AHCCCS – The Arizona Health Care Cost Containment System

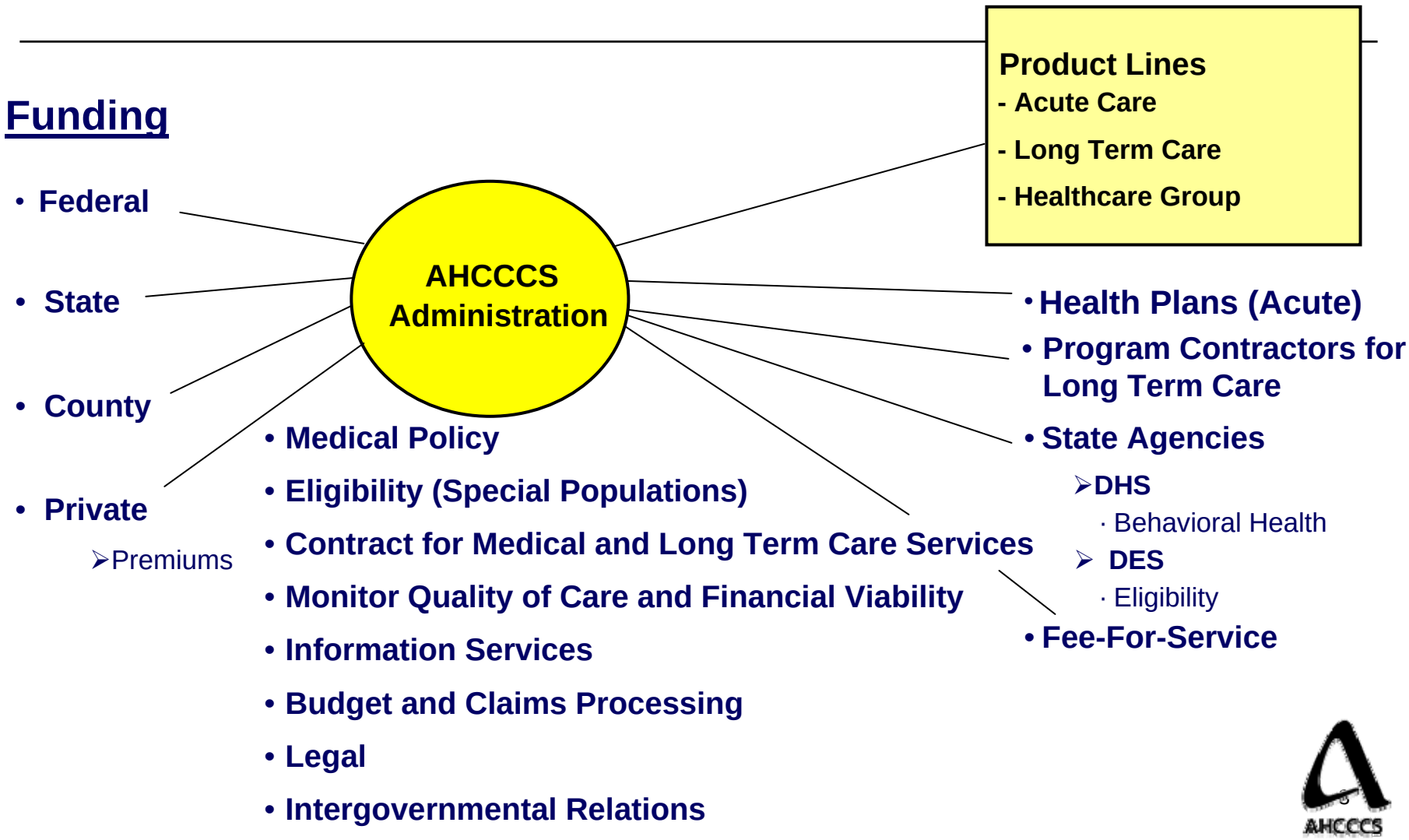
Arizona's managed care model for Medicaid and SCHIP beneficiaries

Anthony Rodgers, Director

Presentation Points

- Overview of AHCCCS
- Description of the Arizona Mandatory Medicaid/SCHIP Managed Care Model
- Performance and Results
- What is Next
- Medicaid Reform

