Senator Smith's Medicaid Roundtable
Testimony of Anthony Rodgers
Director Arizona Health Care Cost Containment System
September 13, 2006

Thank you, Chairman Smith for this opportunity to participate in this roundtable and discuss the key issues facing the future of Medicaid. It is my hope that my testimony will serve to provide insight not only into the problems facing Medicaid but the potential solutions.

As the Director of the Arizona Health Care Cost Containment System, I am proud to lead one of the best run Medicaid programs in the United States. AHCCCS, pronounced ***access***, has operated under an 1115 demonstration waiver since its inception in 1982.

Twenty-five years ago, Arizona was not even part of the Medicaid program, choosing to finance indigent care with only state/local funding. Needless to say, the escalating cost of care and the demand for wider access to health care providers created a strong incentive for the Arizona legislature to rethink its opposition to being part of the Medicaid program. Still, the thought of creating a traditional fee for service Medicaid program was unacceptable to the Arizona legislature and Governor at that time. The Arizona legislature and Governor devised a program that would be different than the traditional fee for service Medicaid program operating in every other state. TheArizona Medicaid program would be organized to avoid the financial and operational problems plaguing other state Medicaid programs. It would be built around the principles of managed care to control costs, assure quality of care, and provide access to primary care.

As the name implies, the Arizona Health Care Cost Containment System was established on the principle that quality of care and cost containment are not mutually exclusive outcomes. AHCCCS integrates the principles of managed care throughout acute care and long term care programs. Contracts with health plans require that a managed care organization (MCO) is capable of delivering all needed services in return for a prepaid monthly capitation. Admittedly, it was only after some initial ups and downs, that the Arizona Medicaid managed care program has become a model for other states.

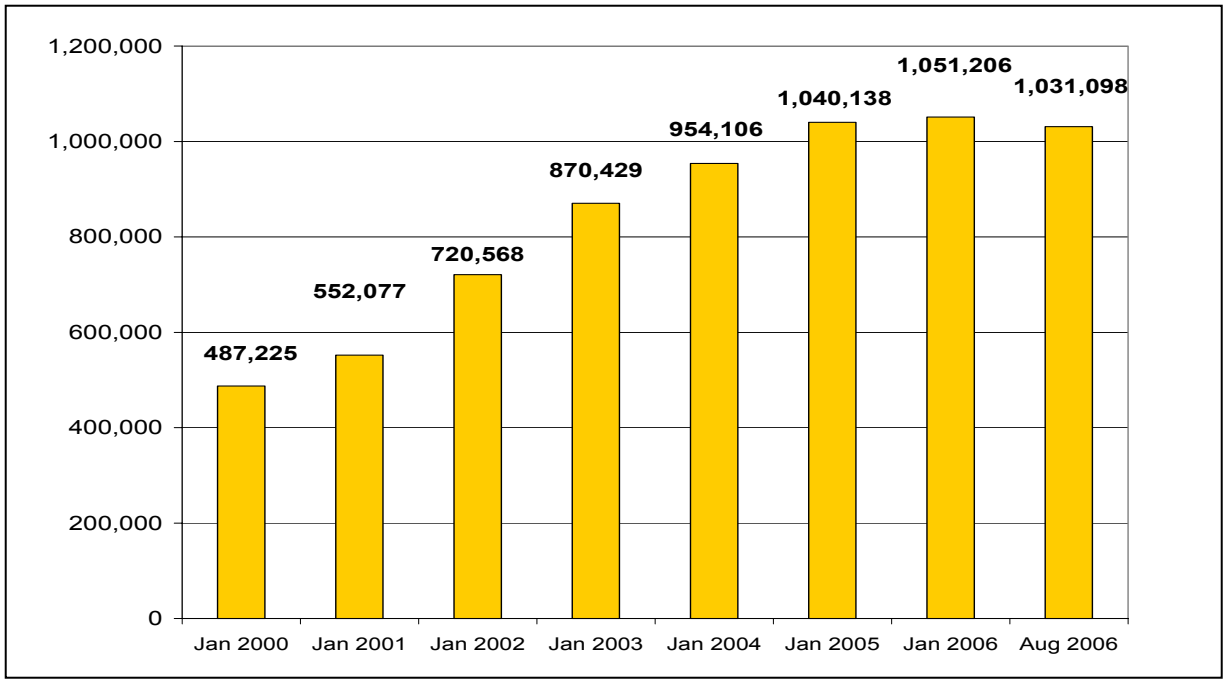
Arizona's Medicaid managed care program was expanded in 1989, via another 1115 waiver, to include long term care beneficiaries. This was another first for Arizona and represented how confident Arizona had become in providing both Medicaid acute care and long term care services using managed care as the primary health care delivery model.

Over the years many states have attempted to duplicate Arizona's success with Medicaid managed care but with mixed success. Arizona has learned a few things along the way that has helped to assure that Arizona Medicaid managed care is sustainable and has widespread credibility as a well run Medicaid program. The lessons learned in managing managed care can be categorized under the headings of financial accountability and cost control, quality of care improvement, access to primary and preventive care, contract management and innovation in health care delivery.

Chart 1
Who Does AHCCCS Serve?

Program	Enrolled Members	Member Profile as of August 1, 2006
Acute	931,152	Primarily children and women with children.
ALTCS (Long Term Care)	42,128	Individuals with developmental disabilities, physical disabilities, or over 65 years of age.
KidsCare	57,818	Children through the age of 18.
Healthcare Group of Arizona	22,027	Employees of small businesses. Member count not included in Chart 2.
Total	**1,0531,25**	

Chart 2
Total Enrollment – 2000 to 2006



Financial Accountability and Cost Control

As the name implies one of the fundamental values of AHCCCS is cost containment. However, this value is never at the expense of quality medical care or access to needed care. It is an

underlying belief that cost containment comes from being able to verify that the health care services provided were necessary to assure the wellbeing and health maintenance of the beneficiary. It is unnecessary or untimely medical, pharmacy, emergency, or inpatient care that drives up cost in Medicaid.

Utilization Management

Lesson Learned: Successful Medicaid managed care organizations have mature information systems and medical management infrastructures.

AHCCCS contracts with managed care health plans that are accountable to manage care and control costs, using appropriate managed care utilization management tools. The ability of the MCO contractor to manage medical risk is a prerequisite to a successful managed care program. The contractor must be able to assure enrolled members have access to a primary care services. This has been proven to reduce unnecessary emergency room utilization and inpatient care by early identification and medical management of chronic illnesses and disease. The primary care provider becomes the primary source of care for the enrolled members rather than the emergency room.

