A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Arizona Health Care Cost Containment System

Rate-Setting Processes

AUGUST • 2002
REPORT NO. 02 – 06

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

August 26, 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)—Rate-Setting Processes. This report is in response to an August 9, 2001, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §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.

As outlined in its response, the Arizona Health Care Cost Containment System agrees with all of the findings and recommendation.

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 27, 2002.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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FACT SHEET

Arizona Health Care Cost Containment System
Office of Managed Care

Services:

The Office of Managed Care performs the following services:

1. Setting and adjusting capitation rates for acute and long-term care;
2. Setting and adjusting fee-for-service rates for AHCCCS physicians and other healthcare providers;
3. Monitoring the financial viability of its contractors;
4. Monitoring encounter data (records of healthcare services provided) submitted by contractors;
5. Performing data validation studies on encounter data submitted by contractors;
6. Performing research to support rate-setting and development processes; and
7. Negotiating contracts for the acquisition and provision of healthcare services to AHCCCS members.

Facilities:

The Office performs its duties at the state-owned building at 701 East Jefferson Street, in Phoenix.

Equipment:

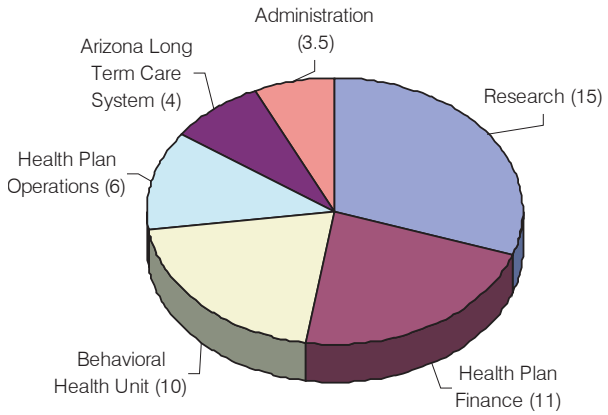
The Office uses and owns only standard office equipment.

Mission:

To enhance the capability of the AHCCCS program to ensure the provision of quality healthcare services to its members and obtaining full economic value for monetary resources expended.

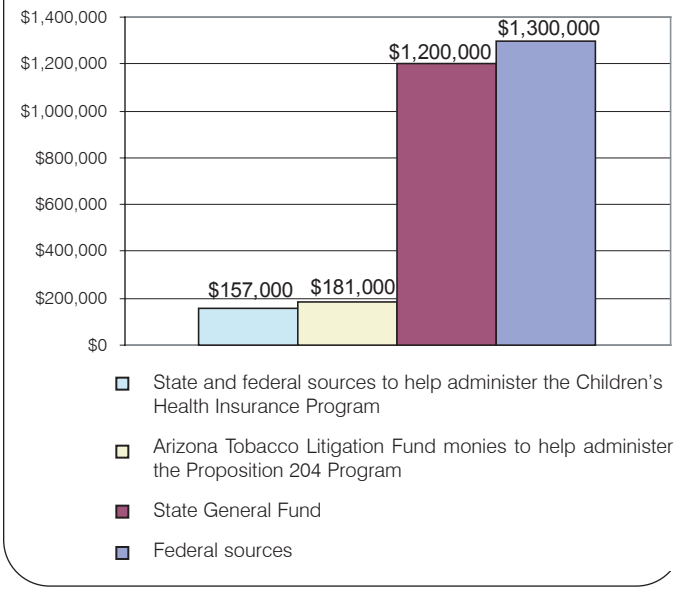
Office staffing:

49.5 full-time equivalent (fiscal year 2002)



Office funding sources:

$2.8 million (fiscal year 2002)



Office goals (fiscal years 2002-2004):

1. **To ensure acute care health plans and ALTCS program contractors comply with AHCCCS contract provisions.**

2. **To ensure the availability and accessibility of AHCCCS health plan providers throughout the State.**

3. **To improve the completeness and quality of encounter data collected from health plans, program contractors, and behavioral health.**

Adequacy of goals and performance measures:

The Office of Managed Care's 3 goals appear to be appropriate for its mission, and it has established 16 performance measures that correlate to its goals. A review of the Office of Managed Care's mission and goals indicates that they are aligned with each other, and that the performance measures reasonably align with the goals.

The Office has established performance measures covering input, output, outcome, and efficiency. Although the Office has periodically conducted surveys to obtain feedback on performance, the Office has not formally established any performance measures addressing quality. Quality performance measures emphasize reliability or responsiveness to the customer or stakeholder, such as client satisfaction with physician or physician satisfaction with health plan/contractor.

Further, the Office reports only input measures for its third goal regarding encounter data. The Office could report on at least one outcome measure. Outcome measures indicate the results achieved and whether efforts are meeting proposed targets. For example, the Office already reports the percentage of encounter data determined to be accurate through medical file reviews to the federal Centers for Medicare and Medicaid Services and could report this measure to the Governor or Legislature.

SUMMARY

The Office of the Auditor General has conducted a performance audit of the rate-setting processes used by the Office of Managed Care within the Arizona Health Care Cost Containment System (AHCCCS) to develop rates for contractors and healthcare providers in the State's major healthcare program. AHCCCS administers Arizona's Medicaid program and is also the State's healthcare program for low-income Arizonans who do not qualify for Medicaid. This audit, part of a Sunset review of the agency, was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-1279 and 41-2951 et seq. It is the second in a series of five audits of AHCCCS. Other audits in the series cover the Division of Member Services, quality-of-care, medical services contracting practices, and a response to the 12 factors listed in Arizona's Sunset law.

AHCCCS administers Arizona's Medicaid program principally through a capitated managed care system. Within this system, AHCCCS pays healthcare contractors a capitation rate each month to coordinate medical services for each AHCCCS member enrolled with that contractor. This capitated rate applies regardless of the type or level of services used by the member. Contractors in turn authorize, monitor, and pay for services provided to AHCCCS members through a network of physicians and other healthcare providers. For certain groups within the population, AHCCCS also has a fee-for-service system that pays providers directly for services. For fiscal year 2002, AHCCCS' healthcare expenditures totaled nearly $3.4 billion. As of July 1, 2002, 686,000 of AHCCCS' members were covered under the capitated program, while 88,900 were covered under the fee-for-service program.

