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Lessons From Arizona’s Medicaid Managed Care Program

With thirteen years of experience, Arizona’s Medicaid managed care program offers valuable insight into the potential and pitfalls of this form of safety-net system.

by Nelda McCall

With increased pressure on public programs to decrease costs while maintaining a safety net of service use for beneficiaries, many state Medicaid programs are looking to managed care as an important component of an improved and more cost-effective delivery system. This paper examines the lessons learned from evaluations of the first statewide managed Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS).1 The paper focuses on two questions: (1) Does the experience in Arizona justify expansion of Medicaid managed care to other states? (2) What lessons learned in Arizona should other states consider as they move into Medicaid managed care?

The AHCCCS Program

The AHCCCS program began in October 1982 as an alternative to traditional Medicaid. Before AHCCCS, Arizona was the only state not participating in Medicaid. The original AHCCCS program did not cover nursing home care. In 1989 the Arizona Long-Term Care System (ALTCS) was incorporated into AHCCCS. ALTCS provides a full range of acute home-based and community-based services and nursing home services to Medicaid eligibles who are at risk of institutionalization.

The AHCCCS program provides managed care services through acute care plans and long-term care contractors capitated by the state. Covered services for Medicare beneficiaries are paid for on a fee-for-service basis by Medicare. Providers are required to bill Medicare first for such services.2 The state provides the overall direction for the program with responsibilities for eligibility and enrollment; selecting, paying, and regulating capitated providers; monitoring the quality and appropriateness of care; and maintaining an information system to support program operations. In addition, Arizona provides reinsurance for inpatient services and coverage for catastrophic services. In the past, AHCCCS has also acted as the plan or contractor in counties for which it was unable to find a qualified organization at an acceptable capitation rate.

Plans and contractors engage in a broad range of service delivery, internal monitoring, and data-sharing activities. Besides providing case-managed covered services, they must manage a provider network, distribute a member handbook, and collect third-party

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and patient liabilities. They must also maintain systems for quality management, financial management, grievance and appeals, and data management. The data management system must support timely submission of data to AHCCCS.

AHCCCS covered about 463,000 beneficiaries in the acute part of the program and 23,000 beneficiaries in ALTCS in March 1997. Most acute care beneficiaries were served through one of the fourteen health plans selected through a competitive bidding process. The state releases a request for proposals that lists participation requirements and evaluation criteria. Acute care beneficiaries choose from among the health plans available in their county. All of the counties have more than one health plan.

The long-term care program serves those who are financially eligible (up to 300 percent of Supplemental Security Income eligibility) and determined by state assessors, using a preadmission screening instrument, to be at risk of institutionalization. Beneficiaries include the elderly and physically disabled and the mentally retarded/developmentally disabled. Five counties and two private entities serve as contractors for the elderly and physically disabled. There is only one contractor per county. The Arizona Department of Economic Security is the contractor for the mentally retarded/developmentally disabled. Contractors provide case management and make placement decisions. They are capitated at a negotiated rate using a methodology that provides economic incentives to care for beneficiaries at home rather than in nursing homes.

DOES ARIZONA’S EXPERIENCE JUSTIFY EXPANSION OF MEDICAID MANAGED CARE?

The successes and failures of the longest-running statewide Medicaid managed care program serving all eligibility groups should be considered by other states in their decisions about whether and how to implement Medicaid managed care. This section summarizes the evaluation of several aspects of the Arizona program: cost of the program, use of health care services by program beneficiaries, and access to and quality of services received under AHCCCS.

■ COST. The cost analyses for the acute care AHCCCS program compared the actual per capita costs by eligibility group with an estimate of the per capita costs of a traditional Medicaid program in Arizona. Comparison states were those with reliable and complete data that were similar to Arizona in their Medicaid requirements. For fiscal year (FY) 1983 through FY 1993, savings of $197 million were estimated, an average savings per year of approximately 11 percent of medical service costs and 7 percent of total costs (medical service costs plus administrative costs). The average annual increase in cost for the AHCCCS acute care program (9.1 percent) was also smaller than the annual increase for the traditional program (10.3 percent).

