



A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Sunset Review

Arizona Health Care Cost Containment System—Sunset Factors

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Auditor General

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September 24, 2012

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Tom Betlach, Director
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, *A Sunset Review of the Arizona Health Care Cost Containment System (AHCCCS)*. This report is in response to an October 26, 2010, resolution of the Joint Legislative Audit Committee and was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq.

Included with this report is a written response from AHCCCS.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on September 25, 2012.

Sincerely,

Debbie Davenport
Auditor General

Attachment

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INTRODUCTION

Scope and Objectives

The Office of the Auditor General has conducted a sunset review of the Arizona Health Care Cost Containment System (AHCCCS) using the criteria in Arizona’s sunset law. The analysis of these sunset factors was conducted pursuant to an October 26, 2010, resolution of the Joint Legislative Audit Committee and prepared as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq.

This report includes responses to the sunset factors specified in A.R.S. §41-2954 and is the final in a series of four reports on AHCCCS. In the first report, auditors found that AHCCCS has processes in place that help it comply with state and federal requirements for coordinating the payment of healthcare benefits with other responsible parties. In the second report, auditors found that AHCCCS and the Department of Economic Security appropriately determined Medicaid eligibility for almost all Medicaid applicants, but that 1.11 percent of the determinations are at risk for being incorrect. In the third report, auditors found that AHCCCS should enhance several processes related to Medicaid fraud and abuse prevention, detection, investigation, and recovery.

AHCCCS administers Arizona’s Medicaid program

Majority of AHCCCS program operates under managed care model

AHCCCS was established to administer Arizona’s Medicaid program, which provides healthcare for certain low-income individuals and families living in Arizona. Medicaid is a federal healthcare program for low-income individuals and families that is jointly funded by the federal and state governments. AHCCCS was implemented in October 1982 as the nation’s first state-wide Medicaid program designed to provide medical services to eligible persons primarily through a managed care system. Under a managed care system, AHCCCS contracts with entities, known as health plans, which coordinate and pay for the medical services AHCCCS members receive from registered AHCCCS healthcare providers, such as physicians and hospitals. To cover the costs of coordinating and paying for members’ healthcare, the contracted health plans receive monthly capitation payments (see textbox).

Capitation payment—A fixed monthly amount paid in advance to AHCCCS’ contracted health plans for each enrolled member. At least annually, based on information such as the historical use and cost of medical services provided and inflation data, capitation payment amounts are determined using mathematical and statistical methods. Monthly capitation amounts paid to AHCCCS’ contracted health plans can vary by individual based on factors such as age, gender, geographical service area, and program (see examples below):

Examples of average <i>Acute Care</i> monthly capitation rates ¹					Average <i>Arizona Long Term Care System</i> monthly capitation rate ¹
Age <1 Male/Female	Age 1-13 Male/Female	Age 14-44 Female	Age 14-44 Male	Age 45+ Male/Female	
\$460	\$97	\$222	\$138	\$347	\$3,000

¹ See page 2 for explanation of Acute Care and Arizona Long Term Care System programs.

Source: Auditor General staff analysis of AHCCCS information contained in its contracts, actuarial certifications, and Acute Care and Arizona Long Term Care System rates effective October 1, 2011.

Approximately 90 percent of AHCCCS members are enrolled in managed care.

Approximately 90 percent of AHCCCS' members are enrolled with its contracted health plans in managed care. For the remaining members, known as fee-for-service members, AHCCCS reimburses registered healthcare providers directly.¹ According to the Kaiser Family Foundation, as of October 2010, 47 states and the District of Columbia used managed care programs to some degree, but only 9 states, including Arizona, had 80 percent or more of their members enrolled in comprehensive managed care programs.^{2,3}

AHCCCS members receive a full range of medical services under the following three primary programs:

- **Acute Care**—As shown in Table 1 (see page 3), the majority of AHCCCS' members are enrolled in its Acute Care program. This Medicaid program provides a wide range of healthcare services, such as inpatient and outpatient hospital services, physician services, immunizations, and laboratory and x-ray services to children, pregnant women, and other low-income adults.
- **Arizona Long Term Care System (ALTCS)**—A small percentage of members receive services under ALTCS. The ALTCS program provides acute care, behavioral health, long-term care, and case management services to individuals who are elderly, physically disabled, or developmentally disabled and meet the criteria for institutionalization.
- **KidsCare**—Children under age 19 may receive medical services under KidsCare, the name given to Arizona's federal Children's Health Insurance Program. Children may qualify for KidsCare if their family's income exceeds the limit allowed for Medicaid, but is still below the federally established amount for this program. Children enrolled in KidsCare receive the same medical services available under Arizona's Acute Care program. New enrollment in the KidsCare Program has been frozen since January 1, 2010, due to lack of funding, and AHCCCS has established a waiting list of applicants. However, effective May 1, 2012 through January 1, 2014, AHCCCS will be receiving monies from three hospitals that will allow AHCCCS to provide coverage for 21,700 children in what is being called KidsCare II.⁴ This state-wide program will offer the same benefits, but has a lower income eligibility threshold than the KidsCare program.

¹ AHCCCS reimburses providers on a fee-for-service basis for (1) individuals receiving services under the Federal Emergency Services program, or (2) Native American members who choose to receive services through a tribal fee-for-service contractor.

² Comprehensive managed care is defined as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally Qualified Center services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment services; (7) family planning services; (8) physicians' services; and (9) home health services.

³ Kaiser Family Foundation. (2010). *Medicaid enrollment in comprehensive managed care as a share of total Medicaid enrollment, October 2010*. Retrieved January 31, 2012, from www.statehealthfacts.org

⁴ Laws 2011, Ch. 234, §2 allows AHCCCS, subject to U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approval, to authorize any political subdivision to provide monies necessary to qualify for federal matching monies to provide healthcare coverage to persons who would have been eligible pursuant to A.R.S. §36-2901.01.

Table 1: AHCCCS Enrollment by Program
At July 1, 2009, 2010, 2011, and 2012
(Unaudited)

Program	2009	2010	2011	2012
Acute Care	1,174,598	1,272,118	1,300,674	1,212,693
Arizona Long Term Care System	48,673	50,241	51,314	52,498
KidsCare	51,838	30,445	17,649	15,330
Total	<u>1,275,109</u>	<u>1,352,804</u>	<u>1,369,637</u>	<u>1,280,521</u>

Source: Auditor General staff analysis of the AHCCCS July 1, 2009, 2010, 2011, and 2012 *Population Highlights* reports.

Organization

AHCCCS organizes its staff among four larger organizational units: Central Administration and three divisions that primarily serve AHCCCS members and oversee the contracted health plans. AHCCCS reported 1,077.9 FTE (full-time equivalent) positions, including 141.1 vacancies as of June 30, 2012.¹

AHCCCS' Central Administration consists of six operating offices or divisions that provide strategic leadership, technology, legal, and financial direction and coordination as follows:

- **Office of the Director (29.5 FTEs, 4 vacancies)**—The Director's office provides the overall policy direction for the agency and dedicates specific staff to public information, government relations, medical policy oversight, and strategic plan coordination.
- **Information Services Division (131.4 FTEs, 18.1 vacancies)**—This division is responsible for developing, acquiring, securing, and maintaining AHCCCS' information systems and technology services necessary to support AHCCCS' functions.
- **Division of Business and Finance (56 FTEs, 3 vacancies)**—This division is responsible for a variety of activities including developing and monitoring AHCCCS' budget, paying AHCCCS' Acute Care and ALTCS contractors and fee-for-service providers, and compiling internal and external financial reports. Other responsibilities include overseeing purchasing, facilities management, and AHCCCS' contractor, who performs third-party liability services. As indicated in the Office of the Auditor General's performance audit on AHCCCS' coordination

¹ This FTE count does not include 14 FTEs for the Healthcare Group of Arizona and 4 FTEs for the Advisory Council on Indian Health Care (Council). Healthcare Group is a state-sponsored, public-private partnership created to provide healthcare coverage for small businesses with 2 to 50 employees as well as Arizona's political subdivisions. The Council was established to develop a comprehensive healthcare delivery and financing system for Arizona's tribes (see Sunset Factor 10, page 24, for more information on the Council).

of benefits, AHCCCS contracts with Health Management Systems, Inc. (HMS), a national firm, which helps identify whether AHCCCS members have other insurance before claims are paid to help avoid costs, and also works to recover monies from liable third parties after claims have been paid (see Report No. 12-01).

