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ARIZONA MEDICAID

Competition Among Managed Care Plans Lowers Program Costs

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Health, Education, and
Human Services Division

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The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

Dear Mr. Chairman:

Seeking to control escalating health care costs and improve access to the Medicaid program, states are adopting various managed care delivery systems. More than 13 years ago, Arizona was the first state to obtain approval from the Health Care Financing Administration (HCFA) to develop and implement a mandatory statewide Medicaid managed care system. Arizona's Medicaid program today benefits significantly from health plans competing with each other to win contracts to provide health care to Medicaid beneficiaries in both the state's urban and rural areas.

Because of Arizona's experience in implementing a statewide managed care program, you asked us to review Arizona's Medicaid program and, specifically, to discuss (1) the program's cost containment experience, (2) the role of health plan competition in the program's cost containment success, (3) the effect of cost containment on beneficiary access to appropriate care, and (4) lessons about Arizona's cost containment success that could apply to other states' Medicaid programs.

To do this work, we interviewed federal and state Medicaid officials and officials of managed care plans operating in Arizona. We reviewed documents relating to the 1994 competitive contract process, Arizona Health Care Cost Containment System's (AHCCCS) quality management policies for health plans, and many studies of Arizona's Medicaid program. We obtained and analyzed cost information for 1991 to 1995 and plan profit data from 1986 to 1994. We also interviewed local advocacy groups representing the Medicaid population, such as attorneys in state and county legal aid offices and private nonprofit groups, and reviewed beneficiary satisfaction studies. Our review addresses Medicaid's acute care expenditures and services only. We conducted our work from September 1994 through August 1995 and followed generally accepted government auditing standards.

Results in Brief

While many states are converting their traditional fee-for-service Medicaid programs to managed care delivery systems, Arizona's Medicaid program

offers valuable insights—especially in fostering competition and monitoring plan performance. Since 1982, Arizona has operated a statewide Medicaid program that mandates enrollment in managed care and pays health plans a capitated fee for each beneficiary served. Although the program had problems in its early years, such as the contract termination of the program administrator and the state's takeover of the administration, it has succeeded both in containing health care costs and providing beneficiaries access to mainstream medical care.

Arizona's recent cost containment record is noteworthy. According to one estimate, Arizona's Medicaid program saved the federal government $37 million and the state $15 million in acute care costs during fiscal year 1991.[1] While other states' per capita costs for Medicaid have continued to grow, Arizona's capitation rates declined by 11 percent in 1994. Reviews have also shown that, since its inception, the per capita growth rate of Arizona's program has been less than the national per capita growth rate for states with traditional Medicaid programs. Although the amounts that Arizona spends to administer its program are higher than what other states spend, these additional expenditures more than pay for themselves in net program savings.

Arizona's program succeeded in containing costs by developing a competitive Medicaid health care market. Health plans that submit capitation rates higher than their competitors' bids risk not winning Medicaid contracts. In the latest cycle, seven plans bid unsuccessfully, including two that had previously had contracts. Health plans compete to serve Arizona's Medicaid population because doing so can be profitable. In 1994, health plans earned an aggregate of $56 million in profits, or 6.7 percent of gross income. Altogether, 95 bids, double the number from the previous contract cycle, were submitted for the 42 contracts awarded.

Arizona's emphasis on cost control does not appear to have hindered beneficiaries' access to appropriate care. For one thing, the competitive bidding process assigns more points to access and quality factors than capitation rates. In addition, the program specifies standards that plans must meet for the number and types of providers in each contract's geographical location, requires plans to routinely provide data documenting a plan's stability and levels of care provided, and requires plans to conduct various studies measuring patient outcomes. According to HCFA, Arizona is among the states taking the lead in developing systems

[1]This is the latest year for which a comprehensive study exists of Arizona's cost containment performance compared with similar states with traditional Medicaid programs.

that collect encounter data and more accurately measure patient outcomes. Equally important, beneficiaries and their advocates have expressed overall satisfaction with Arizona's program.

Although each state's Medicaid program is different, other states that are considering implementing or are currently operating a managed care program can benefit from Arizona's experience. Our work suggests that key conditions for containing Medicaid costs without compromising beneficiaries' access to appropriate medical care include

- freedom from certain federal managed care regulations,
- development and use of market forces,
- controls to protect beneficiaries from inadequate care, and
- investment in data collection and analysis capabilities.

Arizona's experience also demonstrates that a successful program requires substantial preparation and development. States need a transition period to make the dramatic shift from third-party payer in a fee-for-service system to health plan overseer monitoring costs, access, and quality of care.

Background

Almost all states pay for the bulk of their Medicaid beneficiaries' health care through a fee-for-service system, which simply reimburses providers for their services. To control service utilization and therefore costs, states are increasingly adopting managed care—which coordinates beneficiaries' care—for the acute care portion of their programs. Managed care can range from capitated models that pay organizations a set monthly fee for all services to primary care case management models (PCCM), which pay for each service rendered but also pay certain primary care physicians a small amount to coordinate their patients' care. Capitated models are considered the strongest form of managed care because they give providers the greatest incentive to control utilization; PCCMs are considered the weakest.[2] Most states with managed care programs use a PCCM model alone or in conjunction with some care paid on a capitated basis.

[2]Capitated payment systems challenge health plans to establish cost-effective health care systems and search for new ways to achieve savings and manage utilization. Health plans are at risk for the cost of services provided to an enrollee and must absorb the loss if these costs exceed the monthly capitation payment. Health plans' cost control methods include emphasizing cost-effective preventive medicine; identifying inefficient patterns of obtaining health care, such as going to the emergency room for primary care; contracting with a third party to handle segments of care, such as home health or pharmaceuticals; and bargaining with providers to obtain substantial discounts from usual fees.

Arizona's Medicaid program is different. The state never participated in the traditional fee-for-service Medicaid program, implementing instead in 1982 a program that mandates managed care for all beneficiaries and pays all of its health plans a fixed amount per person to provide all covered services. The program, AHCCCS (pronounced "access"), features a competitive contract award process to purchase health care services from private- or county-operated health care plans. The capitation rate is set after a bidding process in which health plans submit separate bids for each county they wish to serve. (App. I summarizes the competitive contract process.)

To help ensure that AHCCCS beneficiaries have access to appropriate medical care, health plan contracts stipulate specific provider networks, ensuring provider availability in both urban and rural locations. AHCCCS monitors the medical and financial performance of contracting plans. (App. II summarizes oversight activities.)

For a state to mandate enrollment of its Medicaid population in a statewide managed care program, it must obtain an 1115 demonstration waiver from the federal government.[3] In 1982 Arizona was the first state to have a waiver approved for this purpose. Initially, AHCCCS had waivers from federal regulations requiring that a full scope of services be provided to enrollees. Over the years, however, AHCCCS has added the full range of Medicaid services, including family planning, behavioral health, and long-term care.[4]

As the program has evolved, however, it has had difficulties, including a failed attempt to contract for administrative services in its start-up phase, health plans with financial difficulties, and impediments in setting up data systems. We have reviewed the program throughout its history and made recommendations that HCFA and the state have implemented.[5] (App. III details AHCCCS' history.)

[3]Named for section 1115(a) of the Social Security Act, these waivers enable states to conduct demonstrations that operate differently from conventional fee-for-service Medicaid programs. Since 1992, 11 states have obtained such waivers from HCFA.

[4]In 1989 AHCCCS began the Arizona Long Term Care System (ALTCS) that offers acute care, nursing home care, and home and community-based services to the elderly and physically and developmentally disabled. Currently, ALTCS has about 20,000 enrollees. Since 1990 AHCCCS has expanded mental health care coverage to people enrolled in both its ALTCS and acute care programs.

[5]Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993); Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987); Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 10, 1985); and The Health Care Financing Administration's Monitoring of the Arizona Health Care Cost Containment System (GAO/HRD testimony, June 15, 1984).

AHCCCS' acute care program now serves over 432,000 beneficiaries in 15 counties.[6] About three-fourths of the beneficiaries live in Arizona's two urban counties, encompassing the cities of Phoenix and Tucson. The remaining beneficiaries live in Arizona's 13 rural counties. Several of the rural counties are so remote they are categorized as "frontier."