AHCCCS' Office of Managed Care is responsible for AHCCCS' oversight of its healthcare contractors. The Office of Managed Care negotiates the contracts, monitors contractor financial performance, and works with an actuary (a statistician who calculates insurance payments) to develop the capitation rates. The Office of Managed Care also sets and adjusts rates to directly reimburse providers who treat fee-for-service program members.

This audit focuses on three primary responsibilities of the Office of Managed Care: developing capitation rates, setting and adjusting physician fee-for-service rates, and

monitoring the financial solvency of healthcare contractors. The report also includes other pertinent information about inpatient hospital reimbursement rates.

Accuracy of capitation rate data reasonably ensured (see pages 7 through 11)

AHCCCS reasonably ensures the accuracy of the information it uses to set capitation rates, but should better document some of the procedures it uses in processing this information. With AHCCCS spending $2.4 billion on capitated managed care in 2002 alone, the soundness of these procedures is vital. In working with an actuary to develop capitation rates, the Office of Managed Care summarizes information from contractors about the extent to which members use medical services and the amount that contractors pay medical providers for the services provided.

The Office of Managed Care validates healthcare service information (i.e., encounter data) through monthly processing and performs annual validation studies. Each month, AHCCCS electronically checks the encounter data for errors. The Office also performs annual validation studies, in which two AHCCCS staff each independently attempt to match a random sample of data submitted by a contractor with a corresponding medical record submitted to the contractor by its service providers. AHCCCS uses the study results to determine the quality of the rest of the contractors' encounter data and sanctions contractors who exceed allowable error rates. Although these control efforts appear adequate to ensure the reasonableness of the utilization data given to the actuary, some of the Office's procedures to verify this utilization information are not fully documented. Better documentation would help ensure that the Office's approach stays consistent over time.

AHCCCS also has adequate controls over the cost data used in the calculation of capitation rates, and has documented its processes. Specifically, AHCCCS provides its contractors guidelines for recording and reporting financial information and monitors quarterly and audited annual financial statements, which help to ensure the accuracy of the cost data used in capitation rate setting.

Process for setting physician fee-for-service rates appears appropriate (see pages 13 through 16)

AHCCCS' approach to developing and adjusting its physician fee-for-service rates appears appropriate. While most AHCCCS services are provided through the

capitated managed care system, AHCCCS directly compensates physicians and other healthcare providers for services provided to Native Americans enrolled in Indian Health Services and non-qualified aliens treated through the Emergency Services Program. These two groups accounted for 88,900 AHCCCS members as of July 1, 2002. AHCCCS' fee-for-service expenditures totaled approximately $363 million in fiscal year 2002.

AHCCCS' approach in setting fee-for-service rates is similar to some other states in that AHCCCS develops rates using the annually updated fee schedule for the federal Medicare program as a guideline and a point of comparison for each rate. In addition to comparing its rates with Medicare's, AHCCCS incorporates other considerations into the process. Medicare's clients and AHCCCS' clients differ in the extent to which they use some services, such as maternity care, and in such instances, AHCCCS develops its own rates to better reflect members' medical service use patterns. Additionally, AHCCCS uses physicians' input when setting and adjusting rates. AHCCCS obtains this input from staff with medical training and industry experience and by consulting with outside physicians.

AHCCCS monitors contractors' solvency (see pages 17 through 19)

AHCCCS has a reasonable system for monitoring contractors' financial solvency. Such a system is important, because a contractor's financial insolvency could have profound effects on the AHCCCS system, potentially disrupting medical services to AHCCCS members and jeopardizing healthcare providers' participation in the system. AHCCCS contractually requires quarterly and audited annual financial reports from contractors and uses this report information to monitor contractors' solvency. For example, AHCCCS calculates several important financial ratios from contractor data to assess contractors' financial viability and identify problems. AHCCCS also assesses contractors' compliance with financial reporting requirements during annual onsite reviews. If AHCCCS identifies significant problems with a contractor's financial solvency, AHCCCS may impose more frequent monitoring. Closer monitoring keeps AHCCCS apprised of the contractor's financial status and, if necessary, facilitates proactive efforts to ensure continuity of AHCCCS members' healthcare.

Other pertinent information (see pages 21 through 22)

During the audit, auditors gathered information about the rates paid to hospitals for inpatient services on a fee-for-service basis. Statute prescribes AHCCCS' methodology for calculating hospital reimbursement rates and annually adjusting these reimbursement rates for inflation. Some stakeholders in the medical community have raised concerns that the methodology and inflationary adjustment do not fully compensate hospitals. The Legislature established a Hospital Reimbursement Workgroup to assess the adequacy and appropriateness of the rates. This group's work is still in process. Led by AHCCCS and composed of representatives from six hospitals and the Arizona Hospital and Healthcare Association, the workgroup must submit its findings to a joint legislative committee by November 15, 2002.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the rate-setting processes used by the Office of Managed Care within the Arizona Health Care Cost Containment System (AHCCCS) to develop rates for contractors in the State's major healthcare program. AHCCCS administers Arizona's Medicaid program and is also the State's healthcare program for low-income Arizonans who do not qualify for Medicaid. This audit, part of a Sunset review of the agency, was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and 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 second in a series of five audits of AHCCCS. The first audit covered the Division of Member Services, while subsequent audits in this series will cover quality-of-care, medical services contracting practices, and a response to the 12 factors listed in Arizona's Sunset law.

AHCCCS overview

AHCCCS administers Arizona's Medicaid program, and is also the State's healthcare program for low-income Arizonans who do not qualify for Medicaid. The majority of AHCCCS' members receive services through one of two managed care programs—the acute care program, which provides a wide range of healthcare services, and the Arizona Long Term Care System, which provides long-term care services such as institutional nursing care and home- and community-based services. Under its managed care system, AHCCCS does not directly provide healthcare services to its members, but pays contractors a fixed amount in advance each month, called a capitation rate, for each member, regardless of the number or level of services provided. Contractors in turn pay healthcare providers for covered services provided to AHCCCS members. As of July 1, 2002, AHCCCS contracts with 10 contractors to provide acute care services to 652,000 members, and with 8 contractors to provide long-term care services to 34,000 members. Additionally, as of July 1, 2002, AHCCCS served 88,900 recipients who receive healthcare services on a fee-for-service basis, where AHCCCS directly pays providers for services.

Fact:

AHCCCS serves approximately 774,900 members under its capitated and fee-for-service programs.