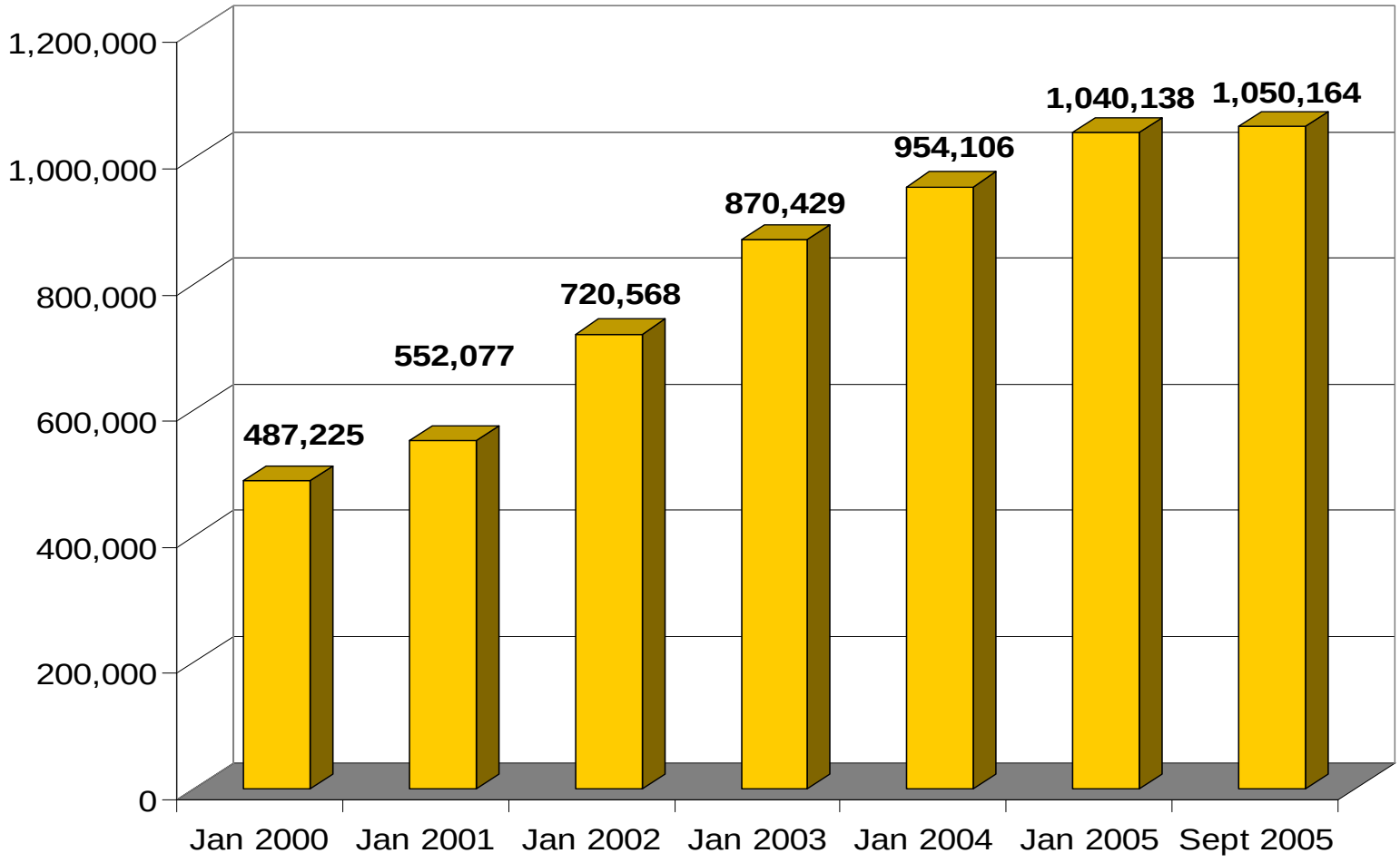
AHCCCS Model



The Evolution of AHCCCS Health Care Coverage

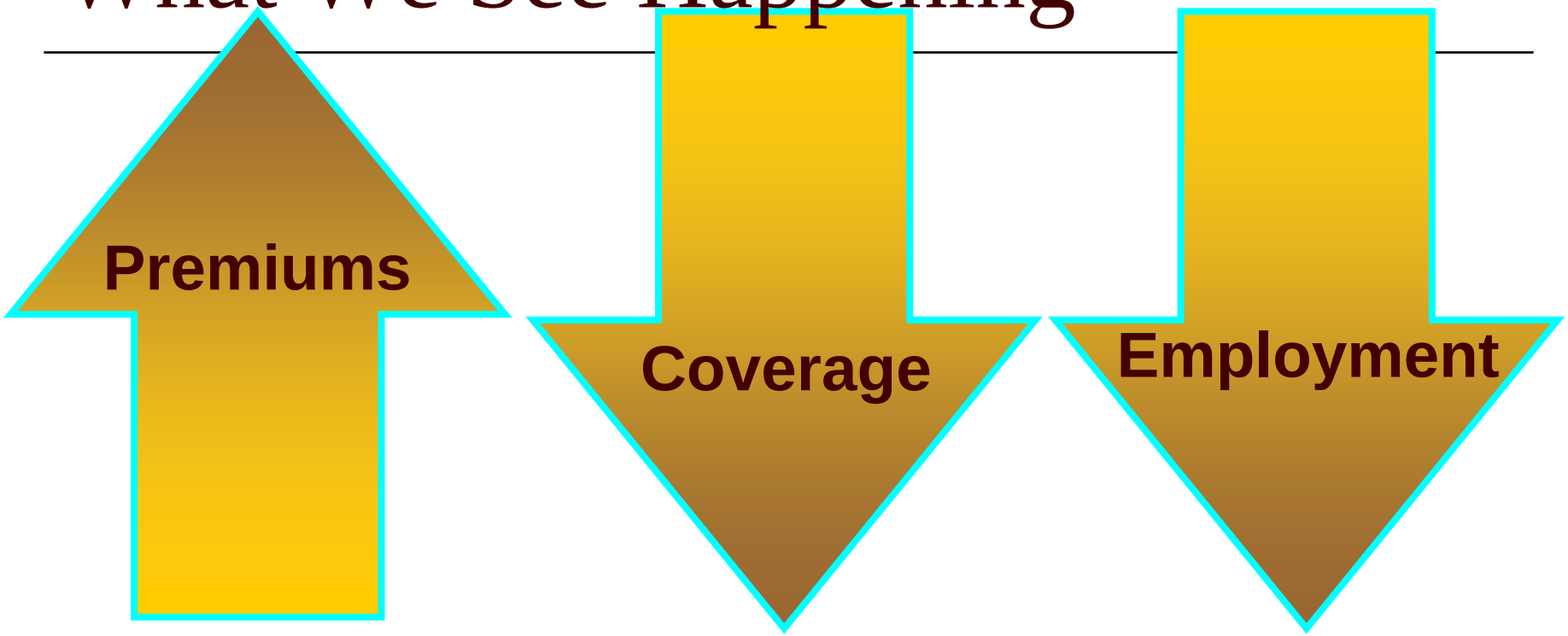
- **1982 Arizona becomes the last state to establish a Medicaid state agency. Arizona is granted an 1115 Waiver to create the first statewide managed care system in the nation.**
- **1996 Federal welfare reform de-linked Medicaid and welfare cash assistance allowing states to more easily expand healthcare coverage to low income workers and children.**
- **2001 Arizona voters expanded AHCCCS coverage to persons who make less than 100% of FPL. At the same time, SCHIP allows the state to expand coverage to children and parents above 100% FPL.**

Total Enrollment



Note: Excludes SLMBs, QI-1s, and HealthCare Group

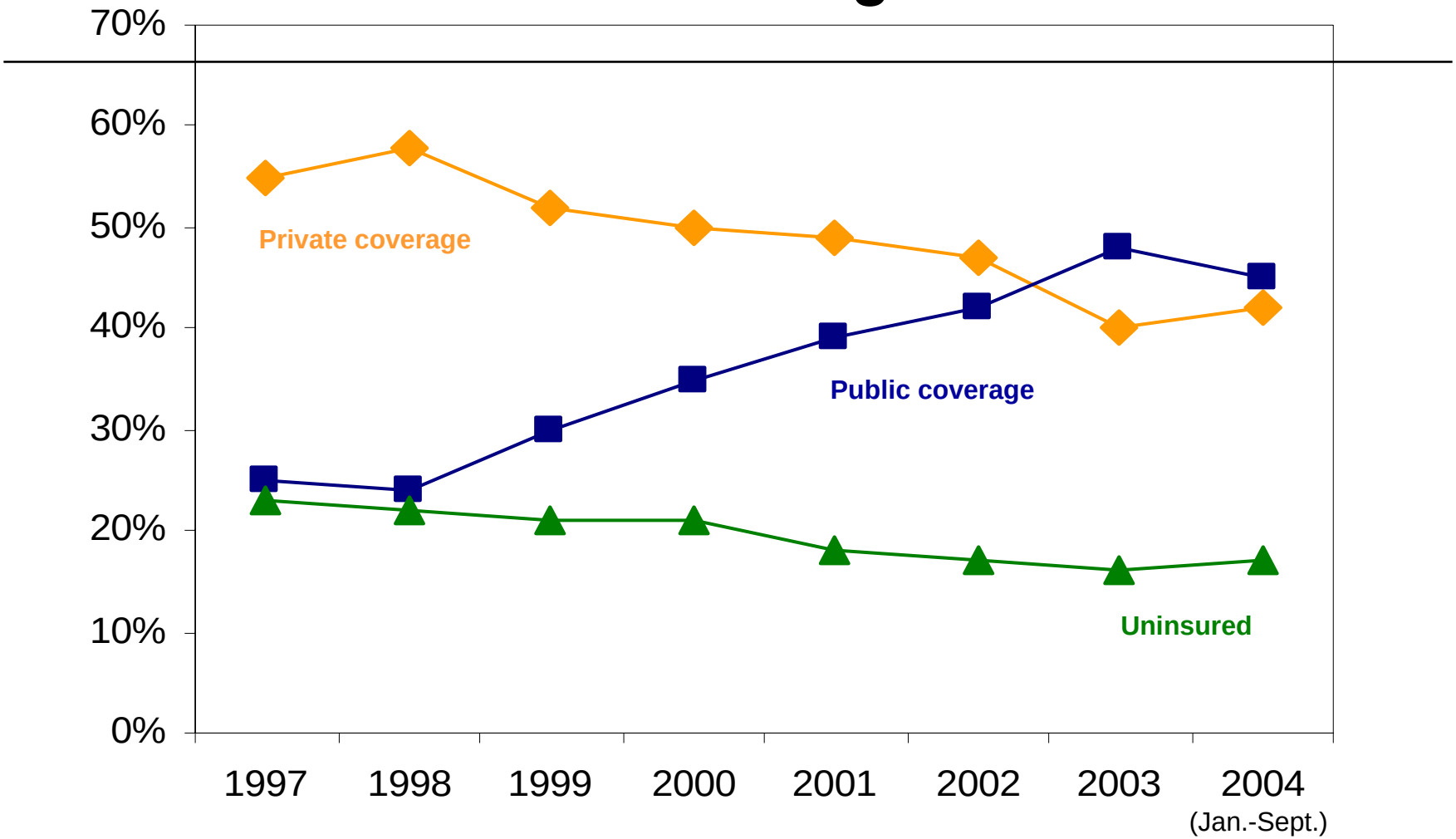
What We See Happening



For every one percent increase in premiums 200,000 to 400,000 people lose coverage nationwide

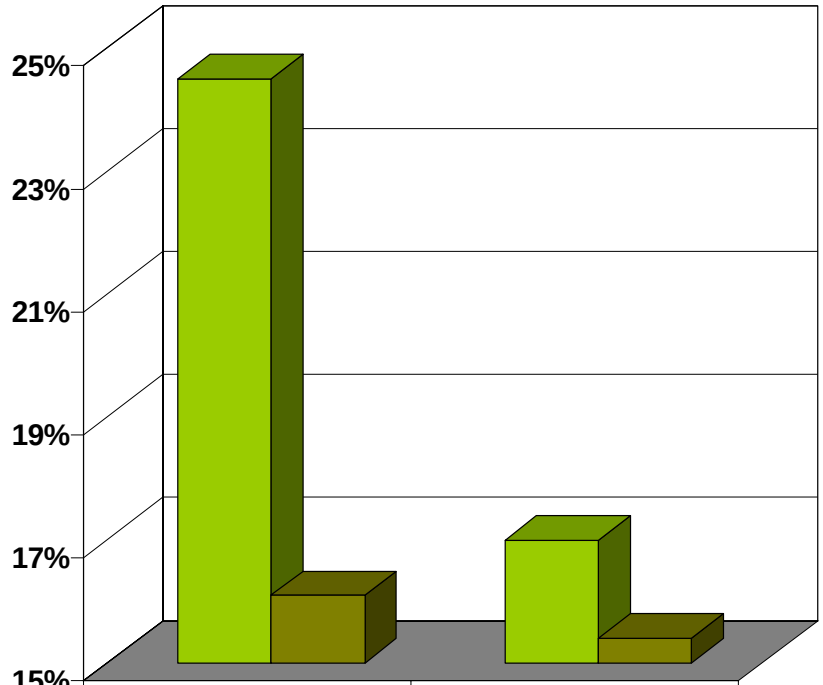
Source: The Lewin Group, 1997

Change in Public vs. Private Coverage



Data Source: CDC Early Release of Health Insurance Estimates Based on Data From the 2004 National Health Interview Survey

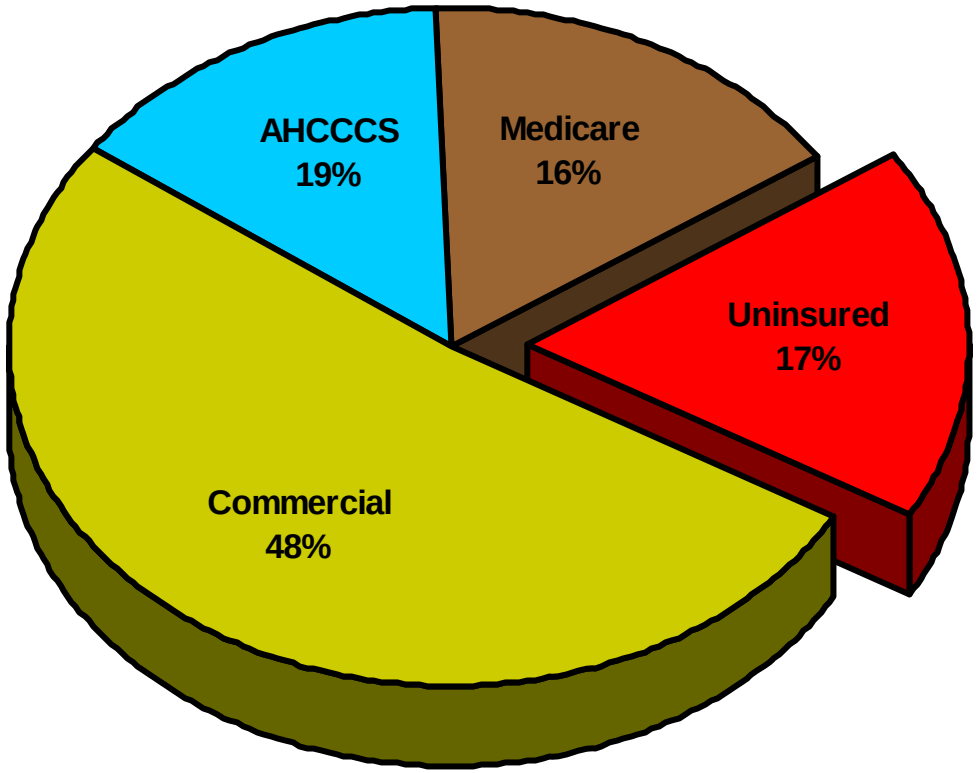
While the rate of uninsured in Arizona has declined significantly since 1997, 17% of Arizona residents remained uninsured in 2004.



