



A REPORT  
TO THE  
ARIZONA LEGISLATURE

Performance Audit Division

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Performance Audit

# Arizona Health Care Cost Containment System

Division of Member Services

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JULY • 2002  
REPORT NO. 02 – 05



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**Debra K. Davenport**  
Auditor General

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AUDITOR GENERAL

STATE OF ARIZONA  
OFFICE OF THE  
AUDITOR GENERAL

WILLIAM THOMSON  
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July 31, 2002

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Ms. Phyllis Biedess, Director  
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Health Care Cost Containment System (AHCCCS)—Division of Member Services. This report is in response to an August 9, 2001, resolution of the Joint Legislative Audit Committee. The performance audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-1279 and 41-2951 et seq. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

This is the first in a series of reports to be issued on the Arizona Health Care Cost Containment System.

As outlined in its response, AHCCCS agrees with all of the findings and recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on August 1, 2002.

Sincerely,

Debbie Davenport  
Auditor General

Enclosure

# PROGRAM FACT SHEET

## Arizona Health Care Cost Containment System

Division of Member Services

### Services:

The Division provides the following services:

- 1 Determining eligibility for the Arizona Long Term Care System (ALTCs) and for other Supplemental Security Income Medical Assistance Only (SSI/MAO) programs, as well as for the Children's Health Insurance Title XXI Program called KidsCare;
- 2 Enrolling eligible acute care and ALTCs members and providing member eligibility and enrollment information;
- 3 Performing oversight of the Department of Economic Security's Medicaid eligibility determinations; and
- 4 Providing information to healthcare providers and AHCCCS members through its 24-hour Communications Center.

### Facilities:

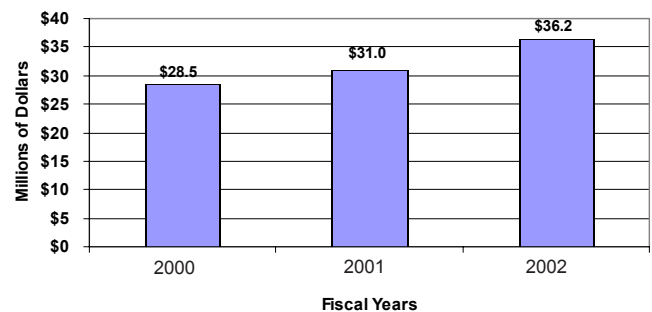
The Division performs its duties at two state-owned buildings located at 701 and 801 East Jefferson Street in Phoenix, Arizona, and at 18 leased field offices statewide. The total lease costs are approximately \$2.5 million annually.

### Equipment:

The Division uses and owns standard equipment such as computers, copy machines, scanners, and fax machines. The Division owns 112 vehicles, including pickup trucks, sport utility vehicles, sedans, and vans. The Division's Communications Center also owns a phone system that allows calls to be routed to individual operators and tracks such information as number of calls waiting and caller wait times.

### Program revenue:

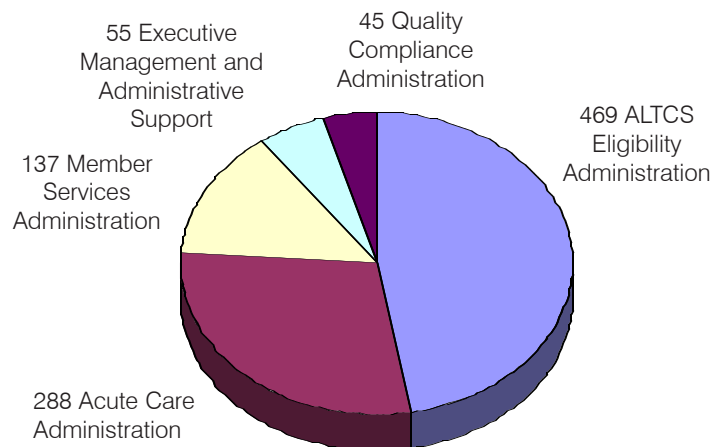
**\$36.2 million (fiscal year 2002, estimated)<sup>1</sup>**



<sup>1</sup> The estimated fiscal year 2002 program revenue includes \$1.2 million in funding from the Tobacco Settlement Litigation Fund to help administer the increased workload that resulted from Proposition 204, approved by voters in November 2000, which expanded criteria for medical coverage eligibility.

### Program staffing:

**994 approved FTE (nearly 45 percent of which determine eligibility statewide)**



### Division Mission

To assist AHCCCS-eligible members in accessing healthcare.

### Division goals:

1. To administer eligibility processes for ALTCS, KidsCare, SSI/MAO, and four Medicare Cost-Sharing Programs in a timely manner.
2. To determine eligibility in an accurate manner.
3. To ensure that member information in the recipient database is accurate and updated in a timely manner.
4. To provide accurate eligibility and enrollment information to providers and members in a timely manner.
5. To ensure compliance with federal Medicaid Eligibility Quality Control requirements.

### Adequacy of goals and performance measures:

The Division of Member Services' 5 goals appear to be appropriate for its mission, and it has established 16 performance measures that correlate to its goals. A review of the Division's performance measures finds that the Division has established measures that adequately convey its performance in each of its primary areas of responsibility: conducting timely and accurate eligibility determinations, providing information through its Communications Center, maintaining a database of member information, and ensuring compliance with certain federal requirements.

# SUMMARY

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The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System's (AHCCCS) Division of Member Services as part of a Sunset review of the agency. This audit was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-1279 and 41-2951 et seq. This is the first in a series of five audits of AHCCCS, the first performance audits the Office of the Auditor General has performed on AHCCCS since its inception. Subsequent audits will cover AHCCCS' rate setting processes, quality-of-care, medical services contracting practices, and the agency-wide Sunset Factors.

AHCCCS administers healthcare programs for approximately 800,000 low-income Arizonans. Most of them receive healthcare through Medicaid, a joint federal/state healthcare program for low-income persons. AHCCCS also administers several other healthcare programs for low-income persons who are not eligible for Medicaid. AHCCCS operates under a managed care system, in which it contracts with health plans who in turn contract with healthcare providers to provide care for qualified persons.

The Division of Member Services (DMS) is the largest division within AHCCCS and is responsible for determining and overseeing applicant eligibility for healthcare programs for the poor. DMS determines eligibility for some of these healthcare programs, including Arizona's Children's Health Insurance Program, known as KidsCare, the Arizona Long Term Care System (ALTCS), and other healthcare and medical assistance programs. Additionally, the Division is responsible for overseeing other eligibility determinations for the Medicaid program. While AHCCCS has an intergovernmental agreement with the Department of Economic Security (DES) to actually perform the determinations, DMS is responsible for ensuring that DES makes the determinations in an accurate and timely manner. Finally, DMS maintains enrollment information about all individuals enrolled in Medicaid and AHCCCS programs and makes this information available to healthcare providers.

## Changes underway to address the increase in Medicaid applicants (see pages 7 through 11)

A November 2000 voter initiative, Proposition 204, significantly changed the State's Medicaid program by expanding eligibility for medical assistance to all Arizonans whose income falls below the Federal Poverty Level and changing the eligibility process.<sup>1</sup> Prior to October 1, 2001, Arizona's 15 counties were responsible for determining individuals' eligibility for Arizona's state-only funded healthcare programs for low-income individuals. However, effective October 1, 2001, Medicaid expansion absorbed those state-funded programs and DES became responsible for determining the eligibility for those individuals. AHCCCS and DES have an intergovernmental agency agreement that outlines DES' new responsibilities, how AHCCCS will oversee this process, and the payments AHCCCS will make to DES for performing the determinations.

Changes in determining eligibility for the State's Medicaid program have created many new challenges for DES, particularly in its relationship with hospitals, but DES has taken some positive steps to address these challenges. For example, hospitals were initially concerned that they were not receiving timely information from DES regarding patients' eligibility status. It is important that the hospitals have this information as soon as possible so they can determine whether they should bill a health plan under contract with AHCCCS or if they should try to obtain payment from the patient. To give hospitals this information, DES sends the hospitals written notification of each eligibility determination. According to some hospital representatives, they are now receiving these notifications in a more timely manner and the information is helpful for them so they will know whom to bill for services. DES is also exploring automated ways for hospitals to access applicants' eligibility status information.