The ALTCS cost analyses compared the number of users, cost per month, and total cost for ALTCS with estimates of what a traditional Medicaid program in Arizona would have cost for the first five years of the program, 1989 through 1993. Estimates for the traditional program were made for comparison states using the Medicaid Statistical Information System. ALTCS costs, including medical and administrative costs, were on average 16 percent per year lower than the costs of a traditional Medicaid program in Arizona. When considering medical services alone, the ALTCS savings were 18 percent per year. Total cost savings were almost $290 million, and these savings increased substantially over time (0.2 percent in 1989, 8 percent in 1990, 15 percent in 1991, and 21 percent in 1992 and 1993). The average annual cost increases for ALTCS were lower than the increases for a traditional program, 4.0 percent per year versus an estimated 9.6 percent per year.

■ USE OF SERVICES. Examination of the long-term care and acute care programs found that beneficiaries in these programs used less institutional care than Medicaid beneficiaries in New Mexico used and more or about the same amount of ambulatory care.
The analysis for the acute care program was based on Medicaid claims and encounters for a 5 percent randomly selected sample of AHCCCS and New Mexico Medicaid beneficiaries for FYs 1991 and 1992. For the long-term care program, ALTCS claims data and encounters data for all eligible beneficiaries receiving chronic long-term care services in New Mexico were linked with Medicare claims to give a full picture of all medical care service use for January 1991 through September 1992. Services in both states were categorized using the same methods.7

Beneficiaries of Aid to Families with Dependent Children (AFDC) in the acute care programs in Arizona and New Mexico had about five evaluation and management visits (that is, office, home, nursing home, specialty, consultations, and therapies) per person-year, but the number of hospital days per thousand person-years was 40 percent lower in Arizona (590 days versus 976 days). Evaluation and management visits for ALTCS elderly and physically disabled eligibles resulted in more visits (thirteen versus nine), but the number of hospital days per thousand person-years was 22 percent lower than in the traditional program in New Mexico (3,692 versus 4,731).

QUALITY AND ACCESS. Several quality and access studies of the AHCCCS and ALTCS programs, which used New Mexico Medicaid beneficiaries as the control group, revealed mixed results. An access and satisfaction survey conducted in 1985 indicated better access to routine and urgent care in AHCCCS than in the New Mexico program and high satisfaction scores for services. Primary prevention, preventive care use, and use of medical care for particular symptoms were similar in the two states. A review of Medicaid records of AFDC children and pregnant women in 1985–1987 indicated earlier, more frequent, and more complete health care for children in Arizona. Maternity care and pregnancy outcomes were similar in the two states, but Arizona had later initiation of pregnancy care and fewer prenatal visits.

With respect to the ALTCS program, a review of nursing home records in 1991 and 1992 revealed that Arizona’s elderly and disabled beneficiaries were more likely than New Mexico’s elderly and disabled to have pressure sores, fever, or a catheter inserted and less likely to be offered an influenza vaccine. The incidence of falls and fractures and the use of psychotropic drugs were similar in the two states. In response to these findings, ALTCS initiated steps to include monitoring of the problem areas in their ongoing quality assurance activities.

Analyses of new admissions of elderly and physically disabled beneficiaries into the long-term care program found a much more coordinated system of care in Arizona, which permitted transitions from nursing home to home care and vice versa. Evaluation of the cost-effectiveness of home care provided under ALTCS indicated that attempts to limit spending on long-term care by diverting clients to home care settings have been successful. This is in stark contrast to previous evaluations of home and community-based care programs that have found home care to be a complement to institutional care, not a substitute.8

The analyses of the two programs’ outcomes indicated that the program was providing better access to good-quality care at a lower cost. However, some of the analyses showed the program to be doing worse than a traditional Medicaid program, suggesting the need for close monitoring of quality-of-care and access issues. Studies performed over the course of the two evaluations highlighted areas in which AHCCCS procedures and methods could be improved and demonstrated the importance of having an ongoing analysis capacity within the administration of a managed care program.

LESSONS FROM ARIZONA?