The MCO's ability to manage unnecessary utilization is critical to effective cost containment. This requires the managed care organization to have adequate medical management information systems that provide computerized utilization and case management tools for staff involved in the case management of those in the hospital or who are being medically managed for chronic illness and disease. Managing the 20% of high risk medical cases is the primary focus of Arizona's MCOs. When they do this well cost is contained.

One of the major out of control costs that plagues many Medicaid programs is the cost of drugs. Drug cost management is another area of utilization management that mature MCOs are adept at managing and controlling. This is accomplished not by denying needed medications, but by using generic drugs first before prescribing more expensive brand drugs. Because MCO contract with providers, they are able to create cost effective drug formularies and educate providers on providing "step therapies" that use generic drugs first before managing the patient with a more expensive brand drug. According to a 2004 *The Lewin Group* report on pharmacy cost management in Arizona's Medicaid program, AHCCCS had the nation's most cost efficient pharmacy cost management of any other State Medicaid program. Table 1 provides a cost comparison of pharmacy cost based on the findings in the Lewin Report.

Table 1
Cost Comparison of Drug Cost and Utilization

Drug Cost and Utilization Comparison	Medicaid FFS	Other State's Medicaid Managed Care	AHCCCS
Acute Care Generic Use	38.1%	86.0%	93.1%
Acute Care Average Cost Per Prescription	$47.10	$28.16	$14.75
Long Term Care Generic Use	29.3%	38.8%	76.5%
LTC average cost Per Prescription	$69.00	$76.63	$38.91
TANF Beneficiaries	0.69 PMPM	0.56 PMPM	0.41 PMPM

AHCCCS managed care model has produced outstanding pharmacy cost management results in several areas without having to place benefits restrictions or limits on the number of prescriptions beneficiaries can be given. Generic drug use is the highest in the nation, cost per prescription is the lowest, and average prescription per beneficiary is also lower than any other state. This cost effective performance is a direct result of Arizona's Medicaid managed care model.

Member Enrollment and Capitation

Lesson Learned: Size matters. MCOs need adequate membership to remain financially solvent and manage high risk high cost cases.

One of the basic tenets of managed care is paying capitation rather then fee for service to managed care contractors who are at full risk for managing the patient care within the per member per month capitation payment. In Arizona most, if not all, of the MCO contractors reimburse their network providers on a negotiated fee for service rate for the care provided. This assures that claim encounters are submitted to the plan. The provider does not receive reimbursement unless the claim is submitted. A claim is essential to assure care has been rendered at the appropriate cost. Paying capitation to MCOs is a very effective way to align incentives between the Medicaid agency and the MCO contractor. The MCO is at financial risk for managing patient care cost effectively. The Medicaid Agency does not have to create sophisticated claims and medical management systems. Having more than one health plan contractor competing for member enrollment enhances business discipline and creates an incentive for MCOs to assure beneficiary and provider satisfaction with the performance of the MCO.

Capitation of Medicaid physician groups or hospital system providers has proven less successful. In many cases it has been a financial disaster for capitated provider groups. Inadequate or poorly managed capitation reimbursement has led many Medicaid providers into financial default. Most provider groups, but especially Medicaid provider groups, are ill equipped to manage capitation. These groups seldom achieve the membership enrollment critical mass effectively manage the medical cost risk under capitated arrangement.

This was a lesson AHCCCS learned very early on in its history. To remain financially solvent, an acute care MCO must have an enrollment of at least 25,000 beneficiaries and a LTC MCO at least 1,500 members. When enrollment in the MCO is below this threshold, the plan is at a greater risk of adverse selection and financially unsustainable medical losses. To assure that each plan has a large enough beneficiary pool to mitigate the medical cost risk of high cost patients, AHCCCS uses auto assignment of members that choose a plan to the MCO which is below the threshold. Contracting with too many MCOs will often create this critical mass problem. One role that the state Medicaid agency must play is to assure the competitive playing field is level. Having a significant disparity in MCO membership size does not create the necessary environment for positive market driven competition.

Some states have implemented Medicaid managed care by contracting with a number of local community health plans. Many of these local health plans formed specifically to contract for Medicaid managed care. Unfortunately, many of the community health plans never grow large enough to make capitation reimbursement work. It has been our experience that local plans, which are often organized around safety net providers, must be given a reasonable opportunity to reach the critical enrollment threshold. It is the state's responsibility to create administrative rules and processes that support that result.

Actuarial Soundness

Lesson Learned: Actuaries may be boring but they know the numbers. We have learned that manipulating capitation to meet a predetermined budget target, without reducing the MCO's medical cost exposure, will eventually destroy a Medicaid manage care program.

MCO capitation rates must be actuarially sound. States that do not adhere to sound rate setting principles eventually destabilize their MCO contractor's financial position. This is one reason many private health plans have left state Medicaid managed care programs. AHCCCS employs a staff of actuaries to consistently review and validate capitation rates. They use sophisticated cost and medical trend analytical tools to evaluate paid claims data and utilization from the MCO contractors. We have learned that it is critical to the financial viability of our MCO contractors that AHCCCS accurately and consistently set capitation rates based on sound actuarial principles. To set capitation rates correctly you must take into account both utilization trends and medical cost inflation factors. It is a very short-sighted strategy to establish rates based on a predetermined budget figure. It may work for a year or so but will eventually create deterioration of managed care plan effectiveness and participation. It is better to reduce benefits, increase co-payments or place caps on membership growth than to set rates that will eventually lead to financial insolvency for MCO contractors. This philosophy has made AHCCCS successful over the years and has actually helped AHCCCS control capitation rate inflation over time. One

additional benefit to setting actuarially sound rates is that more providers are willing to participate in the program. Having better provider network choice leads to better primary care access and beneficiary satisfaction, which we find reduces emergency room use.

Charts 3, 4 and 5 provide additional reference information.

Chart 3
Example of Capitation Rates Paid by AHCCCS to MCOs

- Acute capitation payments made to the health plans are based on the age and sex of the enrolled member (effective 10/1/04)

For example:

- 6 year old child $ 97/month
- 26 year old woman $172/month
- 45 year old man $343/month
- 65 year old woman with Medicare $265/month

- Arizona Long Term Care System Capitation $2,766/month
- AHCCCS regulates compliance with contract terms including quality of care and fiscal accountability.
- Evaluations sponsored by the federal government have consistently shown that AHCCCS saves money.