- **Human Resources and Development (11 FTEs, 1 vacancy)**—This division is responsible for a variety of personnel functions including overseeing the hiring process, maintaining employee records, managing the employee benefits programs, and providing training classes, such as a new employee workshop and computer classes.
- **Office of Administrative Legal Services (24 FTEs, 1 vacancy)**—This office provides legal counsel to the divisions within AHCCCS and provides legal representation for the agency in a variety of matters. It also oversees certain aspects of AHCCCS' complaint-handling system including providing an administrative dispute resolution mechanism for applicants, members, and providers; scheduling hearings with the Office of Administrative Hearings; and issuing AHCCCS' decisions following a hearing (see Sunset Factor 6, pages 17 through 21, for more complete information on AHCCCS' complaint-handling process).
- **Office of Inspector General (63 FTEs, 6 vacancies)**—This office is responsible for the prevention, detection, and investigation of Medicaid fraud and abuse. Once a member or provider suspected of Medicaid fraud or abuse has been convicted of a criminal offense or has signed a civil settlement agreement, this office is also responsible for collecting the amounts owed (see Auditor General Report No. 12-06 for more information on this office).

The following divisions primarily serve AHCCCS members and oversee the contracted health plans:

- **Division of Member Services (608 FTEs, 93 vacancies)**—This division is responsible for determining the eligibility for some Medicaid applicants. Specifically, as indicated in the Office of the Auditor General's performance audit on Medicaid eligibility determination (see Report No. 12-02), as of July 1, 2011, this division performed about 11 percent of the eligibility determinations. It completes determinations for the ALTCS program, the KidsCare program, and the Supplemental Security Income—Medical Assistance Only population, which is part of the Acute Care program. The Division also maintains day-to-day liaison with, and provides oversight of, the Department of Economic Security (DES), which performed about 82 percent of the Medicaid eligibility determinations as of July 1, 2011.¹ DES has an intergovernmental agreement with AHCCCS to

¹ Approximately 7 percent of AHCCCS members are automatically eligible for Medicaid services such as children born to women who are on Medicaid or individuals who have been determined eligible for other programs, such as aged, blind, or disabled individuals in the U.S. Social Security Administration's Supplemental Security Income Cash program.

AHCCCS' Division of Member Services determines eligibility for some applicants and oversees DES, which performs the majority of Medicaid eligibility determinations.

perform Medicaid eligibility determinations in conjunction with eligibility determinations for other federal programs, such as the Supplemental Nutrition Assistance Program. Additionally, the Division is responsible for conducting two federally required quality control reviews related to eligibility determination.

- **Division of Health Care Management (81 FTEs, 8 vacancies)**—This division is responsible for the procurement of contracts with AHCCCS' health plans and helping to ensure the health plans' financial viability. For example, staff from this division conduct financial and operational reviews of AHCCCS' Acute Care and ALTCS programs' health plan contractors. These reviews focus on assessing compliance with various contract requirements in areas such as medical management/prior authorization, member services, provider network, grievance systems, and third-party liability; and addressing noncompliance through corrective action plans or other actions, such as monetary sanctions. This division is also responsible for developing and maintaining actuarially sound capitation rates and appropriate provider reimbursement rates, including supplemental payments; and for ensuring contractors report complete, accurate, and timely encounter data.¹
- **Division of Fee-for-Service Management (74 FTEs, 7 vacancies)**—This division is responsible for various activities related to AHCCCS' fee-for-service population. For example, this division completes prior authorizations, which involve determining in advance whether a service that requires prior authorization, such as breast reconstruction surgery or home health services, will be covered. Specifically, a nurse will review requests for prior authorizations and verify items such as the member's eligibility, whether the provider is a registered fee-for-service provider, and whether the requested service is covered. This division also processes fee-for-service claims.

Budget

AHCCCS receives federal monies along with state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program. As shown in Table 2 (see page 6), during fiscal year 2012, AHCCCS estimates that its revenues will total more than \$8.4 billion, with approximately \$5.66 billion coming from the federal government, approximately \$2.16 billion from the State, about \$341 million from the counties, and \$275 million from other sources. AHCCCS' estimated expenditures for fiscal year 2012 total nearly \$8.4 billion, with about \$6.4 billion, or 76 percent, going toward capitation payments. AHCCCS' estimated revenues and expenditures for fiscal year 2012 are each approximately \$1.2 billion less than fiscal years 2010 and 2011 because some changes were made to Arizona's Medicaid program during the 2011 legislative session. For example, enrollment in Arizona's Medicaid program for some individuals,

AHCCCS receives federal, state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program.

¹ Encounter data are the records of medically related services rendered by registered AHCCCS providers to AHCCCS members enrolled with its contracted health plans.

Table 2: Schedule of Revenues, Expenditures, and Changes in Fund Balance¹
Fiscal Years 2010 through 2012
(In Thousands)
(Unaudited)

	2010	2011	2012²
	(Actual)	(Actual)	(Estimate)
Revenues:			
Federal government ³	\$ 7,229,797	\$ 7,077,440	\$ 5,663,201
State government ³	1,720,054	2,012,179	2,163,412
County government ³	247,043	277,663	341,131
Other ⁴	302,363	272,449	275,024
Total revenue	<u>9,499,257</u>	<u>9,639,731</u>	<u>8,442,768</u>
Expenditures and transfers:			
Capitated payments—			
Acute care	4,181,191	4,163,405	3,150,673
Long-term care	1,940,629	1,957,650	1,959,774
KidsCare	91,795	55,095	36,068
Mental health and Children's Rehabilitation Services ⁵	1,413,917	1,422,241	1,234,025
Fee-for-service—			
Acute care	847,605	874,121	759,836
Long-term care	119,705	127,138	134,366
Other ⁶	685,871	805,577	898,318
Administrative	177,092	163,936	180,616
Total expenditures	<u>9,457,805</u>	<u>9,569,163</u>	<u>8,353,676</u>
Transfers to the State General Fund	2,699	1,268	1,244
Net transfers to other state agencies ⁷	39,213	38,184	41,928
Total expenditures and transfers	<u>9,499,717</u>	<u>9,608,615</u>	<u>8,396,848</u>
Net change in fund balance	(460)	31,116	45,920
Fund balance, beginning of year	685	225	31,341
Fund balance, end of year	<u>\$ 225</u>	<u>\$ 31,341</u>	<u>\$ 77,261</u>

¹ The table includes all AHCCCS financial activity except the Healthcare Group. The Healthcare Group provides medical coverage primarily to small, uninsured businesses and is managed as a self-supporting operation.

² The estimates for fiscal year 2012 revenues and expenditures are significantly less than fiscal years 2010 and 2011 because multiple changes were made to the Medicaid program and the State's contribution during the 2011 legislative session that affected fiscal year 2012 (see page 7 for additional information).

³ Consists of all monies that originally came from the federal, state, or county governments, including monies passed through other entities, such as other state agencies.

⁴ Amounts primarily consist of monies that were authorized for use on AHCCCS expenditures by the Legislature or voters, such as tobacco litigation monies, gaming revenues, and tobacco tax monies administered by AHCCCS. For example, Proposition 204 (November 2000) authorized the use of tobacco settlement monies to increase the number of people eligible for coverage in AHCCCS. Similarly, Proposition 202 (November 2002) provides a portion of gaming revenues to be used for a trauma and emergency services program.

⁵ Amounts consist of capitated mental health and Children's Rehabilitation Services expenditures that were passed through to the Arizona Department of Health Services. Beginning in fiscal year 2012, the Children's Rehabilitation Services appropriation was moved to AHCCCS; therefore, AHCCCS no longer passes through these monies to the Department and instead makes payments directly to the providers.

⁶ Amounts consist of various other expenditures that were not paid as capitated payments or fee-for-service. For example, reinsurance, a stop-loss program for partial reimbursement after a deductible is met, is included in this category.