Hospitals were also concerned about the expansion of Medicaid criteria under Proposition 204 and DES' ability to enroll all eligible individuals. To better ensure that DES can reach as many potentially eligible applicants as possible, it has stationed eligibility staff at several hospitals 24 hours a day. According to one hospital representative, having DES workers in the hospitals is helpful because they can answer patients' questions concerning AHCCCS. Finally, some problems occurred when 650 county eligibility workers transferred to DES to help conduct Medicaid eligibility determinations starting on October 1, 2001. Many workers had not received training in DES' processes before transferring, which led to problems such as information being entered incorrectly into DES' computer system. DES has since developed and completed a training program for former county workers.

While DES has begun to address many early challenges associated with the program changes, AHCCCS is ultimately responsible for ensuring that the Medicaid

<sup>1</sup> For 2002, the Federal Poverty Level is \$8,860 for an individual and \$18,100 for a family of four.

eligibility determinations DES performs are accurate and timely. AHCCCS has developed a program to regularly review samples of DES' eligibility determinations for accuracy and timeliness and may financially sanction DES for unacceptable amounts of errors. However, because of the program's newness, some of AHCCCS' procedures for overseeing DES' activities were not yet in place when this audit was completed.

## AHCCCS has addressed problems with eligibility determination processes (see pages 13 through 17)

AHCCCS determines eligibility for some programs, including the Arizona Long Term Care System (ALTCS), Supplemental Security Income/Medical Assistance Only (SSI/MAO), and the State's Children's Health Insurance Program (KidsCare). In addition, AHCCCS staff calculate error rates for eligibility determinations associated with each of these programs to identify the number of correct and incorrect eligibility determinations. During the audit, AHCCCS substantially addressed problems in the eligibility determination process for ALTCS and SSI/MAO. However, AHCCCS should discontinue calculating error rates for the KidsCare program because they are neither meaningful nor federally required.

- **The Arizona Long Term Care System (ALTCS)**—During the audit, AHCCCS eliminated many ALTCS medical reassessments that appeared to be of limited usefulness, but it needs to change its rules accordingly. ALTCS provides healthcare to approximately 34,000 elderly or physically or developmentally disabled persons who require a high level of care. Those who apply must meet standards related to financial and medical conditions. Under the program's rules, AHCCCS must reassess their financial eligibility annually and their medical eligibility on a regular basis. In April 2002, after finding that fewer than 1 percent of the members whose cases were reviewed for medical eligibility were no longer eligible for ALTCS, AHCCCS decided to stop conducting medical reassessments in most instances. By not conducting these reassessments, AHCCCS states that it may save on travel expenses, and have more staff available to complete other important tasks. However, if AHCCCS continues with this change, it needs to revise its administrative rules accordingly.
- **Supplemental Security Income/Medical Assistance Only (SSI/MAO)**—During this audit, AHCCCS addressed a significant workload increase in its SSI/MAO unit by adding staff and prioritizing staff efforts. The SSI/MAO unit performs eligibility determinations for the elderly, blind, or disabled who may qualify for Medicaid. After Proposition 204 expanded SSI/MAO eligibility, the number of Medicaid enrollees in this category increased more than four-fold within 1 year, and as of May 2002, was nearly 18,500. Due to this increased workload,



AHCCCS was unable to process eligibility renewal applications in a timely manner and did not initiate renewal applications for 6 months. AHCCCS has addressed this issue by adding additional staff to conduct eligibility determinations and developing a new division within the unit to focus only on renewals. AHCCCS should continue to monitor its workload because it will now have to perform thousands more annual renewals than in the past.

- **KidsCare**—AHCCCS should discontinue calculating error rates for KidsCare eligibility determinations. KidsCare provides healthcare to approximately 48,200 children who are 18 years old and younger, are not covered under private health insurance, and do not qualify for Medicaid. As they do with other programs, AHCCCS staff review a sample of eligibility determinations to evaluate whether they were made correctly. These reviews allow AHCCCS to calculate an error rate for the samples and to identify programs with high numbers of incorrect determinations. For this program, however, the error rates do not provide meaningful results, are not federally required, and are unnecessary because other ways exist to ensure the quality of eligibility determinations. AHCCCS should discontinue calculating KidsCare error rates, thus making four staff available for other work.

## Communications center has improved its services (see pages 19 through 23)

AHCCCS has initiated various ways to improve the services its Communications Center provides, but should take additional steps to improve. The Communications Center provides enrollment and other information to AHCCCS members and healthcare providers 24 hours a day. To improve the way it shares information with healthcare providers, AHCCCS has implemented automated methods, such as a touch-tone phone information system and swipe-card system to enable healthcare providers to verify their patients' enrollment in AHCCCS programs. AHCCCS is also developing an Internet-based system for enrollment verification. AHCCCS has also tried to improve the performance of its Communications Center staff through an incentive program that pays operators and others up to \$200 more per month for high performance. However, some of the criteria for determining these incentive payments need to be adjusted or replaced to better reflect the participants' performance. Finally, AHCCCS should assess satisfaction with the Communication Center's services. It has never formally surveyed enrollees who have called the Communications Center and has not surveyed healthcare providers since 1999.

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# INTRODUCTION & BACKGROUND

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The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System's (AHCCCS) Division of Member Services as part of a Sunset review of the agency. This audit was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-1279 and 41-2951 et seq. This is the first in a series of five audits of AHCCCS, the first performance audits the Office of the Auditor General has performed on AHCCCS since its inception. Subsequent audits will cover AHCCCS' rate setting processes, quality-of-care, medical services contracting practices, and the agency-wide Sunset Factors.

## AHCCCS' history

AHCCCS administers Arizona's Medicaid program, as well as several other healthcare programs for low-income Arizonans who do not qualify for Medicaid. Prior to 1982, Arizona's counties were responsible for providing medical care for the indigent. Because of the financial burden this placed on the counties, the Legislature created AHCCCS as a means of bringing federal Medicaid funding to the State. When AHCCCS began service on October 1, 1982, Arizona became the last state to implement a Medicaid program but the first state to have a managed care Medicaid program. To implement a managed care Medicaid program, Arizona had to obtain special approval from the Health Care Financing Administration, now known as the Centers for Medicaid and Medicare Services (CMS).

Under the managed care system, AHCCCS contracts with health plans, who in turn contract with healthcare providers to provide medical services for health plan members. Though for a large majority of its members AHCCCS does not directly pay providers for services, it plays an important role in service provision by procuring health plans and monitoring the services provided to AHCCCS members. Under the managed care system, AHCCCS pays health plans a fixed amount in advance each

AHCCCS administers  
Arizona's Medicaid  
program.

Proposition 204 expanded Medicaid coverage in Arizona.

month, called a capitation rate, for each enrolled member, regardless of the number or level of services provided. From the capitation rate, health plans pay healthcare providers for covered services provided to AHCCCS members.

In November 2000, Arizona voters approved an initiative, Proposition 204, which authorized the use of the State's share of the multi-state tobacco litigation settlement to help pay for providing medical coverage in Arizona to all individuals who fall below the Federal Poverty Level.<sup>1</sup> Prior to Proposition 204, many of the responsibilities for determining whether individuals were eligible for medical coverage were held by Arizona's 15 counties. After Proposition 204, these responsibilities were transferred to the Department of Economic Security (DES). While DES performs most Medicaid eligibility determinations, AHCCCS is still ultimately responsible for overseeing DES and ensuring that Medicaid eligibility determinations are both accurate and timely. (See Finding 1, pages 7 through 11, for more information on Proposition 204.)

## DMS' primary responsibilities

DMS is the largest division in AHCCCS.

