UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:45 A.M.
Friday, June 15, 1984

STATEMENT OF

MICHAEL ZIMMERMAN
ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE

ON

THE HEALTH CARE FINANCING ADMINISTRATION'S MONITORING OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

We are pleased to be here today to discuss the Health Care Financing Administration's (HCFA's) monitoring of certain aspects of the Arizona Health Care Cost Containment System (AHCCCS), commonly referred to as "ACCESS." AHCCCS is a 3-year demonstration project, approved by HCFA on July 13, 1982, to provide Medicaid services in Arizona.[1] Before AHCCCS, Arizona was the only state without a Medicaid program.

---

[1]Medicaid provides medical services to persons unable to pay for such care. Under AHCCCS Arizona is required to provide health care to the federally mandated eligible groups (recipients of the Aid to Families with Dependent Children and Supplemental Security Income Programs). It also must provide all the federally mandated Medicaid services except for skilled nursing facility care, home health care, nurse mid-wife services, and family planning services.

Under the authority of section 1115 of the Social Security Act, HCFA granted waivers to Arizona enabling AHCCCS to operate differently from conventional Medicaid programs and to test a number of significant innovations. For example, AHCCCS contracts with health care providers to deliver all necessary and required care to beneficiaries for a fixed, agreed upon monthly fee determined through competitive bidding. In contrast, conventional Medicaid programs usually pay for services on an item-by-item basis, referred to as a fee-for-service system. AHCCCS also requires beneficiaries to choose one provider from whom they will receive their health care for a year. Under conventional Medicaid programs, beneficiaries are permitted to change providers as often as they wish. Lastly, AHCCCS imposes copayments on beneficiaries for the services they receive. Until March 1984 the state contracted with a private company to administer AHCCCS. However, it now administers the project.

HCFA oversees and monitors AHCCCS for compliance with the waiver requirements. Section 1115 of the Social Security Act requires that the project be evaluated. HCFA has contracted with a private, not-for-profit organization to make the evaluation, which is scheduled to be completed in October 1986.

Through September 30, 1985, AHCCCS is projected to cost $284.2 million for treating the federally eligible population,

of which the federal government's share is estimated to be $176.3 million. As of March 31, 1984, the total costs for federal beneficiaries were about $129.3 million, and the federal payment to the state was about $79 million. Some 85,000 federally eligible beneficiaries were enrolled in AHCCCS.

My statement will address the three areas you requested, namely:

--What assurances does HCFA have that the project is not incurring costs in excess of conventional fee-for-service Medicaid programs?

--What has been the financial performance of contracting providers under AHCCCS?

--What protections were afforded federal beneficiaries from underservicing or poor quality care?

Since beginning our examination of AHCCCS 2 months ago, we have collected alot of information from program files and through interviews with HCFA and state officials. Because of the short timeframe, and the limitations of the data, we can not draw conclusions on the issues in question.

I would also like to point out however, that during and after our discussions with HCFA officials, HCFA and the state took several actions to obtain data essential to any evaluation of AHCCCS, including ours. While we have not had a chance to evaluate the new data, we view these actions as steps in the right direction. I would now like to turn to the areas of your concern.

WHAT ASSURANCES DOES HCFA HAVE THAT THE PROJECT IS NOT INCURRING COSTS IN EXCESS OF CONVENTIONAL FEE-FOR-SERVICE MEDICAID PROGRAMS?

Federal regulations require that Medicaid payments to contracting providers not exceed fee-for-service costs for the same services. HCFA did not waive this requirement for AHCCCS. In fact, HCFA has adopted a policy that the federal government's financial participation in AHCCCS would not exceed the costs of an equivalent Medicaid program whose payments are determined on a fee-for-service basis.

However, because Arizona had no precise fee-for-service cost data upon which to determine the maximum federal share of AHCCCS in the first year, actuarial estimates were made based on the cost of Medicaid programs in other nearby states, adjusted for differences in benefits and the cost of purchasing services in Arizona. These estimates were made for the state by an actuarial firm and critiqued by a HCFA contractor in September 1982, 1 month before AHCCCS was implemented. While the HCFA contractor raised a number of technical and policy questions concerning the assumptions upon which the estimate was based, he concluded that the state methodology was sound and represented a sensible second-best technique given the absence of data directly attributable to the group being insured and the setting in which they were to receive coverage. However, the HCFA contractor suggested that every effort be made to use data from Arizona's county health care programs (which preceded AHCCCS) as a check on the estimated costs developed by the state contractor.

The same actuarial firm estimated the second year fee-for-service cost and submitted it to HCFA in September 1983. The estimate called for a 10.6 percent increase in the federal payment. The HCFA contractor reviewed the estimate soon there after and questioned whether a valid estimate could be prepared without the use of local data. Such data existed, as of August 1982, for Arizona's largest county where nearly one half of AHCCCS' beneficiaries reside. We understand that HCFA and the state are still negotiating the second year federal payment and for now are continuing payments at the first year rate. We have not performed an actuarial assessment of the first year's federal payment or the second year's estimate and therefore are unable to comment at this time on their reasonableness.