	1997	2004
Arizona	24.5%	17.0%
United States	16.1%	15.4%

Source: U.S. Census Bureau, Housing & Household Economic Statistics Division.

Health Coverage in Arizona



5.4 M Arizonan's

2.6 M Commercial

1.0 M AHCCCS

0.7 M Medicare

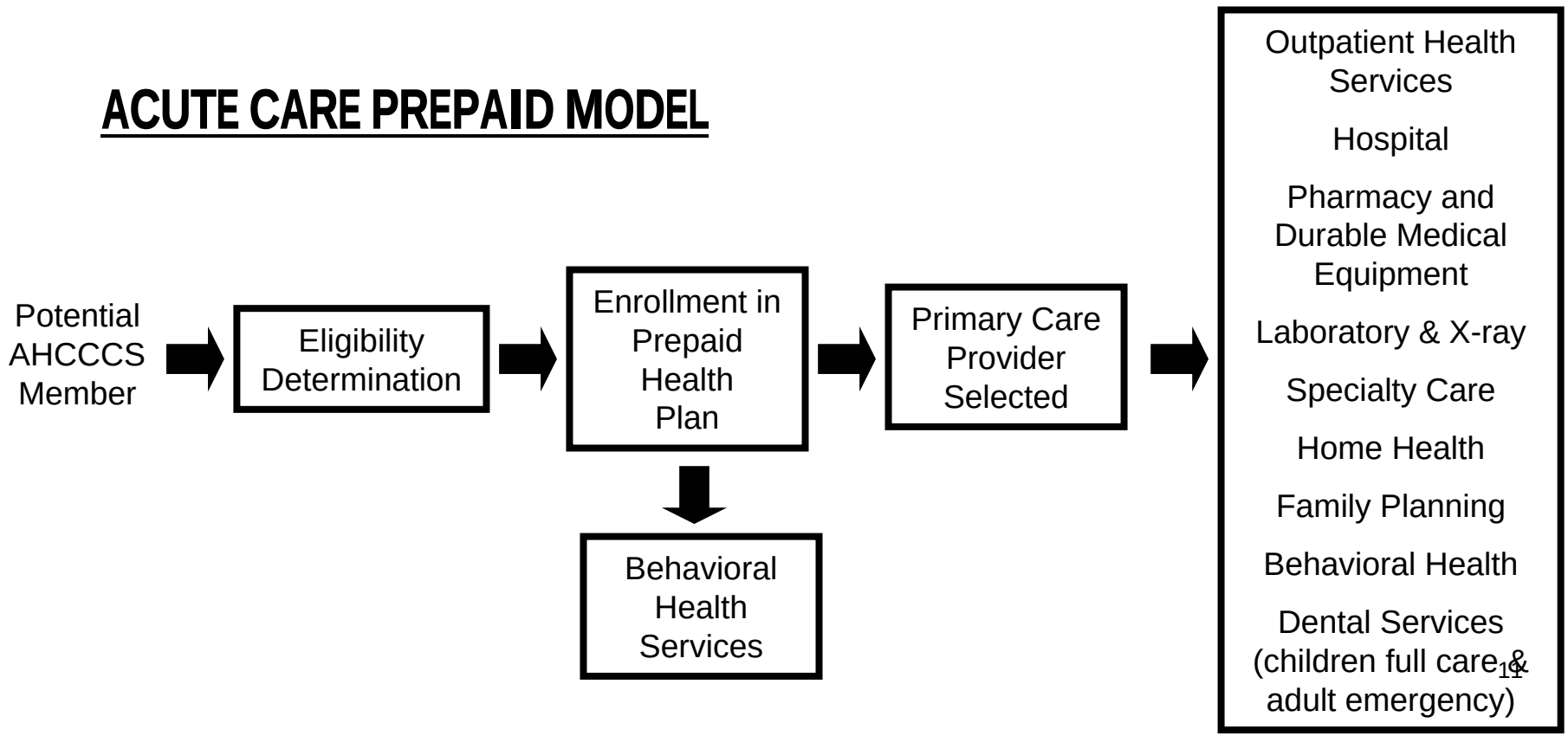
1.0 M Uninsured

AHCCCS Membership

Program	Enrolled Members	Member Profile
Acute	953,770	Primarily children and women with children. (Includes 106,330 from Proposition 204)
ALTCS (Long Term Care)	40,805	Individuals with developmental disabilities, physical disabilities, or over 65 years of age.
KidsCare	49,315	Children through the age of 18.
Healthcare Group	13,250	Employees of small businesses.
Total	**1,057,140**	

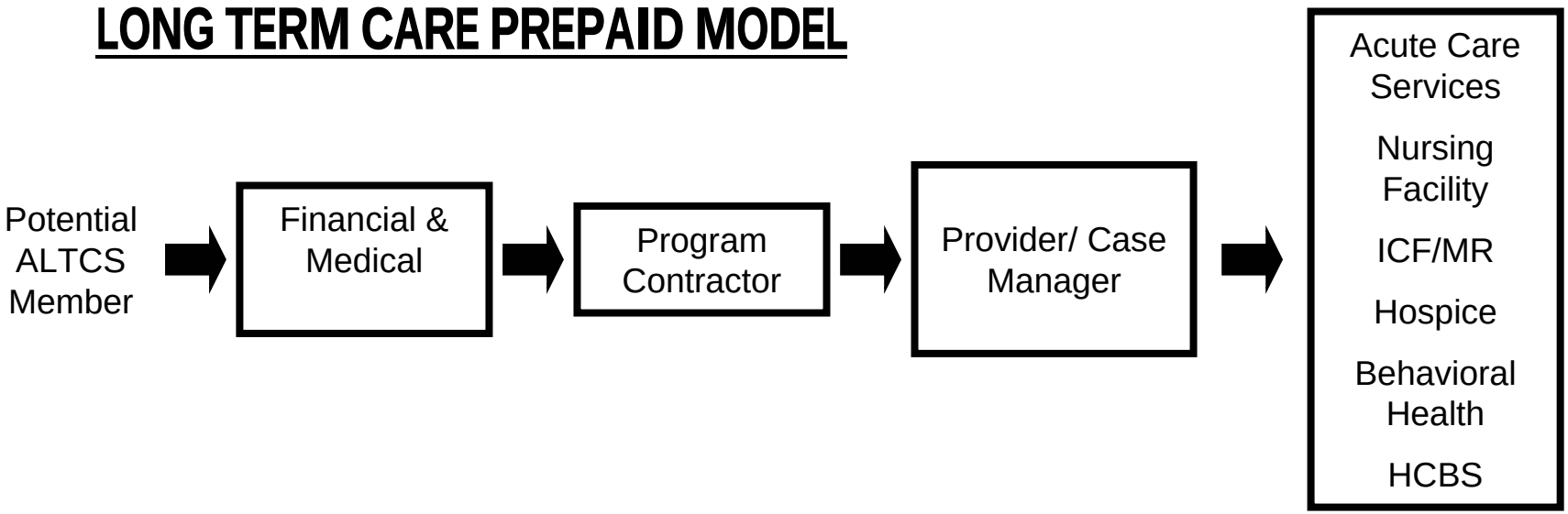
AHCCCS Acute Care Model

The AHCCCS Acute Care program is a statewide, managed care system which delivers acute care services through prepaid, capitated health plans, plus Indian Health Service.



AHCCCS Long Term Care Model

The ALTCS program is a statewide, managed care system which delivers both acute and long term care services through 8 prepaid, capitated program contractors, plus Native American Tribes or Associations



AHCCCS for Native Americans

- Native Americans in Arizona can choose to belong to a contracted health plan or obtain service on a fee-for-service basis through IHS
  - Acute care
  - Long term care
  - Disease management
- Collaboration with IHS and tribal governments

