ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Quarterly Report

October 1, 2001 through December 31, 2001

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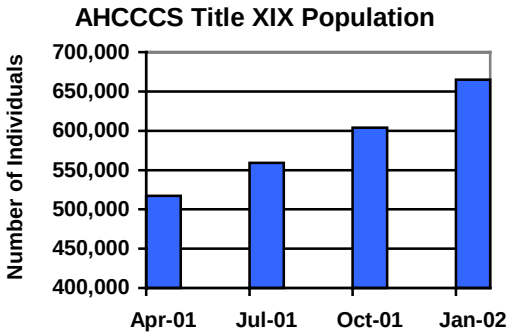
Executive Summary

During the first quarter, AHCCCS' population increased over 10% due to the implementation of Proposition 204. AHCCCS and the Department of Health Services (ADHS) implemented the Breast and Cervical Cancer Treatment Program effective January 1, 2002. An Universal Application was implemented which streamlined the application process. AHCCCS held numerous workgroups and seminars on the implementation of Proposition 204 and using the Universal Application.

AHCCCS Population

On January 1, 2002, the AHCCCS Title XIX population totaled 664,871 individuals. This represents a 10% increase since last quarter. This number includes 631,381 individuals receiving acute care services, an increase of 60,296 members, and 33,490 members receiving ALTCS services, an increase of 770 members.



Much of this net increase was due to the implementation of Proposition 204 which increases the income limit to 100% FPL for the non-categorical population including parents with children under the age of 18.

New Developments

Breast and Cervical Cancer Program

Effective January 1, 2002, AHCCCS begins Medicaid coverage to eligible women under the optional coverage group created by the Breast & Cervical Cancer Prevention and Treatment Act. For over the past year AHCCCS has been working closely with staff from the ADHS which administers the National Breast and Cervical Cancer Early Detection Program in Arizona through the Well Woman Healthcheck Program (WWHP). AHCCCS and ADHS worked closely to ensure that eligible women receive needed treatment as soon as possible and jointly developed an application process designed to expedite an eligible woman's access to AHCCCS medical services. AHCCCS will process a Breast & Cervical Cancer Treatment Program application within seven days after receiving a completed application from WWHP.

Streamlined application processing by AHCCCS is possible because WWHP staff will assist potentially eligible women to complete AHCCCS applications including gathering the documentation needed for an eligibility decision. AHCCCS provided eligibility training to the ADHS and WWHP staff during a statewide conference held in Phoenix in December 2001.

Expanded Quality Compliance Administration

As a result of the implementation of Proposition 204 and the corresponding eligibility changes effective October 1, 2001, the Quality Compliance Administration (QCA) in the Division of Member Services (DMS) was given the additional responsibility of reviewing various quality control samplings of eligibility processing and decisions made by the Department of Economic Security (DES). QCA's pilot proposal was approved by CMS earlier this year and covers the quality control process used for DES-approved as well as AHCCCS-approved Medicaid cases. In addition to traditional Medical Eligibility Quality Control sampling, a sample of high dollar cases, a Management Evaluation process, and a Pre-Determination Quality Control process for hospitalized cases are also being implemented. QCA currently has a waiver pending with CMS to add the pilot process to AHCCCS' 1115 waiver.

Health-e-Application

With the Health-e-App implementation underway in California, Arizona becomes the next state to test the automated web-based application for enrolling low-income children, adults and families in Title XIX and Title XXI (KidsCare.)

Through a partnership between the Community Health Centers Collaborative Ventures, Inc. (CHCCV), AHCCCS and DES, Health-e-App will be piloted at seven CHCCV organizations in 35 sites statewide beginning May 2002.

Universal Application

In October 2001, AHCCCS implemented a Universal application to simplify the eligibility processes for individuals and families. Since July 2001, a team from AHCCCS, DES and Premium Sharing has been meeting bi-weekly to develop and evaluate the status of the application, as well as referral processes.

Applications are mailed directly to the AHCCCS Central Screening Unit (CSU) for processing. The CSU screens the application and refers the applicant to the most appropriate eligibility office for a determination. If an application is received at an AHCCCS local office, the eligibility specialist reviews the application to determine if eligibility can be approved at that office, or if not, refers the application to the CSU.