Office of Managed Care overview and responsibilities

AHCCCS' Office of Managed Care (Office) is responsible for oversight of the agency's healthcare contractors. The Office negotiates with contractors to provide services to members and monitors contractors' financial performance through regular review of their financial statements and an onsite review process. It also works with an actuary to develop the capitation rates paid to contractors and maintains a large database of all services provided to AHCCCS members. Finally, it is responsible for setting rates within the fee-for-service program.

For fiscal year 2002, the Office has 49.5 full-time equivalent staff (FTEs) and includes six units:

- Research (15 FTE)—This unit develops payment rates for physicians and hospitals and performs studies on members' usage of the medical services provided.
- Health Plan Finance (11 FTE)—This unit works with independent actuaries to develop capitation rates paid to contractors. The unit also monitors the financial solvency of the contractors by reviewing quarterly and annual financial information, conducting onsite reviews, and developing policies and procedures for healthcare contractors to follow.
- Behavioral Health Unit (10 FTE)—This unit oversees all behavioral health programs provided by the Arizona Department of Health Services as well as acute and long-term care contractors. Additionally, the unit develops quality-of-care standards for behavioral health services, and provides technical assistance to contractors.
- Health Plan Operations (6 FTE)—This unit conducts annual onsite reviews of each acute care contractor. Unit staff interview contractor staff, examine policies and procedures, and write a report with recommendations to improve performance.
- Arizona Long Term Care System (ALTCS) (4 FTE)—This unit monitors the contractors' delivery of long-term care services, monitors and evaluates whether contractors are in compliance with contractual requirements, participates in the development and negotiation of contractor capitation rates, and provides technical assistance.
- Administration (3.5 FTE)—This unit oversees the budget, all personnel issues, and other projects for the Office of Managed Care.

Funding and budget

As illustrated in Table 1 (see page 4), the Office of Managed Care's actual budget for fiscal year 2002 was approximately $2.8 million. The Office received approximately $1.2 million from the State's General Fund. The Office also received $1.3 million from federal sources, in addition to approximately $157,300 in state and federal monies, to help administer the Children's Health Insurance Program.

Audit scope and methodology

This audit focused on three responsibilities within the Office of Managed Care: developing capitation rates, developing fee-for-service rates, and monitoring contractors' financial performance. The audit focused on these areas to determine if AHCCCS uses sound methods for developing capitation rates paid to contractors and for developing fee-for-service rates for other providers, and if AHCCCS adequately monitors the financial performance of its contractors to help ensure a viable healthcare system for its members.

This report contains findings in three areas:

- AHCCCS' efforts to ensure the accuracy of data for determining capitation rates are reasonably ensured, but some parts of the process need to be better documented;

- AHCCCS' approach for developing fee-for-service rates for physicians appears to be appropriate; and

- AHCCCS monitors the financial performance of its contractors to help ensure a viable healthcare system for its members.

The report also includes other pertinent information on hospital inpatient fee-for-service rates. A legislatively mandated workgroup is studying these rates and the methods AHCCCS uses to develop them. Their report is due to the Legislature on November 15, 2002.

Auditors used a variety of methods to study the issues addressed in this report:

- To evaluate AHCCCS' process for developing capitation rates, auditors interviewed AHCCCS staff to learn how the rates are developed. Auditors reviewed policies and procedures for monitoring contractors' cost data and for conducting the Office's annual service use data study. Auditors observed and interviewed Office staff responsible for performing quality control reviews on the

Table 1 Office of Managed Care
Schedule of Revenues and Expenditures
Years Ended June 30, 2000, 2001, and 2002
(in Thousands)
(Unaudited)

	2000	2001	2002 [1]
Revenues:			
Appropriations:			
State General Fund	$2,312.1	$2,306.2	$1,201.4
Children's Health Insurance Program Fund [2]	298.7	377.3	157.3
Federal	1,584.7	1,478.6	1,294.2
Tobacco settlement litigation monies [3]		.2	180.7
Total revenues	$4,195.5	$4,162.3	$2,833.6
Expenditures:			
Personal services	$3,222.5	$3,292.5	$2,158.2
Employee-related	633.2	663.6	521.4
Professional and outside services	114.2	10.4	11.2
Travel, in-state	21.9	18.2	8.2
Travel, out-of-state	10.5	5.4	5.4
Other operating	159.7	146.4	116.5
Equipment	33.5	25.8	12.7
Total expenditures	$4,195.5	$4,162.3	$2,833.6

1 Excludes revenues and expenditures of approximately $1.5 million relating to the Eligibility Quality Control Section that was moved to another division.

2 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 federal matching monies for providing health insurance coverage to uninsured children whose families meet certain income requirements.

3 Consists of the portion of monies obtained from a settlement with the tobacco companies allocated to the Division and used for its role in 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 June 30, 2000, 2001, and 2002.

data used to develop capitation rates. Auditors also interviewed staff in AHCCCS' Information Services Division and reviewed their policies and procedures for generating reports. In addition, auditors interviewed the actuary who participates in the rate development process.

- To learn about the research and the analyses performed in the process AHCCCS uses for setting its physician fee-for-service (FFS) rates, and to assess the strength of that process, auditors interviewed AHCCCS staff. Additionally, auditors interviewed representatives of the Arizona Medical Association and the Arizona Hospital and Healthcare Association to gain their perspective on FFS rate issues. Auditors also contacted the Centers for Medicare and Medicaid Services (Centers), the federal agency responsible for administering Medicare and Medicaid, to obtain a perspective on FFS rate development processes and

more specifically to obtain research Medicaid performed in developing its FFS rate schedule. Further, auditors contacted other states' Medicaid agencies to obtain information on their FFS rate-setting processes.[1] Auditors also reviewed Web site information and pertinent documents for the Centers and other states.

- To determine how AHCCCS monitors its contractors' financial performance, auditors who are Certified Public Accountants reviewed AHCCCS policies and procedures governing its financial monitoring of contractors. Auditors also analyzed AHCCCS' financial files for five contractors, including reviews of quarterly and annual financial statements, to verify that policies and procedures were being followed.

This audit was conducted in accordance with government auditing standards.

The Auditor General expresses appreciation to the director of AHCCCS and her staff for their cooperation and assistance throughout the audit.

[1] Other states contacted during this audit: California, Colorado, Hawaii, Idaho, Nevada, New Mexico, Oregon, Texas, Utah, Washington, and Wyoming.