AHCCCS Produces Noteworthy Cost Savings Record

Arizona's success in encouraging competition among managed care health plans has saved the state and the federal government money. AHCCCS has lowered the 1995 per member capitation rates paid to health plans from rates paid a year earlier. In the last several years, it has also contained the rate of growth in per capita Medicaid expenditures, resulting in per capita costs that are lower than those in traditional, but otherwise comparable, Medicaid programs. While AHCCCS' program management requires high administrative expenditures of the state, the large savings in medical costs still result in a net savings.

AHCCCS Capitation Rates Decreased by 11 Percent in 1995

AHCCCS capitation rates fell, on average, by about 11 percent from 1994 to 1995, which is remarkable for at least three reasons. (Fig. 1 shows the annual change in capitation rates by beneficiary category for each of the last 4 years.) First, average spending per Medicaid beneficiary was projected to rise nationally during the same period. Second, the cost of serving beneficiaries in the AHCCCS program was already below the cost that would have been incurred in a traditional Medicaid program.[7] Third, health plans serving AHCCCS beneficiaries are now exposed to greater risk than under previous contracts for expenses generated by beneficiaries with extensive health care needs.[8] Typically, the plans' exposure to greater financial risk would have tended to make the contracts less attractive to

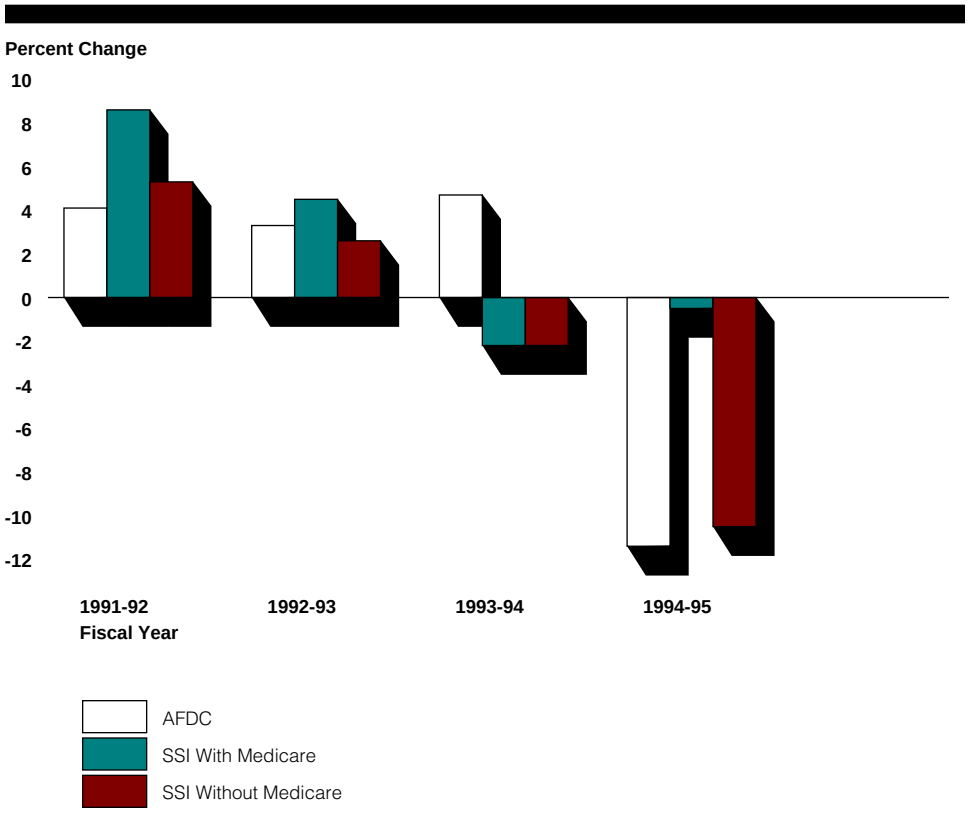
[6]Eligible AHCCCS beneficiaries include the federally mandated groups—Aid to Families With Dependent Children (AFDC) recipients, Supplemental Security Income (SSI) recipients, and women and children covered under the 1987 Sixth Omnibus Budget Reconciliation Act (SOBRA). Medicaid-eligible American Indians can choose to receive services from the Indian Health Service or, off-reservation, from an AHCCCS health plan.

[7]This is the finding of a 1994 Laguna Research Associates study (see footnote 9).

[8]Effective October 1, 1994, AHCCCS changed its reinsurance and deferred liability policies. Reinsurance is a benefit that AHCCCS provides to contracted health plans to reduce their financial risk for services rendered to a member whose liability reaches a certain amount, known as a deductible. Reinsurance is now limited to inpatient services only (ambulatory claims were eliminated), and the acute care services threshold was increased. In 1994 deferred liability was eliminated. Deferred liability allowed health plans to be reimbursed on a fee-for-service basis for care provided to newly enrolled beneficiaries who met special conditions, such as being hospitalized at the time of enrollment, receiving active chemotherapy, or enrolling in the program in the last 2 weeks of a high-risk pregnancy. AHCCCS made these changes to shift more risk to the health plans and encourage them to manage care efficiently.

health plans and, all else equal, would have led to higher—not lower—capitation rates.

Figure 1: Annual Percentage Change in AHCCCS Capitation Rates, by Eligibility Category



Study Showed AHCCCS Controlled Costs Better Than Traditional Programs

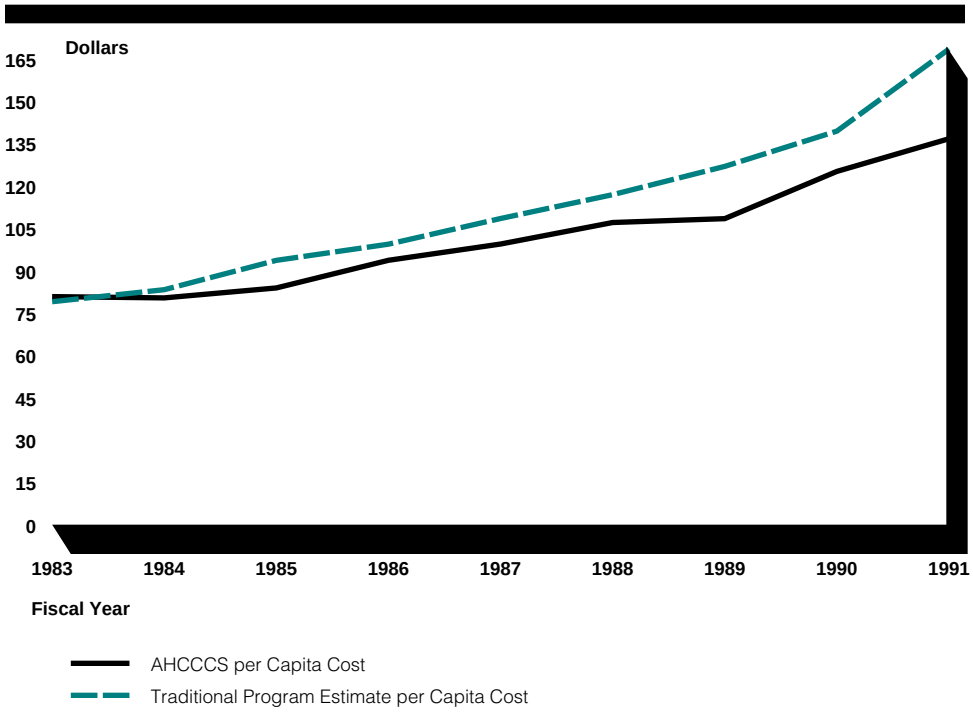
AHCCCS slowed the growth rate in Medicaid expenditures compared with what would have occurred had Arizona served the same beneficiaries using a traditional Medicaid fee-for-service program,[9] according to a 1994 Laguna Research Associates study conducted for HCFA. Specifically, AHCCCS' annual per capita growth rate from 1983 through 1991 (the most recent year for which these cost comparison figures are available[10]) for the combined AFDC and SSI beneficiary population was 6.8 percent versus

[9]Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994) (study limited to AFDC and SSI recipients).

[10]Laguna Research Associates has submitted a draft report to HCFA that updates this comparison to fiscal year 1993. The data in this draft report show a continuation of this trend: that is, AHCCCS per capita costs grew more slowly in 1992 and 1993 than they would have under a traditional program.

9.9 percent for a traditional Medicaid program. (See fig. 2 for a comparison of AHCCCS costs with traditional Medicaid costs.)