The Division of Member Services (DMS) is the largest division in AHCCCS, comprising 994 of AHCCCS' 1,522 authorized FTEs. Nearly 45 percent of DMS' staff are eligibility workers who are located in Phoenix and in field offices statewide. DMS' four primary responsibilities are:

1. **Determining Eligibility**—DMS determines eligibility for three main program areas: the Arizona Long-Term Care System (ALTCS), Supplemental Security Income/Medical Assistance Only (SSI/MAO), and KidsCare.
  - **ALTCS**—ALTCS serves elderly or physically or developmentally disabled individuals who require a high level of care and who are both financially and medically eligible. DMS determines the financial and medical eligibility of long-term care applicants. Once enrolled in ALTCS, an individual receives complete medical services, and may receive care through residential nursing facilities, assisted living facilities, or home-based care as needed. As of May 2002, approximately 34,000 individuals were enrolled in ALTCS.
  - **SSI/MAO**—The SSI/MAO unit determines eligibility for elderly, blind, or disabled individuals who may qualify for healthcare coverage through Medicaid. As of May 2002, the unit was responsible for assessing the eligibility of nearly 18,500 elderly, blind, or disabled individuals enrolled in Medicaid, and a program that pays a portion of their Medicare premium.
  - **KidsCare**—KidsCare is Arizona's Children's Health Insurance Program (CHIP) for children under 18 who are residents of Arizona, are not covered by private health insurance, and do not qualify for Medicaid. DMS

<sup>1</sup> For 2002, the Federal Poverty Level is \$8,860 for an individual and \$18,100 for a family of four.

determines the financial eligibility of families who apply for KidsCare coverage for their children. DMS also performs yearly eligibility reassessments of all KidsCare members. Once enrolled, children receive coverage which includes medical, dental, and vision services, for which there may be a premium of up to \$20 per month per family. As of May 2002, approximately 48,200 children were enrolled in KidsCare.

2. **Measuring Accuracy and Timeliness of Eligibility Determinations**—DMS reviews the eligibility determinations performed by ALTCS, KidsCare, and SSI/MAO staff for accuracy and timeliness. Likewise, the Division is also responsible for checking DES' Medicaid eligibility determinations for accuracy and timeliness.
3. **Supplying Information To Providers and Members**—DMS provides information to AHCCCS members and to healthcare providers through its Communications Center. The center employs 67 operators who provide members with information about AHCCCS programs and healthcare providers with verifications of AHCCCS members' enrollment. DMS also works with members, healthcare providers, and health plans to resolve eligibility and billing issues.
4. **Maintaining Member Information**—DMS maintains a database of member enrollment information, which is updated daily. A member's enrollment file contains information such as his or her health plan, the AHCCCS programs he or she is eligible for, and demographic information.

## Budget and funding

As illustrated in Table 1 (see page 4), DMS' estimated budget for fiscal year 2002 is approximately \$36.2 million. AHCCCS budgeted to DMS approximately \$13.1 million from its State General Fund appropriation and approximately \$4.4 million from the Children's Health Insurance Program Fund. The CHIP Fund's monies include state funding from tobacco tax revenues and federal matching monies. DMS also received approximately \$17.5 million in non-CHIP federal funding. Finally, AHCCCS budgeted DMS approximately \$1.2 million from the Arizona Tobacco Litigation Fund to help pay for additional staff, including eligibility workers hired as a result of AHCCCS' new Proposition 204 responsibilities.

## Audit scope and methodology

This audit focused on three areas related to the Division of Member Services' responsibilities. First, the audit reviewed challenges DES faced relating to the Medicaid eligibility process resulting from the 2000 voter-approved initiative,

**Table 1** Statement of Revenues, Expenditures, and Changes in Fund Balance  
Years Ended or Ending June 30, 2000, 2001, and 2002  
(Unaudited)

	<b>2000</b> <b>(Actual)</b>	<b>2001</b> <b>(Actual)</b>	<b>2002</b> <b>(Estimated)</b>
<b>Revenues:</b>			
Appropriations:			
State General Fund	\$11,093.9	\$11,828.4	\$13,136.0
Children's Health Insurance Program Fund <sup>1</sup>	4,031.5	3,837.6	4,424.9
Federal	13,397.8	14,928.0	17,517.7
Tobacco litigation settlement monies <sup>2</sup>		<u>420.3</u>	<u>1,160.1</u>
Total revenues	<u>\$28,523.2</u>	<u>\$31,014.3</u>	<u>\$36,238.7</u>
<b>Expenditures:</b>			
Personal services	\$17,743.8	\$19,285.6	\$23,139.4
Employee-related	4,342.5	4,762.4	6,160.7
Professional and outside services	387.4	722.6	455.1
Travel, in-state	218.2	174.9	221.6
Travel, out-of-state	4.4	8.9	6.8
Other operating	5,429.3	5,200.4	5,878.2
Equipment	<u>397.6</u>	<u>859.5</u>	<u>376.9</u>
Total expenditures	<u>\$28,523.2</u>	<u>\$31,014.3</u>	<u>\$36,238.7</u>

<sup>1</sup> Consists of monies allocated to the Division for its role in administering the Children's Health Insurance Program. Monies are appropriated from the Children's Health Insurance Program Fund and consist of tobacco taxes and matching federal monies for providing health insurance coverage to uninsured children whose families meet certain income requirements.

<sup>2</sup> Consists of the portion of monies obtained from a settlement with the tobacco companies that is allocated to the Division for administering the Proposition 204 program.

Source: Auditor General staff analysis of financial information provided by the Arizona Health Care Cost Containment System for the years ended or ending June 30, 2000, 2001, and 2002.

Proposition 204, which expanded medical coverage, and AHCCCS' oversight process of these eligibility determinations. Second, the audit reviewed how AHCCCS performs and monitors the accuracy of eligibility determinations for three programs: ALTCS, Supplemental Security Income/Medical Assistance Only, and KidsCare. Finally, the audit examined the ways AHCCCS provides information to healthcare providers and members through its Communications Center and how staff productivity in this center is measured.

This report contains findings in three areas:

- The Department of Economic Security has made changes in the Medicaid eligibility determination process to address challenges resulting from

Proposition 204, which expanded medical coverage in Arizona, and AHCCCS' processes to oversee DES' eligibility determinations are not yet fully implemented.

- During this audit, AHCCCS significantly reduced the number of medical reassessments it performs in its long-term care program and addressed substantial growth in the workload for its Supplemental Security Income/Medical Assistance Only program. However, because they are neither meaningful nor federally required, AHCCCS should discontinue calculating error rates for KidsCare eligibility determinations.
- AHCCCS has implemented a variety of automated methods at its Communications Center to more easily provide information to healthcare providers, and should make additional changes to further improve its services.

Auditors used a number of research methods to study the issues addressed in this report. Specifically:

- To determine DES' progress in adapting to significant Medicaid program changes, auditors interviewed AHCCCS and DES staff to learn how the agencies administer the expanded Medicaid program and work together to ensure the program meets federal and state standards. Auditors also observed and interviewed DES eligibility staff regarding the eligibility determination process and changes made to address the expanded program requirements. In addition, auditors observed and interviewed representatives from hospitals and interviewed representatives from the Arizona Hospital and Healthcare Association to learn how program changes have affected hospital processes and procedures. Finally, auditors reviewed federal and state statutes, state rules, legislation relating to the Medicaid program, and an intergovernmental agency agreement between AHCCCS and DES signed in 2001 to understand new procedures and oversight guidelines for DES' Medicaid eligibility determinations.
- To determine how AHCCCS performs eligibility determinations and how it assesses their accuracy, auditors reviewed eligibility policies and procedures and observed eligibility workers performing their tasks. Auditors also interviewed AHCCCS management and staff to gain a further understanding of eligibility determination processes. Additionally, auditors interviewed CMS representatives to obtain their perspective regarding certain elements of AHCCCS' eligibility determinations. Further, auditors reviewed state statutes and state rules to identify eligibility requirements and also reviewed federal guidelines, which provide assistance for some aspects of the eligibility determination process. Finally, auditors reviewed literature for trends in assessing the accuracy of KidsCare eligibility determinations.