FINDING 1

Accuracy of capitation rate data reasonably ensured

AHCCCS reasonably ensures the accuracy of the information used in setting capitation rates but should better document its methods. AHCCCS uses two main types of information to set capitation rates: data on the extent to which members use medical services, and data on the amounts its contractors pay to healthcare providers. Although adequate systems are in place for ensuring the quality of data on use of services, AHCCCS' Office of Managed Care (Office) needs to establish written procedures for its efforts to ensure the reasonableness of reports developed from this data. AHCCCS has appropriate steps to ensure the cost data is accurate, and these steps are documented.

Capitation rate development process

AHCCCS administers the managed care system by paying healthcare contractors a fixed capitation rate per member per month to coordinate healthcare services for AHCCCS members. According to agency reports, AHCCCS spends 70 percent of its healthcare expenditures to provide services to members enrolled in its capitated programs.[1] In the fiscal year ended June 30, 2002, AHCCCS' capitation expenditures for acute and long-term care totaled $2.4 billion. With such considerable amounts of money involved, AHCCCS needs sound processes for developing reasonable capitation rates. If AHCCCS sets rates too high, it will spend more money than is necessary to provide healthcare to its members; if AHCCCS sets rates too low, it will create a disincentive for contractors to participate in AHCCCS programs.

Because the federal Social Security Act requires that capitation rates used in state-managed care systems be actuarially sound, AHCCCS works with an independent actuary (a statistician who calculates insurance payments) to develop capitation rates annually. Figure 1 (see page 9) illustrates the capitation rate development process. AHCCCS' Office of Managed Care, with the help of AHCCCS' Information

Fact:

AHCCCS spends 70 percent of its healthcare expenditures, or $2.4 billion, on capitated programs.

1 Does not include KidsCare or Behavioral Health programs.

Definitions:

Utilization data summarize the frequency with which AHCCCS members use different types of healthcare services (i.e., encounter data).

Cost data summarize expenditures made by contractors to provide AHCCCS members with different types of healthcare services.

Services Division, provides the actuary with the two primary inputs used to develop capitation rates: utilization and cost data. The actuary uses the utilization and cost data, in addition to considering national and AHCCCS-specific trends, such as fee-for-service rate changes, to develop capitation rates for AHCCCS' acute and long-term care programs. The actuary formulates rate ranges for each capitation rate category in contract bid years and identifies specific rate adjustments in contract renewal years. The Office in turn uses the actuary's input to determine the reasonableness of rates proposed by potential contractors or to adjust existing contractors' capitation rates, depending on the contract year.

Utilization data controls adequate, but some additional documentation is needed

The systems and procedural controls over the utilization data that the Office provides to its actuary appear adequate but some additional documentation is needed. Controls over the data used to compile reports for the actuary are appropriate and well-documented, as are controls over creating the final report submitted to the actuary. However, some of the procedures for creating the final report are not fully documented, increasing the potential for inconsistent procedures from year to year.

Validating healthcare service data—To ensure the soundness of utilization data, the Office validates the encounter data used to produce the utilization data reports for the actuary. The Office not only checks encounter data for errors on a monthly basis, but also conducts additional validation studies approximately 12 months after the end of each contract year. Both of these processes examine the encounter data that AHCCCS requires healthcare contractors to submit electronically.

Definition:

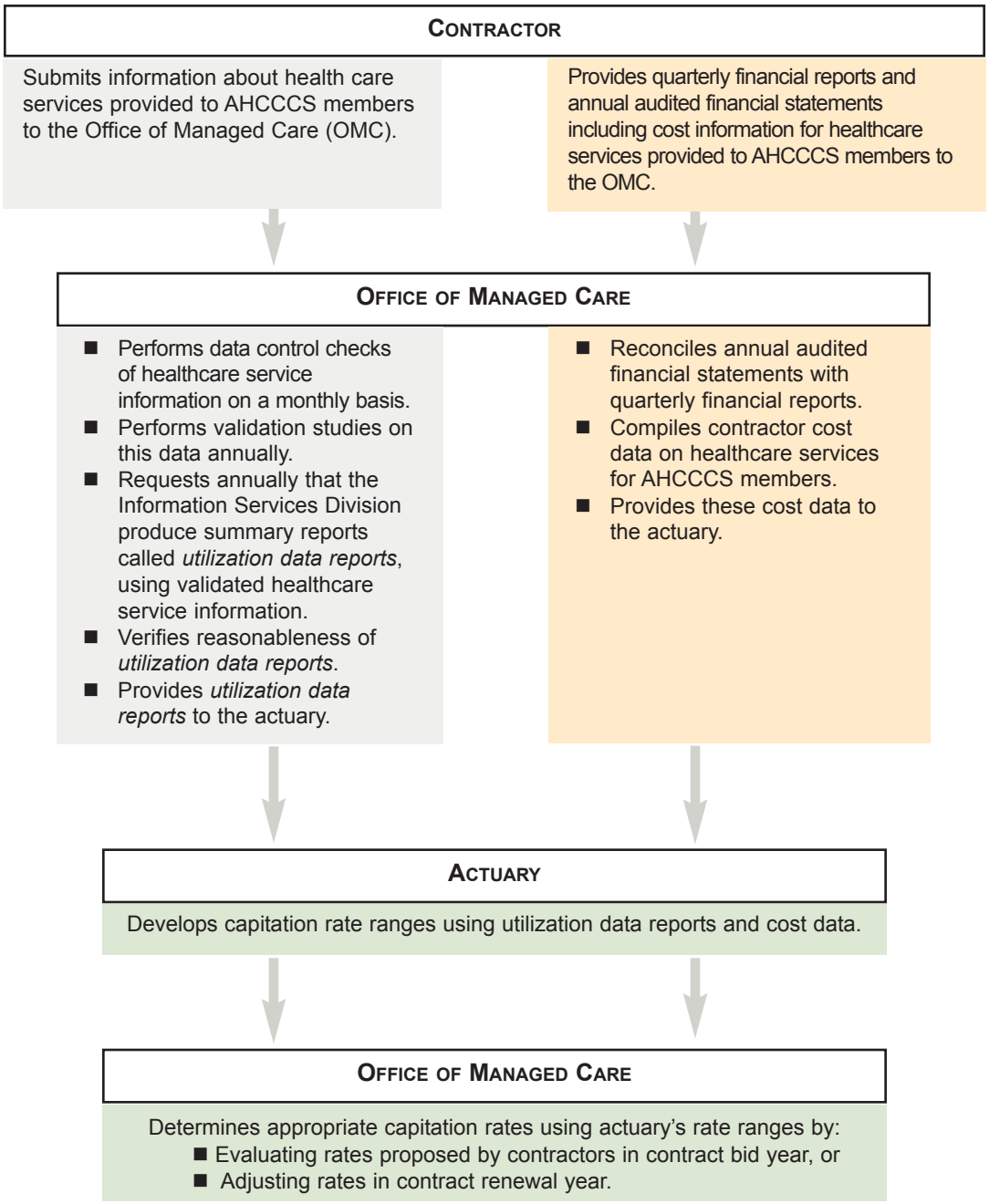
Encounter data collectively refers to the records of healthcare services provided to AHCCCS members.