By developing a strong evaluation component, AHCCCS will identify the strengths and weaknesses of the Universal Application and ensure that a continuous quality improvement process is in place. Evaluation will focus on the following factors:

- how the application addresses the needs of the long-term care and acute populations;
- identifying any issues related to users from different agencies;
- the feasibility of having combined English/Spanish applications; and
- the format of the application itself.

Questionnaires, suggestion forms, staff interviews, customer surveys and focus groups will be used in the evaluation process. The first phase of the evaluation process will be implemented in the latter part of February 2002, after the distribution of Version II of the Universal Application, and will focus primarily on the user groups.

Users of the Universal Application include the general public, eligibility staff, hospitals, advocacy groups, community-based organizations and other agencies. The Universal Application is also available for printing from the Internet.

All Program Areas

Outreach and Education

During this quarter AHCCCS conducted the following outreach and education activities:

- Assisted in the formation of the Asian Health Initiative Health Coalition which provides health and community services and is a resource for the Asian and Pacific Islander communities.

- Met with the City of Phoenix, Lead Base Paint Rehabilitation project, to develop a process to refer to KidsCare children of families whose homes are being retrofitted for lead based paint.

- Held Proposition 204 seminars for the Arizona Hospital Association, community organizations, cities and towns, statewide associations, professional organizations and other interested groups throughout the state.

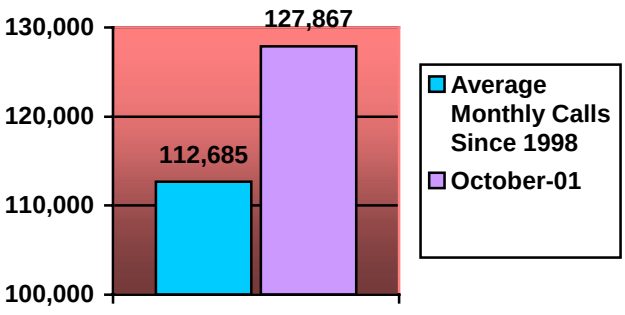
- Contracted with seven Community Based Organizations (CBO's) to perform outreach and Universal Application assistance statewide. For this quarter, the CBO's submitted 16,463 Universal Applications.

- Met with White Mountain Apache Tribe regarding how AHCCCS could assist them with the outreach portion of their Health Resources and Services Administration (HRSA) grant. AHCCCS trained three members of the White Mountain Apache Tribe to perform outreach for all AHCCCS programs on their reservation. Outreach staff will assist tribal members in filling out the Universal Application and utilizing AHCCCS services.

New Record for the Communications Center

Historically, the AHCCCS Communications Center experiences record call volumes during August and September when Open Enrollment occurred. However, since the implementation of the Annual Enrollment program in 1998, which spreads enrollment choices over the twelve months of the year, the number of calls per month have remained consistent.

OPERATOR ASSISTED CALLS



In October 2001, 127,867 operated assisted calls were received by the Communications Center. This number represents an increase of 15,182 or 13.5 % of number of calls, compared to the monthly average of 112,685. Incoming calls are handled by 75 staff members.

This increase in the number of calls is attributed to the increase in the AHCCCS population. Proposition 204 changes were implemented in October and the county population was absorbed

into the new eligibility categories. At this time AHCCCS cannot predict that this is representative of a new trend.

The number of automated verification calls has remained relatively constant over the last ten months averaging 522,691 a month. The Administration has plans to pilot a web-based verification process in early 2002, which will shift more provider calls from Communications Center staff to the automated system.

Information Systems

Health Insurance Portability and Accountability Act (HIPAA)

This 1996 Administrative Simplification Act standardizes the administrative and financial health care transactions to reduce the costs and administrative burden of health care. The transactions covered by HIPAA primarily include health care claims, claims payments, enrollment, and eligibility. The provisions apply to all health care plans, including Medicare and state Medicaid agencies, health care clearinghouses, and health care providers that transmit in electronic form any health care information covered by HIPAA. The rules include standards for electronic submission of health care transactions, code sets, identifiers for recipients, providers, and payers of health care services, and security and confidentiality issues around health care data.