- To determine how AHCCCS could further improve the effectiveness of services in its Communications Center, auditors observed and interviewed Communications Center operators and team supervisors to learn the types of calls they handled, how they address those calls, and how the operators were evaluated. Auditors also interviewed representatives of call centers from four state agencies in Arizona regarding methods they use to measure their effectiveness.<sup>1</sup> Additionally, auditors interviewed AHCCCS management and staff regarding the types of automated enrollment verification currently in use and what new methods of automation might be implemented. Auditors further investigated the automation issue by interviewing vendors regarding how the automation methods are used and their costs.<sup>2</sup> Finally, auditors reviewed literature on incentive pay programs to learn how well they work and the characteristics of successful incentive programs.<sup>3</sup>

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the director and staff of the Arizona Health Care Cost Containment System for their cooperation and assistance throughout the audit.

<sup>1</sup> Auditors spoke with call center management at the Arizona Department of Economic Security, Division of Child Support Enforcement; the Arizona Department of Revenue; the Arizona Department of Transportation, Motor Vehicle Division; and the State Compensation Fund.

<sup>2</sup> Auditors spoke with representatives of the two companies under contract with AHCCCS to provide systems that allow healthcare providers to verify that a patient is currently enrolled in AHCCCS.

<sup>3</sup> In reviewing the Communications Center incentive program, auditors used multiple sources, including Pfiffner, J.P. and D.A. Brook. *Civil Service Reform and Incentives in the Public Service in The Future of Merit*. The Woodrow Wilson Center Press, 2000; United States General Accounting Office. *Human Capital: Key Principles from Nine Private Sector Organizations*. Washington, D.C.: GAO, May 2, 2000; United States General Accounting Office. *Human Capital: Using Incentives to Motivate and Reward High Performance*. Washington, D.C.: GAO, May 2, 2001; Swope, Christopher. "Paying For Performance." *Governing*, November, 1998. pp. 75 et seq.; Texas Comptroller of Public Accounts. "Linking Employee Pay to Performance:" (Chapter 5, Section 2) in *Challenging the Status Quo: Toward Smaller, Smarter Government*. Austin, TX: Texas Comptroller of Public Accounts, March 1999; Wiscombe, Janet. "Can Pay For Performance Really Work?" *Workforce*, August 2001. pp. 28-34.

# FINDING 1

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## Changes underway to address the increase in Medicaid applicants

Following the passage of a 2000 voter initiative to expand medical coverage in Arizona, the Legislature made changes to the Medicaid eligibility determination process and shifted all of the counties' responsibilities for determining eligibility to the Department of Economic Security (DES). These changes brought many challenges, including a need to revise procedures and train new staff. DES has taken a number of steps to address these challenges and according to some hospital representatives, has taken some effective action. AHCCCS is responsible for monitoring the accuracy and timeliness of DES' eligibility determinations, but because of the program's newness, some of AHCCCS' processes for overseeing DES' activities were not yet in place when this audit was completed.

## Proposition 204 substantially changed Medicaid program

Proposition 204, passed by Arizona voters in November 2000, and subsequent legislation changed the State's Medicaid program in three significant ways. First, the voter-approved initiative required the State to use monies from its share of the multi-state tobacco litigation settlement to help pay for expanding medical coverage in Arizona to all individuals whose income falls below the Federal Poverty Level.<sup>1</sup> Second, the Legislature shifted all of the counties' eligibility-determination responsibilities to DES. Third, the Legislature also changed the date that an individual's coverage becomes effective, which can affect reimbursements paid to healthcare providers.

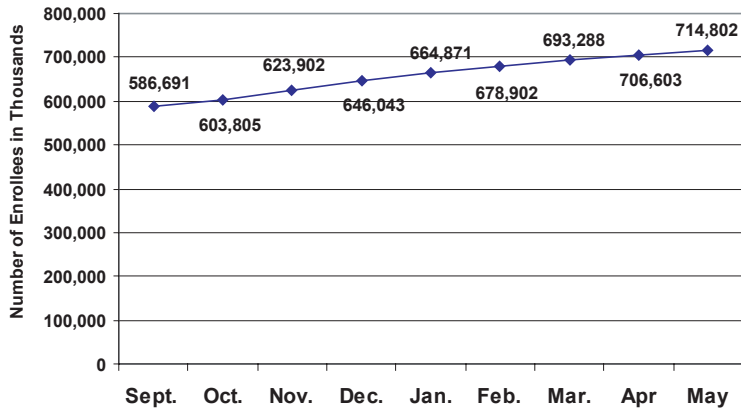
Voter-approved initiative expanded eligibility—Proposition 204, which was implemented by AHCCCS in three phases—April 1, July 1, and October 1, 2001, requires the State to use its share of the multi-state tobacco litigation settlement to

Tobacco settlement monies help pay for expanded Medicaid coverage.

<sup>1</sup> For 2002, the Federal Poverty Level is \$8,860 for an individual and \$18,100 for a family of four.

Figure 1

Medicaid Enrollment  
September 2001 through May 2002  
(Unaudited)



Source: Auditor General staff analysis of information in AHCCCS' *Eligibility and Enrollment Report for May 1, 2002*.

help pay for expanding medical coverage to all citizens who fall below the Federal Poverty Level.<sup>1</sup> Prior to the initiative, medical coverage in Arizona was limited primarily to individuals such as the elderly, disabled, or very low-income families with children who met specific income criteria. Many individuals, who were not elderly or disabled, or who did not have children, were not eligible for medical coverage even though they fell below the Federal Poverty Level. To ensure that all individuals who are now eligible receive coverage, Proposition 204 requires the State to use appropriated funds or federal funds to supplement monies from the litigation settlement as necessary. These changes have significantly increased Medicaid enrollment in Arizona. Not only was this expansion due to the expanded eligibility, but also because AHCCCS enrolled many persons who were eligible under the

previous criteria but had not applied. In the

first 8 months after the expansion became effective, enrollment in Medicaid increased from approximately 587,000 to almost 715,000 (see Figure 1).

Six-hundred fifty county staff transferred to DES.

**Eligibility determination responsibilities shifted to DES**—Following the passage of the voter initiative, the Legislature shifted eligibility determination responsibilities from the counties to DES effective October 2001. To assist DES with this increased workload, approximately 650 county staff transferred to DES. In December 2001, DES signed an intergovernmental agency agreement with AHCCCS that outlines DES' new responsibilities, how AHCCCS will oversee these processes, and payments AHCCCS will make to DES for performing these determinations. For fiscal year 2002, AHCCCS will pay an estimated \$61 million to DES for this purpose.<sup>2</sup>

**Effective dates have changed**—In addition to shifting responsibilities, legislative changes have also modified the date that an individual's Medicaid coverage becomes effective. Once an individual is determined eligible, his or her coverage is effective retroactively to the first day of the month of application for most applicants.<sup>3</sup> This change is especially important for cases that originate in hospitals, because costs have already been incurred before the individual applies for Medicaid.

<sup>1</sup> In 1998, Arizona was 1 of 46 states to settle a lawsuit the states had filed against the manufacturers of tobacco products. As of June 30, 2002, the State had received approximately \$357 million from the multi-state tobacco litigation settlement.

<sup>2</sup> AHCCCS passes through state and federal funds to DES to pay for the costs associated with determining eligibility. State funds are a combination of General Fund and State Tobacco Litigation Settlement Fund monies.

<sup>3</sup> The Medical Expense Deduction program allows individuals whose income exceeds the Federal Poverty Level to deduct their medical expenses from their income and "spend down" to below the Federal Poverty Level. The effective date for program eligibility is the date that the individual's income, minus medical expenses, drops below the Federal Poverty Level.

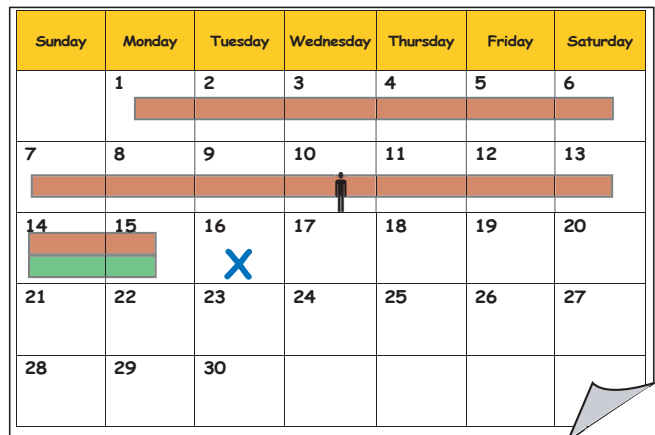
In contrast, prior to this change, AHCCCS would have only paid for the expenses incurred during the 48 hours immediately preceding the date of the eligibility determination, even though the counties had up to 30 days to make a determination (see Figure 2). All expenses incurred prior to that 48-hour period were not covered by AHCCCS.