Besides looking at program outcomes, the analyses also examined the implementation and operation of the major features of the AHCCCS program. States implementing managed care may want to consider the following five recommendations in designing and implementing their programs.
SELECT LEADERS WHO HAVE THE REQUIRED SKILLS. When designing and implementing new managed care programs, leadership is needed in three key positions that do not always exist in traditional Medicaid programs: a chief information officer who knows how to collect and analyze data and use it for policy development; a chief financial officer who has experience in the financial management of managed care organizations and who can lead the monitoring of plan operations; and a chief medical officer who has experience leading activities in assuring and monitoring the quality of care in the delivery of Medicaid services. AHCCCS did not have persons with these kinds of skills in place at the beginning of the program, and many of its implementation problems can be traced to this lack of leadership. In the three areas outlined, the leaders must be in senior positions in the organization and have sufficient stature to conduct discussions and negotiations with other state organizations and with health plan chief executive officers. In addition, these leaders must have the vision to formulate a specific plan of operation and select and manage appropriate staff.

CONSIDER DESIGN OPTIONS FOR THE PROGRAM'S OPERATIONS. The design of the following operational areas is particularly important to the AHCCCS program and should be carefully considered in any new program.

Eligibility determination and enrollment. AHCCCS acute care implementation analyses suggest that carefully thinking through the process of enrollment and how it interacts with the process of eligibility determination can help to avoid unnecessary fee-for-service liabilities. If beneficiaries select from multiple plans, the plans’ marketing materials, media advertising, and solicitation methods should be reviewed and approved. In Arizona’s ALTCS program, the state performs the functional/medical assessment for eligibility using a preadmission screening instrument and therefore controls entry into the system.

Responsibilities of the capitated entities and the state. Central to the workings of the AHCCCS program is the relationship between the state and the health plans and contractors. Responsibilities of the contracting entities in AHCCCS include a specifically defined broad range of service delivery, internal monitoring, third-party liability identification and collection, and data-sharing activities. The state also has defined responsibilities that are consistent with its primary responsibility for overall program direction. Clear definition of authorities and responsibilities is critical to program success.

Rules for participation and selection. Participation and selection criteria also need to be clearly defined. Participation in AHCCCS is restricted to organizations that meet specific network requirements; have internal controls for quality, financial, and grievance monitoring; and have systems in place to produce the data that are required under the program. Selection of winning bidders follows a defined structure that emphasizes the provider network in selection but also considers the capitation rate bid, the ability of the contractor to meet the program’s requirements, and the qualifications of the organization. Having bidders who do not win contracts is important to keeping the marketplace competitive.

Method of setting capitation payment. The way capitation rates have been set has evolved over time in the AHCCCS and ALTCS programs. Specific marketplace considerations should be taken into account in developing an appropriate strategy for each solicitation. In the beginning of a new program, the active involvement of the state may be necessary to help safety-net providers and other potential bidders get organized to participate. In addition, the state may need to assume some of the risk of the cost of delivering services by retroactively adjusting certain components of the capitation payment.

Meeting the information needs of the program. Perhaps most important in managed care is having a management information system that emphasizes not only the operation of hardware and software but also the quality of the input data. Both the state and the participating plans in AHCCCS have demonstrated...
that credible data on eligibility, enrollment, networks, cost, use of services, and, for long-term care beneficiaries, medical and functional assessments can be captured and play an important role in managing the program. Organizations that cannot provide data on plan operations and on the use and cost of services should be excluded from participation because without such data they cannot be a cost-effective partner for the state.

ADDRESS THE STATE’S MANAGEMENT RESPONSIBILITIES. Many of the early problems in implementing the AHCCCS program were related to not having effective systems in place to deal with the state’s management responsibilities. Not having financial management structures in place resulted in Arizona’s not being able to detect impending plan bankruptcies until they were imminent. In the early program years, quality assurance activities, utilization and access monitoring, and program planning functions had no leadership and few operating mechanisms. Early attention to performance in these areas is critical to a well-functioning program, which can avert quality and access problems.

Financial management. Contracting entities must be monitored for financial solvency. If plan failures occur, the stability of the program is threatened. Monitoring the plans can help to identify problems before they become critical or provide early warnings to help a state make arrangements for a plan’s orderly phaseout. The state’s ability to secure competitive rates also depends on the availability of accurate data on costs.