Chart 4

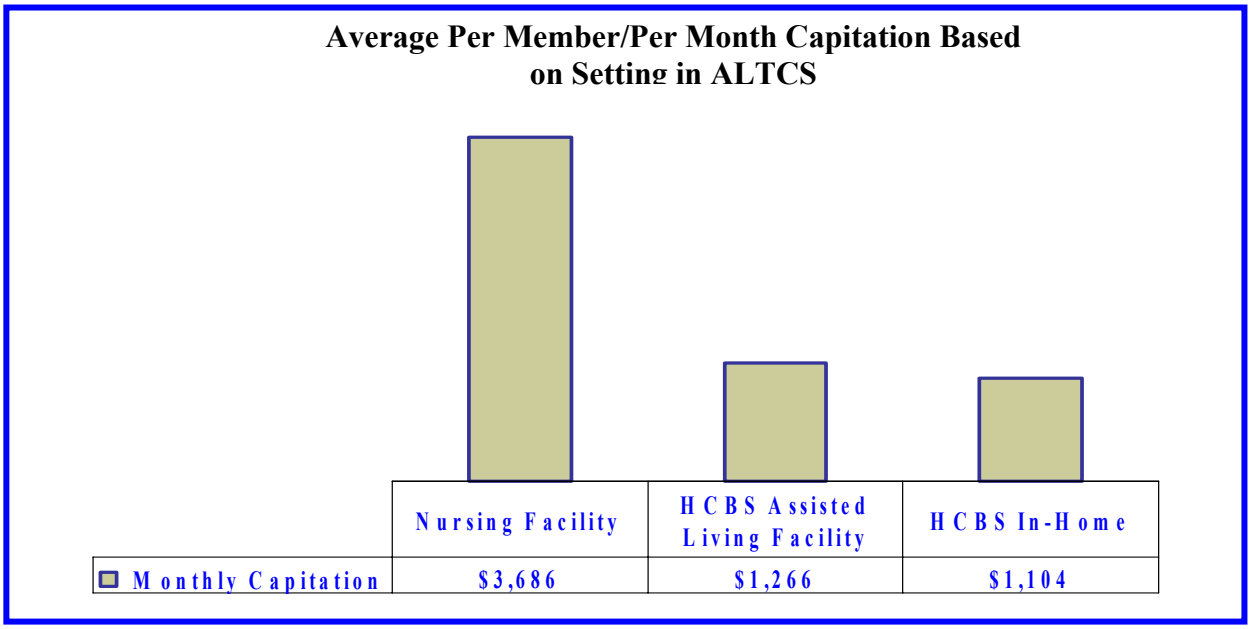
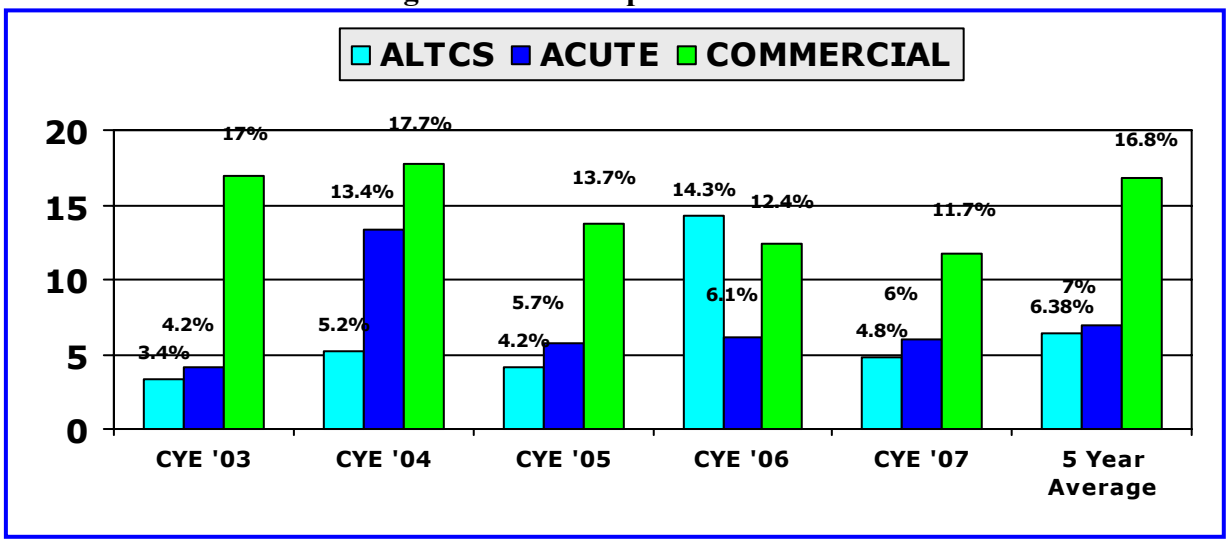


Chart 5
AHCCCS Acute and Long Term Care Capitation Trends vs. AZ Commercial Rates



Comparative MCO Financial and Quality Data

Lesson Learned: You cannot manage what you cannot measure. Financial accountability and quality of care accountability are the two pillars of successful Medicaid managed care.

AHCCCS uses a number of analytical tools and measures to compare the performance of MCO contractors. Being able to compare performance between plans is critical to market competition and driving both quality and cost containment. AHCCCS maintains a data warehouse with five years of AHCCCS eligibility and claims encounter data. This allows AHCCCS management staff to not only evaluate historical and programmatic trends but to evaluate MCO performance year to year.

Managing managed care plans requires setting operational, financial, and quality targets for the plans and having the staff with the core competency and analytical tools to measure performance against target.

Encounter Data Reporting

Lesson Learned: Not having good encounter data is like driving a car blindfolded. There are only two outcomes that can result and both of them are bad. 1. Crash 2. You end up where you did not want to go.

As a condition of the 1115 Waiver, CMS requires AHCCCS to submit specific information regarding services provided to Medicaid and KidsCare members. These records, known as claims encounter data, are submitted to AHCCCS for institutional, professional, dental and prescription drugs. AHCCCS requires all contractors (Health Plans for acute and Long Term Care) to submit encounter data through electronic media within 240 days after the end of the month in which the service was provided. This is critical to assure we can measure both cost and quality of care.

Claims Encounter Reporting supports:

- Evaluation of health care quality and cost effectiveness
- Evaluation of individual contractor performance
- Development and determination of capitation rates paid to the contractor
- Determine Disproportionate Share payments to hospitals
- Develop FFS payment rates
- Pay reinsurance to the contractor

AHCCCS performs annual validation studies on acute care, long-term care and behavioral health encounter data to ensure that the data reported is timely, accurate and complete. We take the submission of encounter data very seriously and we will sanction plans for non-compliance with submission of the plan's encounter data.

Financial Reviews and Operational Reviews

Lesson Learned: As every school kid knows they probably would not work on their studies very hard if they did not have a final exam. The financial and operational reviews are MCO's annual final exam.