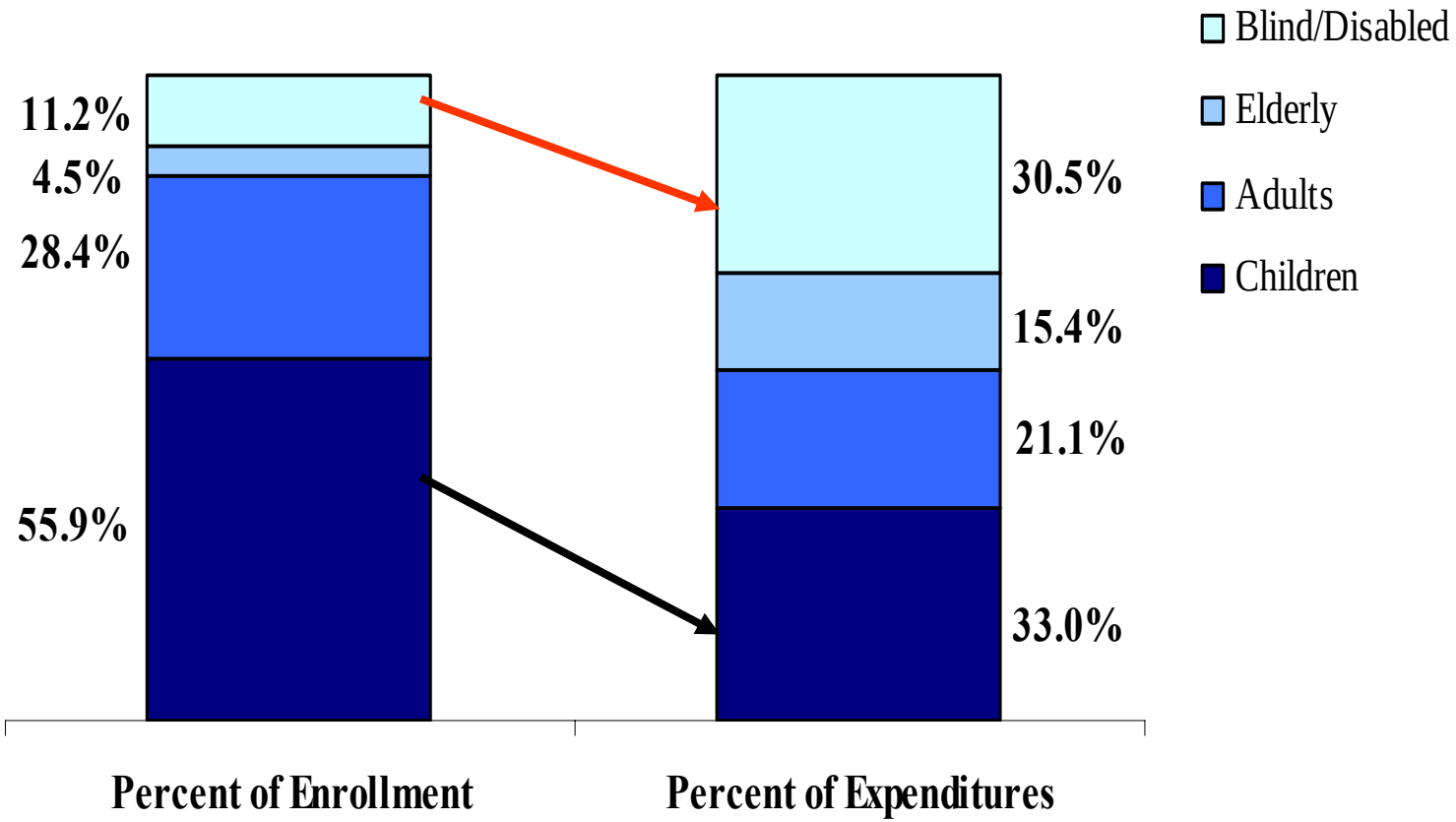
HealthCare Group

- Initially created by Arizona Legislature in 1985 to provide health care coverage for small businesses with ≤ 50 employees
- Targets small, uninsured employer groups offering prepaid HMO benefit package
- Alternative to mandating health insurance coverage for small businesses

Chronic Care: Disease, Illness, Condition

- **Cardiac Disease**
- **Diabetes**
- **Cancer**
- **Renal Disease**
- **Mental Illness**
- **Respiratory Disorders**
- **Cystic Fibrosis**
- **Organ Transplant**
- **Multiple Sclerosis**
- **Immunologic Disorders**
- **Inflammatory Bowel Disease**
- **Alzheimer's**
- **Obesity**

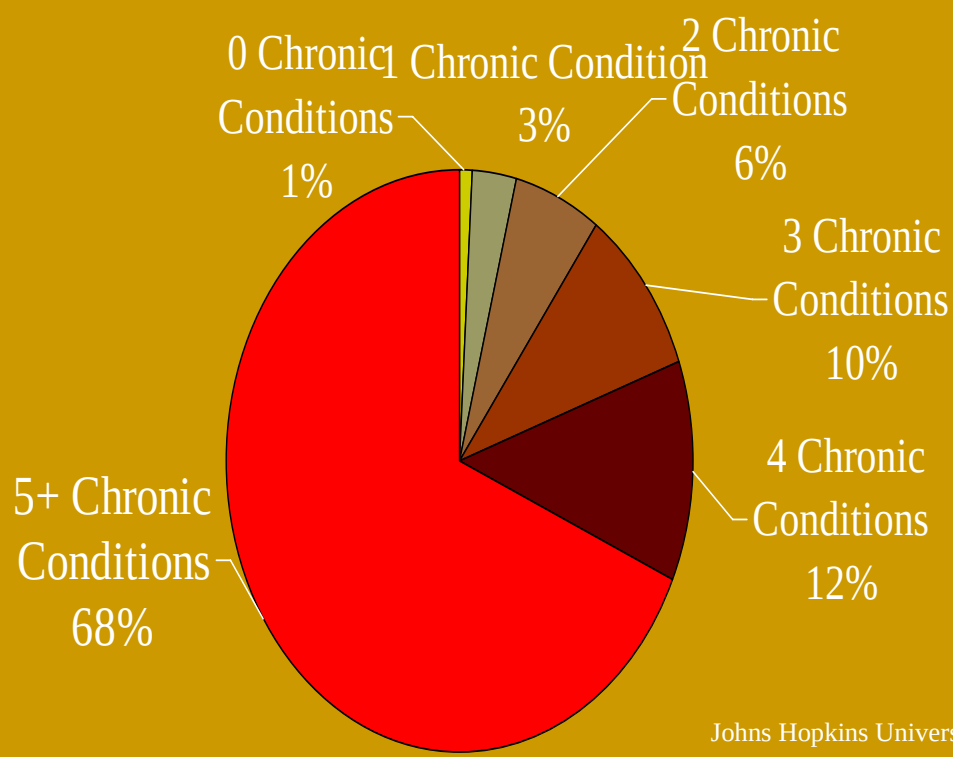
AHCCCS Enrollment v. Expenditures (FFY 2003)



Notes: Includes all Title XIX and Title XXI Programs. Elderly represents age 65 and up and children represent all dependant children age 21 and under. Also, 23.4% of the Blind/Disabled population includes dependent children age 21 and under, which are also reflected in the Blind/Disabled expenditures.

96% percent of ALTCS expenditures are for individuals with multiple chronic conditions

Percent of Expenditures



Johns Hopkins University, Partnership for Solutions

The AHCCCS Managed Care Model

Roles and Responsibilities

Roles and Responsibilities

Area of Responsibility	AHCCCS	MCO Contractor	Provider Network
Policy and Administrative Rule	Establish rules and policies	Implements rules and policies	Follows rules and policies per contract
Capitation and Rate Setting	Sets AHCCCS capitation and provider rates	Establishes provider contractual rates may be different than AHCCCS	Provides feed back on rates
Claims Payment	Monitors MCO claims operations sets performance standards	Pays provider claims and provide 1st level appeals	Submits fee for service claims
Customer Service Management	Monitors customer service operation set performance standards	Provider member services 24 hours a day	Provides medical care coordination
Case Management	Monitors case management	Provides case management	Maybe delegated some case management responsibilities
Grievance/ Appeal Management	2nd level appeal	1st level appeal	Maybe involved in appeal resolution
Network Management	Evaluates Network capacity and design	Establishes Network	Contracts with MCO as part of network
Quality Management and Performance Improvement	Monitors and approve quality improvement projects and QM infrastructure	Organizes and performs QM improvement projects and maintains infrastructure	Participates in quality improvement efforts

Roles and Responsibilities

Area of Responsibility	AHCCCS	MCO Contractor	Network Provider
Third Party Recovery	Identifies TPL adjusts capitation payments	Manages recovery	Cooperates in TPL recovery
Marketing	Approves marketing plans set requirements	Develops and submits marketing plan	May be involved per relationship with MCO
Fraud and Abuse Detection	Monitors and identifies Fraud and Abuse	Establishes fraud and abuse detection program	Cooperates in fraud and abuse detection
Encounter Reporting	Maintains data warehouse and CMS reporting, sets data format standards	Submits encounter data	Submits encounter data or claims as required under contract with MCO
Operational and Performance Reviews	Performs annual operational and financial performance reviews	Cooperates in reviews	Provides information as needed for performance reviews
Financial Management	Sets tangible net equity reserves standards and monitors financial viability	Meets financial standard and providers reports	Provides input on adequacy of rates
Reinsurance	Provides reinsurance	Provides information on reinsurance claims	Cooperates on providing information
Satisfaction Surveys	Surveys members and provider satisfaction	Takes corrective action as necessary	Cooperates in satisfaction surveys

Core Administrative Functions Performed by the State

Contract Administration and oversight of Medical (Acute) and Long Term Care Health Plans	**Information Services and Health Care Outcome Reports**
Establish Medical Policy, Monitor Quality of Care and Financial Viability contractors	**Actuarial analysis and rate setting**
Determine eligibility and enroll members in health plans	**Intergovernmental and Community Relations**
Ensure Compliance with Federal and State Regulations	**Fraud and Member Abuse Investigation**

Role of Health Plans in Managed Care Model

- Primary Care Provider (PCP) usually pediatrician, family practice or internal medicine
- Training to providers on best clinical practices
- Process payment for services through health claims
- Utilization management and authorization
- Health promotion and disease management
- Case management
- Pharmacy management
- Outreach to potential members

Primary Care Provider Coordinates Medical Care

The primary care provider is responsible for all services except:

- Dental services do not require authorization from primary care provider
- The network for the behavioral health system uses Regional Behavioral Health Authorities in the role of coordination of behavioral health services
- Women can elect an OB/GYN or Certified Nurse Midwife provider as their primary care provider.