WHAT HAS BEEN THE FINANCIAL PERFORMANCE OF CONTRACTING PROVIDERS UNDER AHCCCS?

Contractor financial reporting and audits can be used to assess financial performance. AHCCCS requires contracting providers to submit quarterly and annual financial reports to the state noting, among other things, their revenues, expenses, and profits or losses under AHCCCS. The state administrator, according to its contract, was to perform financial audits of contracting providers. HCFA has instructed the state to provide these reports to HCFA and to its project evaluation contractor when requested.

Until last Friday, HCFA had not received any of the financial reports even though it requested them a number of times; the project evaluation contractor had only recently received some of the financial reports and its subcontractor questioned their reliablility; and only one partial financial review of a contracting provider had been conducted by the state's administrator. In April 1984 the state contracted with a public accounting firm for financial reviews of all providers to be completed by August 31, 1984.

We reviewed the financial reports that contracting providers had submitted to the state as of May 18, 1984 (covering their operations back to AHCCCS' beginning) and found that not all providers had submitted the required reports. For the first year, the state received data from 11 of the 17 providers but only six submitted annual financial statements. Twelve of the 19 providers furnished some data the second year but only six of these have submitted both quarterly reports due to date. The few reports, coupled with the fact that only one partial financial review of a contracting provider had been conducted, prevents us from drawing any conclusions as to financial performance of contracting providers at this time.

On a related note, financial performance information would also be beneficial in assessing the reasonableness of bid prices submitted during the competitive bidding process. HCFA and

state officials view competitive bidding by providers on a county-by-county basis as a key element in controlling AHCCCS costs. As I just mentioned however, the state had few financial reports available for use in judging the reasonableness of second year bid prices and as a result none were used. When the state discovered that bid prices, in aggregate, would have exceeded budgeted funds if accepted as submitted, they requested and received voluntary price reductions from providers.

WHAT PROTECTIONS WERE AFFORDED FEDERAL BENEFICIARIES FROM UNDERSERVICING OR POOR QUALITY CARE?

Delivering quality and appropriate care to AHCCCS beneficiaries are primary objectives of the demonstration project. HCFA has required that

--contracting providers develop written quality assurance plans depicting the processes followed in providing and monitoring health services and correcting any deficiencies;

--the state collect and analyze detailed utilization data;

--the state and contracting providers establish, monitor, and review beneficiary grievance procedures; and

--the state conduct medical audits.

Even though a HCFA official asserted that these mechanisms are in place, in our opinion, they have not been fully implemented and neither HCFA nor the state has adequate information to be assured that quality and appropriate care is being provided.

To illustrate, some contracting providers still do not have complete written quality assurance plans, according to the state's April 1984 assessment. This assessment identified the need to give contractors definitive quality assurance guidelines and standards. In short, it appears that many providers may not be sure what is expected of them.

Additionally, the generation of data on the use of provider services which is required under the grant, has been a problem since AHCCCS' inception. As recently as March 29, 1984, HCFA's evaluation contractor reported that a significant proportion of the AHCCCS utilization experience was missing. Also according to the contractor, utilization data was not reported consistently among providers. These data problems have limited both HCFA's and the state's ability to flag possible underservicing or poor quality care, judge AHCCCS' cost effectiveness, and assess the reasonableness of payments to providers.

There are two main reasons for the state's difficulties in producing complete and accurate utilization data. First, the state to date has not been able to fully implement a management information system to process and analyze utilization data.

Second, providers have expressed confusion over what data should be reported and how reports should be formatted, suggesting a need for further state guidance and assistance.

After numerous discussions and reminders that full, accurate, and timely utilization data were required and that the State was extremely deficient in this area, on April 27, 1984, HCFA informed the state that it would not approve the third year of AHCCCS unless the state produced complete and accurate utilization data before the grant's second year expired on June 30, 1984. The HCFA Project Director told us, however, that as long as the state made significant progress in implementing reforms and improvements necessary for producing the information, HCFA would not terminate the grant.

We understand that on May 17, 1984, the state gave HCFA computer listings covering about 80 percent of the documented (provider reported) beneficiary utilization dating back to October 1, 1982. According to a HCFA official, however, verifying the data's accuracy or completeness will be difficult until the state ascertains, by analyzing provider information systems, exactly how the providers count and record the particular data. The state, in addition to the utilization data, has also submitted a plan detailing the steps it will take to meet HCFA's requirements.