Implementing HIPAA will standardize the format of our interface files with external entities, which will be especially helpful when new providers or health plans want to submit data. Providers or health plans will use the healthcare data standard format. In addition, HIPAA will define the standard security requirements and enable us to properly safeguard the data entrusted to us as required by our federal business partners.

The GAP Analysis has been separated into two parts: transactions and code sets, and security and privacy. The transaction and code set analysis is currently underway with a target completion of March 2002.

Hawaii/Arizona PMMIS Alliance (HAPA) Project

During the first quarter, the technical and business teams in Hawaii and Arizona defined the requirements for Hawaii's claims function. Both joint and separate sessions were conducted and a Requirements Definition document was produced. This document is expected to be reviewed and approved in a joint meeting in January 2002. The system is scheduled to be implemented by April 2003.

Arizona identified a number of desired modifications to the Claims and Provider Subsystems to be made prior to beginning any coding changes specific to Hawaii. During this quarter, the last of these changes were coded, tested, and implemented.

Proposition 204/Waiver

The project converted and expanded the AHCCCS program to include the following: QMB Only, Medically Needy/Medically Indigent, Seriously Mental Ill, parents of SOBRA Children at or below 100% FPL, Ribicoff children, Premium Sharing members with income at or below 100% FPL,

Family Planning Services Only, and Food Stamp Only populations. Systems to support these new and expanded programs were implemented as planned.

To accommodate new staff, a new office was developed and several existing offices were redesigned. All areas were cabled with the appropriate voice and data lines and new PCs, printers, servers and telephones were put in place.

Member Grievances, Claims Grievances, and Eligibility Appeals

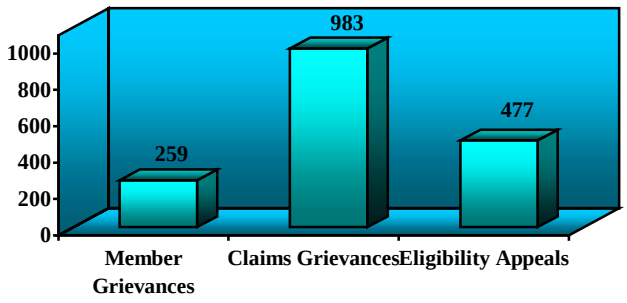
OLA received 1719 cases involving member grievances, claims grievances or eligibility appeals (Chart 1). Over 57% of the cases filed involved grievances regarding claims. OLA resolved 1013 cases informally, eliminating the need for a formal hearing (Chart 2).

The Director issued 677 decisions. The majority of these decisions concurred with the Arizona Law Judges' findings (Chart 3). A total of 6 Final Decisions were issued (Chart 4). Of the six Motions for Rehearing or Review done in the first quarter, five of the Final Decisions accepted the Director's Decision which means that the Motion for Rehearing or Review was denied. One Final Decision rejected the Director's Decision, which means that the Motion for Rehearing or Review was meritorious and the original Director's Decision was incorrect and was stricken.

(Chart 1)

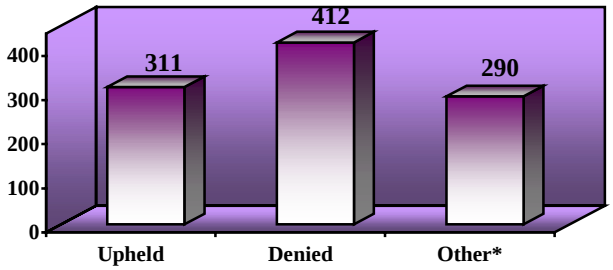
OLA Cases Received
Total 1719

**No bases for grievance, Voluntary Withdrawals, etc.*



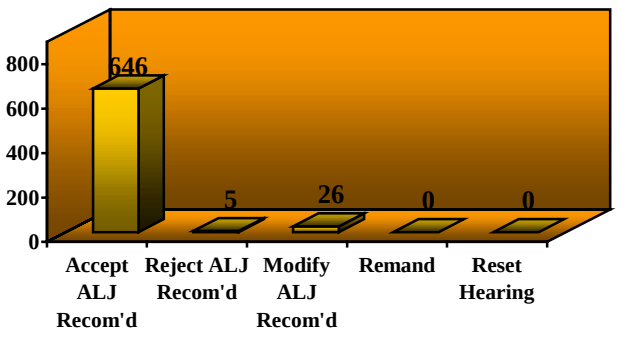
(Chart 2)