⁷ Amounts primarily consist of monies transferred to the Arizona Departments of Health Services and Economic Security for monies appropriated by the Legislature to these agencies. Specifically, the Legislature appropriated over \$35 million each year in fiscal years 2010 through 2012 to the Department of Health Services for behavioral health services from the tobacco tax monies AHCCCS administers. Similarly, approximately \$3 million each year was appropriated to the Department of Economic Security in fiscal years 2010 through 2012 from county contributions for administration costs for Proposition 204 (November 2000) implementation.

Source: Auditor General staff analysis of the AHCCCS fiscal year 2010 and 2011 financial statements audited by an independent certified public accounting firm and AHCCCS-prepared fiscal year 2012 estimates dated January 24, 2012, that are primarily composed of fiscal year 2012 appropriations.

such as childless adults, is no longer being accepted.¹ In addition, the federal matching rate returned to its typical level starting in fiscal year 2012. Specifically, the American Recovery and Reinvestment Act of 2009 and additional federal legislation increased the federal matching rate from approximately 66 percent to between 71 and 76 percent from October 1, 2008 through June 30, 2011. This change and the changes to the Arizona Medicaid program resulted in the fiscal year 2012 estimated federal government revenues being approximately \$1.4 billion lower. However, the State's estimated revenue did not show a similar decrease, in part due to the reduction in the federal matching rate that required the State to contribute more of each dollar spent.

¹ In December 2011, the Arizona Court of Appeals upheld the State's decision to stop new enrollment for childless adults, indicating that it was a political decision that was not subject to judicial resolution. In February 2012, the Arizona Supreme Court refused to review the Appeals Court's decision.

In accordance with Arizona Revised Statutes (A.R.S.) §41-2954, the Legislature should consider the factors included in this report in determining whether the Arizona Health Care Cost Containment System (AHCCCS) should be continued or terminated.

Auditors' analysis of the sunset factors found strong performance by AHCCCS with regard to many of these factors. However, AHCCCS needs to address the recommendations directed to it in the other three audit reports issued as part of this sunset review (see Report Nos. 12-01, 12-02, and 12-06).

1. The objective and purpose in establishing AHCCCS and the extent to which the objective and purpose are met by private enterprises in other states.

AHCCCS was established to administer Arizona's Medicaid program, which provides healthcare for certain low-income individuals and families living in Arizona. In 1981, legislation was passed establishing AHCCCS as a division within the Department of Health Services. By establishing AHCCCS, the Legislature sought to bring federal Medicaid dollars into the State to relieve the counties' burden of the growing cost of indigent healthcare. Although Arizona was the last state to join the Medicaid program, AHCCCS was implemented in October 1982 as the nation's first state-wide Medicaid program designed to provide medical services to eligible persons primarily through a managed care program. In 1984, legislation created AHCCCS as an independent state agency. AHCCCS' statutory purpose coincides with federal law, which requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program.¹

State law allows AHCCCS to enter into an agreement with an independent contractor to serve as the state-wide administrator of the system, and establishes that the Medicaid system consist of contracts for the provision of medical services to members.² Although AHCCCS does not contract for state-wide administration of the State's Medicaid program, the provision of AHCCCS' Medicaid services is largely handled through private contracts (see Sunset Factor 12, pages 24 through 28, for more information on the extent of AHCCCS' use of private contractors).

According to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) Web site, each state establishes and administers its own Medicaid program. However, as indicated in a 2003 Kaiser Commission report, "There is enormous variation from state to state as to how each state's Medicaid program is administered. The variation arises because, although states must operate within federal guidelines, they retain broad flexibility in how they operate their programs"³ (see Sunset Factor 12, pages 24 through 28, for more information on the extent to which AHCCCS has used private contractors as compared to other states).

¹ 42 USC §1396a(5)

² A.R.S. §36-2903 (A) and (B)

³ Schneider, A., Wachino, V. (2003). Medicaid administration. In *The medicaid resource book* (pp. 131-164). Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured.

2. **The extent to which AHCCCS has met its statutory objective and purpose and the efficiency with which it has operated.**

AHCCCS has generally met its statutory objective and purpose to administer Arizona's Medicaid program. According to AHCCCS' *Population Highlights* report, as of July 1, 2012, there were approximately 1.3 million members enrolled in Arizona's Medicaid program. AHCCCS estimated that its expenditures for fiscal year 2012 will total nearly \$8.4 billion (see Table 2, page 6). During fiscal years 2010 through 2012, AHCCCS' costs to administer the program were approximately 2 percent of its total expenditures each year, ranging from \$177 million in fiscal year 2010 to an estimated \$180.6 million in fiscal year 2012. As indicated in Sunset Factor 12, when tasked with new responsibilities, AHCCCS assesses whether it is more cost-efficient to conduct administrative functions on its own or through a private contract (see Sunset Factor 12, pages 24 through 28, for more complete information on AHCCCS' use of private contractors). Further, according to AHCCCS, efficient delivery of covered services is the foundation of the AHCCCS program, and it has been successful in containing expenditures while delivering quality healthcare services through actuarially sound capitation rates and extensive contractor oversight.

In addition, performance audits completed as a part of AHCCCS' sunset review identified several areas where AHCCCS has established procedures that help it ensure that it is meeting state and federal requirements. Specifically:

- **Identifying members' other health insurance and coordinating benefits**—The Office of the Auditor General's April 2012 performance audit on coordination of benefits found that AHCCCS has established various processes to help meet federal and state requirements for identifying members with other health insurance and ensuring these other insurers pay first for a member's medical costs, and recovering monies from other liable parties after members' healthcare costs have been paid (see Report No. 12-01). Federal regulation and state laws require that AHCCCS pay for medical benefits only after other responsible parties have first paid their share, making AHCCCS the payor of last resort. This process is called coordination of benefits. Coordination of benefits involves two key areas—*cost avoidance* and *post-payment recovery*.

To perform cost avoidance, AHCCCS asks for Medicaid applicants' other health insurance information during the application process, obtains data from the federal government to identify whether enrolled members have Medicare, and has a contract with Health Management Systems, Inc. (HMS) to match its enrolled members with HMS' national insurance coverage database. AHCCCS' contract with HMS also includes provisions for post-payment recovery to identify and collect from other liable parties after enrolled members' healthcare costs have been paid. In addition, AHCCCS requires its contracted health plans to conduct coordination of

benefits activities and has established an oversight process to ensure health plans are meeting these requirements.

- **Helping to ensure only eligible individuals or families are approved for Medicaid**—The Office of the Auditor General’s June 2012 performance audit on Medicaid eligibility determination found that AHCCCS and the Department of Economic Security (DES) accurately determined eligibility for almost all Medicaid applicants (see Report No. 12-02).¹ AHCCCS and DES must determine each applicant’s eligibility in accordance with federal and state requirements, which focus on an applicant’s financial status and other conditions, such as legally residing in the United States. The June 2012 performance audit found that AHCCCS and DES have established extensive policies and procedures, and provide training that helps guide eligibility staff through the eligibility determination process. In addition, it conducts quality control reviews to determine the accuracy of its and DES’ eligibility determinations. Based on a review of a representative sample of 279 eligibility determinations, auditors calculated that 5.92 percent of the eligibility determinations are at risk for processing errors, and that 1.11 percent of eligibility determinations are at risk for being incorrect.
- **Preventing and detecting Medicaid fraud and abuse**—The Office of the Auditor General’s September 2012 performance audit on AHCCCS’ Medicaid fraud and abuse prevention, detection, investigation, and recovery processes found that AHCCCS has established processes to help prevent and detect fraud (see Report No. 12-06). Specifically, AHCCCS requires all providers, such as doctors and home healthcare agencies, to register with AHCCCS before they are allowed to provide services to AHCCCS members. At the time of the audit, AHCCCS was also in the process of enhancing its provider registration activities to include site visits during the initial provider enrollment process and as part of the reenrollment process for moderate- and high-risk provider types, such as rehabilitation centers. In addition, AHCCCS had requested that CMS furnish it with Arizona Medicare provider screening data including the results of site visits for moderate- and high-risk Medicare providers. According to AHCCCS, having access to this information allows it to determine whether Medicare has denied enrollment or terminated providers that may also be Medicaid providers. These provider registration processes help ensure only licensed providers that are not already excluded from providing Medicaid services per the U.S. Department of Health and Human Services’ List of Excluded Individuals and Entities are approved for Medicaid registration.