AHCCCS requires that all Health Plans, Program Contractor, and ADHS and its subcontracted Regional Behavioral Health Authorities (RHBAs) adhere to standards expressly stated in their contract with AHCCCS. Health Plans, Program Contractors and RHBAs may not gain financial advantage by under-serving enrolled members. Therefore, each Health Plan, Program Contractor and RBHA must:

- Disclose ownership and related third party transactions;
- Post performance bonds for insolvency protection;
- Prepare contingency plans in the event of insolvency;
- Meet stringent financial management standards established by AHCCCS; and
- Contract for an annual certified audit performed by a certified public accountant.

Semi-annually, AHCCCS completes operational and financial reviews of Health Plans, Program Contractors and ADHS Behavioral Health Services. These site visits review contractors' general administration, including:

- Business continuity plans;
- Cultural competency compliance;
- Staffing;
- Corporate compliance;
- Quality management processes, including provider credentialing;
- Handling of quality of care issues and complaints;
- Care coordination and case management processes;
- The delivery of maternal and child health services;
- The grievance system;

- The delivery system;
- Member services;
- Reinsurance;
- Finances;
- Claims processing and payment;
- Encounter processing and submission; and
- Behavioral health coordination.

AHCCCS has established financial and operational standards that all MCO contractors must meet. Based on these standards, AHCCCS examines MCO profitability and administrative performance through an analysis of five financial viability standards. The following is a brief explanation of each standard and the Health Plan results of the most recent financial audits conducted.

1. Current Ratio - This standard measures whether a Contractor can pay current obligations as they come due.

2. Equity per member - This standard measures a Contractor's ability to withstand adverse utilization over a one-year period.

3. Medical Expense Ratio - This standard shows how well a Contractor manages care. If the medical expense ratio is too low, under-utilization of services may be a problem. If it is too high, the Contractor may not be managing utilization appropriately.

4. Administrative Cost Percentage - This standard measures the percentage of AHCCCS capitation premiums spent on non-medical expenses. Too much money spent on administrative cost may indicate MCO inefficiency.

5. Days of Claims Workload on Hand and Received but Unpaid Claims (RUC) - This standard shows if claims are being paid in a timely fashion. This standard may suggest cash flow problems if Contractors are slow in paying bills.

In addition to the five financial viability standards mentioned above, AHCCCS monitors on a minimum quarterly basis, the operating income or loss of the Contractors as well as the Incurred but Not Reported (IBNR) claims estimates. The IBNR estimates the dollar amount of claims for which the Contractor has provided the service but has not received the actual claim.

Member and Provider Grievance System

Each MCO is required to process grievances in a timely manner. They must communicate denials of grievances in writing to the member or providers. AHCCCS handles grievances not resolved at the MCO level to the satisfaction of the member or provider.

The AHCCCS Office of Legal Assistance (OLA) provides legal counsel to the AHCCCS administration, is responsible for the Agency rulemaking process, and oversees the Grievance System for the AHCCCS Program. Major components of the Grievance system include,

scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions subsequent to recommendations made by Administrative Law Judges.

During the last year, OLA received 8,941 matters, including member appeals, provider claims disputes, ALTCS trust reviews, and eligibility appeals. OLA issued 4,005 Director's Decisions after State Fair hearings were held. OLA was able to resolve 5,783 cases at the informal level, alleviating the need for a State Fair Hearing. Of the 8,941 total cases received by OLA, 736 were member appeals, 5,667 were provider claim disputes, 455 were ALTCS trust reviews and 2,083 were eligibility appeals.

Fraud and Abuse

Lesson Learned: Fraud happens. The best defense is vigilance and a big stick.

The AHCCCS Office of Program Integrity (OPI) is responsible for combating fraud and abuse in the Arizona Medicaid program. OPI consists of three Units: Audits, Member Fraud and Provider Fraud. OPI has developed a comprehensive approach that focuses on strengthening program safeguards, assessing areas of potential vulnerability and investigating allegations of fraud and abuse.

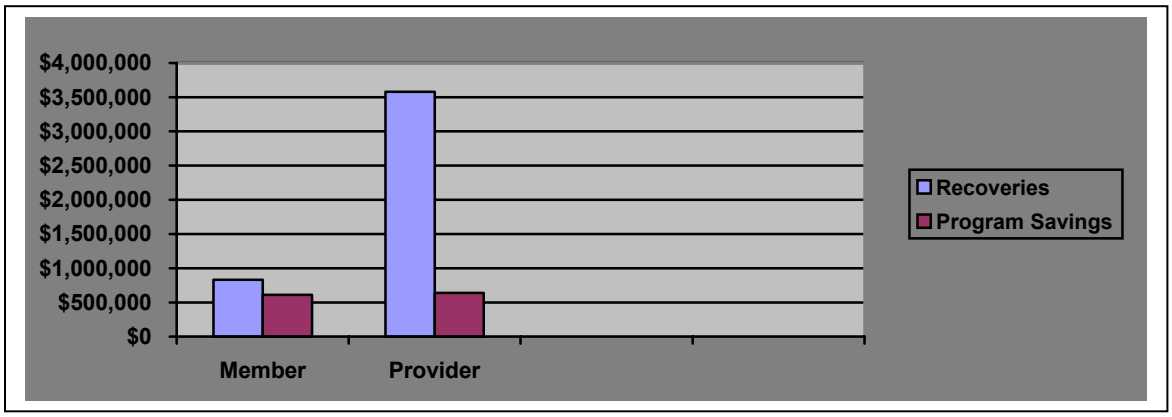
OPI visited AHCCCS Contractors on-site to discuss the development of formal compliance programs. In light of the new requirements and to promote development of effective compliance programs over the next year, OPI has worked with the Division of Health Care Management to strengthen contracts by requiring the formation of Compliance Committees and written criteria for selecting a Compliance Officer. OPI also participates in all the scheduled Operational and Financial Reviews to further strengthen the Fraud Waste and Abuse program. The AHCCCS fraud and abuse policy provides requirements for MCO Compliance Officers. MCOs must report potential/suspected fraud and abuse within ten working days of the discovery of the incident.

OPI continues to host fraud and abuse work group meetings, now called "Compliance Officer Network Group" meetings. Subjects include program safeguards designed to limit abuse and diversion of prescription drugs by AHCCCS members and discussions on any methods to strengthen and improve efforts to prevent, detect and report fraud and abuse in the State's Medicaid Program. Additionally, the Director of Program Integrity and the Director of the Medicaid Fraud Control Unit of the Attorney General's Office have conducted several joint fraud awareness presentations to AHCCCS Contractors.