Quality assurance. Quality assurance activities require early and concerted energy. Important areas include activities to detect underuse of services, review of treatment patterns by diagnosis, monitoring of selected procedures, detection of fraud and abuse, and profiling of plans and physicians for quality and appropriateness.

Utilization and access monitoring. Analysis of the use of medical services is a critical component in understanding how a medical care program is performing. In a capitated program, it is of special importance to ensure that beneficiaries are receiving appropriate treatment by analyzing which services are provided and by monitoring the adequacy of access to ambulatory care.

Planning. Future planning requires systems that can estimate costs of program modifications and future program costs, identify areas that promote long-run cost containment, and research areas for general study.

Coordination with other states. States should participate in developing structures and processes that support national standardization of data collection, sharing of technical knowledge, evaluating what works and what does not, and sharing ideas through collaborative forums.

FOSTER WORKING RELATIONSHIPS WITH THE GOVERNOR, KEY LEGISLATORS, AND THE MEDIA. Integral to the success of a state’s managed care program is the involvement of the governor, key legislators, and their staffs. In Arizona both the legislature and the governor were supportive of the program during its early years. This support was unwavering despite substantial problems in the program’s administration during its first eighteen months. Fostering strong relationships with the legislature and governor is even more critical today. In an era of concern about state spending, strong marketing will be necessary to convince policymakers to allocate sufficient resources for infrastructure development. Without this development, a state runs a serious risk of problems with access, quality of care, and plan viability.

Program staff should include a press spokesperson who briefs the media regularly about what the state is trying to accomplish and who serves as a contact person for spe-
cific problems or concerns. AHCCCS had daily negative press coverage in its first year, which was exacerbated by the lack of staff to represent AHCCCS's positions to the press. In the early implementation stages of any new program, there are likely to be problems. These problems have less potential to explode if members of the media are familiar with the program and its aims and have a specific person to contact when they have questions.

SUPPORT THE DEVELOPMENT OF NATIONAL REPORTING STANDARDS. Reporting formats should include detailed definitions for each element to be included in encounter data, financial reports, quality assessment instruments, satisfaction surveys, and grievance reports. These standards for data collection will not only help the state to attract qualified contracting entities and thereby support market competitiveness, but they also have wide societal uses. Data sets that are integrated across several states can be used to determine disease incidence, document treatment trends, develop knowledge on the success of treatments, and provide a database for general research inquiry. Such a database will make it possible to improve health care for all Americans, not just those eligible for Medicaid.

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NOTES

1. This paper is based on results from two six-year Health Care Financing Administration (HCFA) evaluations of AHCCCS. Detail on the methodologies, findings, and policy conclusions are available in HCFA evaluation reports, discussion papers, articles submitted for publication, and published articles. A complete list of these documents is available from the author on request, at Laguna Research Associates, Suite I190, 455 Market Street, San Francisco, California 94105.
2. Arizona has attempted to get a waiver from HCFA to integrate Medicare and Medicaid financing but has been unsuccessful.
3. Two of the counties and the Arizona Department of Economic Security are mandated contractors. Three counties became contractors through legislatively mandated county right of first refusal in effect until July 1995. The two private entities were selected through a competitive bidding process.
4. The ALTCS program as a whole has a HCFA-imposed cap on the percentage of elderly and physically disabled beneficiaries that can be served in home care. Originally set at 10 percent of beneficiaries, it was slowly raised as the program's use of home care was demonstrated to be cost-effective. The rate was 40 percent in fiscal year 1995.
5. The analyses described were limited by the availability of data and especially by the lack of baseline information on Arizona's experiences before the program was implemented.
6. The per capita costs of the traditional Medicaid program in Arizona were calculated from HCFA Reports 2082s and 64s.
7. The methods used were based on The Urban Institute Type of Service Classification System, adapted by Laguna Research Associates for Medicaid beneficiaries.
8. The risk of institutionalization was developed with data from the Institutional Population Component of the 1987 National Medical Expenditure Survey.