AHCCCS has also developed training for staff making eligibility determinations. This training defines Medicaid fraud and explains how to report fraud.

¹ AHCCCS has an intergovernmental agreement with DES to conduct Medicaid eligibility because DES performs this function for other programs, such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families program.

In addition, AHCCCS systematically reviews claims data for patterns of fraud or abuse. For example, AHCCCS uses claims data to identify patterns that suggest potential fraud or abuse, such as billing for services not provided. AHCCCS also requires its contracted health plans to implement a mandatory compliance program that is designed to guard against fraud and abuse. AHCCCS ensures its health plans are meeting contractual requirements by performing a triennial review of each contracted health plan.

The performance audits completed as a part of AHCCCS' sunset review also identified areas for improvement. Specifically:

- **Taking additional steps to identify other responsible parties and coordinate benefits**—The Office of the Auditor General's April 2012 performance audit on coordination of benefits found that AHCCCS should obtain some additional data to identify other responsible parties and help coordinate benefits (see Report No. 12-01). Specifically, this report recommended that AHCCCS use federal data from the U.S. Departments of Veterans Affairs and Defense and the Office of Personnel Management to determine if its enrolled members have veterans' benefits or federal healthcare coverage that could be used to avoid costs. In addition, the report recommended that AHCCCS establish data-sharing agreements with: (1) the Arizona Department of Transportation's Motor Vehicle Division to obtain data on motor vehicle accidents to identify liable third parties for Medicaid recipients injured in motor vehicle accidents; and (2) the Industrial Commission of Arizona to obtain data on work-related injuries and illnesses that could be used to identify potential liable third parties.
- **Developing and implementing a plan to reduce errors made during eligibility determinations**—Although auditors identified a small number of eligibility determination errors and incorrect eligibility determinations as reported in the Office of the Auditor General's June 2012 performance audit on Medicaid eligibility determination, the report recommended that AHCCCS take steps to address the types of errors identified (see Report No. 12-02). Specifically, in a review of 279 eligibility determinations, auditors found 16 eligibility determinations that had processing errors. All of the errors related to income, such as not verifying or documenting verification of income or miscalculating the amount of income or resources. Therefore, the report recommend that AHCCCS develop a corrective action plan that will help ensure that it and DES correct the types of income and resource verification and calculation errors identified in the audit as well as minimize their frequency going forward.
- **Enhancing Medicaid fraud and abuse investigation and recovery procedures**—The Office of the Auditor General's September 2012 performance audit on AHCCCS' Medicaid fraud and abuse prevention,

detection, investigation, and recovery processes found that AHCCCS should improve some investigation and recovery processes (see Report No. 12-06). For example, a review of AHCCCS' Office of the Inspector General's (OIG) case management data found that although the OIG was investigating many fraud and abuse cases in a timely manner, some cases were also taking more than 1 year to investigate and close or had been waiting to be assigned for investigation for more than 1 year. Although an AHCCCS official reported that it has been able to hire three additional investigators to help address the number of unopened fraud and abuse cases and improve the timeliness of its investigations, given the number of cases awaiting an investigation and the age of the cases, additional measures are needed. Therefore, the report made several recommendations. These include implementing a formalized case screening process, which should include a prioritization system for when cases should be immediately assigned, deferred, or closed; using this system to reassess and reprioritize cases as they move them from deferred to assignment to an investigator to ensure these cases still warrant investigation; and strengthening its policy regarding supervisory review of ongoing investigations.

This September 2012 performance audit also identified that AHCCCS' OIG needed to make several changes in its recovery processes. Once a member or provider suspected of Medicaid fraud or abuse has been convicted of a criminal offense or has signed a civil settlement agreement, AHCCCS is responsible for recovering any amounts owed. The report made recommendations in four areas regarding recoveries:

- **Documenting factors considered when settling recovery amounts—**Based on auditors' review of civil settlement agreement documentation, it is not clear if the OIG is seeking the maximum amounts legally allowed on behalf of the State in civil settlements. Therefore, to show that AHCCCS is pursuing the maximum civil settlements allowed, the report recommended that the OIG document the specific considerations used to arrive at a settlement decision.
- **Reporting recovery amounts to the federal government—**The OIG has not established adequate procedures to ensure that federally mandated reporting of recoveries is accurate. Because the federal government shares in the cost of the Medicaid program, AHCCCS is required to report the recovery amounts established in criminal restitution and civil settlement agreements to the federal government. The federal government's contribution to Arizona's Medicaid program is then reduced proportionately in a future period by the recovery amounts reported. However, auditors' review of a sample of cases showed erroneous reductions in the federal government's share totaling approximately \$12,800. Therefore, the report recommended that the OIG take additional steps to ensure accurate reporting including

conducting a review of completed recovery reporting forms to ensure that information on the forms is accurate and supported by case file information, and establishing a process to periodically reconcile federal reporting records to OIG recovery records.

- **Collecting amounts owed**—The OIG has not established a formal collection policy or program, making it more difficult to collect the nearly \$2.2 million in recovery debts owed to the State that are more than 90 days past due as of April 2012. The OIG should establish a formal collection program that includes written procedures, monthly followup on past-due accounts, assessment of interest on past-due accounts in accordance with written agreements, pursuit of state tax and lottery intercepts, and referral of severely past-due accounts to the Arizona Attorney General's Debt Collection Program for collection.
- **Handling of payments**—The OIG's cash-handling procedures, which are critical in protecting the millions of dollars in cash payments received by the OIG each year, are inadequate and need to be aligned with the *State of Arizona Accounting Manual* requirements.

3. The extent to which AHCCCS serves the entire State rather than specific interests.

AHCCCS ensures healthcare coverage is available state-wide and offers the same services to all enrolled members regardless of where they live in the State. According to AHCCCS' July 2012 *Population By County* report, the Medicaid population ranges from a high of nearly 740,000 in Maricopa County to a low of approximately 1,300 in Greenlee County. Most members receive services through AHCCCS' managed care system, whereby AHCCCS contracts with entities, known as health plans. The contracted health plans coordinate and pay for the medical services AHCCCS members receive. On a monthly basis, AHCCCS' contracted health plans receive a capitation payment for each member who has enrolled in the health plan. There are contracted health plans in every county, but the health plan a member can select depends on the county in which he/she lives. Specifically, according to AHCCCS' Web site there are eight contracted health plans that serve Acute Care members state-wide with each county having at least two health plans for members to choose from; and there are three ALTCS contracted health plans serving members state-wide with ALTCS members in Maricopa and Pima Counties only having more than one health plan to choose from.¹ All contracted health plans provide the same medical services to their enrolled members, but each may work with different doctors, pharmacies, hospitals, and other providers.

¹ The number of health plans indicated above does not include the Acute Care Comprehensive Medical and Dental Plan or the ALTCS Developmental Disabilities health plan administered by DES because these health plans are available only to foster children and the developmentally disabled.

Federal law does not allow states to require an individual who is Native American to enroll in managed care.¹ Therefore, AHCCCS allows Arizona's Native American population to choose either a managed care health plan or enroll in its fee-for-service program. According to AHCCCS' Web site, Native Americans enrolled in its fee-for-service program receive services from any registered AHCCCS providers who have not opted out of AHCCCS' fee-for-service program or from tribal contractors.

