STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Arizona Health Care Cost Containment System

Rate-Setting Processes

REPORT HIGHLIGHTS
PERFORMANCE AUDIT

Subject

The Office of Managed Care develops rates for the contractors who provide acute and long-term healthcare services for Arizona's low-income residents. AHCCCS pays these contractors a capitated rate—a fixed amount, in advance, each month for each member. The contractors in turn pay heathcare providers for covered services they provide to AHCCCS members. AHCCCS also has a fee-for-service system that pays providers directly for services. About 12 percent of AHCCCS members receive services on a fee-for-service basis.

Our Conclusion

The Office of Managed Care does a good job ensuring the accuracy of data used for setting capitation rates, but parts of the process need better documentation. In addition, the fee-for-service rate-setting process appears appropriate. Finally, the Office ensures a viable healthcare system by monitoring its contractors' financial condition.

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AHCCCS Reasonably Ensures Accuracy of Capitation Rate Data

The Office of Managed Care sets rates for all three types of payment systems for AHCCCS services. AHCCCS pays acute care and ALTCS contractors capitated rates; that is, a certain amount is paid in advance each month for each member enrolled. AHCCCS also has a small fee-for-service sysem that pays providers directly for services.

Payment plans:

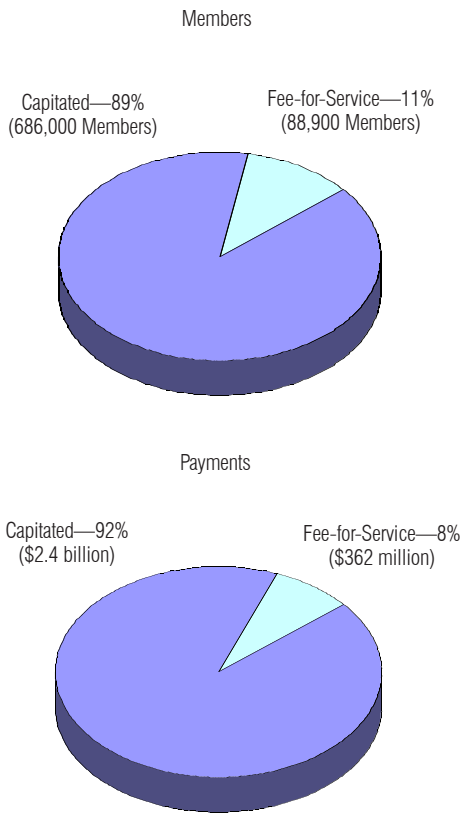
Capitated:

- **Acute Care**—A wide range of healthcare services including physician care and other outpatient services, hospitalization, and pharmacy benefits.
- **ALTCS**—long-term care services (institutional nursing care, home- and community-based services).

Fee-for-Service: AHCCCS provides the same healthcare services as in the capitated plans (physician care, hospitalization, nursing care, etc.) but AHCCCS pays the healthcare providers directly for the services.

In fiscal year 2002, capitated payments accounted for $2.4 billion of AHCCCS' $3.4 billion for all healthcare programs including Behavioral Health, KidsCare, and other programs.

Capitated vs. Fee-for-Service



Rates based on utilization and cost data—The federal Social Security Act requires that AHCCCS' capitation rates must be actuarially sound. AHCCCS works with an actuary (a statistician who calculates insurance rates) to develop the capitation rates annually. To develop the rates, the actuary relies on several types of data regarding how frequently members use healthcare services and how much those services cost.

Validating utilization data—Because accurate data on the use of services is critical to determining rates, AHCCCS checks this data on a monthly basis. It does this by electronically checking the records that contractors provide to AHCCCS showing the type and frequency of services provided to members. The check identifies missing information or conflicts in the information, such as a male giving birth. Records with errors are sent back to the contractor to correct and resubmit.

The Office of Managed Care also conducts annual validation studies. To perform these studies, AHCCCS staff review a random sample of a contractor's paper medical service records and compare it to the data previously submitted to AHCCCS.