Figure 2: Per Capita Cost of AHCCCS Compared With Traditional Program, Fiscal Years 1983-91



The biggest slowdown in AHCCCS growth rates occurred for the SSI-eligible beneficiary population after 1987. From the late 1980s until 1991, costs for Arizona's AFDC-eligible beneficiaries were lower but rose at about the same rate as per capita costs in traditional Medicaid programs. However, during the same period, costs under AHCCCS grew much more slowly for SSI-eligible beneficiaries than the Laguna Research study estimated they would have grown under a traditional program. (See figs. 3, 4, and 5.) For example, per capita costs for disabled beneficiaries grew by 5.4 percent between 1987 and 1991 compared with the 17.3 percent that Laguna estimated they otherwise would have grown. For aged beneficiaries under AHCCCS, annual costs grew by 9.5 percent, compared with the benchmark of 17.2 percent.

Figure 3: Cost of Serving an AFDC-Eligible Recipient in AHCCCS Compared With Estimated Cost in a Traditional Program, Fiscal Years 1983-91

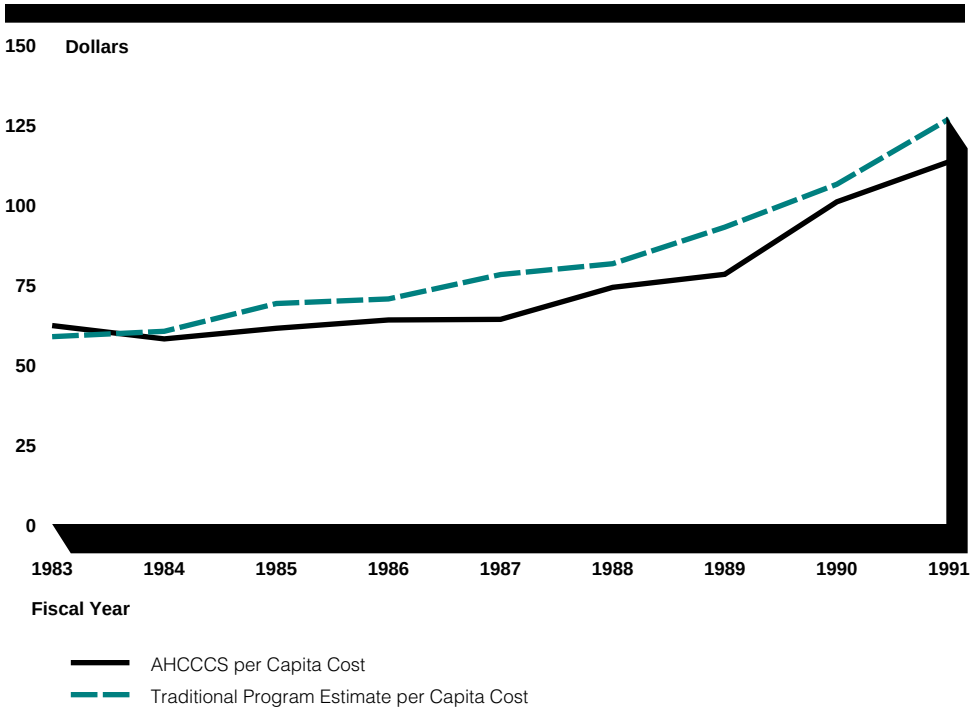


Figure 4: Cost of Serving an SSI Disabled Recipient in AHCCCS Compared With Estimated Cost in a Traditional Program, Fiscal Years 1983-91

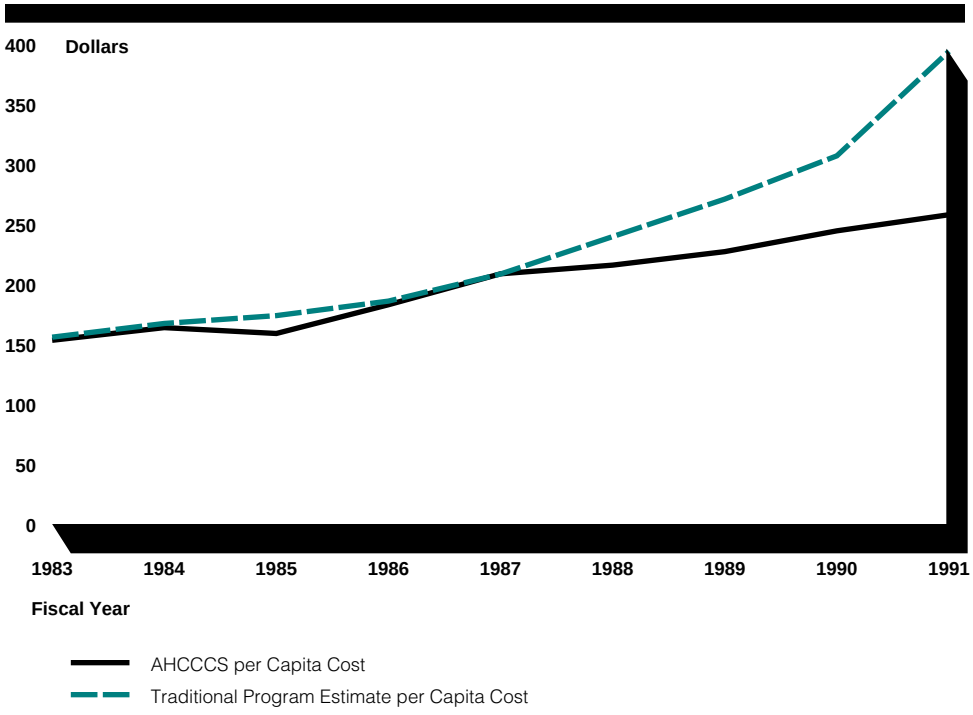
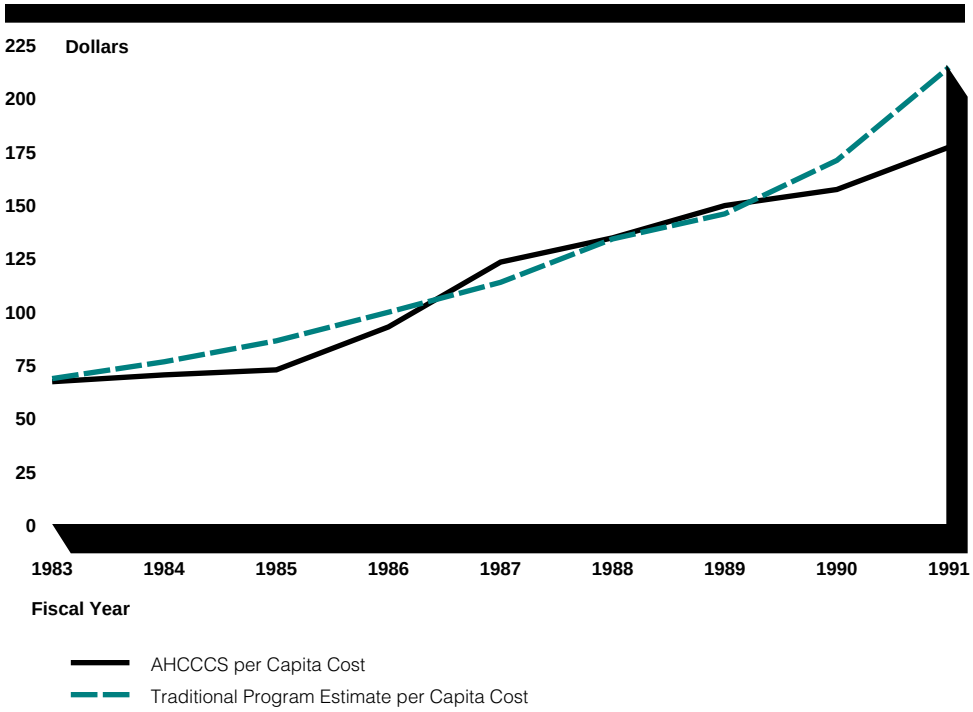
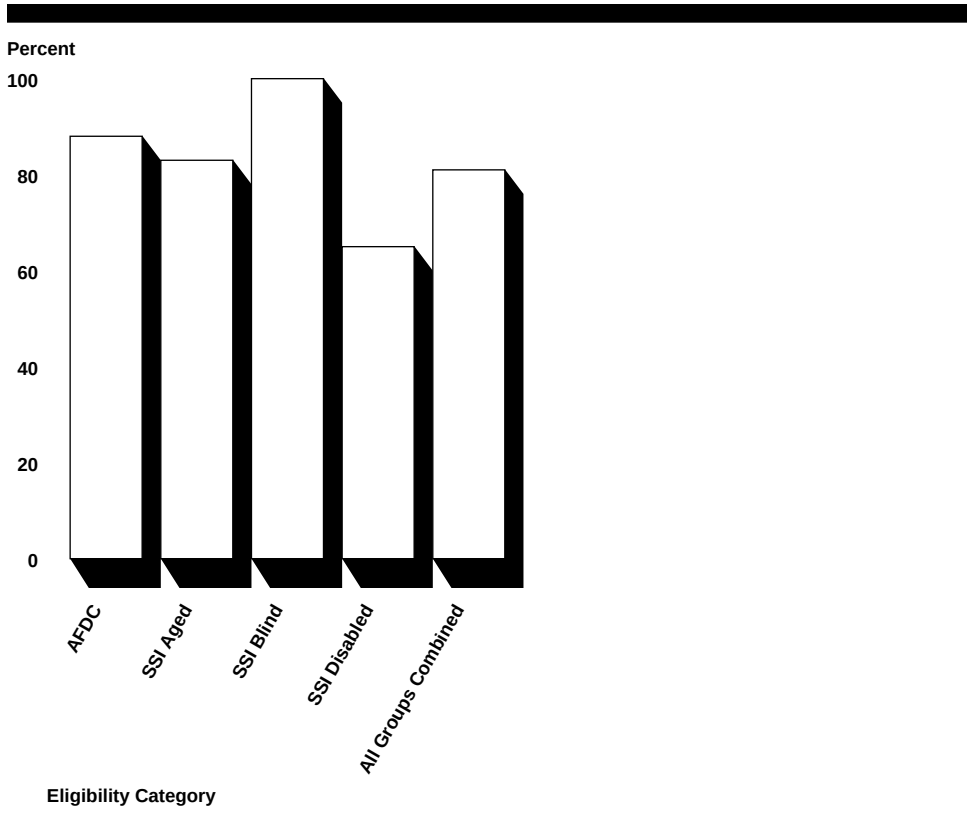