4. The extent to which rules adopted by AHCCCS are consistent with the legislative mandate.

General Counsel for the Auditor General has reviewed AHCCCS' rule-making statutes and believes that AHCCCS' rules are consistent with the legislative mandate. However, in certain areas requiring rules, AHCCCS has not established rules because it has a waiver from CMS or CMS has not authorized AHCCCS to perform a particular activity or function. Specifically:

- **Finger imaging program**—A.R.S. §36-2905.06 requires AHCCCS to work with DES to expand its finger imaging eligibility program and AHCCCS is required to adopt rules related to this program; however, according to the Joint Legislative Budget Committee's *Fiscal Year 2003 Appropriations Report*, CMS had not provided approval for the Finger Imaging Program as a condition of eligibility. Therefore, funding for the program was eliminated in the 2002 legislative session. However, the statute is still in place.
- **Reimbursement levels for ALTCS retroactive eligibility**—A.R.S. §36-2937(B) requires that if an ALTCS member is retroactively eligible pursuant to federal law prior to the date the contracted health plan assumes responsibility for the member's healthcare, AHCCCS shall reimburse noncontracting providers for covered services during the time period that the member was retroactively eligible. AHCCCS is required to adopt rules prescribing the reimbursement levels for services provided during the retroactive eligibility. However, AHCCCS has a waiver from CMS for this federal requirement.
- **Deductible schedule for developmentally disabled ALTCS members**—A.R.S. §36-2939(G) requires AHCCCS to prescribe a deductible schedule for programs provided to developmentally disabled ALTCS members. However, according to AHCCCS, it has not implemented a deductible program for developmentally disabled ALTCS members because CMS has not provided authorization for this.

¹ 42 USC §1396u-2(a)(2)(C)

5. **The extent to which AHCCCS has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.**

When adopting rules, AHCCCS is required to follow the rule-making process, including obtaining public input, with one exception. Specifically, state law exempts AHCCCS from the rule-making process for its fee-for-service schedule, but it has established in rule the methodology it uses to develop its fee-for-service schedule.¹

For the rules it has adopted or amended, AHCCCS has encouraged input from the public through a variety of mechanisms. According to AHCCCS, for issues affecting provider rates and provider reimbursement policies, at least 30 days in advance of the proposed change, AHCCCS files a Notice of Public Information, which provides an opportunity for the public to comment on the proposed change. AHCCCS provides the public with opportunities to provide comments through public hearings, e-mail, or AHCCCS' Web site. For example:

- **Obtaining comments through its Web site**—AHCCCS provides an online form on its Web site that allows the public to submit comments regarding proposed rules or rule changes.
- **Soliciting input through public hearings**—AHCCCS also sometimes holds public hearings to seek input from members, families, and other interested parties on proposed rule changes. For example, effective October 2011, AHCCCS amended its outpatient hospital reimbursement methodology and associated rules through the rule-making process. Prior to amending its rules, AHCCCS held a public hearing in Flagstaff, Phoenix, and Tucson.² Similarly, in June 2012, AHCCCS held a public hearing in Flagstaff, Phoenix, and Tucson to obtain input on rule changes related to streamlining and clarifying the request for proposals process and contract award process.

According to AHCCCS, if comments are received regarding a proposed rule, AHCCCS reviews the comment with subject matter experts to determine whether any changes to the rule are necessary. Then, AHCCCS publishes a Notice of Final Rulemaking on its Web site to inform the public of its actions. For example, the Notice of Final Rulemaking regarding civil monetary penalties noted that the rule was amended to conform the rule to statutory language and more clearly describe the process, circumstances, and timelines under which penalties and/or assessments are determined. The Notice of Final Rulemaking also noted that there were no additional changes made between the proposed rulemaking and the final rulemaking.

¹ AAC R9-22-710, R9-22-712.20, R9-22-712.30, R9-22-712.35, and R9-22-712.40

² According to AHCCCS, there is an employee at each location facilitating the hearing, and the locations are connected through telephone conferencing.

AHCCCS also presents Medicaid program issues to the various tribes and seeks their comments. For example, in July 2011, AHCCCS consulted with tribes about changes to pharmacy payments to federally qualified community health centers and changes to coverage for emergency department visits; and in October 2011, AHCCCS provided an update on healthcare reform to the tribes.

6. The extent to which AHCCCS has been able to investigate and resolve complaints that are within its jurisdiction.

AHCCCS has established processes to address appeals of AHCCCS and health plan decisions regarding a denial or reduction of service or for investigating and resolving complaints related to Arizona's Medicaid program. To help ensure it meets federal and state laws and regulations, AHCCCS has established different processes depending on whether an eligibility decision has been appealed, a complaint has been made by a managed care or fee-for-service member, or a registered AHCCCS provider or contracted health plan files a claim dispute. Specifically:

- **AHCCCS has established a process for providing eligibility decision hearings**—As federally required, AHCCCS provides a hearing process for Medicaid applicants or members who want to appeal an eligibility decision, such as a denial or discontinuation of Medicaid eligibility.¹ This hearing process is administered by the Office of Administrative Hearings and applies only to eligibility determinations made by AHCCCS.² As previously indicated (see page 4), as of July 1, 2011, AHCCCS performed about 11 percent of the eligibility determinations, and completes determinations for the ALTCS program, the KidsCare program, and the Supplemental Security Income—Medical Assistance Only population, which is part of the Acute Care program. DES, which performed about 82 percent of the Medicaid eligibility determinations as of July 1, 2011, has an intergovernmental agreement with AHCCCS to perform Medicaid eligibility determinations in conjunction with eligibility determinations for other federal programs, such as the Supplemental Nutrition Assistance Program. DES has a separate eligibility decision appeals process.³

As required by state law, AHCCCS has established in administrative rule the procedures and time frames for requesting an eligibility-decision hearing.⁴ For example, a person requesting an eligibility decision hearing has 30 days from when he/she received the eligibility decision notice from AHCCCS to request a hearing. Federal regulation also requires that AHCCCS issue and

¹ 42 USC §1396a(a)(3); and 42 CFR §431.200 et seq.

² There is one exception to this requirement. AHCCCS' eligibility hearing process also applies to persons determined eligible by DES if the request for hearing relates to the imposition of or an increase in a premium or copayment (see AAC R9-34-101).

³ Auditors did not review DES' eligibility decision appeals process because it was not within the scope of the audit.

⁴ A.R.S. §36-2903.01(B)(4), and AACR9-34-101 et seq.

publicize its hearing procedures.¹ In addition to the information contained in administrative rule, AHCCCS includes information about how to file an appeal of an eligibility decision on its Web site. According to AHCCCS, when an applicant or member files an appeal of an eligibility decision, AHCCCS schedules a hearing. However, it also reviews the eligibility case in question, and if it finds evidence to show the applicant or member is eligible, then it will reverse the decision and cancel the hearing. If AHCCCS' review indicates that the person was not eligible, it will proceed with the scheduled hearing with the Office of Administrative Hearings.

According to AHCCCS, during calendar year 2011, 1,486 eligibility decision appeals were filed. During 2011, there were also 1,040 eligibility decision administrative hearings scheduled with the following results: 682 were withdrawn by the appellant; 235 of the appellants did not show up so AHCCCS' decision remained; 118 of the appeals were denied; and in 5 cases, AHCCCS' eligibility decision was overturned.

- **AHCCCS requires its contracted health plans to handle complaints from managed care members**—Federal and state laws and regulations require AHCCCS' contracted health plans to have processes for handling complaints from their managed care members, including concerns related to denial of service or quality-of-care.² Therefore, AHCCCS requires its contracted health plans to establish grievance and quality care management processes for handling concerns received from AHCCCS managed care members. For example, AHCCCS' contracted health plans must have written information that clearly explains to enrolled members the process for filing concerns, including the time frames for doing so. In addition, contracted health plans must have staff resources that are able to investigate, resolve, track, and trend quality-of-care complaints, such as abuse by a provider, and staff to handle other concerns from enrolled members, such as denial of service or failure to provide a service in a timely manner. Further, if the enrolled member is not satisfied with the health plan's resolution of his/her concern, the member is allowed to file an appeal for an administrative hearing for specific actions including the denial or limited authorization of a requested service, or failure to provide a service in a timely manner. This appeal is sent to AHCCCS and the administrative hearing process is handled by the Office of Administrative Hearings. AHCCCS' Web site also includes information about how an enrolled managed care member can file a complaint including requesting an administrative hearing.