Informal Decisions Issued
Total 1013



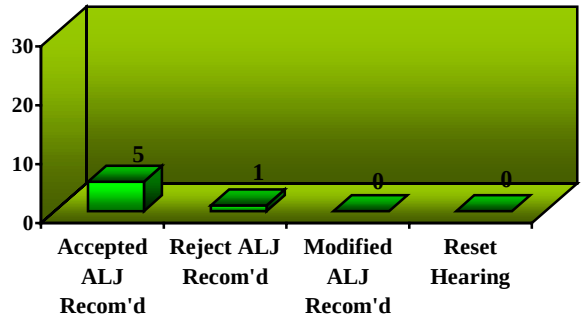
(Chart 3

Director's Decisions Issued
Total 677



(Chart 4)

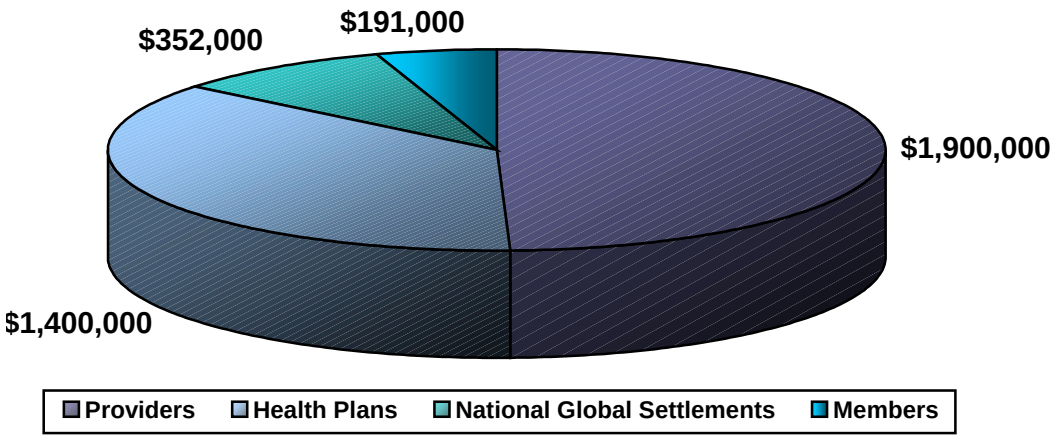
Final Director's Decisions Issued
Total 6



Fraud and Abuse

The Office of Program Integrity (OPI) reported total recoveries for CY 2001 of $3,903,188. Of this amount, over $1.9 million was recovered from AHCCCS providers, $1.4 million was recouped by or on behalf of AHCCCS health plans, and approximately $352,000 was obtained as a result of participation in national global settlements. An additional $191,000 in restitution was received from AHCCCS members convicted of committing eligibility fraud.

TOTAL RECOVERIES



During the quarter, OPI also completed an audit of prescription drug fraud. A report draft and results of the audit have been submitted to AHCCCS executive management for review. The purpose of the audit was to determine whether the program is vulnerable to prescription drug fraud and abuse, to identify and assess existing safeguards, and to explore ways to strengthen program controls. The audit focused on oxycontin and 12 other drugs considered potentially vulnerable to fraud and abuse. Expenditures for these drugs were analyzed, contractor procedures and controls were documented and tested, and pharmacy dispensing and control practices were reviewed. While detailed results of the audit and recommendations are currently under review, the audit found no evidence of prescription drug fraud and abuse in the AHCCCS program.

In November, OPI convened a quarterly fraud and abuse work group meeting, which addressed durable medical equipment (DME) fraud. A representative from the DME regional carrier for Arizona, CIGNA, presented information on DME fraud in the Medicare program. In addition, representatives from AHCCCS health plans discussed current and past concerns about DME contractors and services. The work group meeting served as a forum for sharing information among AHCCCS contractors and between AHCCCS and Medicare.

Encounter Validation Study

The Contract Year 98/99 Encounter Data Validation Study is coming to a close. Analysis of contractor feedback to the Acute and Behavioral preliminary results began this quarter. AHCCCS is sharing with our contracted health plans, the preliminary results of the 98/99 Encounter Data Validation Study. It is expected that analysis will be completed and final results released to the contractors during the next quarter.