Figure 5: Cost of Serving an SSI Aged Recipient in AHCCCS Compared With Estimated Cost in a Traditional Program, Fiscal Years 1983-91



In addition, Laguna Research estimated that AHCCCS spent less per person in 1991 than would have been spent under a traditional program. Overall, Arizona spent 81 percent of what a traditional program would have spent, although this percentage varied by Medicaid eligibility populations. For example, spending for disabled beneficiaries was only 65 percent of spending for those in a traditional program, whereas spending for blind beneficiaries was estimated to have been the same. (See fig. 6 for AHCCCS per capita spending compared with traditional programs by beneficiary category.)

Figure 6: AHCCCS Capitation Rates as a Percent of Estimated per Capita Costs in a Traditional Program, by Eligibility Category, Fiscal Year 1991



Net Savings Generated Despite Slightly Higher Administrative Costs

Arizona's program demonstrates that adequately funding oversight activities more than pays for itself in net program savings. AHCCCS administrative costs are higher than the amount usually spent administering a traditional Medicaid program. In 1994 Arizona's administrative costs amounted to about 7 percent of what the state spent on medical services; most Medicaid programs spend about 4 to 5 percent on administration. Although we did not evaluate the appropriateness of AHCCCS' higher administrative costs, the Laguna Research report concluded that running an AHCCCS-like program is necessarily more expensive than running a traditional Medicaid program. Even with its higher administrative costs, the AHCCCS program generates net savings. For example, the report estimated that in 1991 AHCCCS generated medical savings of $70.7 million, required additional administrative costs of $19.2 million, and thus produced a net savings of $51.5 million for that

year. Because the federal government covers about two-thirds of Arizona's Medicaid costs, it saved roughly $37 million.[11]

Competitive Bidding Controls Costs, While Profits Spur Plan Participation

By using competitive bidding to award Medicaid managed care contracts, Arizona has harnessed market forces to help contain health costs. Plans are not assured of winning a contract; consequently, they have an incentive to submit the lowest bid for which they can provide the required beneficiary services and still earn a profit. Health plans are attracted to the program because they can earn profits from the AHCCCS contracts. Arizona and the federal government both benefit because the health plans—facing a fixed capitation rate—have an incentive to practice cost-conscious medicine and control costs.

Competitive Process Encourages Low Bids

Health plans that submit capitation rates higher than their competitors' risk exclusion from Arizona's Medicaid market. AHCCCS awards a limited number of contracts in each county: a maximum of 10 in Maricopa County—where Phoenix is located; 5 in Pima County—where Tucson is located; and 2 in each of the 13 remaining, more sparsely populated counties.

With each bidding cycle, the state has improved its ability to evaluate bids because it collects encounter, cost, and profitability data from each plan. In the latest contract cycle, seven bidders failed to win any acute care contracts, including two health plans that previously served AHCCCS beneficiaries. These two plans lost their acute care contracts because they failed to fully recognize the competitive pressures.

AHCCCS collects utilization, cost, and profit data from the health plans that serve its Medicaid beneficiaries. Independent actuaries use these data to estimate the cost of serving beneficiaries and establish reasonable bid ranges for capitated payments. Bid range information is not shared with the health plans, but the utilization data are. An AHCCCS official stated that health plans face less risk when they have reliable utilization data on which to base their bids, a factor that also encourages plan participation.

Existing plans know that they face competition not only from other plans but also from first-time bidders. In the latest cycle, two commercial

[11]The federal government pays for a certain share of each state's Medicaid medical expenses, called the federal medical assistance percentage. This varies by state: as of fiscal year 1993 in Arizona, this percentage was 65.89. In addition, the federal government pays 50 percent of most administrative expenses for all states, although it pays a higher percentage for certain administrative categories.

insurers, subsidiaries of Cigna and Blue Cross/Blue Shield, succeeded in obtaining contracts, one for the first time. First-time bidders are not necessarily disadvantaged, compared with current providers, in the contract award process. Prior performance can favorably or unfavorably affect the scores of current health plans' bids. Since first-time bidders have no performance record, their scores are unadjusted. In short, existing AHCCCS health plans with good performance receive some advantage in the contract award process, but first-time bidders do not receive lower scores simply because they have not had an AHCCCS contract previously.

AHCCCS may permit health plans to submit both an initial and a final capitation bid, but the award process favors plans that submit low bids both times. AHCCCS evaluates the initial bids and provides feedback to the plans on their cost projections. However, AHCCCS does not reveal specifics on either the state's own cost estimates or competitors' bids. After receiving feedback, health plans have an opportunity to submit a second—and final—capitation bid. However, both bids are considered in the contract award process. That is, a plan that has submitted a high initial bid will be at a disadvantage compared with a competitor that submitted a low initial bid, even if their final bids are identical.

Another incentive for low bids is tied to the market shares of contract winners. Although all Medicaid beneficiaries may specify which available plan they will join, only about 56 percent actively pick a plan. The remainder are assigned to a plan by AHCCCS, as are all fully state-funded beneficiaries. Although it considers factors other than cost, AHCCCS assigns more beneficiaries to lower cost plans.

Potential Profits, Even in Rural Areas, Encourages Health Plan Participation

AHCCCS' 1994 contract bidding process resulted in an unprecedented level of competition that helped achieve cost savings. Twenty-one health plans submitted 95 bids to provide Medicaid services in Arizona's 15 counties for the 1995-1997 contract period. This was more than double the number of bids (44) submitted in 1992, the start of the previous contract cycle. AHCCCS awarded a total of 42 contracts to 14 of the 21 bidders. The contract recipients included both commercial and noncommercial health plans, showing widespread interest in participating in the AHCCCS program.

Health plan officials cited reported profits as a key reason for the increased interest in obtaining an AHCCCS contract. AHCCCS health plans earned a combined $44 million in profits, representing 5.4 percent of revenue, in 1993. As table 1 shows, aggregate profits for AHCCCS health

plans have been positive since 1990 and have grown steadily. Aggregate profits in 1994 reached $56 million, representing 6.7 percent of plans' total revenue.