## Challenges related to eligibility being addressed

The changes associated with Proposition 204 and subsequent legislation created new challenges for DES related to the eligibility process. However, DES has taken some positive steps to address many of these challenges, as follows:

- Notifying hospitals of eligibility determinations**—In the first few weeks following program changes, hospitals expressed concerns that they were not receiving information from DES regarding the final outcome of many eligibility decisions. Without this information, the hospitals did not know if they could bill a health plan under contract with AHCCCS, or if they needed to try to obtain payment from the patient. DES did not share eligibility information with hospitals without the patient's signed consent because of concerns that this information was confidential. DES worked with AHCCCS and the hospitals to resolve these issues by sending the hospitals written notification of each applicant's eligibility determination and altering the application to include a release form. According to hospital representatives, this situation has improved, and they are now receiving more timely notification of applicants' eligibility determinations.
- Modifying application practices at hospitals**—DES has modified Medicaid application practices at hospitals because Proposition 204 expanded eligibility to include many more potentially eligible individuals whose medical costs could be covered by AHCCCS. To better ensure that DES can reach as many potentially eligible applicants as possible, including treat-and-release patients, it

Figure 2 Comparison of Effective Dates for Medicaid Coverage Previous System vs. Proposition 204 changes



-  = Illustrative date AHCCCS application is initiated.
-  = Illustrative date eligibility determination made.
-  = Before Proposition 204—AHCCCS coverage was retroactive for the 48-hour period immediately preceding the date of the determination.
-  = After Proposition 204—AHCCCS coverage is retroactive to the first day of the month in which the application was initiated.

Source: Auditor General staff analysis of Laws 2001, Chapter 344, §36, §57.

has stationed eligibility staff at several hospitals 24 hours a day. According to one hospital representative, this practice should increase the number of patients who are contacted prior to being released from the hospital, which should in turn increase the number of applicants who are determined to be eligible for Medicaid. Additionally, according to another hospital representative, the DES workers stationed at the hospitals are often able to provide patients with general information about AHCCCS that hospital staff may not know.

Additionally, when DES first began handling treat-and-release applications, DES eligibility workers did not immediately enter applicant information into the DES computer system. Because applications are sent to the various DES field offices for final determination, it was not possible for hospital staff to determine if a patient had already applied for Medicaid until the information was entered into the computer system. Consequently, in some cases, one individual could make multiple visits to a hospital during the determination process, resulting in the hospitals distributing multiple applications to the same person and DES workers performing duplicative administrative tasks for the same person. To reduce the administrative burden this placed on DES and the hospitals, DES now requires eligibility workers stationed in hospitals to immediately enter treat-and-release application information into DES' computer system.

- **Conducting training for former county workers**—When the program changes became effective on October 1, 2001, many county eligibility workers who transferred to DES had not received training on program changes and DES processes. According to DES officials, some of the former county workers were incorrectly coding some information into DES' computer system. For example, workers coded some applications as being both outpatient and inpatient. To prevent these mistakes in the future, DES developed training materials and guidelines for workers to refer to when they code the applications. According to a DES official, DES completed the training for all former county employees in December 2001 and also provides periodic follow-up training for all eligibility workers.
- **Creating automated systems**—Prior to the October 2001 program changes, hospitals in Maricopa County were able to track patients' Medicaid application status through an Internet-based notification and tracking system that allowed hospital and county eligibility staff to share information. However, when the eligibility processes were centralized from the counties to DES, DES discontinued the system after it performed a feasibility and cost-effectiveness analysis that showed it would not be cost effective to expand the system statewide. DES and hospitals now maintain duplicate paper logs of the applications received, and periodically reconcile them. DES is exploring ways for hospitals statewide to have limited automated access to applicants' eligibility

information. According to one hospital representative, this would help the hospitals because they would need less time to obtain a patient's eligibility status.

## AHCCCS oversight of DES is not completely implemented

Although DES has addressed many of the challenges associated with Proposition 204 and the eligibility process, AHCCCS is ultimately responsible for ensuring that the Medicaid eligibility determinations DES performs are accurate and timely. While AHCCCS has developed a quality control program to regularly review eligibility determinations for accuracy, this program had not been fully implemented before this audit was completed. As part of the intergovernmental agency agreement (IGA) signed in December 2001, AHCCCS will not hold DES accountable for any error rates during a 6-month transition period from April through September 2002. Following this transition period, if error rates are above 3 percent, AHCCCS can impose financial sanctions against DES. This is similar to AHCCCS' oversight role with the counties prior to the program changes.

In addition to monitoring the accuracy of DES' eligibility determinations, AHCCCS' quality control staff will monitor their timeliness in accordance with the IGA between AHCCCS and DES. According to rule, DES is required to complete eligibility determinations for hospitalized applicants within 7 days and has up to 45 days for all other applicants. As of May 2002, AHCCCS had compiled timeliness statistics for two of DES' offices. According to AHCCCS, DES' Sierra Vista office made 100 percent of its determinations in a timely manner, and for one of the Phoenix offices, made 91 percent of the determinations in a timely manner. However, AHCCCS has not formally evaluated the timeliness of any determinations DES performs of applications that originate in hospitals.

AHCCCS will begin testing accuracy in September 2002.

## Recommendations

This finding presents information only; therefore, no recommendations are presented.



# FINDING 2

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## AHCCCS has addressed problems with eligibility determination processes

AHCCCS determines eligibility for three main programs including ALTCS, SSI/MAO, and KidsCare. AHCCCS also calculates error rates to identify the number of correct determinations performed for each program. During the audit, AHCCCS substantially addressed problems in the eligibility determination processes for ALTCS and SSI/MAO, but still needs to address one part of its process for the KidsCare program. First, AHCCCS has significantly reduced the number of medical reassessments it performs in its long-term care program because its data showed that the majority of the reassessments were not necessary. Further, AHCCCS has addressed a 450 percent growth in eligibility determinations for the elderly, blind, or disabled who may qualify for Medicaid by adding staff and prioritizing staff efforts. Finally, although AHCCCS has made changes in these programs, it should discontinue calculating error rates for KidsCare because they are neither meaningful nor federally required. Staff time spent developing these error rates could be better applied to other tasks.

AHCCCS determines eligibility for KidsCare, ALTCS, and other programs.

## AHCCCS determines eligibility for some programs

While the Department of Economic Security now determines the eligibility of most Medicaid applicants, AHCCCS performs this function for the non-Medicaid programs the State offers as well as for a limited number of Medicaid applicants. AHCCCS determines applicant eligibility for the Arizona Long-Term Care System (ALTCS) for aged, blind, and disabled applicants who may qualify for Medicaid, and for the State's Children's Health Insurance Program (CHIP) known as KidsCare. Specific eligibility requirements vary for the individual programs, but AHCCCS' responsibilities typically involve verifying the applicant's Arizona residency, income, and resources, and assessing the availability of other insurance to the applicant. Eligibility for ALTCS involves both a financial and a medical determination. In addition to determining individuals' eligibility upon initial



application, AHCCCS also must annually renew the eligibility of most enrollees. As of May 2002, programs for which AHCCCS determines eligibility enrolled approximately 112,000 individuals.

## Medical reassessments reduced but rule changes needed

During this audit, AHCCCS eliminated many ALTCS medical reassessments that appeared to be of limited usefulness, but it needs to change its rules accordingly. Medical reassessments involve periodically redetermining whether patients continue to have medical conditions that qualify them for ALTCS. While AHCCCS' rules allow it to alter the frequency of some reassessments, they currently do not allow it to indefinitely eliminate reassessments for any type of long-term care enrollee.