Pharmacy Management in Managed Care

- AHCCCS health plans are at full risk for the cost of prescription drugs. This creates a strong motivator for the health plans to operate a cost effective prescription benefit focusing on the use of generics.
- AHCCCS has no single statewide Medicaid formulary
  - Each health plan develops a plan-specific formulary and implements prescription benefit management tools to meet member needs and provide cost-effective benefits
  - Similar to MMA Part D Plans design

Keys to Developing Successful Formularies

- Health plans negotiate with input from the provider network
- Contractual relationship between health plans and providers ensures compliance with the formulary
- Non-formulary drugs may be prescribed with prior authorization
- Generic Use Performance
  - Dispensing rate average is 70+%
  - When generic is available, average 98+% generic dispensing rate

Providing Choice through AHCCCS

- Members received an information packet about Health Plans and provider choices
- Members choose between two or more Health Plans in a service area
- Members choose a primary care provider within the Health Plan network
- Members can change primary care providers at any time
- Members can change to a different Health Plan on their one year anniversary date

Measures of Managed Care

Transactional Activities	Episodes of Care	Patient Care Relationships
Encounters	Outcomes	Long-term Wellness
Visits	Rates of Completion	Member Satisfaction
Days	QI Performance Metrics	System Integration
Admits	Percent of Compliance	Continuity of Care
Discharges	Quality of Care	Disease Prevention
Services	Care Process	Chronic Illness Management

The AHCCCS Managed Care Model

Cost and Quality Performance

The AHCCCS Model Produces Results

- Lower pharmacy cost per member
- Lower percent of individuals in nursing facilities
- Lower bed days per 1000
- Lower cost overall for long term care
- High member satisfaction
- Lower number of emergency room visits per 1000
- Greater healthcare access and quality of care
- Greater costs and program compliance accountability

What is Arizona's average annual payment per member, and how does this compare to other states?

- Arizona is third in the nation for the lowest cost per Medicaid enrollee.
- Arizona spends $3,035 per member per year, $976 less than the national average.

Source: The Henry J. Kaiser Family Foundation, Statehealthfacts.org, based on data from CMS (accessed 10/19/05).

What is Arizona's average annual payment per member, and how does this compare to other states?

California	$2,325	Michigan	$3,717	Ohio	$4,826
Tennessee	$2,545	Alabama	$3,780	Kansas	$4,877
Arizona	**$3,035**	Virginia	$3,877	Colorado	$4,893
Georgia	$3,036	Washington	$3,956	Utah	$4,937
Arkansas	$3,059	N. Carolina	$3,999	Iowa	$5,018
Hawaii	$3,119	S. Dakota	$4,018	Massachusetts	$5,141
Oregon	$3,177	Indiana	$4,067	Maine	$5,257
Mississippi	$3,202	Idaho	$4,139	New Jersey	$5,437
Louisiana	$3,251	Wyoming	$4,184	D.C.	$5,441
Oklahoma	$3,302	Kentucky	$4,268	Maryland	$5,542
Florida	$3,488	Nebraska	$4,382	Alaska	$5,588
New Mex.	$3,501	W. Virginia	$4,457	Rhode Island	$5,656
Missouri	$3,516	Wisconsin	$4,498	Minnesota	$5,693
Texas	$3,534	Delaware	$4,518	North Dakota	$5,766
S. Carolina	$3,553	Illinois	$4,531	New Hamp.	$6,381
Vermont	$3,561	Pennsylvania	$4,634	Connecticut	$6,670
Nevada	$3,635	Montana	$4,670	New York	$7,817

Source: The Henry J. Kaiser Family Foundation, Statehealthfacts.org, based on data from CMS (accessed 10/19/05).

Achieving Results in Pharmacy

- 2003 Lewin study of AHCCCS MCO plans found:
  - **Pharmacy costs in the AHCCCS program are the lowest achieved in Medicaid**
  - **Per Member Per Month costs were found to be the lowest among Medicaid programs, 38% below national average for Medicaid programs, even when compared to other state's Medicaid Managed Care programs**
  - **AHCCCS member generic use was 72%**
  - **AHCCCS had an exceptionally low use of drugs per beneficiary for Medicaid program**

Tools to Manage Prescription Costs

- Prior Authorization Procedures
- Step Therapy / Treatment Guidelines
- Appropriate Quantity Limits-early refill edits, maximum monthly quantities
- Disease Management Programs / Specialty Case Management
- Closed Pharmacy Provider Networks
- Mandated Generic Formularies with exception process

Comparison of Pharmacy Costs and Generic Utilization

Comparison	Other States - Medicaid FFS	Other States - Medicaid Managed Care	AHCCCS
Acute Care Generic Use	38.1%	86.0%	93.1%
Acute Care Average Cost Per Prescription	$47.10	$28.16	$14.75
Long Term Care Generic Use	29.3%	38.8%	76.5%
LTC Average Cost Per Prescription	$69.00	$76.63	$38.91
TANF Beneficiaries	0.69 PMPM	0.56 PMPM	0.41 PMPM

Regulatory Controls are Designed to Promote Quality in the Health Plans

- Quality improvement initiative for the contracted health plans in areas of fiscal management and health care delivery
- Encounter data reported by Health Plans on monthly basis
- Grievance and request for hearing process
- Regular financial and operational reviews of all Health Plans

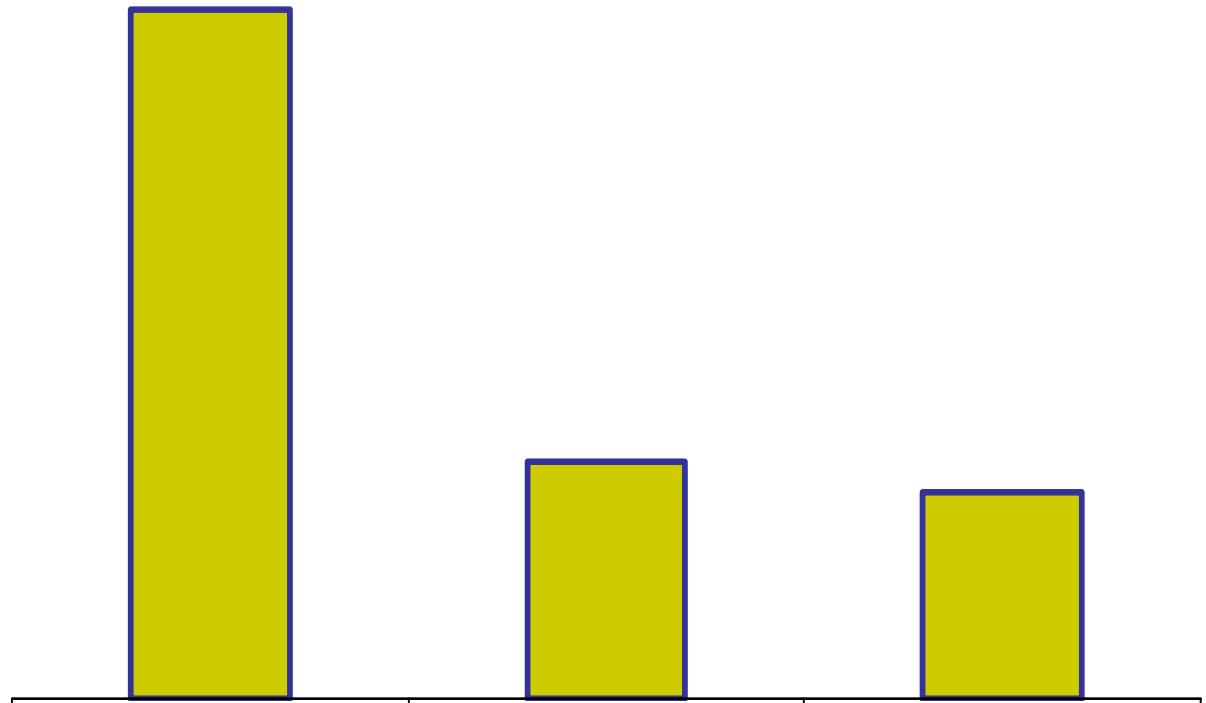
KidsCare Immunization Results

	DTAP (4 doses)	IPV (3 doses)	MMR (1 dose)	Hib (3 doses)	HBV (3 doses)	VZV (1 dose)	4:3:1 Series	4:3:1:3:3 Series
Medicaid	81.8%	90.4%	92.6%	85.4%	86.1%	83.8%	78.9%	69.3%
KidsCare	88.6%	93.4%	95.8%	88.3%	88.1%	89.7%	86.0%	76.1%
Total	**82.8%**	**90.9%**	**93.0%**	**85.8%**	**86.3%**	**84.6%**	**80.0%**	**70.3%**
Previous Total (CYE 2003)	76.7%	89.4%	91.5%	N/A	81.6%	76.1%	73.8%	N/A