Table 1: AHCCCS Health Plans' Revenues and Profits, 1986-94

Year	Total revenue	Net income (dollars)	Net income (percent)
1986	$208,811,761	($3,062,316)	(1.47)
1987	220,636,178	5,088,259	2.31
1988	298,086,180	(8,237,696)	(2.76)
1989	339,063,375	(347,058)	(0.10)
1990	445,346,952	1,299,891	0.29
1991	561,492,337	17,585,993	3.13
1992	713,781,503	34,167,143	4.79
1993	809,463,837	43,528,836	5.38
1994	843,354,415	56,141,598	6.66

Source: AHCCCS Office of Managed Care.

Health plans compete to serve Medicaid beneficiaries in Arizona's rural counties because plans can profit in these areas, as well as urban areas. It is impossible to measure profits for all rural counties because profits are reported for each health plan, not each county, and some health plans serve both urban and rural counties. However, in 1994, six health plans served only rural counties, and five of these plans earned profits ranging from 2 to 3 percent of gross revenues. The remaining plan had unusually low medical costs and earned a profit of over 23 percent. This plan, however, did not win a contract in 1995. The ability of Medicaid managed care to thrive in rural areas stems from the way capitation rates are set. AHCCCS' capitation rates are set by the market on the basis of health plans' costs of providing services. Consequently, capitation rates are only slightly lower in rural counties compared with rates in the two urban counties.

In contrast, relatively few rural Medicare beneficiaries in Arizona receive their health care from health maintenance organizations (HMO). This likely results from the way Medicare capitation rates are set. Unlike the competitive bidding process used by AHCCCS, HCFA sets Medicare rates for each county using a formula based on Medicare fee-for-service costs in that county. In earlier testimonies and reports, we noted several flaws in

the Medicare rate-setting formula,[12] which can understate or overstate the actual cost of providing health care in a managed care setting. For example, if Medicare beneficiaries lack adequate transportation and thus consequently receive less care, Medicare fee-for-service expenditures will be artificially low and the formula will set capitation rates too low for the entire county.[13] Low rates discourage health plans from participating in Medicare managed care (risk contracts) and beneficiaries from enrolling in the plans that do exist.[14]

Flexibility to Waive Federal Requirements Helps Arizona Encourage Plan Participation

AHCCCS has used the flexibility granted by its section 1115 waiver to address federal requirements that tend to limit health plan participation in Medicaid managed care. For example, the waiver allows AHCCCS to award contracts to health plans that serve only Medicaid beneficiaries. Without a waiver, current Medicaid standards require that more than 25 percent of a health plan's enrollees be non-Medicaid, non-Medicare beneficiaries. All 14 of AHCCCS' current health plans serve only Medicaid beneficiaries or other AHCCCS populations, although some of the plans are subsidiaries of larger organizations. The waiver also allows AHCCCS to mandate that beneficiaries enroll in a managed care plan. AHCCCS guarantees an initial enrollment of at least 5 months—even if a beneficiary should lose Medicaid eligibility before that time. This guarantee reduces enrollee turnover and increases the attractiveness of Medicaid contracts to the health plans.

Focus on Cost Does Not Appear to Harm Access to Appropriate Care

Recent comprehensive measures are not available, but several indicators suggest that beneficiary satisfaction is high. AHCCCS' beneficiary satisfaction suggests that the program has established effective controls to ensure beneficiary access to appropriate care. The program, (1) in its competitive bidding process, places more weight on access and quality factors than it does on capitation rates; (2) requires networks to meet certain standards for primary care coverage; and (3) routinely monitors health plans' financial and operational performance. Finally, AHCCCS is

[12]Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995); Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995); and Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[13]Under AHCCCS, rural Medicaid capitation rates are approximately 90 percent of urban capitation rates. The divergence of Arizona Medicare capitation rates is much larger: rural rates amount to only about 50 percent of the rates paid in urban counties.

[14]Low capitation rates also discourage Medicare beneficiaries from enrolling in the HMOs that do exist. In areas with low rates, HMOs offer fewer inducements for beneficiaries to enroll, such as prescription drug benefits, compared with HMOs in areas with high capitation rates. Unlike Arizona's Medicaid beneficiaries, its Medicare beneficiaries are not required to join HMOs.

about to implement a new quality management system that will emphasize the use of outcome-based clinical measures.

Beneficiaries Satisfied With AHCCCS

On the basis of our discussions with beneficiary representatives and HCFA officials, our reviews of patient satisfaction surveys and quality studies, and the data on how often beneficiaries change health plans, the program's emphasis on cost containment appears not to have adversely affected the care provided to Arizona Medicaid beneficiaries. According to officials of advocacy groups representing Arizona's indigent population, Medicaid beneficiaries receive the same level of medical care as others in the state. HCFA officials said that they did not know of any concerns about beneficiary dissatisfaction with the care provided under the program. Further, they said that Arizona has a quality management program in place that fulfills HCFA regulations and all conditions of the waiver.

A Flinn Foundation beneficiary satisfaction survey conducted in 1989—the most recent comprehensive survey available—found that nearly 90 percent of adult current and former beneficiaries were satisfied with the care they received through AHCCCS.[15] A February 1995 survey also indicates beneficiary satisfaction with AHCCCS, although this survey is limited in scope. The survey, conducted by the Arizona State University Survey Research Laboratory, found that over 85 percent of contacted beneficiaries were very or completely satisfied with the prenatal and maternity care they received.

Relatively few beneficiaries voluntarily change health plans during the annual open season, which, according to AHCCCS officials, is another indicator of beneficiary satisfaction. In 1993, only 6 percent of beneficiaries changed health plans during the annual open season. In 1994, mainly because of new health contracts, 16 percent of the beneficiaries voluntarily changed plans, but in many cases their providers remained the same. In 1995, only 4.4 percent of the total acute care population changed health plans during open enrollment.

In AHCCCS' Bid Process, Access and Quality Factors Outweigh Cost

Although the competitive bidding process is important in keeping capitation rates low, two-thirds of the scoring comprises access and quality items. For example, the process considers the extent of a health plan's provider network, including the number, type, and geographic

[15]Another Flinn Foundation survey scheduled for publication in 1995 will include a measure of AHCCCS beneficiary satisfaction.

location of its physicians. AHCCCS also reviews a health plan's ability to meet the contract requirements in areas such as member and provider services and quality management. AHCCCS also considers a bidder's ability to perform the administrative tasks of the contract and its financial ability to meet all the contract terms.

By establishing a minimum allowable capitation rate, AHCCCS prohibits unreasonably low bids that might force health plans to curtail services and adversely affect the quality of care provided. This precludes harmful price competition among health plans.

Well-Developed Networks Ensure Access to Needed Services

Two factors are responsible for Arizona's Medicaid beneficiaries' good access to medical care—a high level of provider participation in AHCCCS and AHCCCS' minimum provider network requirements.

In Arizona, 81 percent of licensed and practicing physicians are registered Medicaid physician providers. Similarly, 70 percent of obstetricians and 71 percent of pediatricians participate in Medicaid. This level of participation is generally found in all of the state's 15 counties. Of Arizona's 104 hospitals, 96 participate in AHCCCS. According to health providers and their representatives, reasonable payment rates and the assurance of getting paid for the services provided through a monthly prospective payment system account for the high level of physician and hospital participation.[16]

AHCCCS' minimum network requirements ensure beneficiaries' access to appropriate care, even in rural areas. Contracts stipulate the type and location of providers in each county, with minimum provider-enrollee ratios. Beneficiaries have access to all levels of services, including obstetrics and other specialist services, through their primary care provider. The state also requires that plans make transportation available, when necessary, so that beneficiaries have access to needed services.

AHCCCS Oversees Health Plan Performance

As mandated by HCFA, AHCCCS monitors health plans' financial and operational performance. Health plans are required to submit periodic financial and encounter data to the state. Annual reviews by AHCCCS ensure

[16]The willingness of Arizona providers to participate in AHCCCS may also be partly due to the market alternatives they face. As of 1993, penetration of private managed care was high in the state, 28 percent compared with a national rate of 19 percent. Thus, Arizona physicians, facing the alternative of a large private managed care market, may be more willing to participate in Medicaid managed care than physicians in other states who derive a greater share of their business from the fee-for-service sector.

that plans are financially stable and help the state assess the level of care that Medicaid beneficiaries are receiving. Studies are also conducted to measure the appropriateness of care in specific areas—such as immunizations and prenatal care.