Each month AHCCCS electronically checks the encounter data for errors. The checks identify not only simple errors, such as fields missing data, but also more complex errors. For example, the checks identify conflicting information within an encounter record, such as a male giving birth. If the Office identifies encounters with errors, it returns them to the contractor to correct and re-submit. Once the encounter data has gone through this process, the Office uses the data to develop utilization reports for the actuary to use in developing capitation rates.

In addition to monthly checks, the Office's annual validation studies serve as an important control over contractor-submitted encounter data. For example, for acute care services, two AHCCCS staff each independently review a random sample of paper medical service records against contractors' previously submitted encounter data. They attempt to match a sample of contractor-submitted encounter data with their corresponding medical records or claims submitted to the contractor by its

Figure 1

Arizona Health Care Cost Containment System
Office of Managed Care
Capitation Rate Development Process
As of April 2002



Source: Auditor General staff analysis of Arizona Health Care Cost Containment System (AHCCCS) policies, procedures, and interviews with AHCCCS staff.

service providers. AHCCCS uses the study results to determine the quality of the rest of the contractor's encounter data. According to the Office, in a given year, approximately 40 percent of the encounter data used to develop that year's utilization data reports for the actuary is validated through this process, while the remaining 60 percent is validated in the subsequent year.

The Office calculates error rates for each contractor based on the study results and the federal Centers for Medicare and Medicaid Services require AHCCCS to sanction contractors who exceed allowable error rates. The possibility of financial penalties serves as a deterrent for contractors to submit inaccurate or incomplete encounter data. Further, the Office uses the study results to educate contractors about common problems to avoid in future encounter submissions.

Controls over utilization data adequate but need documentation—

Once AHCCCS validates the encounter data provided by contractors, on an annual basis AHCCCS converts this information into utilization data reports for the actuary's use. AHCCCS' controls over the conversion of the encounter service data into utilization data reports adequately ensure the reasonableness of the data provided to the actuary. Efforts to check the reasonableness of the utilization reports are particularly important in light of the complex computer programming required to create the reports, which is performed by AHCCCS' Information Services Division (ISD). Auditors reviewed ISD's policies, procedures, and related documentation and determined that ISD maintains an extensive quality control process for the work it performs. For example, in creating utilization data reports for the Office, ISD analysts not only test the programming reliability prior to sending the reports to the Office, but also must document the Office's approval of the product as a final quality control check.

The Office of Managed Care could ensure consistency of its efforts by developing written procedures for verifying the utilization reports.

Although the Office's approval of the utilization data reports is documented in ISD's project files, the Office lacks written procedures for the processes it uses to verify the reasonableness of the report data. According to Office staff, they corroborate utilization data in the current report by confirming the number of members with quarterly enrollment reports, comparing the current healthcare service usage with past utilization reports, and considering potential effects of recent program changes. However, to ensure the consistency of these efforts over time, the Office should develop written procedures for verifying the reasonableness of the utilization data reports ISD creates that are used by the actuary.

Policies, procedures ensure accuracy of cost data

AHCCCS' controls over the second type of data—cost data—are adequate. Auditors reviewed a sample of AHCCCS contractor financial files to determine whether AHCCCS follows its policies and procedures for monitoring contractors' financial information, including cost data. As part of AHCCCS' efforts to monitor the financial

viability of its contractors (see Finding 3, pages 17 through 19), AHCCCS has also established policies and procedures to determine the correctness and completeness of contractors' financial data.

To determine whether AHCCCS follows these policies and procedures, auditors reviewed AHCCCS' financial monitoring documents for a sample of five acute and long-term care contractors. Auditors concluded that the files contained evidence that AHCCCS staff follow the financial monitoring policies and procedures. Auditors also reviewed and confirmed the appropriateness of the mathematical formulas used to calculate contractor adherence to AHCCCS' performance standards.

Controls are adequate over cost data.

In addition, AHCCCS' controls over financial information from contractors include data submission requirements and reviews of the accuracy and completeness of the submitted data. For example, AHCCCS provides its contractors with cost allocation guidelines for recording and reporting financial information under specific categories to help establish consistent contractor reporting. Auditors reviewed these guidelines and determined that they provide appropriate and sufficient guidance for contractors to allocate their costs. AHCCCS also requires contractors to submit annual audited financial statements and reconcile them with quarterly reports. Using information from audited financial statements, rather than financial data prepared by contractors, provides additional assurance that financial information used in setting capitation rates is accurate.

Recommendation

AHCCCS' Office of Managed Care should develop written procedures for verifying the reasonableness of the utilization data reports that the Information Services Division produces.

FINDING 2

Process for setting physician fee-for-service rates appears appropriate

AHCCCS' approach to developing and adjusting its Physician Fee-for-Service (FFS) rates appears appropriate. While most AHCCCS members' services are paid through the capitated managed care system, 11 percent of AHCCCS' members' services are paid on a fee-for-service basis. AHCCCS, like some other states, uses Medicare's rates as a guideline in the initial phase of its FFS rate review and development process. Further, because some of Medicare's rates and rate adjustments are not appropriate for the AHCCCS FFS population, AHCCCS has developed a process for setting and adjusting many of its own physician FFS rates. This process incorporates two key elements: AHCCCS-specific service use patterns and physician perspective.

Some services paid on a fee-for-service basis

While the majority of AHCCCS members receive services through the capitated program, approximately 88,900 members, or 11 percent of AHCCCS' population, receive services through the FFS program, as of July 1, 2002. FFS program recipients are primarily served through the Emergency Services and Indian Health programs. The Emergency Services Program provides services for non-qualified aliens, while the Indian Health Services program provides all available services for Native Americans. In fiscal year 2002, AHCCCS spent approximately $204 million on services for FFS clients (outpatient only). AHCCCS uses an FFS rate schedule to directly compensate physicians and other healthcare providers serving these clients. Moreover, some AHCCCS health plans, program contractors, and other entities also use AHCCCS' FFS rates to compensate their physicians.

