the state would need to backfill approximately \$207 million to continue coverage of the Proposition 204 population, either through a revenue increase or spending reductions in other areas of the state budget. A mechanism known as a “special health care assessment” is one potential solution that would solve this budget gap and is considered by many to be a viable remedy.<sup>22</sup>

### Special Health Care Assessment

As discussed earlier in this brief, the states and the federal government share the responsibility for financing Medicaid. One common financing mechanism used by many states to generate their share of the contribution is known as a “special health care assessment.” The basic structure of a special health care assessment is the following:

1. Health care providers make a payment to the state. There are many ways to determine the size of the payment made by each provider. Some examples include:
  - Alabama collects a \$0.10 fee on each prescription that is greater than \$3.
  - Tennessee collects a \$2,225 annual fee per nursing home bed.
  - Kansas collects an annual 1.83% assessment on hospital inpatient operating revenues.
2. The money collected from the providers is dedicated to the Medicaid program. This state spending on Medicaid triggers federal matching

funds at the pre-determined FMAP rate.

3. Monies derived from the assessment are used to reimburse providers for the cost of treating Medicaid patients.
4. Special health care assessments are not passed on to consumers because providers are reimbursed through increased Medicaid payments. The existence of an assessment does not lead to increased costs for individuals or businesses that incur health care costs.

The special health care assessment is a powerful tool that helps states leverage federal funds. However, the current debate in Congress related to federal deficit reduction has prompted a discussion of curtailing or eventually eliminating the use of special health care assessments.<sup>23</sup> While the use of a special health care assessment is still currently a viable vehicle, policy makers should recognize that federal actions could change use of this option in the future.

#### *Federal Requirements<sup>24</sup>*

The federal government requires special health care assessments to meet three primary criteria:

1. **Broad Based:** There are 19 classes of health care services that can be subject to a special health care assessment. In order for an assessment to qualify as broad based, all providers within a given class must be subject to the assessment.
2. **Uniformly Imposed:** In order for an assessment to be imposed uniformly, the assessment rate must be the same for all entities within a class. For example, if nursing homes pay an assessment on net revenue, the rate must be the same for all nursing homes. Imposing a 1% assessment on nursing home A and 2% assessment on nursing home B would not be allowed.
3. **Cannot Hold Providers Harmless:** A provider

cannot be directly reimbursed by the state for the amount of money that the provider is assessed. Money will flow back to providers who treat Medicaid patients in the form of Medicaid payments, but a provider cannot be guaranteed that the payments will fully offset the size of the assessment.

In addition, the HHS Secretary is allowed to waive both the broad based and uniformly imposed requirements if the assessment is determined to be “generally redistributive.”

#### *Special Health Care Assessments in Other States*

Forty seven states, including Arizona, already have at least one type of special health care assessment in place.

- Nursing Homes: 38 States
- Hospitals: 34 states
- Intermediate care facilities for individuals with mental retardation/disabilities: 34 states
- Managed care organizations: 11 states

Arizona currently has a 2% of net premium provider assessment in place for the AHCCCS health plans.

#### **Potential Expansion of Special Health Care Assessments in Arizona**

Expanding the use of special health care assessments is a potential solution that would enable Arizona to maintain coverage for the Proposition 204 population until the provisions of Federal Health Care Reform begin in 2014. The federal government lists 19 classes of health care services to which special assessments can be applied.<sup>22</sup> Hospitals, skilled nursing facilities, and AHCCCS health plans are among the classes of health care services that have been discussed as possibilities for special assessment expansion in Arizona. The exact size and structure of the assessment on each class is something that would need to be negotiated among policy makers and members of the health care industry, but the basic structure could be some

combination of the following:

*Hospital Assessment*

Assess hospitals based on the number of inpatient days, excluding Medicare days.

*Nursing Facility Assessment*

Assess skilled nursing facilities based on the number of patient days.

*AHCCCS Health Plans*

Increase the assessment on AHCCCS health plans. Currently, AHCCCS health plans are assessed a special health care assessment equal to 2% of premium revenue.

**Conclusion**

Financing the coverage of the Proposition 204 expansion population remains a challenge for Arizona policy makers. Raising taxes or reducing spending on other core government functions are both unpopular and damaging options. A special health care assessment like the one proposed by Arizona's health care community is a viable and workable alternative that should receive active and timely consideration from the legislature. By preventing additional growth in Arizona's uninsured population, the special health care assessment will protect employment in the health care sector and limit business exposure to further damaging increases in the hidden health care tax.

## Notes

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- <sup>6</sup> “AHCCCS Update” presentation. Accessed at <http://www.ospb.state.az.us/documents/2011/cms%20presentation%20-%20ahcccs.pdf>.
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- <sup>12</sup> AHCCCS briefing to CMS. February 2011. Accessed at <http://www.azahcccs.gov/reporting/Downloads/BudgetProposals/FY2012/AHCCCSBrieftoCMS2-8-11.pdf>.
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- <sup>16</sup> Kaiser Family Foundation. [www.Statehealthfacts.org](http://www.Statehealthfacts.org).
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<sup>20</sup> “AHCCCS Update” presentation. Accessed at <http://www.ospb.state.az.us/documents/2011/cms%20presentation%20-%20ahcccs.pdf>.

<sup>21</sup> “Arizona’s Medicaid Reform Plan.” Accessed at <http://www.azahcccs.gov/shared/Downloads/News/TrackingMedicaidReformPlan.pdf>.

<sup>22</sup> In 2011, the concept of a special health care assessment was supported by the Arizona Association of Community Health Centers, Arizona Chamber of Commerce and Industry, Arizona Nurses Association, Flagstaff Chamber of Commerce and Yuma Chamber of Commerce.

<sup>23</sup> “Report of the National Commission on Fiscal Responsibility and Reform. December 2010. Accessed at [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf).

<sup>24</sup> “Medicaid Financing Issues: Provider Taxes.” May 2011. Accessed at <http://www.kff.org/medicaid/8193.cfm>.

<sup>22</sup> 42 CFR 433.56