AHCCCS has established oversight processes to help ensure that its contracted health plans are meeting complaint-handling requirements. Specifically, AHCCCS conducts a review of each contracted health plan

¹ 42 CFR §431.206

² 42 USC §1396u-2(b)(4), 42 CFR §438.400 et seq., A.R.S. §36-2903.01(B)(4), and AAC R9-34-201 et seq.

every 3 years. As part of this review, AHCCCS assesses contracted health plans' compliance with complaint-handling requirements in two distinct areas: (1) quality management standards, which relate to quality-of-care, and (2) grievances, which involve the overall process for filing and handling any type of complaint with the contracted health plans. For example, AHCCCS reviews whether the contractor has the appropriate staff in place to carry out the requirements related to quality management and whether it has a structure and process in place for resolving, tracking, and trending quality-of-care and abuse complaints. Additionally, AHCCCS ensures the contractor's grievance processes meet time frames and written notification requirements.

Auditors reviewed AHCCCS' June 2012 annual external independent review report, which summarizes the 10 health plan contractor reviews AHCCCS conducted in 2010 and 2011.¹ This report notes that compliance with grievance system standards was one of its contractors' strongest performance areas. Further, although contractors were in compliance with many quality management standards, in some areas, contractors were required to establish corrective action plans. For example, one contractor was required to establish a corrective action plan to ensure it developed and implemented a process for tracking and trending quality-of-care concerns.

In addition to its triennial contractor review, AHCCCS monitors and follows up on contractors' resolution of quality-of-care complaints in other ways. First, according to AHCCCS, after a contracted health plan investigates and resolves a quality-of-care issue, the health plan submits a summary of its findings and actions to AHCCCS. AHCCCS reviews the summary and actions taken to ensure the actions are appropriate and timely. In addition, according to AHCCCS, it obtains and reviews quarterly quality management reports from contracted health plans that track cases and resolutions, and it requires all quality-of-care cases to have closure documentation that the contracted health plans follow up on, typically 30 to 60 days later, to ensure that the prescribed corrective actions were taken.

According to AHCCCS, during calendar year 2011, 8,768 managed care member quality-of-care complaints were filed with the contracted health plans. Additionally, 5,496 non-quality-of-care complaints were also filed with the contracted health plans. In calendar year 2011, AHCCCS also received 218 requests for administrative hearings in appeal of its contracted health plans' actions.

- **AHCCCS handles complaints from its fee-for-service members—** AHCCCS is required by federal and state laws and regulations to have processes for handling fee-for-service members' complaints including

¹ Health Services Advisory Group. (2012). *2010-2011 External quality review annual report for acute care and DES/CMDP contractors*. Phoenix, AZ: Author.

concerns regarding denial of service.¹ As indicated in the Introduction (see page 2), about 10 percent of AHCCCS members are fee-for-service members. According to AHCCCS, when fee-for-service members have concerns about AHCCCS' actions such as denial of a service or termination of a previously authorized service, AHCCCS first tries to handle these complaints administratively by reviewing the case and reaching an informal decision. If the AHCCCS member is unsatisfied with the informal decision, then AHCCCS proceeds with a scheduled hearing, which is administered by the Office of Administrative Hearings. According to AHCCCS, in calendar year 2011, there were nine requests for hearings by fee-for-service members.

AHCCCS also processes fee-for-service members' complaints related to quality-of-care, such as abuse or neglect by a provider. AHCCCS is responsible for investigating these complaints and if substantiated, must develop a resolution that could include education, changes to the provider's procedures, or, in some cases, termination of a provider employee. According to AHCCCS, during calendar year 2011, it opened 34 fee-for-service member quality-of-care complaints. In the same year, AHCCCS closed 29 complaints. Of the closed cases, 9 were substantiated, 7 were unsubstantiated, and 13 were unable to be substantiated. According to AHCCCS, for the cases it was unable to substantiate, it was not able to find enough evidence to clearly indicate that the case was a quality-of-care issue.

- **AHCCCS provides a mechanism for handling claim disputes from its providers and/or contracted health plans**—As required by state law and regulation, AHCCCS has established a process for handling claim disputes by registered AHCCCS providers, such as physicians or its contracted health plans.² AHCCCS requires its contracted health plans to resolve provider claim disputes involving managed care members; however, if a provider is not satisfied, it can request that AHCCCS schedule a hearing of the contracted health plan's decision. While scheduling a hearing with the Office of Administrative Hearings, AHCCCS will also work to handle these provider concerns administratively. If the provider is satisfied with AHCCCS' administrative decision, according to AHCCCS, it will cancel the scheduled hearing.

In addition, AHCCCS handles claim disputes from provider claims involving fee-for-service members or those filed by its contracted health plans. According to AHCCCS, it also works to handle these concerns through an informal resolution process before scheduling an administrative hearing.

¹ 42 CFR §431.200 et seq., A.R.S. §36-2903.01(B)(4); and AAC R9-34-301 et seq.

² A.R.S. §36-2903.01(B)(4), and AAC R9-34-401 et seq.

However, according to AHCCCS, the vast majority of cases for which administrative hearings are requested are for provider claim disputes.

According to AHCCCS, when scheduling administrative hearings, it gives priority to eligibility decision and denial or reduction of services appeals before provider claim disputes to help ensure that member and applicant appeals are completed within the federally required time frame. Therefore, according to AHCCCS, as of May 2012, there were more than 4,000 provider claim disputes awaiting a hearing. However, AHCCCS is working with the Office of Administrative Hearings to dedicate the necessary resources to resolve the backlog, including grouping appeals by type of complaint and health plan and setting prehearing conferences to identify cases that can be settled. According to AHCCCS, grouping the providers and health plans can help highlight common recurring problems, which leads to more efficient settlement of multiple disputes. According to AHCCCS, it and the Office of Administrative Hearings began holding 40 preconference hearings per day, 2 days per week, starting in July 2012, to reduce the backlog of provider claim disputes.

7. The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.

The Arizona Attorney General and county attorneys have concurrent authority to prosecute actions related to AHCCCS.¹ For example, both are involved in prosecuting Medicaid fraud cases that AHCCCS refers to them (see the Office of the Auditor General's September 2012 performance audit on AHCCCS' Medicaid fraud and abuse prevention, detection, investigation, and recovery processes, Report No. 12-06, for more information). Specifically, as allowed by federal code, the Arizona Attorney General has established a specific unit, called a Medicaid Fraud Control Unit (MFCU), to investigate and prosecute suspected fraud committed by AHCCCS providers.² AHCCCS has established a Memorandum of Understanding with the Attorney General's MFCU, which calls for AHCCCS to conduct a preliminary investigation of suspected fraud to determine whether there is a sufficient basis to refer the case to the MFCU for a full investigation and prosecution.

According to AHCCCS, cases involving Medicaid member fraud are typically referred to the County Attorney where the member resides for prosecution. Member fraud involves a person providing false or fraudulent information to the state when applying for Medicaid benefits. As indicated in the Office of the Auditor General's performance audit on Medicaid eligibility determination (see Report No. 12-02), AHCCCS and DES must determine each applicant's eligibility in accordance with federal and state requirements, which focus on an applicant's

¹ A.R.S. §§13-2310, 13-2311, 13-3713(G), and 36-2918

² 42 CFR Part 1007

financial status and other conditions, such as legally residing in the United States.¹

8. The extent to which AHCCCS has addressed deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

According to AHCCCS, it has not identified any deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate. However, a few of the statutory changes affecting AHCCCS that were enacted in calendar years 2011 and 2012 include the following:

- **Laws 2012, Ch. 122**—Statutory changes enacted under this law included amending A.R.S. §36-2903.01 to (1) eliminate outdated language regarding reimbursements for inpatient and outpatient hospital services; and (2) allow AHCCCS, effective October 1, 2013, to adopt a hospital reimbursement methodology for inpatient dates of service that is consistent with Title XIX of the Social Security Act. This change also requires AHCCCS to obtain legislative approval prior to adopting the methodology and establish workgroups consisting of representatives from urban, rural, and critical access hospital communities and other groups to provide input on the new methodology.
- **Laws 2012, Ch. 213**—This law amended A.R.S. Title 36, Ch. 29, by adding article 6, which authorizes nursing facility provider fee assessments. Under this new article, beginning October 1, 2012, AHCCCS is allowed to charge a nursing facility provider assessment on patient service revenue to obtain additional federal Medicaid monies. According to the National Conference of State Legislatures' Web site, a provider assessment is a state law that authorizes the collecting of revenue from specified categories of providers; and, in most states it is used to generate new in-state funds and match them with federal funds so that the state gets additional federal Medicaid dollars. According to the Arizona House of Representatives' summary, monies collected through this nursing facility assessment will be used to help AHCCCS qualify for federal matching funds for supplemental medical payments. These supplemental medical payments, along with the nursing facility assessments, will then be used for supplemental payments to nursing facilities for covered Medicaid services. This statutory revision also requires the establishment of a specific fund consisting of monies received from the assessment, and approval from CMS.
- **Laws 2011, Ch. 31**—This law amended several statutes and resulted in a number of changes to AHCCCS' programs. Some of the changes included:

¹ AHCCCS has an intergovernmental agreement with DES to conduct Medicaid eligibility determinations because DES performs this function for other programs, such as the Supplemental Nutrition Assistance Program.