Facts:

Fee-for-service includes the Emergency Services Program for non-qualified aliens and Indian Health Services for Native Americans.

According to AHCCCS, its FFS rate schedule includes a total of approximately 11,000 rates, 99 percent of which are included in the physician portion of the fee schedule, and which cover a wide range of procedures.[1] Because the majority of AHCCCS' FFS rates are included in the physician fee schedule, auditors focused on AHCCCS' process for setting and adjusting those rates.

Medicare's rates used as guideline

AHCCCS, like some other states, uses Medicare's rates as a guideline for establishing its Medicaid FFS rates. Medicare maintains a comprehensive, regularly updated, and publicly available rate schedule. AHCCCS and other states compare their Medicaid FFS rates with Medicare's rates.

Facts:

Medicare's physician fee schedule includes approximately 11,800 rates.

Medicare has a comprehensive physician fee schedule—Medicare, one of the largest purchasers of healthcare services in the nation, maintains a comprehensive, annually updated physician fee schedule. Medicare has established a fee schedule, which covers a broad range of services and includes approximately 11,800 rates. Medicare dedicates significant resources to researching various service rates and offers its fee schedule to the public at no cost. Additionally, Medicare publishes the methodology behind its rate development process in publicly available documents.

Table 2: Service Categories for Physician Fee Schedule

Anesthesia	**Medicine**
Behavioral Health	**Orthotic and Prosthetic Supplies**
Dental	**Pathology and Laboratory**
Drugs and Injections	**Professional and Medical Services**
Durable Medical Equipment	**Radiology**
Enteral/Parenteral[1]	**Surgery**
Evaluation and Management	**Transportation**
Maternity and Delivery	**Vision and Hearing**
Medical and Surgical Supplies	

[1] Meaning nourishment administered through an IV or stomach tube.

Source: Auditor General summary of interviews with Arizona Health Care Cost Containment System personnel and *Physician Procedures*, posted on the agency's Web site.

Comparing rates with Medicare—Medicare's rates are often considered a standard in the medical industry and the rate schedule is easily accessible on the Medicare Web site. Therefore, AHCCCS and 7 of 11 other Western states contacted use Medicare's fee schedule as a guideline when setting and adjusting their Medicaid service rates.[2] For example, in 2000, California's Medicaid program (MediCal) adjusted its rates using Medicare as a guideline. Similarly, New Mexico's Medicaid also compares its rates to Medicare's.

As an initial step in its rate review process, AHCCCS annually compares each of its FFS physician fee schedule rates with Medicare's rates for corresponding services. For those rates that Medicare increased or decreased more than 5 percent in the past year,

1 In this finding, the term "physician" includes all providers of all services listed in the *Physician Procedures* (Fee Schedule) (see Table 2).

2 The following 11 Western states were interviewed: California, Colorado, Hawaii, Idaho, Nevada, New Mexico, Oregon, Texas, Utah, Washington, and Wyoming.

AHCCCS staff conducts research to determine if a similar change to AHCCCS' rates would be appropriate. For example, AHCCCS staff examine:

- **Factors impacting the rate change**—AHCCCS analyzes the reasoning behind Medicare's rate adjustments, which may include changes in medical practice or service definition.
- **Fiscal impact**—AHCCCS determines the proposed rate changes' overall budgetary impact on AHCCCS and its contractors.
- **Rate trends over time**— AHCCCS examines the rates' historical adjustments.
- **Appropriateness/adequacy of the rate**—AHCCCS is required by federal regulations to set FFS rates at a level that is adequate to attract physicians.

Rate-setting process incorporates other key elements

In addition to comparing its rates with Medicare's, AHCCCS incorporates other key elements into its physician FFS rate-setting and adjustment process. Because AHCCCS has determined that not all of Medicare's rates are appropriate for its population, AHCCCS develops its own rates or adjusts Medicare's rates to reflect AHCCCS-specific service use patterns. Further, AHCCCS' process includes physicians' perspectives on current medical practices.

AHCCCS develops some of its own rates; modifies others—AHCCCS develops some of its own physician FFS rates because it determined that not all of Medicare's rates are appropriate for its population. Medicare's client population uses some services more or less frequently than AHCCCS' client population. AHCCCS generates reports reflecting FFS members' usage of covered services, and analyzes differences between Medicare and AHCCCS service usage. For example, Medicare clients have a relatively low need for maternity services, since Medicare's population is largely composed of the elderly. In contrast, according to statistics published in 2001 by AHCCCS, over 40 percent of Arizona births are to women who are either enrolled or eventually become enrolled in AHCCCS.

If AHCCCS determines that some Medicare rates are not appropriate for its population, it may develop its own rates.

If AHCCCS determines that Medicare's rate is not appropriate for AHCCCS' population, AHCCCS develops its own rate or applies Medicare's adjustment to its rate. When developing its own physician FFS rates, AHCCCS performs research and analysis on service costs and AHCCCS client usage to set an appropriate rate. If AHCCCS uses Medicare's rate adjustment, AHCCCS applies the same percentage

to its rate. For example, when Medicare increased its average rate for speech and language treatment by approximately 5 percent, AHCCCS increased its own rate for this service by approximately 5 percent.

Some other states use a similar procedure. For example, the Texas Medicaid Program incorporates its population's service usage when setting some FFS rates. According to a Texas Medicaid Program representative, Texas Medicaid determined that using part of Medicare's rate for some commonly used services, such as well-child exams, is not appropriate for its Medicaid population. As a result, Texas Medicaid sets a higher rate for these services than what Medicare would pay.

AHCCCS incorporates physicians' perspectives—As part of its FFS physician rate development and adjustment process, AHCCCS includes the input of staff and industry physicians. AHCCCS' Chief Medical Officer reviews proposed rate changes, and advises whether the change appears appropriate based on trends and indicators from the medical field. According to AHCCCS medical staff, they reference various clinical journals and other sources when reviewing potential rates and rate changes. Additionally, AHCCCS solicits input from the Arizona Medical Association, as well as from some health plan medical directors.

To prevent some physicians from dropping out of the AHCCCS physician network, AHCCCS did not adopt Medicare's recent year 2002 rate reduction. Medicare reduced physician compensation by 5.4 percent in 2002, and according to AHCCCS, some Arizona healthcare providers expressed concern that AHCCCS would adopt Medicare's rate reduction. Therefore, for 2002, AHCCCS froze its physician fee schedule, in part because it was concerned that adopting Medicare's reduced rates may negatively affect physician participation and client access to services.