For example, a major behavioral health audit was conducted during 2005 by OPI's Office of Audit Services (OAS). Specifically the OAS chose two Regional Behavioral Health Authorities (RHBAs) and one of their providers. The audit was generated from a finding of concern about improper coding for services based on a separate investigation conducted by OPI on a RHBA and their provider. The Audit Unit routinely utilizes the "Medicare Fraud Alerts" to determine if the AHCCCS program is vulnerable to the schemes identified in the Alerts.

In another, a member fraud investigation was initiated after a review of claims data and medical records, OPI took five staff to a small Arizona community on the Mexican boarder to validate members receiving care were the same persons that were originally made eligible for AHCCCS. OPI staff went to the residence listed on each AHCCCS member's application to verify that the person lived at the residence and was the same person who AHCCCS had originally made eligible for service. These investigations are only undertaken when there is probable cause to believe fraudulent use of Medicaid is occurring. Most OPI work is focused on prevention. AHCCCS has earned the confidence of taxpayer because of the vigilance assuring state and federal money is being spent for the right person and on the right services.

Chart 6
Member and Provider Totals for Recovery and Program Savings
October 2004 through September 2005



Quality of Care Improvement

Lesson Learned: Managed Care Organizations will improve performance over time if you show them the data and give them their score card compared to other health plans. Eventually, low performing MCOs lose members to high performing MCOs.

AHCCCS ensures that each contracted MCO has an ongoing quality assessment and performance improvement program for the services furnished to its members, consistent with regulations under the Balanced Budget Act (BBA) of 1997. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services.

Acute-care Performance Measures

Each year AHCCCS measures performance of MCO contractors against previous years' performance and in comparison to the other MCOs' performance.

The results reported here should be viewed as *indicators* of utilization of services, rather than absolute rates for how successfully AHCCCS and/or its Contractors provide care. Many factors affect whether AHCCCS members use services. By analyzing trends over time, AHCCCS and its

Contractors have identified areas for improvement and implemented interventions to increase access to, and use of, services.

Methodology

AHCCCS uses the Health Plan Employer Data and Information Set (HEDIS®) as a guide for collecting and reporting results of these measures. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. Table 2 show results for 2004.

Results

Table 2 shows aggregate results from AHCCCS MCOs. Some MCOs performed better than the aggregate and some worse. All acute-care measures except one improved in the most recent measurement period. Results by measure were as follows:

Table 2

Measure	AHCCCS Current Rate (%)	Previous AHCCCS Rate (%)
Children's Access to PCPs – Medicaid	77.3	75.7
Children's Access to PCPs – KidsCare	79.1	77.7
Adults' Access to Preventive/Ambulatory Health Services – Medicaid	77.8	76.2
Well-child Visits in the First 15 Months of Life – Medicaid	66.9	68.4
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – Medicaid	56.4	51.5
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – KidsCare	61.0	56.7
Adolescent Well-care Visits – Medicaid	32.6	30.9
Adolescent Well-care Visits – KidsCare	37.2	34.6
Annual Dental Visits – Medicaid	53.9	48.5
Annual Dental Visits – KidsCare	63.5	57.8

- **Children's Access to PCPs** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels since AHCCCS began measuring these rates.
- **Adults' Access to Preventive/Ambulatory Health Services** – This measure also increased by a statistically significant amount.
- **Well-child Visits in the First 15 Months of Life** – The overall rate for this measure showed a relative decline of 2.1 percent (the rate includes only Medicaid members, as most children in this age range qualify for AHCCCS under this program).

- **Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels.
- **Adolescent Well-care Visits** – Overall rates for both Medicaid and KidsCare members showed statistically significant improvements from the previous measurement period.
- **Annual Dental Visits** – Rates for this measure also improved significantly, reaching their highest levels ever for both Medicaid and KidsCare members.

The Litmus Tests of Managed Care:

Litmus Test #1: Improved Immunization Rates
The monitoring of AHCCCS immunization rates is critical to identify under vaccinated populations and increase coverage levels, both in children and adults. For children enrolled in managed care plans, nine of ten immunizations evaluated by AHCCCS and recommended by the Centers for Disease Control and Prevention have shown improvement. They include immunizations for diphtheria, tetanus, measles, mumps and rubella, among others. Immunizations and pneumococcal vaccination under the Arizona Long Term Care System also have shown improvement. All seven ALTCS Program Contractors attained rates above the AHCCCS performance standard (APB) for influenza immunizations in HCBS settings, and six obtained ratings above the APB in nursing facility settings. For pneumococcal vaccinations, six contractors were above the APB in HCBS settings and five attained this rating.

Litmus Test #2: Preventive Care
Compared with the most recent national HEDIS means (averages) reported by NCQA for Medicaid health plans, AHCCCS Medicaid rates were higher than the national means for some measures and lower for others. Most notably, the AHCCCS Medicaid rates for Well-child Visits in the First 15 Months of Life and Annual Dental Visits were well above the HEDIS national Medicaid averages for these measures. And, despite the small decline in the current measurement period, the rate for Well-child Visits in the First 15 Months of Life was equivalent to the most recent HEDIS average for commercial health plans, which is much higher than the Medicaid average.

Consistent with previous measurements, children enrolled with AHCCCS Contractors through KidsCare have higher overall rates of preventive services than those enrolled under Medicaid. Depending on their income, parents of KidsCare members may pay a premium for coverage and therefore, may be more likely to ensure that their children receive covered benefits, including well-care visits. These parents also may have a higher level of education and a better understanding of the value of preventive health care.

Driving MCO Performance by Setting Standards and Requiring Constant Improvement

Lesson Learned: To become good at pole vaulting you need to keep raising the bar. AHCCCS has learned that raising the performance bar generates competition and innovations.

AHCCCS has established performance standards for contracted health plans for various quality and access measures. Contractors should meet the AHCCCS *Minimum Performance Standard* for a particular measure and should try to achieve higher goals established by AHCCCS. Every year or

two AHCCCS has raised Minimum Performance Standards in order to encourage Contractors to continue improving their rates. Typically we raise target performance based on the best MCO performance in the previous reporting period.

AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard for any measure, or that show a statistically significant decline, even if they met the minimum standard. Contractors that fail to show improvement may be subject to sanctions. Some Contractors already have corrective action plans in place for Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services. On an ongoing basis, AHCCCS staff will monitor Contractor rates for each measure, especially for those plans that have not met Minimum Performance Standards.

AHCCCS provides technical assistance, such as identifying new interventions or enhancements to existing efforts, to help Contractors improve their performance. For example, AHCCCS began leading a collaborative effort that includes Contractors and some community agencies in early 2004 to improve well-child visits among children 3 through 6 years of age and to support health-related goals of the Governor's School Readiness Board. It appears that this focused effort has contributed to improvements in the rate of well-child visits among this age group during the most recent measurement period. In order to continue improvements in this area and meet AHCCCS goals, the agency has researched evidence-based strategies for improving well-child visits and is working with Contractors to identify and implement a new standardized intervention.