- Transferring responsibility for the Children’s Rehabilitative Services (CRS) program from the Department of Health Services to AHCCCS, effective July 1, 2011. The CRS program is part of AHCCCS’ Medicaid program and provides medical care, rehabilitation, and related support services to AHCCCS-enrolled children with qualifying chronic and disabling conditions. Previously, the medical, rehabilitation, and other support services provided to AHCCCS children who qualified for the CRS program were not the responsibility of AHCCCS’ managed care plans and instead were managed by the Department of Health Services. According to AHCCCS, this resulted in children with complex healthcare needs receiving medical care and other qualifying services from a minimum of two separate systems. By transferring the CRS responsibility to AHCCCS, AHCCCS reports that it should be able to provide CRS services to qualifying children more effectively.
- Specifying that AHCCCS members must pay a monthly premium and copayments for office, urgent care, and emergency room visits.
- **Laws 2011, Ch. 234**—Statutory changes enacted under this law included (1) allowing AHCCCS providers to charge a \$25 missed appointment fee to members who miss scheduled appointments; and (2) authorizing any political subdivision to provide monies necessary to qualify for federal matching monies to provide healthcare coverage to persons who would have been eligible for Medicaid pursuant to A.R.S. §36-2901.01. As indicated on page 2, effective May 1, 2012 through January 1, 2014, AHCCCS will be receiving monies from three hospitals that will allow AHCCCS to provide coverage for 21,700 children in what is being called KidsCare II. This state-wide program will offer the same benefits, but has a lower income eligibility threshold than the KidsCare program (see page 2 for more information on KidsCare).

9. The extent to which changes are necessary in the laws of AHCCCS to adequately comply with the factors listed in the sunset law.

The performance audits conducted as part of AHCCCS’ sunset review (see Reports Nos. 12-01, 12-02, and 12-06) did not identify any needed changes to AHCCCS’ statutes.

10. The extent to which the termination of AHCCCS would significantly affect the public health, safety, or welfare.

Terminating AHCCCS would have a detrimental effect on the health, safety, and welfare of the low-income Arizonans that it serves. According to AHCCCS’ *Population Highlights* report, as of July 1, 2012, AHCCCS provided healthcare services to approximately 1.3 million individuals. Half of these individuals are children, and nearly 6 percent of AHCCCS’ member population is 65 or older,

according to AHCCCS' *Population Demographics* report. To help pay for these healthcare services, in fiscal year 2012, AHCCCS estimates it will receive approximately \$5.7 billion in federal matching funds. By terminating AHCCCS, Arizona would lose these funds, which could result in the approximately 1.3 million AHCCCS members losing their healthcare coverage, unless another state agency assumed AHCCCS' role as Arizona's Medicaid agency. As previously indicated (see page 9), federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program.¹

In addition, eliminating AHCCCS could have a negative impact on other individuals and businesses. Specifically, AHCCCS' enrolled membership represents about 20 percent of Arizona's population, and eliminating AHCCCS and the healthcare services it purchases for its enrolled members could have an adverse effect on the 11 contracted health plans, the nearly 54,000 registered healthcare providers reported by AHCCCS, and their employees. Although the 2010 Federal Patient Protection and Affordable Care Act (Act) requires most individuals to have healthcare insurance, if AHCCCS were eliminated, the number of uninsured individuals in the State could increase if there is not another no cost or low-cost alternative available. Since federal law requires hospital emergency rooms to treat all patients regardless of their ability to pay, the increase in the number of uninsured individuals could put additional financial strain on the State's emergency care system.

Finally, the Advisory Council on Indian Health Care (Council), which was established to develop a comprehensive healthcare delivery and financing system for Arizona's tribes, would also be terminated. The Council was established as a component of the Arizona statutes authorizing and regulating AHCCCS.

11. The extent to which the level of the regulation exercised by AHCCCS compares to other states and is appropriate and whether less or more stringent levels of regulation would be appropriate.

Because AHCCCS is not a regulatory agency, this factor does not apply.

12. The extent to which AHCCCS has used private contractors in the performance of its duties as compared to other states and how more effective use of private contractors could be accomplished.

AHCCCS makes extensive use of private contractors. Specifically, the majority of AHCCCS' revenues are used to pay private contractors who coordinate and pay for healthcare services to enrolled members. Specifically, as indicated in the Introduction (see page 5), AHCCCS' fiscal year 2012 estimated expenditures

¹ 42 USC §1396a(5)

total nearly \$8.4 billion. About 76 percent of this amount, or \$6.4 billion, is used for the capitation payments AHCCCS makes to its contracted health plans. These health plans coordinate and pay for the medical services AHCCCS members receive from registered AHCCCS healthcare providers, such as physicians and hospitals. As indicated on page 1, AHCCCS was the nation's first state-wide Medicaid program designed to provide medical services primarily through a managed care system. According to CMS' Web site, states have traditionally used a fee-for-service system to provide Medicaid benefits, but states have begun to more frequently implement managed care delivery systems. However, Arizona continues to be one of the states with the highest percentage of members in a managed care system. Specifically, as of October 2010, 47 states and the District of Columbia used managed care programs to some degree, but only 9 states, including Arizona, had 80 percent or more of their members enrolled in comprehensive managed care programs.^{1,2}

Auditors determined that AHCCCS' use of private contractors in three key administrative areas appeared comparable to other states. To obtain information on other states' privatization efforts related to state Medicaid agency administrative functions, auditors sent a survey to the state Medicaid agencies in the other 49 states. Auditors received responses from 15 states.³ When asked to describe the benefits of privatizing Medicaid functions, some of the responding states mentioned that private contractors can improve the cost-effectiveness of functions, provide skills that state Medicaid agencies may not have, ease the administrative burden of these agencies, and improve the level of service. The three comparable areas included:

- **Third-Party Liability**—Similar to AHCCCS, most of the 15 states that responded to the auditors' survey reported that they have private contracts to identify Medicaid members' other insurance so that Medicaid costs can be avoided—cost avoidance, or to recover payments from liable third parties—cost recovery. These efforts help to ensure that Medicaid is the payor of last resort, as required by federal regulation.⁴ Specifically, 11 of the 15 responding states reported that they use private contractors for cost avoidance; and 12 of the 15 responding states reported that they used private contractors for recovering payments from liable third parties. As indicated in the Office of the Auditor General's performance audit on AHCCCS' coordination of benefits (see Report No. 12-01), AHCCCS contracts with HMS for both cost avoidance and cost recovery services. This report noted that according to HMS, it

¹ Comprehensive managed care is defined as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally Qualified Center services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment services; (7) family planning services; (8) physicians' services; and (9) home health services.

² Kaiser Family Foundation. (2010). *Medicaid enrollment in comprehensive managed care as a share of total Medicaid enrollment*, October 2010. Retrieved January 31, 2012, from www.statehealthfacts.org

³ The responding states are California, Colorado, Idaho, Indiana, Michigan, New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Washington.

⁴ 42 USC §1396a(a)(25) and 42 CFR §433.135 et seq.

provides coordination of benefits services to 41 agencies in 39 states and the District of Columbia.