**Reduced number of medical reassessments**—ALTCS, which serves the elderly and individuals who are physically or developmentally disabled, has both a financial and a medical requirement for eligibility. AHCCCS must reassess the financial eligibility of all ALTCS members annually. Medical reassessments must also be done on a regular basis although many are not required to be done annually. However, in April 2002, AHCCCS decided to significantly reduce the number of medical reassessments it performs because its data showed that the medical condition of most ALTCS enrollees is not likely to improve. In 2001, AHCCCS performed approximately 16,500 medical reassessments and found only 150 individuals who were no longer medically eligible.

AHCCCS now performs medical reassessments generally for those individuals whose medical eligibility had to be determined by a physician. Physicians are used in some cases if the individual's medical eligibility is considered questionable. AHCCCS will reassess these cases because the individual's condition may have improved to the point that he or she may no longer need costly long-term care. AHCCCS estimates that this change will reduce the number of medical reassessments it performs from about 16,500 annually to approximately 1,000. AHCCCS states that eliminating these reassessments may reduce travel costs and will allow medical eligibility assessors to help perform financial eligibility and other duties.

**Rule changes needed**—While AHCCCS has reduced the number of medical reassessments it performs, its rules still require it to perform medical reassessments for all ALTCS members. Administrative Rule R9-28-306(C) requires AHCCCS to perform a medical reassessment of members annually, with a few specific exceptions. For example, an ALTCS member who is over 80 years of age, and has been enrolled for at least 2 consecutive years, must be medically reassessed only every 4 years. However, the rules do not permit AHCCCS to discontinue performing medical reassessments indefinitely for any members. If AHCCCS continues to not perform reassessments on some members, it needs to seek appropriate rule changes.

## AHCCCS is addressing increased workload in medical assistance-only program

Further, during the audit, AHCCCS largely addressed an increased workload of eligibility determinations that developed in the SSI/MAO unit. The SSI/MAO unit, which performs eligibility determinations for the elderly, blind, or disabled who may qualify for Medicaid, has undergone significant expansion in its workload and process changes as a result of Proposition 204. AHCCCS has addressed the increased workload by adding additional staff. To avoid a backlog, AHCCCS should continue monitoring its workload to ensure timely processing of eligibility determinations.

**Program experienced rapid growth**—The SSI/MAO unit's workload significantly increased as a result of Proposition 204, which expanded medical coverage eligibility to individuals whose income falls below the Federal Poverty Level. These new eligibility requirements took effect for the SSI/MAO unit April 1, 2001, and since then, the unit's total enrollment increased from approximately 4,000 in March 2001 to nearly 18,500 in May 2002. This was due to the expanded eligibility criteria, but also because AHCCCS identified persons who were eligible under the previous criteria but had not applied. Due to this increased workload, AHCCCS was unable to process eligibility renewal applications in a timely manner and from August 2001 to February 2002, did not initiate renewal applications. To help address the increased workload, AHCCCS more than tripled the number of staff in the SSI/MAO unit, from 23 FTE in April 2001 to 78 in December 2001. Then, in the first part of 2002, the unit's management reallocated staff and directed their efforts to processing annual eligibility renewal applications.

Enrollment in SSI/MAO increased more than four-fold.

**Continued monitoring needed**—While AHCCCS has responded to its increased workload, it should continue to monitor the SSI/MAO unit's ability to meet these new demands for two reasons. First, the unit must complete renewals on time to ensure that AHCCCS does not pay for medical coverage for individuals who are no longer eligible. Second, because enrollment significantly increased during the past year, AHCCCS will have thousands more renewals to perform annually than it had previously.

## AHCCCS should discontinue calculating KidsCare error rates

Although AHCCCS has addressed challenges to two of its programs, it should discontinue calculating error rates for KidsCare eligibility determinations. Quality control staff currently review eligibility determinations for this program and calculate the percentage of determinations that were made in error. However, these calculations do not provide meaningful results, are not federally required, and are

unnecessary because other ways exist to ensure the quality of eligibility determinations.

AHCCCS' methods for calculating error rates do not provide meaningful results—AHCCCS' approach for calculating error rates does not provide meaningful results for three reasons:

- First, quality control staff do not review the same information that the eligibility worker used when the original decision was made. KidsCare eligibility workers determine eligibility using the applicant's income for the 30-day period prior to the application date. However, quality control staff review the income earned for a later period of time, which may be significantly different.
- Second, the eligibility workers and quality control staff use different standards for acceptable documentation. KidsCare eligibility staff are encouraged to accept a family's income as the family declares it on the KidsCare application. This is consistent with both federal policy and state law intended to make application and enrollment into CHIP programs as simple as possible. However, quality control reviewers are instructed to use documented income information, such as pay stubs.
- Third, AHCCCS reviews only those applications that were approved for KidsCare, but does not review applications that were denied. Therefore, AHCCCS does not know how often it incorrectly denies someone for coverage.

Other methods ensure quality—Finally, not only is AHCCCS not required to calculate error rates, it has methods in place other than calculating error rates to help ensure that it performs KidsCare eligibility determinations correctly. Although AHCCCS must calculate error rates and report them to CMS for Medicaid programs such as ALTCS, the federal government does not require AHCCCS to report error rates for KidsCare. In addition, AHCCCS has an internal system of random supervisory reviews of completed eligibility determinations to help ensure accuracy. These reviews are intended to help identify problems when they occur, rather than identifying them later, when the error rates are calculated. In addition to the supervisory reviews, AHCCCS performs annual eligibility renewals for all KidsCare members, which prevent an ineligible child from being enrolled for more than 1 year. If AHCCCS stopped calculating error rates in KidsCare, it could assign four staff to other tasks.

AHCCCS has other methods to ensure accurate KidsCare eligibility determinations.

## Recommendations

1. AHCCCS needs to seek appropriate changes to its rules to allow it to discontinue performing medical reassessments for some ALTCS members.
2. AHCCCS should continue to monitor its workload of eligibility determinations and renewals performed by the SSI/MAO unit to ensure that they are completed in a timely manner.
3. AHCCCS should discontinue its practice of calculating error rates for the KidsCare program because it does not provide meaningful results, is not required by the federal government, and other methods are in place to ensure the quality of KidsCare eligibility determinations.



# FINDING 3

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## Communications Center has improved its services

AHCCCS has initiated various ways to improve the services its Communications Center provides, but still needs to make additional changes. The Communications Center provides information to AHCCCS members, healthcare providers, and others through a 24-hour phone center and other automated systems. AHCCCS has improved the center's services by developing several automated ways for providers to obtain patient enrollment information and directing members to the best sources of information. Additionally, AHCCCS administers a performance incentive program for its Communications Center operators in an attempt to enhance productivity and provide quality customer service; however, AHCCCS should alter the way it gives incentive awards. AHCCCS should also conduct regular satisfaction surveys of Communications Center users to help assess the quality of its services.

## The Communications Center provides various services

The Communications Center provides enrollment and other information to AHCCCS members and healthcare providers through a 24-hour call center and through automated systems. The call center employs 67 operators who handle an average of over 100,000 calls per month, most of which come from AHCCCS members seeking general information about their enrollment status, their health plan, and other AHCCCS programs. Healthcare providers, such as hospitals, doctor's offices, and medical labs, call the center to verify that a person they are serving is currently enrolled in AHCCCS, which helps ensure that providers will be compensated for their services. Healthcare providers may also verify a person's enrollment status through various automated systems the center manages.

AHCCCS has a call center and automated enrollment verification systems.

## Changes help share information more effectively

AHCCCS has improved the ways its Communications Center shares enrollment information with AHCCCS members and healthcare providers. AHCCCS' strategy for improvement has been based on developing various types of automated systems and encouraging members to call other, more appropriate sources, such as their health plan.

**Automated systems developed**—To improve its services, AHCCCS has established two automated methods for healthcare providers to verify the enrollment of AHCCCS members they serve, and is currently developing an Internet-based system.