Arizona Long Term Care System (ALTCS) Performance Measures

Lessons Learned: Successful long term care MCOs have learned that it starts with effective case management and mature chronic care management processes.

Diabetes Care

AHCCCS used HEDIS specifications as a guideline for measurement of diabetes care services provided to elderly and physically disabled (E/PD) members. Three indicators, Hb A_{1c} testing, lipid screening and retinal exams were measured.

Methodology

This study measured services provided from October 1, 2003, through September 30, 2004. It included a representative, random sample of ALTCS members who were diagnosed with type 1 or type 2 diabetes, were 18 through 75 years of age, and were continuously enrolled with one ALTCS Contractor for the entire measurement period.

Results

Hb A_{1c} testing – AHCCCS measured the percentage of members who had one or more glycosylated hemoglobin, or Hb A_{1c}, tests during the measurement period. The overall rate of ALTCS members with diabetes who received one or more Hb A_{1c} tests was 76.7 percent.
Lipid (LDL) screening – AHCCCS measured the percentage of members who had one or more fasting lipid profiles performed during the measurement period or the preceding year. The

overall rate of lipid screening during the measurement period or the preceding year was 69.2 percent.

Retinal exams – AHCCCS measured the percent of members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year. The overall rate of members with retinal exams was 50.1 percent.

Performance Standards and Improvement

All Contractors are meeting the current AHCCCS Minimum Performance Standards for diabetes care and most have exceeded current goals. Compared with the most recent HEDIS data for Medicaid health plans, most ALTCS Contractors exceeded national averages for Hb A_{1c} testing and eye exams. It also should be noted that some AHCCCS Contractors are achieving rates of diabetes preventive care services that are comparable with HEDIS commercial health plan averages.

In order to assist ALTCS Contractors with performance improvement efforts, AHCCCS has compiled information on barriers to effective diabetes management and successful strategies for increasing the use of preventive-care practices. AHCCCS is continuing to work with Contractors to improve performance in these indicators.

Measuring Home and Community Based Services (HCBS) Placement

AHCCCS measured the percentage of newly placed HCBS members who received selected services within 30 days of enrollment. Examples of these services include adult day health care, attendant care, home-delivered meals, home health nursing and homemaker assistance.

Methodology

The study covered the measurement period from October 1, 2003, through September 30, 2004. A representative random sample was selected for each Contractor. Data were first collected from AHCCCS encounter data. When services within 30 days of enrollment for a particular member were not found in AHCCCS encounter data, Contractors were asked to provide service delivery information from medical or case management records, or their claims data.

Results

The overall rate of initiation of services was 89.2 percent, a statistically significant improvement from the rate of 83.7 percent in the previous measurement period.

Performance Standards and Improvement

All seven ALTCS Contractors exceeded the AHCCCS Minimum Performance Standard in the current measurement period.

Given the variety and complexity of members' needs and personal situations when they enroll in the ALTCS program, Contractors' case managers face distinct challenges in ensuring that enrollees have prompt access to home and community based services that fit with their individual choices. These services are designed to help long-term care recipients maintain or improve their health and functional status, and enjoy a greater degree of independence. AHCCCS Contractors are effectively meeting this challenge, with some health plans achieving rates of 90 percent or better for this measure.

Performance Improvement Projects (PIPs)

In addition to Performance Measures, AHCCCS requires Contractors to conduct Performance Improvement Projects (PIPs), as defined under BBA regulations. These PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time. PIPs may be conducted in clinical or non-clinical areas that are expected to have a favorable effect on member health outcomes and satisfaction. Contractors design and conduct their own PIPs, and are required to participate in at least one AHCCCS-designed and mandated PIP.

Management of Diabetes

One of the mandated PIPs under way is designed to assist diabetic members and their physicians with establishing and maintaining control of blood-glucose (glycemic) levels, in order to prevent or minimize complications of the disease. This PIP, implemented in CYE 2002, measures annual Hb A_{1c} testing and laboratory levels of selected members.

In CYE 2005, AHCCCS conducted a re-measurement of performance to determine whether Contractors that showed a statistically significant improvement from the baseline measurement to the first re-measurement had sustained that improvement for an additional year. In the first re-measurement, 14 of 15 Acute-care and ALTCS Contractors demonstrated improvement from the baseline measurement and/or were performing at the optimal benchmark established by AHCCCS. All of those Contractors sustained that level of performance in the second re-measurement. The remaining Contractor demonstrated improvement in the second re-measurement, and will continue participating in this PIP until it shows sustained improvement.

Children's Oral Health

The purpose of this AHCCCS-mandated PIP is to increase the rate of annual dental visits among children enrolled in AHCCCS. This project specifically focuses on children who are 3 through 8 years old, as this appears to be a critical time in a child's life to ensure that he or she receives regular dental care. Contractors participating in this PIP include acute-care health plans, CMDP, DDD and ALTCS health plans that serve elderly and physically disabled members.
All Acute-care Contractors except one showed statistically significant increases from the baseline measurement and/or exceeded the goal of 57 percent.

Validation of Performance

Lesson Learned: It is not what you say about yourself that validates you, it's what others say about you that validates you.

AHCCCS has been evaluated by numerous federal agencies over the years, including the United States Government Accountability Office (GAO), Office of Management and Budget, EQROs, and CMS program auditors and consultants. Reports have been positive and have praised various components of the program, including the quality of care and the overall cost-effectiveness when compared with traditional FFS programs in other states.

In addition, AHCCCS has received numerous commendations and awards over the years. Some of these include the Leadership Award for Medical Quality from the American College of Medical Quality, a Health Care Financing Association (HCFA) National Customer Service Award for collaboration with Native Americans, the Council of State Government Award for Eligibility Fraud Prevention Program, and *Health Affairs* cited AHCCCS as one of the few prudent purchasers of health care in the nation.

AHCCCS has been visited by health care system and public health officials from the England, Australia, Mexico and even Afghanistan's Ministry of Health to better understand our model of market competition based managed care contracting.

AHCCCS has also been looked to as a Medicaid managed care model by other state Medicaid agencies. The agency was recently asked to present testimony before Congress on methods to improve the management of Medicaid and health care programs. On May 9, 2005, as the Director of AHCCCS, I presented on the success of AHCCCS to staff of the United States House Energy and Commerce Committee. On June 22, 2005, I was invited to appear before the Health Subcommittee to testify about AHCCCS' success related to "Medicaid Prescription Drugs: Examining Options for Payment Reform." While the presentation was focused on Arizona's management of the prescription drug benefit, testimony was solicited on a variety of other successes accomplished by the agency. On October 27, 2005, I was invited to share Arizona's successful results with the Medicaid Commission recently appointed by Secretary Leavitt. The agenda referred to Arizona's session as "Best Practices on Program Innovation Through an 1115 Waiver." The agency is proud that Arizona's model is looked to as a roadmap for success.