AHCCCS has began the Contractor Year 99/00 Encounter Data Validation Study. The process for collecting all of the encounter data information is in progress and the comparison of medical records to encounters will begin during the next quarter.

Operations

Encounter and report transmissions between AHCCCS and contractors continue by the use of an Internet application that allows you to transfer files between your computer and another computer. While some problems existed in the transmitting of information, AHCCCS has plans to purchase a newer version of the Internet application eliminating any further transmitting problems.

Acute Care Program

Prior Period Coverage (PPC) Reconciliation

Under a provision of the acute care contract, AHCCCS performs a reconciliation of health plans total PPC cost experience. AHCCCS completed a final PPC reconciliation for CYE 00 in December 2001. The net amount of the reconciliation was a pay-out to the health plans of $479,996. The total pay-out represents payments made to those health plans whose costs exceeded the break even reimbursement minus the total of all monies recouped from health plans who had profits in excess of the break even reimbursement. Distributions will be made in February 2002. The reconciliation is done in stages to ensure full encounter data reporting.

Contract Renewal

The acute care contract for CYE 02 became effective October 1, 2001. Amendments to the contract included programmatic changes and other policy clarification as well as capitation rate adjustments.

Rate Adjustments

Proposition 204 increased the AHCCCS eligibility income limits for full acute care medical coverage to 100% of the FPL. Separate capitation rates were developed for the Title XIX Waiver Medical Expense Deduction and non-Medical Expense Deduction groups based on the utilization experience of the state-only members which AHCCCS anticipates may closely resemble this new population. The Office of Managed Care (OMC) will evaluate the Title XIX waiver rates throughout the year as the population grows.

Capitation rates effective October 1, 2001 were adjusted for inflation, utilization changes, expected changes in demographics due to Proposition 204, and other programmatic changes. Programmatic changes include a supplemental "kick" payment for hospitalized Title XIX waiver group members, the effect of the reinstatement of the hospital pilot program and an increase in the profit/risk contingency component.

Hospice rates were increased approximately 2.7% for dates of service on and after 10/1/01.

Analysis of the FFS fee schedule update for April 1, 2002 began, and will continue throughout the next quarter.

Operational and Financial Reviews

Operational and Financial Reviews of acute care contractors continued this quarter. During the quarter OMC and OMM conducted a review at CIGNA Community Choice. The final reports for Maricopa Health Plan were mailed in December and Mercy Care Plan's Operational and Financial Review for CYE 2001 were mailed in November.

Network Strategies Work Group

A work group organized by Health Plan Operations was formed this quarter to discuss obstacles that health plans have experienced while developing their networks. Health plan representatives have agreed to participate in this work group in an attempt to create solutions to shared network issues.

Contracts

During the period October 1, 2001 through December 31, 2001 AHCCCS:

- Initiated, awarded or amended contracts in the following areas: printing services, janitorial services, unarmed security guards, legal services, transplants, and breast and cervical cancer;
- Issued or amended Intergovernmental Agreements for DES Eligibility, ADHS Behavioral Health, and ADHS Breast and Cervical Cancer Program;
- Amended the data sharing agreement with the Internal Revenue Service; and
- Awarded additional projects to Management Consultant contractors for work on HIPAA and HRSA projects.

ALTCS Program

ALTCS Operational and Financial Reviews

During this quarter the ALTCS Review Team began the CYE 02 Operational and Financial Reviews. The focused reviews are concentrated on new contract requirements, historic problematic areas, and will also review compliance with the corrective action plans program contractors submitted as a result of the CYE 2001 reviews.

New Nursing Facility Acuity Assessment Tool

During this quarter, all ALTCS Program Contractors in the Elderly and Physically Disabled program began to use a Uniform Acuity Assessment Tool to evaluate residents of Skilled Nursing Facilities. All residents will be evaluated by January 31, 2002. The purpose of a uniform tool used by all program contractors is to create consistency in assessment, thus creating uniformity in reimbursement. After the data is compiled, AHCCCS will analyze changes from previous determinations, and may adjust reimbursement accordingly.