Summary of Immunization Completion Rates by 24 months of Age,

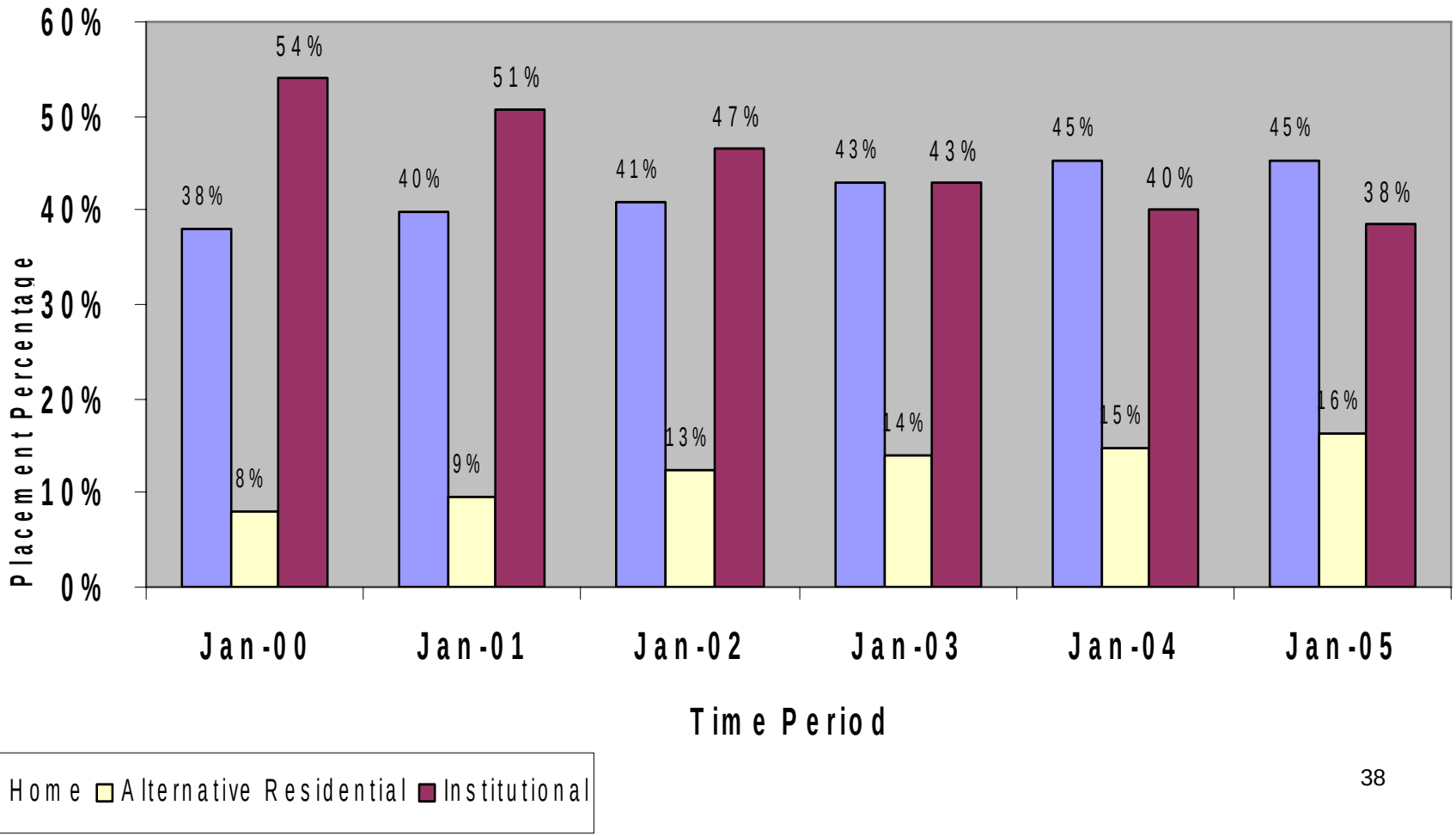
Contract Year Ending September 30, 2004

Average Per Member/Per Month Cost Based on Setting in ALTCS



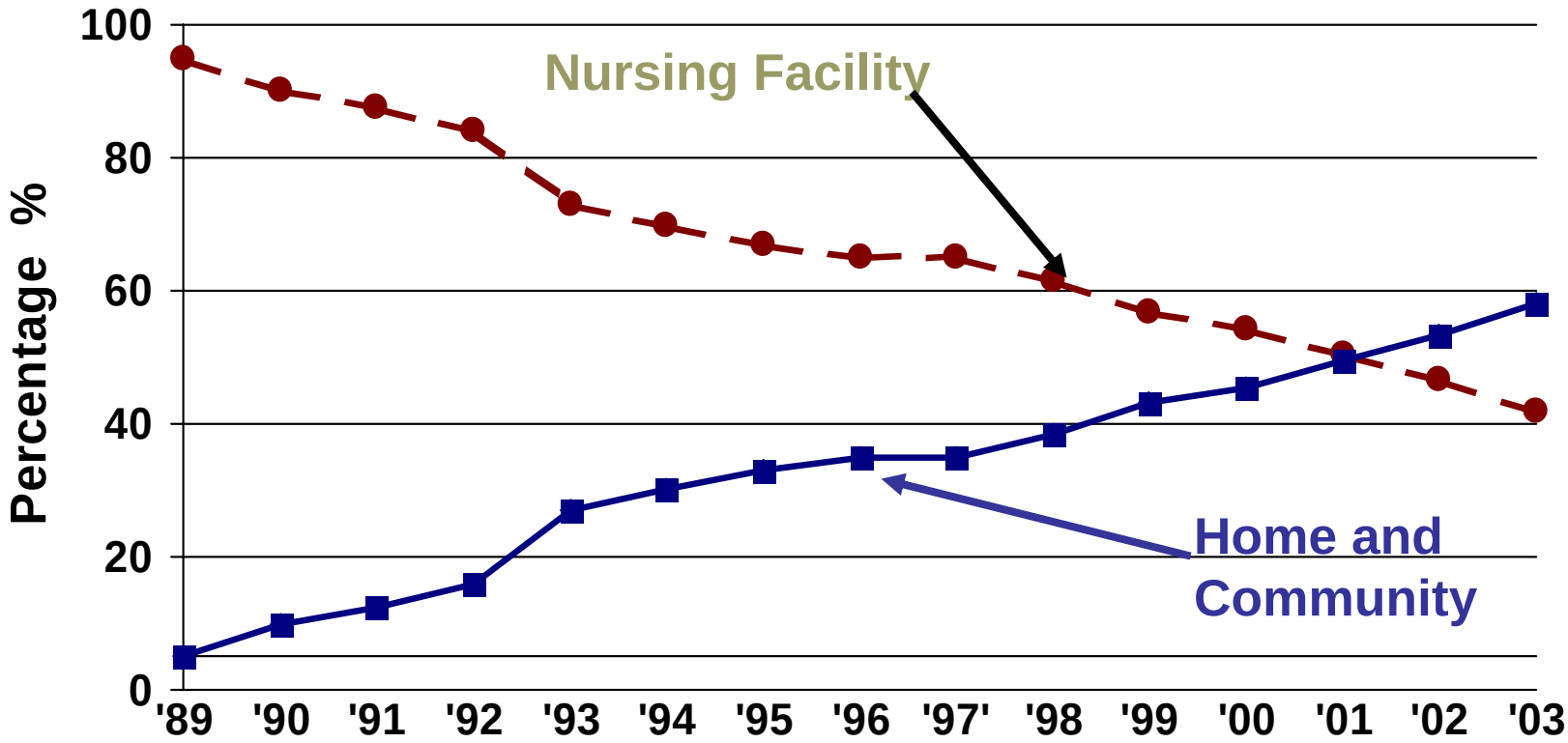
	Nursing Facility	HCBS Assisted Living Facility	HCBS In-Home
Monthly Capitation	$3,686	$1,266	$1,104

Arizona Decreases Institutional Placements and Increases HCBS



Effective Use of Home and Community Based Care

ALTCS Trend in HCBS Utilization



Accountability and Fraud Prevention

- **Multi-tiered fraud and abuse prevention, detection and prosecution**
- **Emphasis on creating a culture of compliance among staff, members, health plans and providers**
- **All AHCCCS health plans are also required contractually to dedicate staff for compliance fraud efforts**

MCO Operational and Financial Review Is An Important Tool Drive Results

- Business continuity plans
- Cultural compliance
- Staffing
- Organizational compliance
- Provider credentialing
- Quality of care issues
- Case management
- Grievance system
- Maternal/Child services delivery
- Member services
- Reinsurance
- Delivery system
- Finances
- Claims processing
- Encounter Processing
- Encounter Submission
- Behavioral health coordination

What others say about the AHCCCS Model

- Pharmacy costs in the AHCCCS program found to be the lowest in Medicaid nationally (Lewin Group 2003)
- AHCCCS is a "smashing success" and cited Arizona as the "Gold standard" for purchasing health care (Rockefeller Institute 2002)
- Of ten states studied, "only Arizona has met the standards required for prudent purchasing of Medicaid Managed Care" (Center for Health Care Strategies 2002)
- AHCCCS "has been able to effectively manage member growth" (Auditor General 2002)