Another important measurement for CMS and other observers was the overall cost of the AHCCCS program when compared with traditional FFS programs in other states and the quality of care provided by the Nation's first statewide managed care program. The following reports, evaluations and surveys reinforce that managed care constrains costs without sacrificing quality of care.

1995 GAO Report

The GAO report in 1995 stated that Arizona's Medicaid program, operating under a waiver from certain federal requirements, has succeeded in containing costs while providing beneficiaries access to what State officials and health providers describe as mainstream medical care. Arizona's AHCCCS program can serve as a model for other Medicaid programs. Rapid escalation in

Medicaid costs has prompted many states to search for new ways to control spending, including moving more beneficiaries into managed care delivery systems. No state, however, is as advanced as Arizona in using market forces to control cost growth. Although each state Medicaid program is unique, states converting from a FFS to a managed care program can learn from Arizona's experience.

Auditor General Report

Published in the last quarter of the federal fiscal year, the Arizona Auditor General reported results of five reports conducted during the year. Four Performance Audits were conducted measuring Medical Services Contracting, Division of Member Services, Rate Setting Procedures and Quality of Care. The fifth audit, the Sunset Review, provides information about the 12 Sunset Factors the Legislature is to consider in determining whether to continue the Arizona Health Care Cost Containment System (AHCCCS).

The Legislative Reference Committee responsible for recommending extension of the agency unanimously approved recommending that AHCCCS be extended for another 10 years.

The Committee not only recommended that the agency be continued, but also added a formal commendation to the agency for its effective service to the public. The report indicates a continued need for AHCCCS, notes that AHCCCS has met its overall objective and purpose and summarizes the four performance audits conducted on AHCCCS that identify opportunity for improvement.

ACUTE CARE EVALUATIONS

Laguna Research Associates' Final Report, published in February 1996, included the following findings for the acute care program:

- Review of the mature AHCCCS acute care program (years 6-11) indicates continued success for the program.
- Cost savings are increasing, the market place is getting more competitive, utilization of services is appropriate and management information system development has stabilized.

As Americans today look for ways to rationalize the delivery of medical care services, capitation appears to demonstrate one viable option. Findings from the evaluations of the AHCCCS programs have indicated success in delivering services statewide to Medicaid eligibles of all eligibility groups.

In July 1996, the **Kaiser Family Foundation** produced The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid which was based on CMS contracted reports produced by Stanford Research Institute (SRI) and Laguna Research Associates. The report highlights areas where states which are implementing programs similar to the AHCCCS acute care program and ALTCS program should focus their attention.

Two of the findings of the report were:

- The experience of AHCCCS demonstrates that capitated Medicaid can be successful in providing high quality, accessible care of costs lower than traditional Medicaid to beneficiaries of all eligibility groups in both urban and rural areas.
- AHCCCS saves money overall even though its administrative costs are higher; states should look beyond the initial investment and higher operating expenses toward future overall cost savings and more effective program management.

The cost effectiveness of the AHCCCS program has been well documented, but less systematic research has been done on quality of care, including members' satisfaction with the program. To make sure that Health Plans are evaluated on other factors in addition to cost, AHCCCS places a high priority on quality monitoring. In an effort to determine the quality of acute care from the perspective of AHCCCS members, AHCCCS conducted telephone interviews of more than 14,000 members to gather information for the first general member survey of its type, the 1996 Member Satisfaction Survey.

The survey provided considerable insight into member satisfaction as evidenced by the following results:

- 75 percent of respondents gave a rating of "good" or "very good" in six areas that were identified to summarize the overall quality rating of the program.
- Office nurses and primary care providers were viewed by the respondents as being the most courteous and respectful with 89 percent of respondents giving the highest rating.
- Over 87 percent of the respondents rated the availability of appointments, whether for checkups or illness, as being satisfactory or very satisfactory.

ALTCS Performance Evaluations

The success of the ALTCS program rests principally on the cost effectiveness of quality HCBS and an effective PAS process that ensures persons who become eligible for ALTCS are at risk of institutionalization.

In 1992, William Weissert, Ph.D. completed a CMS-funded evaluation of HCBS cost-effectiveness in the ALTCS program. As a result of the Weissert study, CMS removed the HCBS cap on enrollment. However, as a condition of removing the HCBS cap, AHCCCS was required to conduct a cost-effectiveness study of HCBS as a follow-up to the earlier study. As anticipated by AHCCCS, Dr. Weissert's conclusions were the same in 1998 as they had been in 1992.

- The ALTCS program appears to be maintaining eligibility standards at about the level they were during the program's early years. This analytical approach demonstrated cost-effectiveness then and it again shows cost-effectiveness now.
- In spite of the fact that a higher HCBS cap is in place, the present study did not find evidence to support the assumption of a woodwork effect large enough to offset savings from substitutions of HCBS for nursing facility care.

The Final Report completed by Laguna Research Associates in February 1996 summarized their evaluations of the AHCCCS program by saying:

- In summary, both the AHCCCS acute care program and ALTCS seem to be successful in producing cost savings.
- Cost of the program as compared to a traditional Medicaid program is 7 percent less per year for the acute care program averaged over the first 11 years of the program, and 16 percent less per year for the long-term care program for its first five years.

In 2002, the Nelson A. Rockefeller Institute of Government called AHCCCS a "smashing success" and cited Arizona as the "gold standard" for the nation as a model purchaser of health care services.