AHCCCS continues to refine its data collection efforts and improve its ability to monitor health plans. For example, AHCCCS discovered that health plans reimbursed providers for each patient's prenatal care and delivery in one lump sum, which discouraged providers from recording each separate encounter with the patient. As of October 1995, AHCCCS requires providers to report each encounter separately so that it can accurately monitor the frequency of patients' prenatal visits.

AHCCCS is developing a new quality management system that will gather standardized encounter data from all plans and increase the emphasis on outcome-based clinical standards. This will further enhance its capacity to ensure that plans provide appropriate care. AHCCCS expects this system to be operational in October 1997. According to HCFA officials, Arizona is a leader among all the states in developing encounter-based data to support a new quality management system. This system would produce such indicators as prenatal care and birth weights.

Several Conditions Contribute to AHCCCS' Success

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. Several findings supply evidence of lower costs, widespread provider interest in serving Medicaid patients, and beneficiary satisfaction with the program.

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 fee-for-service to a managed care program can learn from Arizona's experience. Our study of Arizona's Medicaid program suggests that the following conditions, regardless of the state, are necessary for an effective program.

- Flexibility to deviate from constraining regulations: The flexibility granted under the section 1115 waiver allowed Arizona to encourage the development of managed care in ways that are not possible under current HCFA regulations. Because of the waiver, Arizona can mandate that beneficiaries enroll in managed care plans. Also, health plans can be created that serve Medicaid patients exclusively. Without a section 1115 waiver, more than 25 percent of each health plan's enrollees would have to be non-Medicaid patients. This "75-25" rule was originally designed to help ensure that Medicaid patients received an acceptable quality of care because health plans would have to attract a minimum share of private patients. Arizona has decided to allow plans to have 100 percent of Medicaid enrollees and instead sets quality standards and monitors plan performance directly.
- Development and use of market forces: In contrast to Medicare—which uses administratively set capitation rates to pay HMOs—and other Medicaid programs, Arizona's Medicaid program relies on marketplace competition to determine capitation rates. The state gives plans an incentive to submit the lowest reasonable bid on capitation rates, excluding plans that propose rates below an invisible floor—to protect against impractically low bids. This system enables Arizona to buy the best priced plans. It also allows health plans to earn potential profits, which encourages the interest of both existing and new plans in serving Medicaid patients.
- Controls to protect beneficiaries from inadequate care: Arizona takes several steps to protect beneficiaries. First, all health plans must meet several basic requirements, including minimum numbers of participating providers to ensure beneficiaries' access to medical care. Second, in awarding contracts, Arizona assigns more points to factors that influence the quality of care that a plan can deliver than it does to the capitation rate bid. Third, the state continuously monitors health plans' performance.
- Investment in data collection and analysis capabilities: Arizona collects cost, profitability, and patient encounter data from each health plan. This information is then analyzed to help the state meet its goals of controlling costs and providing appropriate health care. On the basis of these data, independent actuaries estimate the cost of serving Medicaid patients in each county. This estimated cost is then used to evaluate the bids received at the start of each contract cycle. These data also enable the state to oversee the care provided to beneficiaries and protect against underprovision of medical services.

The final lesson of Arizona's program is that other states are likely to encounter problems changing from a fee-for-service delivery system—in which the Medicaid administrators primarily determine beneficiary

eligibility and act as third-party payers—to a managed care system that requires administrators to develop market forces and carefully monitor the care provided. As noted in our earlier reports, Arizona faced several difficulties along the way. In particular, attempts to contract out the program's administration and data information system failed. Furthermore, other states' competitive managed care programs will likely need to evolve, as did AHCCCS, to maximize their effectiveness in their own economic environment. One such change Arizona made was to limit the number of contracts awarded in each county. One of our earlier reports recommended this: because it increases plans' possibility of not winning a contract, it strengthens their incentives to submit low bids. Arizona has been expanding and refining its market-driven approach to Medicaid since 1982; it is unlikely that other states could adopt equally successful programs without substantial preparation and development of the capabilities Arizona now has.

Agency Comments

We obtained comments from HCFA and AHCCCS officials on a draft of this report, and they agreed with our findings. Technical comments that HCFA and AHCCCS provided have been incorporated where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, AHCCCS officials, and other interested parties. We will also make copies available to others upon request.

Please call me on (202) 512-7123 or James Cosgrove, Assistant Director, on (202) 512-7029 if you or your staff have any questions about this report. Karyn Papineau, Tony Padilla, and Mary Needham were major contributors to this report.

Sincerely yours,

William J. Scanlon
Associate Director,
Health Financing Issues

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Abbreviations

AFDC	Aid to Families With Dependent Children
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
OMD	Office of the Medical Director
PCCM	primary care case management
PMMIS	prepaid medical management information system
RFP	request for proposal
SOBRA	Sixth Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income

Arizona Health Care Cost Containment System Managed Care Contracts Award Process

The Arizona Health Care Cost Containment System's (AHCCCS) Office of Managed Care is responsible for the procurement process used to competitively select the health plans that will provide medical services to Medicaid beneficiaries. The nearly year-long process starts with a bidders' conference where potential bidders learn how the process works and continues with bid submissions, evaluation of bids, contract awards, and readiness reviews before contract implementation.

AHCCCS completed its most recent procurement of managed care contracts in 1994, covering October 1, 1994, to September 30, 1997. Previously, contracts were awarded for a 2-year period. In the last cycle, contracts were competitively awarded on a county-by-county basis. The major steps in the 1994 contract process are described below.

Bidders' Conference

After advertising statewide that it would issue a request for proposal (RFP) to health plans to provide medical services to Medicaid beneficiaries, AHCCCS invited all potential bidders to a bidders' conference in March 1994. AHCCCS officials briefed attendees and answered questions on the Medicaid program, contract requirements, the award process, and responding to the RFP.

To facilitate the preparation of capitation proposals, AHCCCS provided each bidder with a Data Supplement Book. AHCCCS officials said that this book contained historical medical service utilization data. However, AHCCCS stated that each bidder would be solely responsible for researching, preparing, and documenting its capitation proposal and that this book should not be used as the sole source of information in making decisions about the capitation proposal.

Issuance of the RFP

On March 7, 1994, AHCCCS issued its RFP describing the requirements that a health plan must meet to deliver health care services to eligible recipients. The RFP instructed bidders in preparing a response to the state. Bidders were required to submit a proposal for each county in which they wished to compete for a contract. All interested health plans were required to respond to the RFP by June 1, 1994. For the contract cycle beginning October 1, 1994, 21 health plans submitted 95 bids for 42 Medicaid managed care contracts in 15 counties. The 95 bids were more than twice the number (44 bids) received in the previous procurement cycle (1992).

Evaluation of Proposals

AHCCCS selected in-house staff with managed care expertise to serve on teams to evaluate all bids submitted. AHCCCS evaluated the bids submitted in four areas, which are assigned a percentage value of the total score: (1) provider network, (2) capitation rates, (3) program, and (4) organization. AHCCCS also contracted with private consulting firms that independently verified the evaluation and scoring done by AHCCCS' internal evaluation teams. The scores received in each of the four areas were combined and weighted to get a final score for each bidder, by county.

Provider Network Scores

The provider network score included two categories—network development and network management. Network development involves developing contractual arrangements with a sufficient number of providers capable of delivering high-quality covered contract services to eligible recipients in a specified service area according to AHCCCS standards. AHCCCS identified service area minimum network standards describing location requirements by county. Network management involves the health plan's process of communicating with its network and monitoring and evaluating its providers.

Capitation Rate Scores

Following HCFA requirements, AHCCCS contracted with an actuary to analyze historical utilization data and certify the capitation rate ranges that AHCCCS used to evaluate the capitation rates (prices) submitted by each bidder. The actuaries developed ranges for each eligibility group (for example, AFDC and SSI) in each of Arizona's 15 counties.