The AHCCCS Managed Care Model

Key Prerequisites For Implementing a Successful Medicaid Managed Care Program

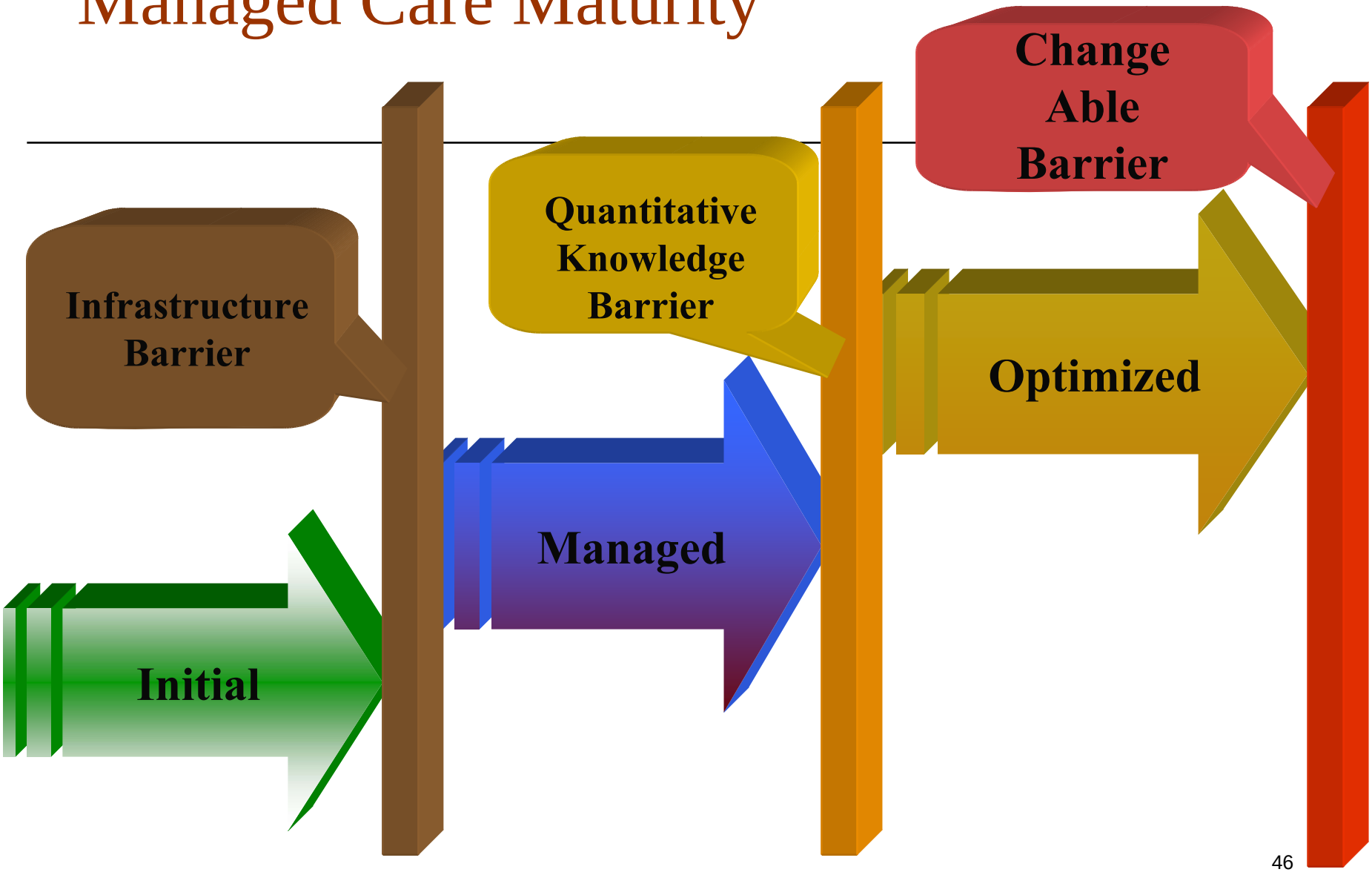
Essentials for Building a Managed Care Model

- Core competency of State Agency staff to oversee performance MCO contractors and drive managed care maturity
- Business rules and practices parameters
- Data Warehousing and reporting capability
- Political Will" to stay the course
- Operational and financial review process
- Compliance and program integrity process
- Outcome driven reimbursement strategy

Essentials for Maturing a Managed Care Model

- Capability Maturity Management
  - Aggregate knowledge and organization focus
  - Change Able Capability
- Organizational Core Competency Maturity
  - Know how and organizational alignment
  - Integration of systems and information
  - Resource Capability and Maturity
- Infrastructure Capability and Maturity
  - Operation systems (claims, CRM, UR/QM)
  - Procedural and Process Maturity
  - Communication Capability (internal and external)
  - Management Control Maturity

Managed Care Maturity



State Agency's Role in MCO Maturity Development

- Evaluate levels of MCO maturity and develop strategies to improve MCO capability
- Compliance management and control
- Collaborate with MCO to develop organizational capability
- Provide focus, direction and program priority
- Provide information, best practices and consultation to MCOs
- Provide incentives for optimizing MCO performance

Short-term Financial Saves and Future Cost Avoidance

- Fraud and abuse savings
- Pharmacy cost savings
- ER and and inpatient utilization reduction savings
- Reduction of specialist costs from greater use of primary care
- Effective medical management which reduces long term capitation inflation
- Administrative cost reduction through economies of scale
- Reduction of long term care cost by greater use of Home and Community based services

The Value of Managed Care to State's Health Care Goals

- Improves health status and reduce cost of high risk populations
- Better medical care cost control
- Market competition for members drives quality and innovation.
- Provides a organized health plan for business community buy-in.
- Stabilizes provider networks
- Improves State's economic vitality
- Complements other State public health and human service goals

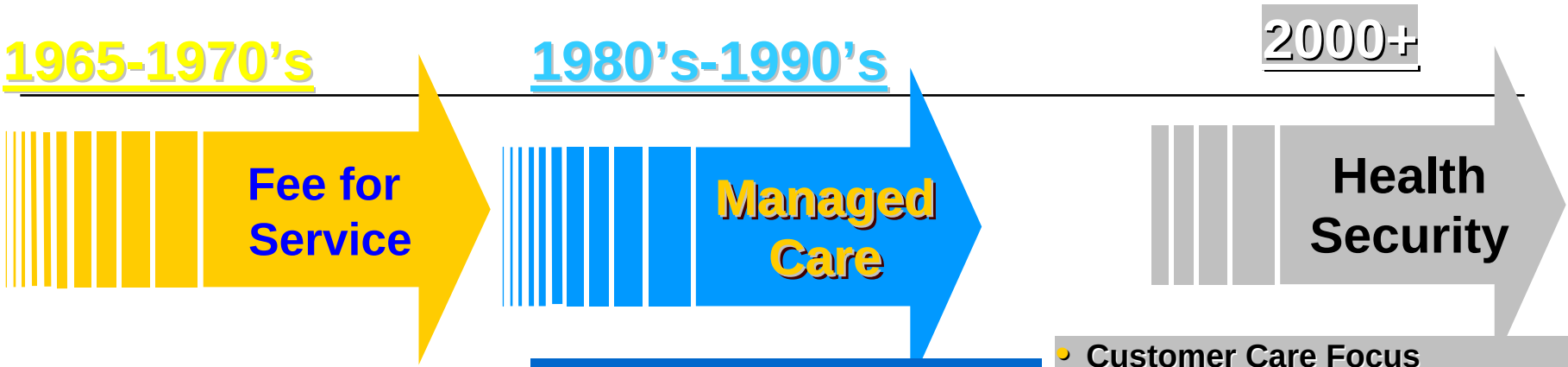
The AHCCCS Managed Care Model

Foundation for Health Security for Arizonans

Closing the Gaps in Managed Care Model

- **Identify those at risk**
- **Prevention education**
- **Case assessment**
- **Treatment Intervention**

The Health Security Model For Arizona



- **Insurance product**
  - Inpatient focus
  - Limited O/P coverage
  - Rare pharmacy benefit
- **No networks**
- **Focus on paying claims**

- **Prepaid healthcare**
  - More comprehensive benefits
  - More first dollar coverage
- **Network-based products**
- **Focus on cost control and preventive care**
  - Gatekeeper
  - Utilization management
  - Network contracting

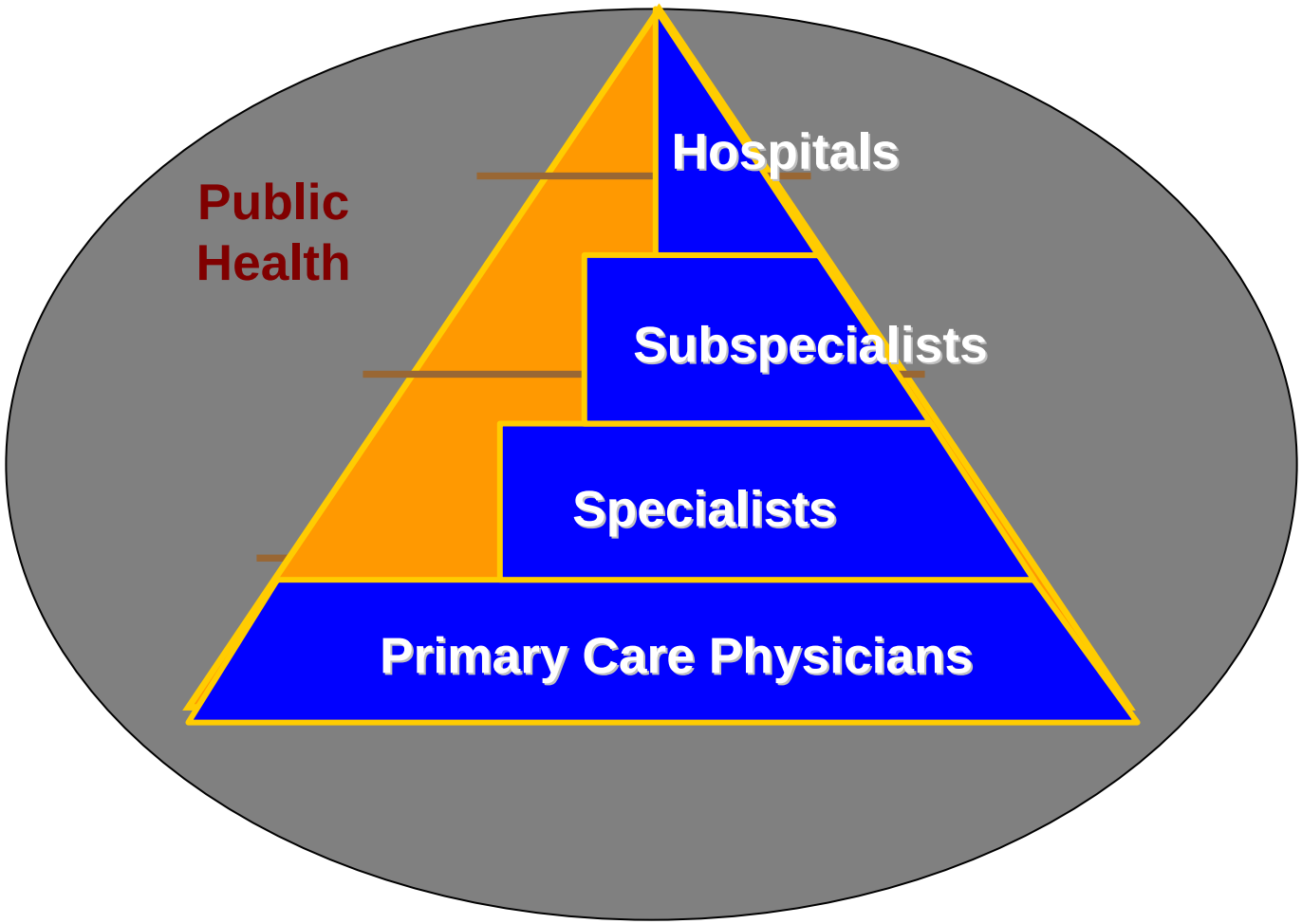
- **Customer Care Focus**
  - Member Centered
  - Choice
  - Accessible/Affordable
  - Incentive for wellness
- **Multiple integrated network and community resources**
- **Effective cost management**
- **Committed to improving quality of care**
- **Focus on member/provider assistance and service**
  - Information
  - Disease management
  - E-health capable