Chart 7
Increase by Program

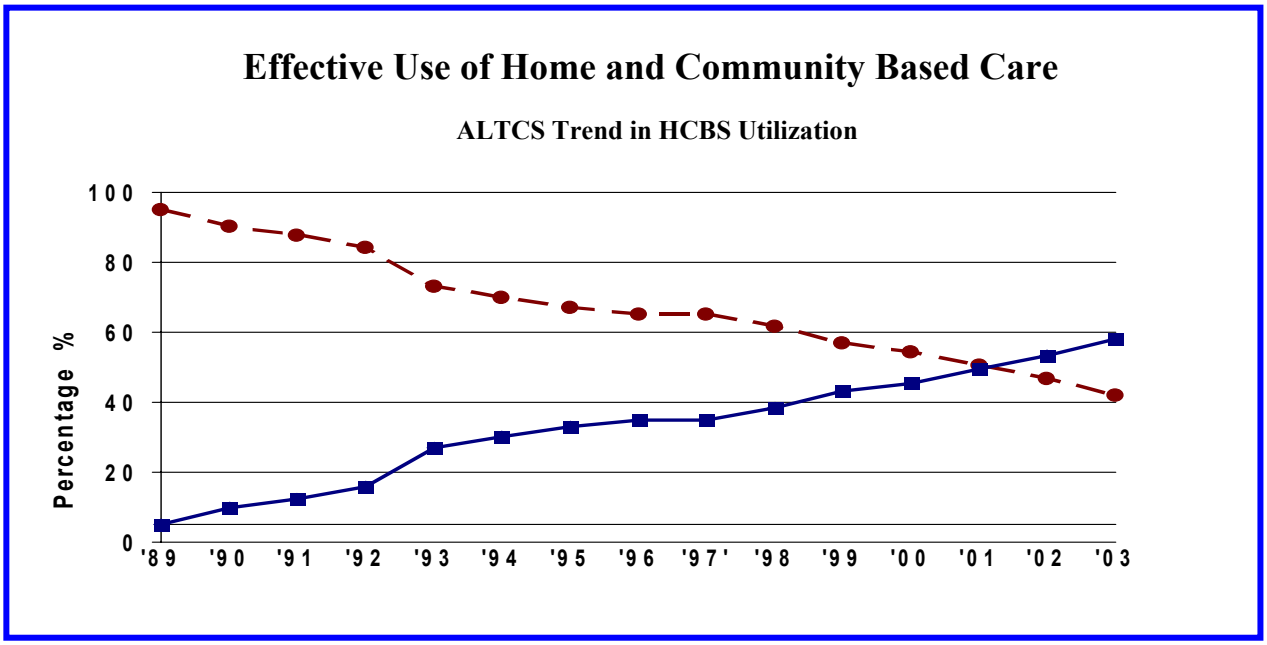
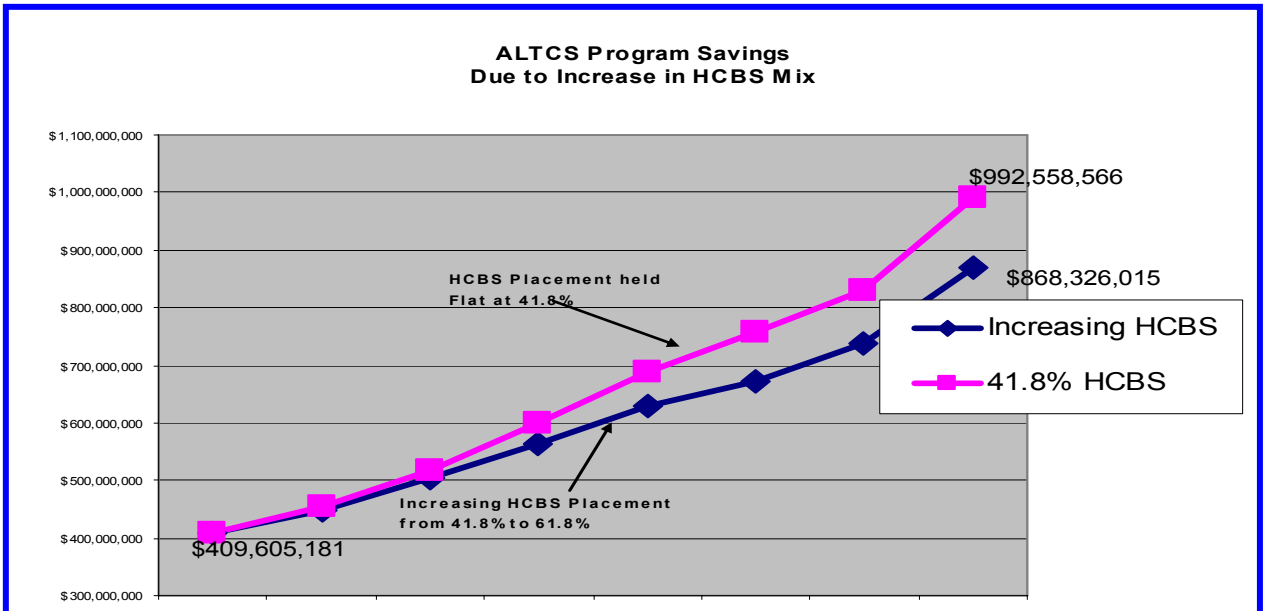


Chart 8



Innovations

1. **HAPA, the Hawaii project**. The project between Arizona and Hawaii allows the two states to share database information and resources, thereby providing better service to the people of each state. HAPA stands for Hawaii and Arizona PMMIS Alliance. The PMMIS (Prepaid Medical Management Information System) is AHCCCS' comprehensive computer system designed specifically for Arizona's managed care Medicaid program. Under the agreement, Hawaii would be able to use the PMMIS for its own Medicaid program and bear most of the expense of the project, also sharing the cost of improvements to the system.

2. **Web Technology**. Two major projects fall under this category: The Health-e-Arizona project and the Provider Web Project. Health-e-Arizona is a web-based application designed to interview and screen applicants for Medicaid, KidsCare and community-based health care programs. It offers English and Spanish versions in an application that is fully compliant with ADA. It is a partnership between AHCCCS, the Department of Economic Security (DES) and the Community Health Centers Collaborative Ventures. Health-e-Arizona users include Arizona FQHCs, several hospitals, other health care clinics and a variety of agencies. Once potential eligibility for Medicaid or KidsCare is identified, imaged documentation of eligibility and electronic signatures are forwarded through the web site to the appropriate Medicaid and/or KidsCare offices. DES is currently working with its partners to add screening for Food Stamps and TANF.

   The Provider Web Project is a pilot project using a website that allows AHCCCS providers to verify member eligibility and enrollment electronically. It is yet another alternative providers can use for eligibility verification rather than calling by telephone.

   AZ 2-1-1 was implemented by AHCCCS to create a public web portal for health and human services information to provide a single source for Arizonans to access information about public and private health and human services programs and resources available in their communities. AZ 2-1-1 also serves to provide emergency and disaster resource information during a declared emergency.

3. **Health Insurance for Small Business.** Healthcare Group of Arizona is a self-funded health care coverage insurance for small business administered by AHCCCS. Healthcare Group is able to use the AHCCCS buying power to offer affordable health coverage options to businesses with 50 employees or less.

4. **Electronic Health Information Exchange.** AHCCCS is currently participating in a public private effort to develop a statewide web based health information exchange utility portal for providing electronic personal health record access to providers, hospitals, long term care facilities. AHCCCS is developing the health information exchange utility for Medicaid beneficiaries.