AHCCCS did not share with bidders the capitation rate ranges used to evaluate the capitation rate bids. Competitors may have been asked to submit two bids, an initial bid and a best and final bid. AHCCCS scored both bids. The closer the bid was to the low end of the range, the more points a bidder received. The higher the bid, the fewer points the bidder received. When the bids are below the range, but, in AHCCCS' view, not unreasonably low, the state considers the bid at the low point on the range and assigns the corresponding points. If a bid is excessively below the range, the state may consider it nonresponsive and unacceptable. When an initial bid is above the range (considered an unacceptable bid), a bidder may be allowed to submit a second bid, the best and final offer. In scoring, the first bid (the unacceptable bid) received the least points. The best and final bid was scored on the basis of the bid's ranking within the acceptable range.

Between submission of initial and final bids, AHCCCS officials reviewed bidders' detailed cost and utilization data (for example, estimates of hospital days, physician visits, administrative costs, and profits) supporting the bidders' initial capitation rate bids. Although AHCCCS pointed out to bidders specific items that required adjustments on the basis of AHCCCS' knowledge of historical medical service utilization and cost data, bidders are solely responsible for deciding the capitation rate that they wish to bid.

AHCCCS evaluated the final bids the same way it scored the initial bids. The initial and final bids received equal weight for evaluation and scoring.

Program Scores

For program issues, AHCCCS evaluated the following: (1) executive management and staff, (2) medical director's role, (3) member services, (4) provider services, (5) quality management, (6) maternal child health/early periodic screening diagnosis and treatment/family planning, (7) grievance and appeals, and (8) behavioral health.

AHCCCS also considered its past experience with continuing program bidders in evaluating proposals in this area. It did this by reviewing the results of its most recent operational and financial reviews of these bidders. AHCCCS adds points to a score if a bidder's past AHCCCS performance has significantly exceeded the requirements of the RFP. AHCCCS subtracts points from a score if a bidder's past performance has been poor. If AHCCCS does not have past program experience with a bidder, then the program score is based on the bidder's response to the RFP.

Organization Scores

For organization, reviewers examined the bidders' prospective ability to perform the administrative tasks necessary to support the contract's requirements. AHCCCS used financial planning and financial viability criteria to evaluate and score this bid factor. AHCCCS reviewed in detail the many management and administrative systems, including a bidder's encounter data reporting system, financial reporting system, contracting and subcontracting process, grievance standards and process, and medical records.

Contracts Awarded

On July 11, 1994, AHCCCS awarded 42 contracts to 14 health plans. AHCCCS awarded 2 contracts in each of its 13 rural counties. In Maricopa County, where Phoenix is located, 10 contracts were awarded. In Pima County,

where Tucson is located, six contracts were awarded. The current contract period runs from October 1, 1994, to September 30, 1997. Seven bidders, including two health plans that previously had managed care contracts, did not win any contracts.

Readiness Review

Between submission of contract award and the start of health care delivery, (for example, July 11, 1994, to Oct. 1, 1994) AHCCCS conducted operational and financial readiness reviews for new successful bidders. The purpose of readiness reviews is to assess new contractors' readiness and ability to provide contract services to members at the start of the contract period.

Although AHCCCS gives new contractors until the end of the first quarter of the contract year (for example, Oct. 1, 1994, to Dec. 31, 1994) to complete pending readiness items, a new contractor is permitted to begin operations only if the readiness review concerns have been addressed to AHCCCS' satisfaction. An example of a pending item would be the unsuccessful testing of a health plan's data system to collect encounter information.

AHCCCS' Oversight of Health Plan Performance

Health Plan Reporting Requirements

HCFA mandates that AHCCCS conduct annual reviews of its contracted health plans to determine their financial and operational stability. AHCCCS has established financial and operational standards for the health plans and their providers to ensure that beneficiaries receive appropriate care. The state conducts on-site financial and operational reviews at least annually to ensure that health plans comply with operational and financial standards. In addition, AHCCCS monitors health plans' data (for example, financial and encounter data) submitted through monthly, quarterly, and annual reports.

The on-site reviews identify potential deficiencies that affect the delivery, quality, or integrity of services or care. Corrective action plans are developed to resolve any identified deficiencies. These plans must state and describe the corrective action, the agency responsible for implementing the corrective action, and the suggested date for implementing the corrective action. AHCCCS monitors a contractor's progress in implementing these corrections and provides technical assistance if necessary.

AHCCCS' financial review ensures the reliability of a plan's accounting systems, claims processing and encounter reporting systems, and recovery systems and the stability of its financial position. It also reviews financial management operations, such as reinsurance, and evaluates any proposed changes to the program such as new subcontractors and new management companies. AHCCCS also requires each health plan to submit an annual audited financial statement.

The operational segment of AHCCCS' annual on-site review documents how a health plan manages and monitors its delivery system and the quality of care as measured by standards developed by AHCCCS' Office of the Medical Director (OMD). According to a HCFA official, these standards reflect proposed standards issued by HCFA in 1993 for Medicaid managed care programs. The OMD policy requires health plans to develop quality management plans that articulate requirements; promote quality improvement; comply with federal, state, and AHCCCS requirements; ensure the participation of a health plan's members and providers; and ensure health plan leadership participation.

Quality and Utilization Management Requirements

AHCCCS requires that health plans' quality management plans incorporate quality indicators to monitor performance in areas such as preventive health, women's health, birth outcomes, prenatal care, and accessibility and availability of services. OMD has established standards adopted from

commonly accepted medical standards of care and relies on performance goals established by the Department of Health and Human Services. Health plans must also have systems to detect underutilization as well as overutilization. Health plans are responsible for providing feedback to health professionals and health plan staff regarding performance.

Health plans are also required to complete an annual quality of care study on a topic approved by AHCCCS. Topics have varied, including subjects such as the review of pharmacy utilization by plan members, specialty physician referrals documentation, and the appropriateness of emergency room use. According to AHCCCS officials, the study results are used to improve the quality of services provided.

AHCCCS oversees health plans' quality management by monitoring member and provider grievances; monitoring networks; and reviewing various monthly, quarterly, and annual reports on plans' adherence to performance measures.

Quality Studies Complement Quality Management Efforts

AHCCCS has completed various studies on quality issues, some of which have been completed to meet federal or state legislative requirements. These studies compare the care provided to AHCCCS members with national standards and point out the need to develop reliable data and constantly improve the system of care to beneficiaries.

In 1995 AHCCCS completed the second year of a state-required annual review comparing the immunization levels for AHCCCS members under 6 years of age with national data and Centers for Disease Control and Prevention standards. The review found that the percentage of children receiving immunizations increased from 1993 to 1994, although the rates need further improvement to meet HHS' 90-percent immunization goal. In addition to reviewing immunization rates, the second year's study also identified reasons for beneficiaries' not receiving recommended immunizations. The researchers found that providers missed opportunities to give immunizations. AHCCCS is sharing this information with health plans for use in their provider education efforts.

In another study, AHCCCS looked at the underutilization of dental services. The study found that AHCCCS' requirement to have health plans refer beneficiaries to dentists was deterring beneficiaries from using available dental services. AHCCCS implemented a new policy on October 1, 1994, to allow beneficiaries direct access to dentists.

New Quality Program Being Developed

AHCCCS is developing a new quality management program that reflects current national trends on quality management in Medicaid programs. With its most recent waiver extensions, HCFA has encouraged Arizona and other states to improve their use of encounter data in quality management programs. According to HCFA officials, the recommendation to change AHCCCS' program reflects increased interest in quality standards for Medicaid programs at the national level rather than problems with Arizona's current system.

AHCCCS is adopting new quality standards to reflect HCFA's national initiative to develop standards for the Medicaid population. Changes to the current standards for commercial managed care plans are needed to reflect, for example, Medicaid's enrollment fluctuations. In addition, AHCCCS plans to standardize the information received from its health plans. This effort will ultimately be used to monitor and compare participating health plans' performance.

This new standardizing of information has four components that measure both outcomes and health plan operations. Clinical indicators, financial indicators, member satisfaction, and provider satisfaction will be used to evaluate health plans. The standardizing of information from the health plans, the main difference between current efforts and the new plan, will improve monitoring efforts and reduce the current time-intensive reliance on on-site record review.

As of July 1995, AHCCCS was completing the clinical indicators for monitoring the health plans and establishing baseline data. It is updating its computer systems to support the increased reliance on encounter data. AHCCCS plans to implement the new standards for the next health plan contract cycle beginning on October 1, 1997.

History of AHCCCS

Before 1982, Arizona was the only state in the nation that did not participate in the federal Medicaid program. Health care for low-income people was provided and funded by county governments, with care provided by county hospitals and clinics or through contracted providers. Each county set its own income and resource guidelines with certain minimum standards set by the state. The range of services also varied from county to county.