- **Enrollment verification units**—Several providers use enrollment verification units that allow them to enter a patient's AHCCCS identification number or to swipe the patient's AHCCCS membership card (see Photo 1). AHCCCS established the identification number system in 1992 and the swipe card system in 1998. The verification units function in the same manner as a credit card machine. The system searches AHCCCS' database to determine if the patient is currently enrolled in AHCCCS and prints out a small receipt showing the patient's enrollment status. Some units permit providers to transmit several verification requests simultaneously, which is especially helpful for those with a high volume of patients, such as hospitals. Healthcare providers buy or lease the unit from vendors under contract with AHCCCS to provide this service and also pay a subscription fee. They are also required to pay a variable transaction fee for each inquiry.<sup>1</sup> According to Communications Center reports, in February 2002 providers used the verification unit system for approximately 493,000 enrollment verifications.

Photo 1: Verification Unit



- **Touch-tone phone verification**—Providers may also verify a patient's AHCCCS enrollment using a touch-tone phone. Through this technology, which AHCCCS implemented in 1995, the provider dials into the system, then enters a patient's AHCCCS identification number. The system verifies the patient's enrollment status over the phone, but in Maricopa County, the provider also has the option of requesting a faxed verification for recordkeeping purposes. Unlike the enrollment verification units, the touch-tone phone verification system is free of charge to the healthcare provider. A major disadvantage of the phone system is that it does not allow multiple verifications to be requested simultaneously. According to Communications Center reports, in February 2002 the system was used to verify over 72,000 enrollments.
- **Internet-based system**—In addition to the above systems, AHCCCS is currently developing an Internet-based enrollment verification system, which it plans to

<sup>1</sup> The transaction fee ranges from 20 to 35 cents, depending on the company to which the provider subscribes and on the number of verifications a provider conducts in a month.

pilot-test in July 2002. This system would allow any healthcare provider with Internet access to log into the AHCCCS enrollee database to perform enrollment verifications. According to AHCCCS' Information Services Division, this system would have several advantages. First, the provider's cost would be limited to the cost of a computer and Internet connection, which many providers may already have. Additionally, providers would not have to pay a fee for each inquiry. Further, according to AHCCCS management, once the system is established, system maintenance costs would be small.

**Encouraging members to seek information from more appropriate sources**—AHCCCS has attempted to more effectively serve AHCCCS members by directing their calls to more appropriate locations. Some AHCCCS members call with questions about their health plan, such as what procedures are allowed, who is covered under the plan, and who their primary care physician is. In an attempt to remind members that for some of their questions, a call to their health plan would be more appropriate, AHCCCS has begun listing the member's health plan on the enrollee's AHCCCS identification card. In addition, AHCCCS plans to begin listing the number of the enrollee's Regional Behavioral Health Authority (RBHA) on the identification card in an effort to direct questions related to members' mental health coverage to their RBHA.

## The incentive program should be adjusted

The AHCCCS Communications Center has initiated a performance incentive program designed to improve its staff's performance. Under this program, operators and others can receive up to \$200 per month in incentive payments, but do not always receive the full amount. However, some of the center's measures used to calculate the payout should be adjusted or replaced.

**Incentive program uses team approach to improving performance**—The center has organized the incentive program by placing its operators in teams headed by a team supervisor. Each operator and supervisor typically receives the same bonus—up to \$200 per month in addition to his or her regular salary. Thus, the reward of each team member is dependent in part upon the performance of his or her teammates. The center's management believes that this results in peer pressure that enhances the entire team's performance. Performance is evaluated on three criteria, as follows:

- **Attendance**—Having a fully staffed team of operators is critical to the center's ability to answer the number of calls that it receives; therefore, part of the incentive program is calculated on operator attendance. This criteria is designed to reduce the number of unplanned absences. If a team meets the center's attendance goal, each member can earn \$80 in incentive pay.



- **Unanswered calls**—The center measures the monthly percentage of calls that disconnect before an operator can answer. Currently, if the center fails to answer more than 10 percent of incoming calls, no center operator receives any payout for this criterion. If the unanswered call rate is 6 percent or below, every center operator will receive \$60 in incentive pay.
- **Quality of customer service**—Operators are also rated on the quality of their phone performance through evaluations performed by their supervisors. Currently, supervisors monitor operators' calls from a remote location and evaluate them on the quality of their phone service and the accuracy of the information they provide. Team members may earn up to \$60 in incentive pay based on the team's average quality score.

While the Communications Center staff may earn up to \$200 per month in incentive payments, staff usually earn less. For example, according to Communications Center data for January 2002, the Communications Center staff each earned an average of \$60 that month.

**Changes are needed to two performance criteria**—Two of the three current criteria for making awards do not appear to be good measures to use. One does not relate to individual performance, and the other is subject to manipulation.

- **Measure for unanswered calls is not related to individuals or teams**—As currently used, the measure of unanswered calls is related to the overall adequacy of the center's staffing resources and not to individual operator or team performance. Because this measure cannot be attributed to individual performance, AHCCCS should replace it. Incentive program literature auditors reviewed indicates that incentive programs work best when performance criteria are clearly related to an individual's performance. For example, a clear measure of individual performance would be the average time spent handling a call. In addition, auditors spoke to four other State of Arizona call centers and found that they all measure the average time it takes each operator to handle a call.<sup>1</sup>
- **Measure for quality of customer service may be subject to inflation**—Because supervisors receive the same monthly incentive payment as their team members, supervisors may have a financial incentive to inflate their teams' customer service quality rating. While auditors found no evidence of wrongdoing, this potential for inflation should be removed. If AHCCCS continues to include Communications Center supervisors in the incentive program, their incentive payments should be based on different criteria than their teams,<sup>1</sup> or AHCCCS should have another team's supervisor make the quality of customer service assessment.

<sup>1</sup> Auditors spoke with call center management at the Department of Economic Security, Division of Child Support Enforcement; the Department of Revenue, the Arizona Department of Transportation, Motor Vehicle Division; and the State Compensation Fund.

## AHCCCS should regularly survey communications center users

Finally, AHCCCS needs to regularly survey both providers and members in order to reassess users' needs and satisfaction with the center. The Governor's Office of Excellence in Government encourages executive agencies, such as AHCCCS, to learn how their customers rate the agency and to seek ways to improve that rating. However, AHCCCS has never formally surveyed AHCCCS members who have called the Communications Center and has not surveyed healthcare providers since 1999. Regular surveys would help better evaluate the needs and satisfaction of both members and providers. For example, a member survey could identify whether they want access to the automated methods of enrollment verification. Additionally, a survey of providers could help AHCCCS identify additional ways to improve its automated verification systems.

## Recommendations

1. To better measure the individual performance of its operators for calculating payments for its performance incentive program, the AHCCCS Communications Center should replace the rate of unanswered calls with a different individual performance measure, such as the average time it takes operators to handle calls.
2. If AHCCCS continues to include Communications Center supervisors in its performance incentive program, it should remove any potential for teams' customer service quality ratings to be inflated by basing supervisors' incentive payments on different criteria than their teams' or having another team's supervisor perform the quality of customer service assessments.
3. AHCCCS should implement regular satisfaction surveys of members who use the AHCCCS Communications Center to better discern both the quality of service that it provides and the needs of its customers.
4. AHCCCS should regularly survey its healthcare providers to assess their satisfaction with the Communications Center and the automated verification systems.



# AGENCY RESPONSE

July 29, 2002

Debra K. Davenport, CPA  
Auditor General  
Office of the Auditor General  
2910 North 44<sup>th</sup> St, Ste 410  
Phoenix, AZ 85018

RE: Performance Audit, Draft Report dated July 19, 2002

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the AHCCCS, Division of Member Services Audit. We appreciate the efforts of the audit team and believe that the implementation of the findings will further enhance the efficiency and effectiveness of the AHCCCS programs.

Below are our responses to each recommendation in the report in the order they are listed.

**Recommendations: Page 17**

1. AHCCCS needs to seek appropriate changes to its rules to allow it to discontinue performing medical reassessments for some ALTCS members.

Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

We believe the current rule as promulgated provides the AHCCCS administration the flexibility to identify population groups within the ALTCS Program for which a reassessment period greater than one year is appropriate. However, once we finalize the changes to the reassessments, which will be based on more experience with the current pilot process to reduce the frequency of pre-admission screening and our policies are further clarified, we will make the appropriate changes in the rule.

To clarify the reason for AHCCCS' actions in altering its reassessment process, less than 1% of the 16,500 reassessments were determined to no longer require ALTCS services. More important, more than 99% of our ALTCS members were found to be appropriately placed in this program.