- **Fraud detection**—Similar to AHCCCS, most of the states that responded to the auditors' survey reported that they contract for some fraud detection services. Specifically, 11 of the 15 responding states reported that they use private contractors for fraud detection services. For example, one state said that it uses its Recovery Audit Contractor to provide fraud detection services that will complement similar work performed by the state's Medicaid Program Integrity Unit. Another state said that fraud detection work is being performed by third-party liability and auditing contracts. As indicated in the Auditor General's performance audit on AHCCCS' Medicaid fraud and abuse prevention, detection, investigation, and recovery processes (see Report No. 12-06), AHCCCS uses a contractor, EDI Watch, Inc., to assist in the detection of fraud and abuse. In addition, on December 12, 2011, AHCCCS entered into a contract with three companies for data analytics consulting services related to fraud prevention and detection. Based on discussions with CMS and state Medicaid officials from California, Illinois, Maryland, and Texas, data analysis techniques are an essential practice in preventing and detecting fraud and abuse.
- **Eligibility determination**—Similar to AHCCCS, most of the states that responded to the auditors' survey reported that they did not contract out the eligibility determination function. Specifically, 14 states responded to this question and 9 reported that they did not contract out this function. Five of the states reported partially contracting out this function, but it appeared that for one of these states, their contract was with another state agency and not a private contractor. This would be similar to AHCCCS, which has an intergovernmental agreement with DES to perform the majority of eligibility determinations on its behalf (see Introduction, pages 4 through 5, for more information). According to statute, AHCCCS is required to enter into an interagency agreement with DES to establish a streamlined eligibility determination process.¹

In addition to contracting for key operational areas, AHCCCS reports that it also contracts for various other services including custodial; mailroom and courier; building security; groundskeeping; and building, vehicle, and equipment repair and maintenance.

The survey identified three areas where it appeared states may be making greater use of private contracts, but AHCCCS has specific reasons for not using or more fully using private contractors in these areas. Specifically:

- **Actuarial services**—Most of the states that responded to the auditors' survey indicated that they contract for actuarial services. Actuaries review

¹ A.R.S. §36-2903.01(B)(2) and (3)

and analyze medical claims data and other data, such as financial statements or reports, to develop and recommend the monthly capitation rates that are paid to contracted health plans. Ten of the 15 states responding to the auditors' survey reported that they fully contract for actuarial services and 5 states reported that they partially contract for actuarial services. According to AHCCCS, it brought actuarial services in-house in early 2004, and it has seen significant savings. Another benefit that AHCCCS reported is that its in-house actuaries are more knowledgeable about the AHCCCS data, including anomalies in the data, the AHCCCS programs and requirements, and changes to the programs due to their daily immersion in the agency. AHCCCS also reported that it has a contract for actuarial services, but indicated that this contract is used for nonroutine actuarial reviews such as consulting on capitation rate risk adjustments for the contracted health plans.

- **Claims payment processing**—Most states that responded to the auditors' survey also reported that they contract for claims payment processing. Claims payment processing are the processes an agency uses to ensure providers are paid for the covered services provided to Medicaid members. Specifically, 10 of the 15 states indicated that they fully contract for this service, and 3 states indicated that they partially contract for claims processing services. In Arizona, most claims processing is handled by AHCCCS' contracted health plans for its managed care members. However, AHCCCS processes the claims for its fee-for-service members. Further, according to AHCCCS, it helps process claims for other entities, including claims for Maricopa County inmates, and until June 30, 2012, Department of Corrections inmates.
- **Medicaid Management Information Systems**—Most states that responded to the auditors' survey reported that they contract out the operation of their Medicaid Management Information Systems (MMIS). MMISs are used to process and/or record Medicaid claims and other data that is needed for federal and state program administration and audit purposes. Each state is federally required to have an MMIS. Nine of the states responding to the survey indicated that operation of their MMIS was fully contracted and four states indicated that the operation of their MMIS was partially contracted. CMS' Web site indicates that private contractors, known as fiscal agents, may operate states' MMIS. According to an April 27, 2012, report on CMS' Web site, 36 states and the District of Columbia had fiscal agent contracts. According to AHCCCS, it developed an in-house MMIS system with the assistance of a vendor because there was not a viable vendor-operated system for a managed care Medicaid program available at the time. Further, AHCCCS reported that it has been operating its MMIS since about 1990, and continues to operate its MMIS because it is cost efficient compared to the very large fees vendors are charging for comparable systems. In addition, AHCCCS also operates Hawaii's MMIS, and reported it has done so since

1999, which allows AHCCCS to have a partner that shares in the cost of operating its MMIS.

Although the performance audits conducted as part of AHCCCS' sunset review did not identify any areas where AHCCCS could more effectively use private contractors, AHCCCS reported that it has a process for assessing whether it is efficient and effective to use contracted services. Specifically, when tasked with new responsibilities by the federal government and/or the State, AHCCCS considers various factors when deciding whether to contract for the service or perform it in-house. These factors include assessing whether there are existing contractors with the infrastructure and expertise to perform the function and whether a contractor could more efficiently perform the work than AHCCCS.

For example, in 2010, AHCCCS was tasked with the collection of rebates for outpatient prescription drugs dispensed to its enrolled members. According to CMS' Web site, the Medicaid Drug Rebate Program "is a partnership between CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients." According to AHCCCS, it determined that it would be more cost-effective to contract for this rebate function because it could leverage a vendor's program expertise, infrastructure, existing contracts, and relationships with drug labelers, and achieve economies of scale associated with a vendor's rebate-billing work for multiple states and collection programs. In December 2010, AHCCCS entered into a contract with a private vendor to process Medicaid fee-for-service and managed care drug rebates according to CMS guidelines.

APPENDIX A

Methodology

This appendix provides information on the methods auditors used to meet the audit objectives.

This performance audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Auditor General and staff express appreciation to the Arizona Health Care Cost Containment System (AHCCCS) Director and his staff for their cooperation and assistance throughout the audit.

AHCCCS' performance was analyzed in accordance with the statutory sunset factors. Performance audit work related to AHCCCS' Coordination of Benefits (see Auditor General Report No. 12-01), Medicaid Eligibility Determination (see Auditor General Report No. 12-02), and Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes (see Auditor General Report 12-06) provided information for this report. Auditors also reviewed and analyzed information on AHCCCS in the *Fiscal Years 2010-2013 Master List of State Government Programs*, and obtained and reviewed information from AHCCCS on the number of full-time staff and vacancies as well as other information such as contracts, policies and procedure manuals, and AHCCCS' member population data. In addition, auditors reviewed federal and state laws and regulations related to the Medicaid program and AHCCCS including session laws. To assess AHCCCS' use of private contractors as compared to other states, auditors sent a survey to the other 49 states. Fifteen states responded: California, Colorado, Idaho, Indiana, Michigan, North Carolina, New Jersey, North Dakota, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Washington.

Auditors' work on internal controls focused on AHCCCS' processes and procedures for ensuring compliance with federal and state laws and regulations for handling complaints about the Medicaid program, such as appeals of eligibility determination decisions. Conclusions on this work are included in Sunset Factor 6, pages 17 through 21. Computerized system information was not significant to auditors' objectives; therefore, auditors did not conduct test work on information systems controls.

AGENCY RESPONSE

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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

September 14, 2012

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

RE: AHCCCS Sunset Review; Revised Draft Report dated September 12, 2012

Dear Ms. Davenport:

Thank you for the opportunity to review the revised report of the Sunset Review of the Arizona Health Care Cost Containment System (AHCCCS). As there are no formal recommendations requiring a response, let me take this opportunity to thank you again for your commitment to the AHCCCS Sunset Audit. We appreciate the professionalism and cooperation of the audit team as we worked together to gather the comprehensive information necessary for an evaluation of the twelve criteria specified in A.R.S. § 41-2951 et seq.

We look forward to sharing our progress as we continue to address the recommendations offered in the three focused audit reports (i.e. COB, Eligibility, Fraud and Abuse) issued as a part of this Sunset Review.

Sincerely,

Thomas J. Betlach, Director

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10-08	Department of Corrections—Prison Population Growth	11-12	Arizona Board of Regents—Sunset Factors
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11-02	Arizona State Board of Nursing	12-02	Arizona Health Care Cost Containment System—Medicaid Eligibility Determination
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