I might add that the lack of utilization data has already adversely affected the HCFA project evaluation contractor's ability to fulfill its contract obligations. For example, the evaluation contract called for a statistical report by March 31, 1984, reflecting such things as first year utilization by provider and type of eligible beneficiary. The contract also specified that a draft analytical report be provided by April 30, 1984, showing such things as comparisons of utilization under AHCCCS with fee-for-service systems and information on the appropriateness and quality of care. We were told that the statistical report has not yet been produced and that the analytical report has been indefinitely postponed because of insufficient utilization data provided by the state.

Another component of the quality assurance system required by HCFA calls for the providers to establish procedures for receiving and resolving beneficiary grievances and for the state to insure proper implementation of these procedures. It appears however, that an adequate grievance process has not yet been fully implemented even though all providers have some sort of grievance system. As early as April 1983 a HCFA review revealed that beneficiaries and providers were apparently not well informed of grievance rights, procedures, and possible outcomes. More specifically, the HCFA review disclosed that (1) some providers had not distributed grievance procedure information to

beneficiaries, and (2) one provider had given incorrect information. HCFA's report to the state summarizing these findings recommended that the state routinely review the numbers and types of problems and complaints received and focus more attention on assuring that beneficiaries are educated about the fundamental tenets of AHCCCS.

At the time of our visit, HCFA had recently completed another review of this issue but had not yet written its report. However, an official informed us that similar findings were made.

We observed that the state maintains a log of grievances filed and resolved at the state level including beneficiary appeals to grievance decisions made by providers. The state had little information describing the number or type of beneficiary grievances received and resolved at the provider level. Our analysis of the state's beneficiary grievance log revealed that as of April 30, 1984, the state had received 18 grievances since AHCCCS' inception. As of May 1, 1984, 7 of the 18 grievances had been resolved and one was unclear. Only 4 of the 18 grievances filed had received decisions within the prescribed timeframe (30 days), and 2 outstanding grievances date back to July 1983.

State officials informed us that they were preparing for a review of provider grievance procedures, which they anticipated

would begin soon after our visit. We were also informed that AHCCCS grievance procedures were going to be revised.

The last quality assurance component I will discuss is medical audits. Federal regulations specify that the state must establish a system of periodic medical audits to insure that prepaid contractors provide quality and accessible health care. Audits must be conducted at least annually and provide data specifying reasons for enrollment and termination, use of services, and management information. Medical audits were conducted during the first year of AHCCCS by the Accreditation Association for Ambulatory Health Care Inc. (AAAHC) under contract with the former administrator. All AHCCCS contracting providers and a judgmentally selected sample of their sub-contractors were visited. The audits assessed administration, quality assurance, and safety as judged by AAAHC standards.

HCFA and the state have concluded that the audit results provide substantive evidence that, with few exceptions, AHCCCS recipients are receiving care equivalent to non-AHCCCS patients. However, a HCFA medical advisor who observed some of the audits, for acceptability, reported in October 1983 that (1) the quality of care as reflected in medical records was generally substandard, (2) the AAAHC physicians were inclined to understate their adverse findings, (3) the AAAHC findings were not quantified, and (4) too little time was available for the

reviews. He also told us that the quality of medical records was poor.

He suggested that future audits could be improved, and would provide more reliable estimates of problem gravity, if the reasonableness or correctness of diagnoses were assessed and the deficiencies found were quantified and weighted for the seriousness of their implications on patient health and safety. As an alternative to the first year approach, he suggested that future audits might concentrate on the most frequent serious physician errors reported in previous years. For these same reasons, we believe the quality and appropriateness of care under AHCCCS requires a closer look. We were told that the medical advisor's findings and suggestions were communicated orally to the state in November 1983. The state has not yet fully planned the second year medical audits.

On a related note, state officials provided us summary results of a November 1983 beneficiary satisfaction survey conducted in Maricopa County, Arizona, where about half of AHCCCS' beneficiaries reside. The survey was undertaken by a research firm, under contract with the state as a result of an agreement between the state and a Phoenix-based legal aid group which had threatened legal action unless a number of alleged AHCCCS problems were addressed by the State. The survey

revealed that 76 percent of the beneficiaries were satisfied with the health care they received under AHCCCS. On the negative side, however, the survey showed that many AHCCCS members were still uncertain how to get emergency care, file a formal complaint, and obtain transportation from their provider.

- - - -

In conclusion, I would like to restate that AHCCCS has not generated the program information necessary to render an opinion at this time on either the financial performance of contractors or the quality of care. Additionally, without an actuarial assessment, we cannot conclude on the reasonableness of the federal payment. However, we view the recent actions taken by HCFA and the state to obtain the necessary data as a sign of momentum toward fulfilling the waiver requirements. Continued and concerted efforts will be required, however, if HCFA and the state are to capitalize on this momentum.

This concludes my statement, Mr. Chairman. I will be glad to answer any questions you may have.