Network Development

HEALTH SECURITY

- Integrated networks
- Centers of Excellence
- Clinical collaboration

Integrated Networks

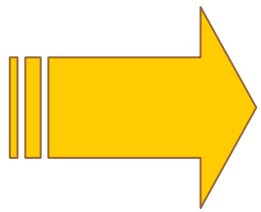


Centers of Excellence

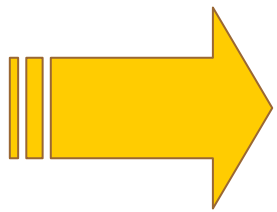
- **Target health care institutions for major services**

Assess and Communicate:

- Survival rates
- Complications rates
- Number of cases
- Quality of medical team



Better Outcomes



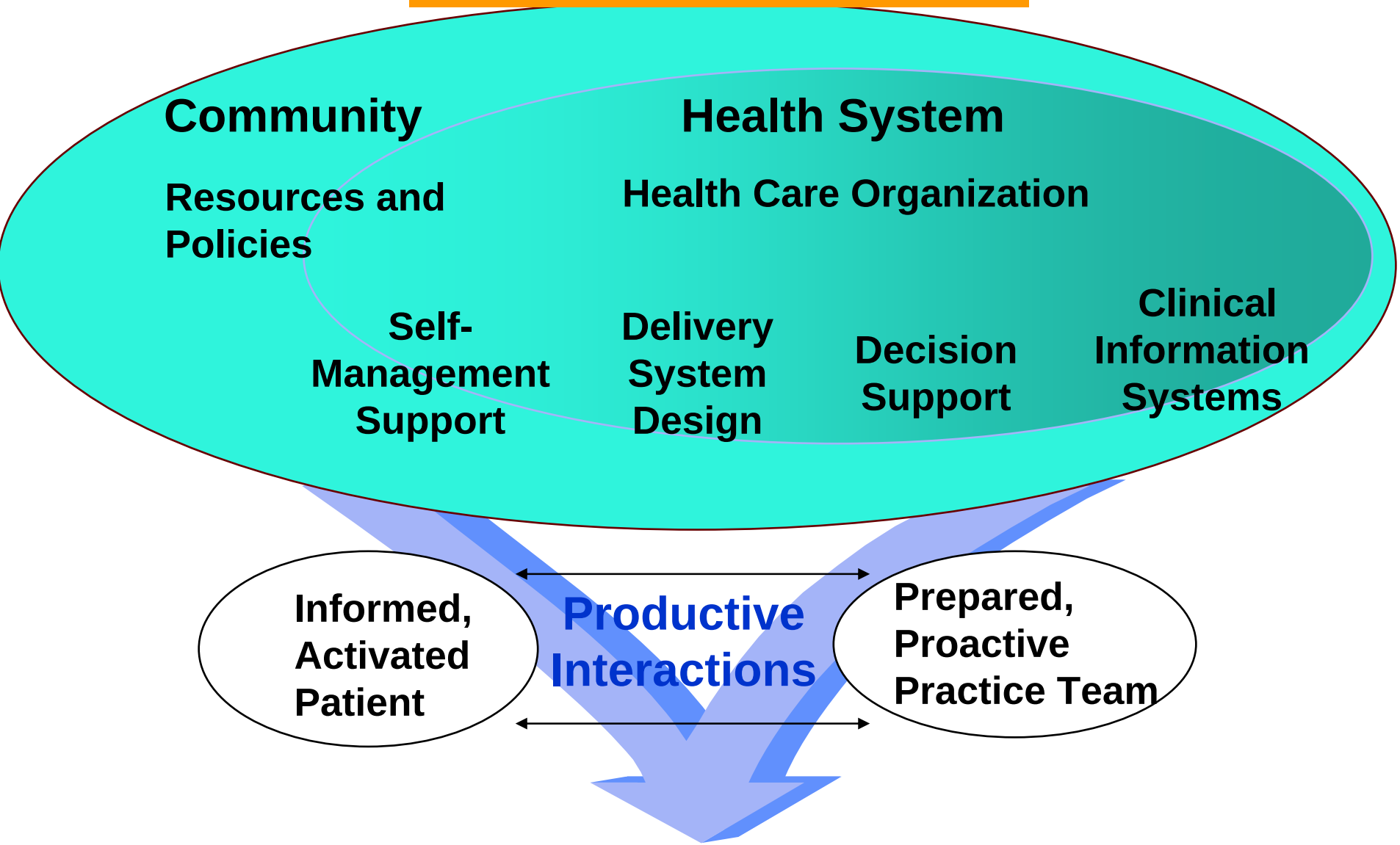
Lower Costs

Medical Management

HEALTH SECURITY

- Patient care planners vs. Utilization Management
- Patient Centered Treatment
- Targeted medical management
  - Chronic Illness and Disease management
  - Patient care planning for special need population
  - Preventive care & Community Health

Chronic Care Model



The AHCCCS Managed Care Model

The Arizona Model and Medicaid Reform

Rationale for Medicaid Reform

Current model of Medicaid is unsustainable

- Erosion of employer coverage
- Budget demands on federal government
- Rising health care costs
- Pressure on state budgets

Scope of Reform

- Fiscal Reform
- Eligibility Reform
- Benefit Reform

Medicaid Fiscal Reform

- Fiscal Control, Accountability, and Discipline
- Establish a common financial reference point for each state (PMPM).
- Targets for fiscal performance that aligns incentives between Federal and State government.
- Establish targets for direct care expenditures vs. administrative and indirect expenditures
- Provide state of the art tools to states to manage health care coverage cost (predictive modeling and forecasting tools).
- Establish common performance metrics.

Medicaid Eligibility Reform

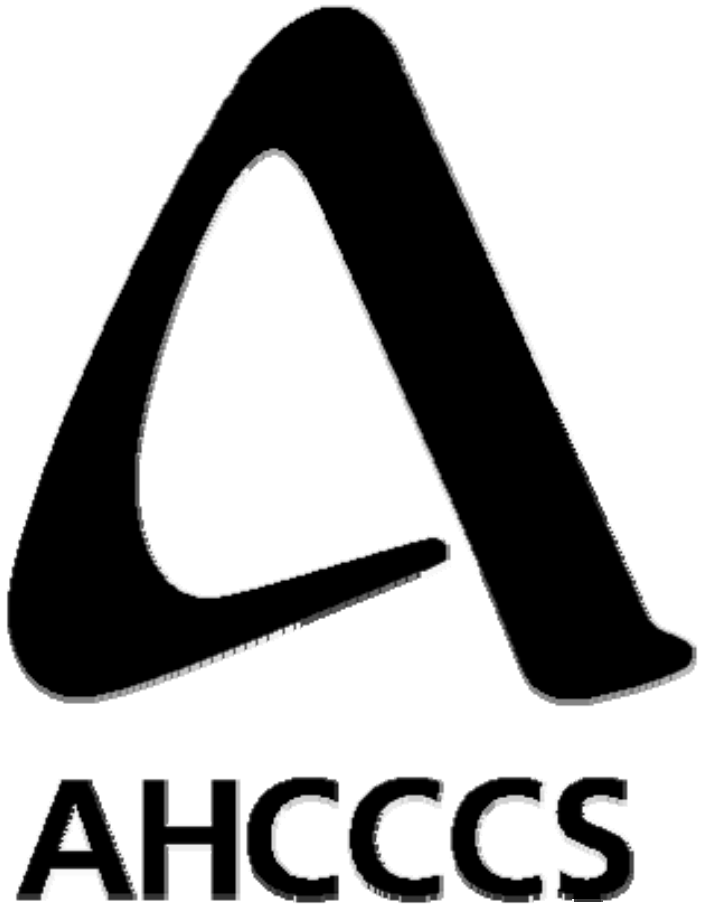
- Traditional Populations: No change
- Low Income workers should be offered health security coverage through Medicaid
- Employers should be able to apply for health security benefits for low income workers.
- Health Security benefits should be transferable as the employee move between employers.

Medicaid Benefit Reform

- Allow states greater flexibility to determine the cost effectiveness of benefits
- Allow greater flexibility for employers and employees to buy in to Medicaid health coverage for low income workers.
- Allow states greater flexibility to determine mandatory co-pays for individuals.

Making Medicaid Sustainable

- Fiscal Discipline
- Benefit flexibility
- Creating a healthy workforce is good for businesses
- Encourage greater state collaboration and core competency sharing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