In 1981 Arizona legislators recognized that the counties could not continue to pay the full cost for health care and began to explore options that would relieve the counties and, for the first time, bring federal Medicaid dollars to the state. In 1981, the state government passed legislation to create AHCCCS as the first statewide Medicaid managed care system. In 1982 Arizona sought approval from HCFA to operate AHCCCS under a section 1115 demonstration waiver. Named for section 1115 (a) of the Social Security Act, 1115 waivers enable states to operate differently from conventional Medicaid in certain ways, such as limiting beneficiaries' choice of providers.

On July 13, 1982, HCFA approved AHCCCS as a 3-year acute medical care demonstration project, and the state implemented the program on October 1, 1982. AHCCCS became the first statewide Medicaid managed care system in the nation based on a prepaid, capitated financing arrangement with private health plans. Arizona's intent was to create a managed care delivery system that would deliver quality services, control costs, discourage the use of emergency rooms for primary care, and avoid the fraud and abuse reported in fee-for-service programs.

Initially, AHCCCS was required to provide medical services only to the federally mandated eligible group for which Arizona received federal matching funds (recipients of AFDC and SSI), recipients commonly referred to as "categorical."

Today, AHCCCS still serves these groups as well as women and children covered under the 1987 Sixth Omnibus Reconciliation Act. Medicaid-eligible American Indians can choose to receive services from the Indian Health Service or, off reservation, from an AHCCCS health plan. The Arizona Department of Economic Security determines eligibility for AFDC. The Social Security Administration determines eligibility for SSI. As of August 1, 1995, over 432,000 beneficiaries were enrolled in the acute care program.

Initially, AHCCCS was also required to provide all the federally mandated Medicaid services except for skilled nursing facility care, home health care, nurse midwife services, family planning services, and nonacute mental health services. Today, AHCCCS provides these services.

AHCCCS also provides services to groups of low-income people who do not qualify for Medicaid and who are funded entirely by state and county dollars. These groups are the medically needy/medically indigent, eligible assistance children; eligible low-income children; and undocumented individuals, who receive some emergency services. These groups of recipients are commonly referred to as "noncategorical." These state-funded groups generally receive the same acute care services available to the federally funded populations except for comprehensive behavioral health services and, until recently, heart, liver, and bone marrow transplants.

Initially, AHCCCS' day-to-day operations were carried out by a private contractor selected through a competitive procurement to act as the AHCCCS administrator. The administrator's responsibilities included procuring and monitoring providers, establishing and monitoring medical quality assurance systems, enrolling beneficiaries, maintaining provider relations, providing technical assistance to health plans, and collecting and compiling reports using claim and utilization data.

After a little more than a year, on March 15, 1984, Arizona was forced to cancel the contract because of disputes. The AHCCCS Division of Arizona's Department of Health Services took over as administrator. After this, the state terminated two health plan contracts due to plan insolvency. In addition, another plan was reorganized with new management under the federal bankruptcy statutes.

Subsequently, the AHCCCS Division became a separate agency reporting directly to the governor. The AHCCCS structure was also changed so that the Division could assume a stronger regulatory role. AHCCCS' new challenges included financial and contractual compliance reviews of health plans; quality control review of the county eligibility systems; medical quality of care audits of the health plans; and increased staffing for the audit, compliance, and utilization review functions.

We first reported on AHCCCS[17] in June 1984. We testified on HCFA's monitoring of certain aspects of the AHCCCS program before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives. At that time, we reported that AHCCCS had not generated the program information necessary to render an opinion on the financial performance of health plans, the quality of care provided, or the reasonableness of payments to providers.

In response to GAO's recommendations, both HCFA and AHCCCS began the steps necessary to obtain data essential to evaluating AHCCCS. Although HCFA informed AHCCCS that it would not approve an extension of its waiver unless the state produced complete and accurate utilization data, HCFA told us that as long as AHCCCS made significant progress in implementing reforms and improvements necessary for producing the information, HCFA would not terminate the program. In addition to providing HCFA with some utilization data dating back to 1982, AHCCCS submitted a plan detailing the steps it would take to meet HCFA's requirements.

In November 1985, we reported that many AHCCCS health plans had not complied with federal requirements for disclosure of ownership information. We reported that some AHCCCS plans either had not disclosed direct or indirect ownership interests or had not disclosed officers or directors. We recommended that the Secretary of HHS direct the Administrator of HCFA to review AHCCCS plan contract proposals and renewal submissions and determine the extent to which federal financial participation should not be available for plans that did not comply with disclosure laws for ownership and control information or related-party transactions. Our other recommendations were that AHCCCS and HCFA institute procedures to ensure that AHCCCS plans comply with these disclosure requirements in the future.

In response to GAO's recommendations, HCFA and AHCCCS said that they would act to ensure that future health plan contracts follow disclosure requirements. AHCCCS currently has a reporting guide that establishes the monthly, quarterly, and annual reporting requirements for acute care contracting health plans. The guide requires reports on owners, officers, directors, related-party transactions, and full financial disclosure and also

[17]The Health Care Financing Administration's Monitoring of the Arizona Health Care Cost Containment System (GAO/HRD testimony, June 15, 1984; Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985); Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987); and Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

establishes financial penalties if the health plan contractors fail to comply with these requirements.

In March 1987, we reported on AHCCCS' first 3 years of operation (Oct. 1982 through Sept. 1985). We addressed Arizona's approach to (1) competitive bidding for procuring health plan contracts, (2) collection of utilization data from the prepaid plans on the health care services provided, and (3) financial oversight of the prepaid health plans. In our March 1987 report, we stated that Arizona had experienced many start-up problems that prevented an assessment of the effectiveness of its cost containment features.

We reported that states planning on using prepaid health programs should, among other things, (1) develop adequate financial and utilization reporting systems and program controls before implementing the program, (2) establish penalties for noncompliance with reporting requirements, (3) establish requirements to demonstrate the financial viability of prepaid health plans and devote adequate resources to monitoring health plans' performance, and (4) design health plan procurements to promote competition. As previously indicated, AHCCCS officials have acted to resolve these problems. Today, for example, AHCCCS limits the number of contracts it awards in each rural county to two—a recommendation we made to promote competition and reduce costs.

In 1986 AHCCCS contracted with a private consulting firm to design and develop a prepaid medical management information system (PMMIS). Contract disputes resulted in the termination of this contract in 1990 as the system was set to enter the testing phase. In May 1990, AHCCCS took over the testing, user training, conversion, and implementation of PMMIS. AHCCCS officials told us that its management information system has for several years enabled them to collect and analyze adequate financial and utilization data to assess plans' finances and set sound capitation rates. They added that such data are beginning to be used to conduct outcome-based monitoring and evaluation of the quality of care being provided to beneficiaries.

In 1981 Arizona passed authorizing legislation allowing small employers with up to 25 employees to purchase health care from AHCCCS. This program began in 1988, and in 1991 the employee limit was raised from 25 to 40. AHCCCS currently has contracts with four health plans to provide health coverage under its small employer program called Healthcare Group of Arizona. Currently, about 5,800 employers are enrolled providing

care for over 18,000 employees and dependents. AHCCCS does not receive federal financial assistance for this program.

In 1989 AHCCCS implemented the Arizona Long Term Care System (ALTCS), which offers long-term care, acute care, and home and community-based services to the elderly or physically and developmentally disabled. As of August 1995, over 20,000 people were enrolled in ALTCS.

In March 1993, we reported on various states' managed care program initiatives including Arizona's. We described (1) states' use of managed care programs; (2) the difficulty states face in implementing certain program components; (3) the effect of the managed care approach on health care access, quality, and cost; and (4) the presence of features that ensure the quality of health services and providers' financial stability.

AHCCCS began its 14th year on October 1, 1995. It continues today under an August 1994 waiver extension as a statewide Medicaid managed care demonstration project. The most recent waiver extension authorizes AHCCCS to operate until October 1, 1997.

In March 1995, AHCCCS submitted to HCFA an amendment to its waiver, contingent on approval by the Arizona legislature, which would streamline the eligibility determination process and offer health care services to low-income and working poor individuals who have income levels up to 100 percent of the federal poverty level. The Arizona legislature did not approve the AHCCCS proposal.

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