2. AHCCCS should continue to monitor its workload of eligibility determinations and renewals performed by the SSI/MAO unit to ensure that they are completed in a timely manner.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

3. AHCCCS should discontinue its practice of calculating error rates for the KidsCare Program because it does not provide meaningful results, is not required by the federal government, and other methods are in place to ensure the quality of KidsCare eligibility determinations.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Current staff resources used to calculate error rates will be redirected to other activities where we are understaffed.

We do wish to advise you that the Centers for Medicare and Medicaid Services (CMS) is currently reassessing the need for a quality control process for the KidsCare Program. While CMS has urged states to reduce barriers to the application and eligibility process for the State Children's Health Insurance Program, they are concerned with the quality of the decisions. Also, we believe the quality control reviews completed have provided data pinpointing error prone areas requiring further training and closer monitoring by supervisors.

**Recommendations: Page 23**

1. To better measure the individual performance of its operators for calculating payments for its Performance Incentive Program, the AHCCCS Communications Center should replace the rate of unanswered calls with a different individual performance measure, such as the average time it takes operators to handle calls.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2. If AHCCCS continues to include Communication Center supervisors in the Performance Incentive Program, it should remove any potential for teams' customer service quality ratings to be inflated by basing supervisors' incentive payments on different criteria than their teams' or having another team's supervisor perform the quality of customer service assessments.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

3. AHCCCS should implement regular satisfaction surveys of members who use the AHCCCS Communications Center to better discern both the quality of service that it provides and the needs of its customers.

Debra K. Davenport, CPA  
July 29, 2002  
Page 3

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

AHCCCS has in the past conducted focused, informal surveys to determine member and provider satisfaction with our annual enrollment process and overall satisfaction with the service provided by Communication Center operators. Limited funds and staffing resources will impact the length and frequency of the surveys but we certainly agree to the benefit of surveys. This note also applies to the following finding.

4. AHCCCS should regularly survey its healthcare providers to assess their satisfaction with the Communications Center and the automated verification system.

Response: The finding of the Auditor general is agreed to and the audit recommendation will be implemented.

Again, I would like to thank the Auditor General and staff for their time and effort in evaluating AHCCCS. We appreciate the professional approach of the audit team as well as their cooperative attitude with AHCCCS staff.

Sincerely,

Phyllis Biedess  
Director

PBDR:gs



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**ARIZONA DEPARTMENT OF ECONOMIC SECURITY**

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Jane Dee Hull  
Governor

John L. Clayton  
Director

Ms. Debra K. Davenport  
Auditor General  
Office of the Auditor General  
2910 North 44<sup>th</sup> Street  
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Dear Ms. Davenport:

Thank you for giving us the opportunity to respond to the audit of AHCCCS. As you noted in your report, Proposition 204 substantially changed the State's Medicaid program. This was the largest transition in the history of DES and was accomplished in less than five months.

As a result of the changes in Proposition 204, in addition to determining eligibility for food stamps, cash assistance and general assistance, DES now determines eligibility for 80% of all Medicaid categories. Although there were no recommendations provided in the report, I would like to clarify the following information that was provided regarding training and the implementation of Proposition 204.

The implementation of Proposition 204 required negotiating intergovernmental agreements with 15 counties and the transferring of over 650 staff into new offices statewide. We increased from 85 to 172 sites. Enrollment in the program also increased by 35 percent.

The report notes that many county workers who transferred to DES had not received training on the new program changes and processes within DES by October 1, 2001. It is important to note that all fifteen Counties had to continue their operations through midnight on September 20, 2001, and consequently could not release their employees for training prior to October 1, 2001. DES worked very closely with the counties and developed an alternative plan that allowed a portion of the county's staff to be trained prior to October 1, 2001. This plan included a formal training program and a "buddy system" in which the staff that had been trained prior to October 1<sup>st</sup>, worked side by side the DES staff while the remainder of the County employees were trained. All remaining staff was trained within a few months of being transitioned to State service.

Ms. Debra Davenport



This approach ensured that the counties were able to operate their programs through September 30, 2001. Additionally, the transitioned County staff had to learn new program rules and transition from a manual to an automated eligibility process.

The transition from a County run medical program to a State run program combined with the numerous program changes was an enormous undertaking. Given the size and complexity of the project, the outcome was incredible. We have a great sense of accomplishment that we were able to implement all of the changes with a minimum number of problems and at the same time alleviated the fears and concerns of the hospital community. Our success is validated by the acknowledged improvement of the hospital community both verbally and in writing. Please see attached letter from Banner Hospital Systems expressing their satisfaction with the success of the program and attesting to the significant strides of the program.

In closing, I want to stress the magnitude of DES' and AHCCCS' accomplishments in successfully implementing this program in such a short period of time. We have developed collaborative relationships with the hospitals and will continue to work closely with the hospitals and AHCCCS to strengthen and improve the program.

Sincerely,

John L. Clayton

Enclosure

RECTOR  
MOA  
DEPUTY DIR  
GENERAL

DEME A.D.S.  
939A



Banner Health System

March 18, 2002

John Clayton  
Director  
Department of Economic Security  
1717 West Jefferson  
Phoenix, Arizona 85007



Dear Mr. Clayton:

It would be a serious understatement to say that I have been pleasantly surprised by the outstanding performance of your staff enrolling people in AHCCCS at our Banner Health System hospitals. (Attached is a graph reflecting DES's enrollment performance for Banner's Samaritan and Lutheran hospitals.) The truth of the matter is that I have been amazed by the outstanding job they are doing, and by their dedication to serving the poor and medically needy in Arizona. Skeptical that you would be able to gear up so quickly in assuming the responsibilities of the Arizona Counties, we had requested DUC pool funding to compensate for our expected losses during the enrollment start-up period. Clearly, our skepticism was unfounded.

Especially as one new to Banner and to Arizona, it is really gratifying to witness such exceptional performance by employees in an agency that is crucial to *our* ability to effectively serve this patient population. Above all, I want to thank you, and let you know how very impressed I am with the commitment, competence and professionalism of your people in getting an important assignment done, with excellence.

Clearly, you and your staff are determined to do the very best you can for the poor and medically needy in our state; and in a complementary way, Banner is steadfastly committed to providing quality health care for all Arizonans. It is a pleasure working with you in achieving our related missions.

Sincerely,

Peter S. Fine, FACHE  
President & Chief Executive Officer

cc: Governor Jane Dee Hull  
Rick Collins  
Debi Wells

## Performance Audit Division reports issued within the last 12 months

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<b>01-18</b>	Arizona Department of Corrections—Administrative Services and Information Technology	<b>01-29</b>	Department of Public Safety—Sunset Factors
<b>01-19</b>	Arizona Department of Education—Early Childhood Block Grant	<b>01-30</b>	Family Builders Program
<b>01-20</b>	Department of Public Safety—Highway Patrol	<b>01-31</b>	Perinatal Substance Abuse Pilot Program
<b>01-21</b>	Board of Nursing	<b>01-32</b>	Homeless Youth Intervention Program
<b>01-22</b>	Department of Public Safety—Criminal Investigations Division	<b>01-33</b>	Department of Health Services—Behavioral Health Services Reporting Requirements
<b>01-23</b>	Department of Building and Fire Safety	<b>02-01</b>	Arizona Works
<b>01-24</b>	Arizona Veterans' Service Advisory Commission	<b>02-02</b>	Arizona State Lottery Commission
<b>01-25</b>	Department of Corrections—Arizona Correctional Industries	<b>02-03</b>	Department of Economic Security—Kinship Foster Care and Kinship Care Pilot Program
<b>01-26</b>	Department of Corrections—Sunset Factors	<b>02-04</b>	State Parks Board—Heritage Fund
<b>01-27</b>	Board of Regents		
<b>01-28</b>	Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau		

## Future Performance Audit Division reports

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Arizona Health Care Cost Containment System—Rate Setting Processes

Arizona Health Care Cost Containment System—Quality-of-Care

Arizona Health Care Cost Containment System—Contracting

Department of Economic Security—Child Protective Services, Removal/Appeal Process