Network Development and Management Plans

During this quarter, all Program Contractors submitted Network Development and Management Plans. This is the first year AHCCCS has required these plans. The purpose of the plan is to identify the current status of the network at all levels (institutional, HCBS, acute, alternative residential, etc.) and to project future need based upon membership growth. The plans must include:

- Current status of network;
- Current network gaps;
- Immediate short term interventions when a gap occurs;
- Interventions to fill network gaps, and barriers to those interventions;
- Outcome measures/evaluation of interventions;
- Ongoing activities for network development;
- Coordination between contractor and outside organizations, including the member/provider council;
- Specialty populations; and
- Membership growth/changes.

Annual Enrollment Choice Transition

October 1, 2001 marked the first Annual Enrollment Choice transition. Approximately 2000 members in Maricopa County were mailed Annual Enrollment Choice information in August. Only 1.2% of those members elected to switch program contractors. There were similar transitions on November 1 and December 1. All three Program Contractors designated staff persons as Transition Coordinators to ensure uninterrupted services to those members who chose to change. There were no reported incidents of service delivery problems. The Annual Enrollment Choice process will continue on a monthly basis.

Behavioral Health

Contract Amendments

OMC's Behavioral Health Unit initiated two amendments to the ADHS/DBHS Behavioral Health contract which complete the implementation of the Covered Services Project, new behavioral health facility licensure rules, and Institution for the Mental Diseases expenditure authority.

Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21

AHCCCS, in collaboration with ADHS (the state's Medicaid Certification agency) has incorporated federal seclusion and restraint requirements in state licensing regulations as well as in the Intergovernmental Agreement (IGA) between the two state agencies. State licensing regulations for inpatient psychiatric facilities have been revised to be in conformance with 42 CFR 441 and 483. The IGA establishes ongoing monitoring activities for compliance with implementation of seclusion and restraint procedures and injury/death reporting requirements. Access to AHCCCS provider registration database has been made available to ADHS Office of Behavioral Health Licensure to facilitate monitoring of inpatient psychiatric facilities.

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JK Settlement Annual Action Plan

As part of the settlement agreement in the class action lawsuit, AHCCCS and ADHS are required to submit an annual action plan demonstrating progress in meeting the terms of this agreement. AHCCCS and ADHS have worked collaboratively with plaintiff's counsel and stakeholders to draft the first annual action plan submitted to the plaintiff's counsel on November 1, 2001.

This year's implementation activities will focus on improvement initiatives addressing the twelve key principles in the following areas:

- staff and stakeholder training;
- respite care;
- specialty providers;
- expansion of Title XIX/XXI covered services;
- state-only funded flex funds;
- medication monitoring practices;
- 300 Kids projects;
- substance abuse services;
- quality management and improvement systems; and
- stakeholder participation.

Through aggressive and collaborative efforts by AHCCCS and/or ADHS/BHS, a number of actions required under the settlement agreement and included in the initial action plan, were accomplished during the prior or current report quarter. These include: expansion of types of services, supports and authorized providers; training activities which foster delivery of services according to the principles; and expansion of the "300 Kids" projects including hiring of a "collaborator" position by ADHS/DBHS to overcome system barriers and help agencies work together more effectively.

During this report period, community forums were held across the state to both inform local stakeholders about the actions planned for the period November 1, 2001 through October 21, 2002 and to elicit feedback from stakeholders prior to finalizing the first annual action plan. The final plan was then published and distributed.

Quarterly Health Plan/Program Contractor Behavioral Health Coordinator Meeting

The OMC, Behavioral Health Unit planned and convened the quarterly meeting of the Behavioral Health Coordinators representing both Health Plans and Program Contractors. The agenda included presentations, and feedback, and dialogue on:

- Updates on AHCCCS and ADHS' community initiatives focusing on enhancing coordination of care between acute and behavioral health systems and providers;
- Refinement of the problem resolution process and forms;
- The AHCCCS survey of Health Plan Medical Directors regarding types of information to be forwarded to Primary Care Physicians from the behavioral health providers;
- The psychotropic medication project;
- Title XIX eligibility processes and coordination of care for members discharged from the Arizona State Hospital; and
- Transition and coordination of care for members transitioning from Health Plans with behavioral health benefits provided through the ADHS and Regional Behavioral Health Authority to the ALTCS program.