AHCCCS uses physicians' input to develop and adjust fee-for-service rates.

Like AHCCCS, Medicare and other states include physicians' input when developing and adjusting FFS rates. For example, the Relative Value Update Committee, sponsored by the American Medical Association, reviews and develops part of the Medicare rate development process and solicits input from groups of physicians when determining how to set rates. Likewise, the Texas Medicaid Program, Nevada Medicaid, and four other Western states use physician advisory committees when considering rate adjustments. MediCal also consulted a workgroup of providers and provider advocates in deciding how to implement its last rate adjustment.

Recommendation

This finding provides information only. Therefore, no recommendations are presented.

FINDING 3

AHCCCS monitors contractors' solvency

AHCCCS has a reasonable system for monitoring contractors' financial solvency. Monitoring contractors' financial performance helps AHCCCS determine that contractors can continue to operate and obtain healthcare services for AHCCCS members. AHCCCS has developed a variety of policies, procedures, and financial review processes to guide its efforts. These include calculating various indicators of financial health, conducting annual onsite reviews, and instituting additional monitoring when significant problems are noted. Auditors' review showed that AHCCCS staff members were adhering to these policies and procedures.

Financial solvency critical to viable system

AHCCCS evaluates contractors' financial solvency, which is critical to maintain a viable healthcare system in Arizona. AHCCCS contracts with 10 contractors for acute care services and 8 contractors for long-term care. Under AHCCCS' managed care system, contractors are paid a capitated rate and placed at financial risk for providing care to enrollees. Contractors are responsible for contracting with, maintaining, and paying an adequate network of physicians and other healthcare specialists; obtaining all covered services for AHCCCS enrollees; and providing case management and coordination of care. In this environment, contractor financial insolvency could have profound effects on the AHCCCS system. If a contractor should become insolvent, AHCCCS would need to ensure that members still receive care and that healthcare providers continue to be paid. For example, AHCCCS' largest acute care contractor operates in 13 counties and is one of only two contractors in 11 of those counties. If this contractor were no longer able to operate, approximately 212,706 members, or 32 percent of all AHCCCS acute care enrollees, would be affected along with their healthcare providers.

Facts:

AHCCCS contracts with:

- 10 contractors for acute care services, and
- 8 contractors for long-term care.

Policies and procedures, financial reviews guide monitoring

AHCCCS uses a variety of methods to monitor contractors' solvency. Specifically, AHCCCS has developed policies and procedures to guide its oversight of contractors' quarterly and annual financial reports, including the calculation of several important financial ratios. Annual financial reviews performed by a team of AHCCCS staff also provide valuable insight into contractors' financial issues. If these efforts reveal financial concerns, AHCCCS performs closer monthly monitoring of contractors to ensure their continuing solvency.

Indicators of financial solvency—AHCCCS calculates important financial ratios to use as indicators of contractors' solvency and help to identify problems with financial viability. Specifically, AHCCCS monitors several important financial ratios, that are standard to accounting or healthcare, which contractors are required to maintain. Auditors confirmed that AHCCCS staff are monitoring each contractor's financial solvency using a fairly extensive list of financial ratios, including:

- Equity per Member—Long-term and acute care contractors must maintain at least $2,000 and $150 per enrollee, respectively, in equity. This indicates whether contractors can meet financial obligations, such as paying healthcare providers.

- Current Ratio—This ratio, calculated by dividing current assets by current liabilities, should be at least 1.00. If current liabilities exceed current assets, contractors may not be able to meet financial obligations as they come due.

- Medical Expense Ratio—AHCCCS contracts specify that contractors must spend more than 85 percent of their capitation revenues on direct medical care for AHCCCS enrollees. A lower percentage would signal enrollees not receiving or utilizing enough services.

- Total Administrative Percentage—AHCCCS contracts also specify that contractors should not spend more than 10 percent of capitation revenues on administrative expenses.

- Days Outstanding Received but Unpaid Claims (RBUCs)—RBUCs are medical claims received from healthcare providers but not yet paid by the contractor. Claims should be paid within 30 days and longer time frames may suggest contractor cash flow problems.

- **Other information**—AHCCCS also monitors other important financial indicators, such as operating income/loss, profitability by rate category, and overall profitability.

These ratios were designed to capture critical information that can be used to measure the likelihood of a contractor becoming insolvent. AHCCCS requires all contractors to submit quarterly financial statements and annual audited financial reports to its Office of Managed Care (see Finding 1, page 11). AHCCCS staff with financial expertise, including some that are Certified Public Accountants, use these financial statements and reports to calculate the ratios. These ratios are compared to a contractor's previous performance and to other contractors. Staff note any problems or concerns and contact contractors to obtain further information or clarification as needed. Auditors' review of AHCCCS' financial monitoring files confirms that staff are adequately calculating and monitoring these ratios.

Facts:

AHCCCS requires quarterly and annual audited financial statements.

Financial reviews are additional monitoring efforts—AHCCCS also monitors contractors' compliance with financial reporting requirements during its Operational and Financial Reviews. During these on-site reviews, a team of AHCCCS staff determines whether contractors are submitting complete, timely, and accurate financial statements, including quarterly and annual financial reports. AHCCCS compares contractors' quarterly financial statements to annual audited financial reports to identify any concerns or discrepancies. For example, the AHCCCS team also reviews contractors' performance in meeting required financial ratios, as mentioned above.

Closer monitoring when concerns identified—If significant problems or concerns with financial statements or ratios are noted, AHCCCS may impose more stringent monitoring. AHCCCS closely monitors contractors when financial concerns are identified, either through quarterly and annual financial statements or operational and financial reviews. Currently, 2 of AHCCCS' 18 contractors must provide financial statements on a monthly basis. Monthly reporting allows AHCCCS to more closely monitor contractors' financial status, avert contractor insolvency, or proactively transition members to other contractors if necessary. Auditors' review of AHCCCS' financial monitoring files for these two contractors confirms that staff are closely monitoring them and following up on pertinent information as warranted.

Recommendation

This finding provides information only. Therefore, no recommendations are presented.