Although the Office's procedures help ensure the accuracy of the utilization data, some of the procedures are not documented in writing, which would help ensure that they are consistently followed.

Controls over cost data—AHCCCS has adequate controls over the cost data used to set rates. AHCCCS requires contractors to submit information on the costs of the services provided and reviews the information for accuracy and completeness. AHCCCS also has documented its procedures in writing and AHCCCS follows its procedures.

Recommendations

AHCCCS should:

- Develop written procedures to verify its utilization data.

Fee-for-Service Rate-Setting Process Appears Appropriate

About 88,900 members receive medical care on a fee-for-service basis. These members are primarily served through Emergency Services and Indian Health programs.

> Fee-for-Service Rates
>
> AHCCCS' fee-for-service rate schedule includes over 11,800 rates that cover a wide range of medical procedures.

Medicare Used as Guideline

AHCCCS uses Medicare's fee schedule as a guideline for establishing its fee-for-service rates. However, when Medicare increases or decreases rates by more than 5 percent, AHCCCS conducts research to determine if a similar change is appropriate. It considers several factors before making a change, including whether the new rate is sufficient to attract physicians.

Sometimes the Medicare rates are not appropriate for AHCCCS' members— For example, Medicare's population is mostly composed of the elderly, who have little need for maternity services. In contrast, over 40 percent of the births in Arizona are to women who are enrolled or eventually become enrolled in AHCCCS.

Physician input—To maintain physician participation in the program, AHCCCS considers their input before making rate changes. For example, based on healthcare provider input leading to concerns that some physicians may drop out of the program, AHCCCS did not adopt Medicare's 5.4 percent decrease in physician compensation in 2002.

AHCCCS Monitors Contractors' Solvency

AHCCCS' contractors are responsible for:

- Contracting with and paying an adequate network of physicians
- Obtaining covered services for AHCCCS members
- Providing for case management and coordination of care

Contractors' solvency is important to AHCCCS because if one should become insolvent, AHCCCS would have to ensure that members still receive care and that healthcare providers continue to be paid.

AHCCCS regularly monitors several financial ratios for each contractor that are standard to the healthcare service industry.

AHCCCS requires all contractors to submit quarterly financial statements and annual audited financial reports. In addition, an AHCCCS team monitors whether contractors are submitting complete, timely, and accurate financial statements and reports by conducting onsite visits. If significant problems or concerns with these reports and statements occur, AHCCCS may impose more stringent reporting requirements, such as monthly filing instead of quarterly. Currently, 2 of the 18 contractors must report monthly.

Financial Ratios Monitored

- Net resources per member
- Assets to liabilities
- Percentage of revenues spent on direct medical care
- Percentage of revenues spent on administration
- Number of days received claims remain unpaid

Hospital Reimbursement Rates

AHCCCS is permitted by federal regulations to establish its own process for determining hospital inpatient rates, as long as the rates are sufficient to attract providers. The current tiered per diem rate system became effective on March 1, 1993.

Tiered per diem rate

AHCCCS classifies each covered patient hospital day of care into one of seven levels or tiers. The rate paid per day per service tier is called the tiered per diem rate. The seven tiers are:

- Maternity
- Neonatal intensive care
- Intensive care
- Surgery
- Psychiatric
- Nursery
- Routine

AHCCCS establishes the rates for the tiers in October at the beginning of the federal fiscal year, after adjusting for inflation.

Some stakeholders are concerned that the tiered per diem system does not take into account all the hospitals' cost for providing inpatient services. Another concern is that the annual inflation rate adjustment may not actually keep pace with inflation.

To address these concerns, the Legislature established a work group composed of AHCCCS and hospital representatives to consider reimbursement levels, actual costs, what other states are doing, and federal requirements. This work group reports to the joint legislative committee in November 2002.

TO OBTAIN MORE INFORMATION

A copy of the full report can be obtained by calling
(602) 553-0333

or by visiting our Web site at:
www.auditorgen.state.az.us

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