OTHER PERTINENT INFORMATION

During the audit, auditors examined an ongoing study addressing the adequacy of inpatient hospital reimbursement rates. Historically, inpatient reimbursement rates have been a source of contention between AHCCCS and some hospitals. However, AHCCCS cannot alter its current methodology for calculating inpatient reimbursement, because the methodology is established in legislation. To address stakeholder concerns, the Legislature mandated a Hospital Reimbursement Workgroup to evaluate a number of objectives related to inpatient rate payment. The work of this group is still in process.

States can determine inpatient reimbursement methodology—Federal regulations allow state Medicaid agencies to establish their own process for calculating hospital rates, as long as the rates are sufficient to attract providers. Arizona's current inpatient payment structure dates back to a 1989 study conducted by the AHCCCS administration. At the time of the study, AHCCCS reimbursed hospitals on a system that based rates on hospitals' charges, as opposed to hospitals' costs. According to the study, the charge-based system failed to promote efficiency or equity. Laws 1989, Chapter 293 §26 mandated that AHCCCS develop a new hospital reimbursement system. After analyzing a wide variety of inpatient payment alternatives, AHCCCS determined that a tiered per diem (see text box) payment system most effectively met AHCCCS evaluation criteria and legislative requirements. The Legislature amended A.R.S §36-2903.01 (Laws 1992, Ch. 302 §3), approving the tiered per diem payment system, effective March 1, 1993.

As defined in statute, AHCCCS must establish its tiered per diem payment rates at the beginning of the federal fiscal year. These payment rates remain constant for the duration of the payment period. However, legislation requires that AHCCCS annually adjust these rates for inflation using Standard & Poor's inflationary adjustment. AHCCCS' inpatient rates include reimbursement for a hospital's operating and capital costs.[1] Using information such as diagnosis and procedure codes, and depending on the type of service provided, AHCCCS assigns each inpatient day of care to the appropriate service tier (see text box). AHCCCS then reimburses hospitals for each inpatient day of service based on the tiered rate.

Tiered Per Diem Rate—AHCCCS classifies each covered inpatient hospital day of care into one of seven service tiers (see below). The rate paid per day per service level is called the tiered per diem rate.

Inpatient Tiers:

Maternity

Neonatal Intensive Care

Intensive Care

Surgery

Psychiatric

Nursery

Routine

[1] Operating costs include the daily cost of hospital operation, such as utility costs. Capital costs are a blend of statewide and hospital-specific costs, and include expenditures for buildings and fixtures.

Stakeholders have raised concerns—Several stakeholders in the medical community have expressed concerns with AHCCCS' current hospital inpatient reimbursement rates. Specifically, some stakeholders are concerned that the tiered per diem methodology does not fully recognize hospitals' cost for providing inpatient services. For example, some stakeholders believe that the methodology does not adequately recognize the full cost of trauma center services. Additionally, one stakeholder expressed concern that AHCCCS' annual inflationary rate adjustment fails to keep pace with actual inflation.

AHCCCS and hospitals are working together—Because of legislative requirements, AHCCCS currently lacks the flexibility to change its inpatient hospital reimbursement methodology. However, in 2001, the state legislature established a Hospital Reimbursement Workgroup, which may address some stakeholder concerns. The workgroup, led by AHCCCS, includes representatives from six hospitals and the Arizona Hospital and Healthcare Association. According to legislation, some workgroup objectives include:

- Reimbursement Levels—Developing a methodology to compare AHCCCS reimbursement levels with the reimbursement levels paid by others, including Medicare and commercial health plans. AHCCCS hired an independent consultant to conduct the actual payment comparison.

- Rates Paid vs. Actual Costs—Evaluating the relationship between and adequacy of AHCCCS' inpatient hospital reimbursement rates with hospitals' actual costs of serving AHCCCS members.

- Other States' Methodologies—Reviewing other states' inflationary indicators for increasing hospital reimbursement, as well as selected states' methodologies for determining inpatient hospital reimbursement for Medicaid clients.

- Federal Requirements—Reviewing federal requirements regarding the reimbursement of emergency services provided to undocumented aliens.

The workgroup must report its assessment of the inpatient rates' adequacy and appropriateness to the Joint Legislative Committee on the implementation of Proposition 204 by November 15, 2002.

AGENCY RESPONSE

August 20, 2002

Ms. Debra Davenport, CPA
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Re: Draft Rate Setting Processes Report dated August 16, 2002

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the revised preliminary report draft on AHCCCS' rate setting and contractor financial monitoring processes. Below is our response to the one recommendation in the report.

Page 11 Recommendation:

AHCCCS' Office of Managed Care should develop written procedures for verifying the reasonableness of the utilization data reports that the Information Services Division produces.

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

Since the audit took place, a policy has been written by the Office of Managed Care's Finance Unit addressing both the development of the data reports which are submitted to the actuary as well as the verification processes for the utilization data contained in the reports.

AHCCCS is gratified that the Auditor General recognized the efforts of the Office of Managed Care to set appropriate rates and successfully monitor the financial viability of our medical services contractors. AHCCCS has worked hard to develop and continually improve these processes given that their importance cannot be over-emphasized. We appreciate the efforts of the audit team and believe the recommended policy will be effective in ensuring that procedures will be applied consistently each year.

Sincerely,

Phyllis Biedess
Director

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Performance Audit Division reports issued within the last 12 months

01-17 Arizona Board of Dispensing Opticians
01-18 Arizona Department of Corrections—Administrative Services and Information Technology
01-19 Arizona Department of Education—Early Childhood Block Grant
01-20 Department of Public Safety—Highway Patrol
01-21 Board of Nursing
01-22 Department of Public Safety—Criminal Investigations Division
01-23 Department of Building and Fire Safety
01-24 Arizona Veterans' Service Advisory Commission
01-25 Department of Corrections—Arizona Correctional Industries
01-26 Department of Corrections—Sunset Factors
01-27 Board of Regents
01-28 Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29 Department of Public Safety—Sunset Factors
01-30 Family Builders Program
01-31 Perinatal Substance Abuse Pilot Program
01-32 Homeless Youth Intervention Program
01-33 Department of Health Services—Behavioral Health Services Reporting Requirements

02-01 Arizona Works
02-02 Arizona State Lottery Commission
02-03 Department of Economic Security—Kinship Foster Care and Kinship Care Pilot Program
02-04 State Park—Heritage Fund
02-05 Arizona Health Care Cost Containment System—Member Services Division

Future Performance Audit Division reports

Arizona Health Care Cost Containment System—Medical Services Contracting
Child Protective Services—Removal and Appeal Process
Arizona Health Care Cost Containment System—Sunset Factors