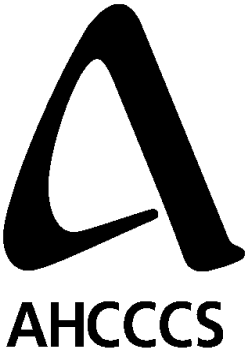

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

QUARTERLY REPORT

OCTOBER 1, 2002 THROUGH DECEMBER 31, 2002

PHYLLIS BIEDESS, DIRECTOR
SUBMITTED FEBRUARY 2003

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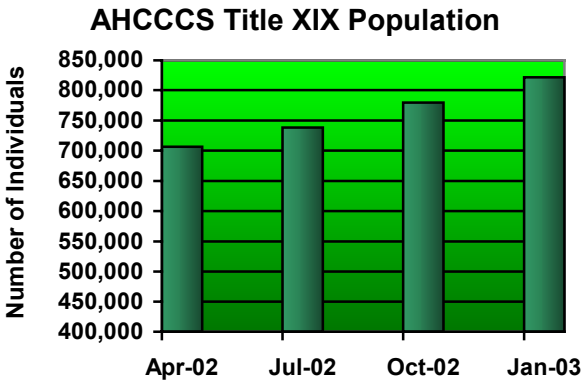
EXECUTIVE SUMMARY

This report covers the time period between October 1, 2002 and December 31, 2002. Activities this quarter included the final implementation efforts for two new programs offered by AHCCCS: The Freedom to Work program and Phase II of the Health Insurance Feasibility and Accountability Act.

Activities included the Hawaii/Arizona Prepaid Medical Management Information System Alliance (PMMIS) Alliance; operational and financial reviews (OFRs); contract awards, amendments, and renewals; Balanced Budget Act and the Health Insurance Portability and Accountability Act implementation; and the Office of Program Integrity fraud and abuse programs.

Notable changes from last quarter's report include an increase of 5.4% in the total population number of Title XIX members and a decrease of 27% in the total number of cases received by the Office of Legal Assistance.

AHCCCS POPULATION



On January 1, 2003, the AHCCCS Title XIX population totaled 821,748 members. This represents an increase of 5.4% over last quarter's enrollment figures. This number includes 785,354 individuals receiving Acute Care services and 36,394 members receiving Arizona Long Term Care System (ALTCS) services.

The total number of members is comprise of individuals eligible under the following Medicaid categories: 1931, SSI, SOBRA, HIFA I's and II's, Freedom to Work, ALTCS, Qualified Medicare Beneficiaries, Transitional Medical Assistance, Emergency Services and the Breast and Cervical Cancer Program. Also included are 110,003 Native American members.

NEW DEVELOPMENTS

Health Insurance Feasibility and Accountability Act (HIFA II) Implementation

In October 2002, AHCCCS began implementation of the HIFA II Demonstration Waiver. In accordance with Special Term and Condition #25, AHCCCS will include information on the HIFA II program in a separate section within the Quarterly Report.

Implementation occurred in two phases:

- Phase One of HIFA II was implemented on October 1 2002, when all eligible parents currently enrolled in the Premium Sharing Program and who are parents of children enrolled in KidsCare or Medicaid, became eligible for, and enrolled as, HIFA parents.

- Phase Two of HIFA II was implemented effective January 1, 2003, when eligibility for HIFA II parents was made available for the parents of children enrolled in KidsCare and Medicaid.

The Arizona Department of Economic Security (ADES) will conduct the initial screening of parents of children enrolled in Medicaid, and the AHCCCS Administration will conduct the initial screening of parents of children enrolled in KidsCare.

An expenditure limit for this new program has been set, and once funds have been exhausted, AHCCCS will stop taking applications and suspend enrollment. Eligibility determinations and enrollment will continue when there are an adequate number of vacancies in the program.

In an effort to reduce confusion, a HIFA II information kit was developed for distribution to various community organizations and providers, detailing the program and providing examples of what a member can expect to receive.

In November and December, 50,614 flyers were sent to households, which appeared to meet the eligibility criteria for HIFA II. Of the flyers sent, approximately 23% were returned expressing interest in becoming members, and a willingness to pay the premium.

All parents who are eligible under the HIFA II program must pay a premium to retain eligibility. Rates established under the HIFA II program range from $15 to $25, depending on household income.

As of January 1, 2003 the HIFA II program had enrolled 6,135 members.

Activities By Divisions

Office of the Director

Community Relations

The Community Relations Coordinator presented information on Acute Care, ALTCS, Medicare Cost Sharing, and KidsCare programs; to community groups, public and private organizations, governmental agencies and healthcare providers including:

- Ageless Times–ADES/Area Agency on Aging Newsletter
- Arizona Coalition to End Homelessness Conference
- Arizona State Hospital Staff Health Fair
- Article on ALTCS
- Blue Goose Club (retired insurance executives)
- Cigna Case Managers and Social Workers
- City of Peoria Boys and Girls Club Health Fair
- Gambro Dialysis staff with Anna Shane and Celeste Gilman
- Gateway Community College Health Administration class
- Healthy Kids Healthy Arizona Health Fair
- HIFA Overview - Children's Action Alliance Conference

- John C. Lincoln Adult Care Center
- Phoenix Ranch Market Employees Health Fair
- Senior Exposition
- Sunset Health (Medicare HMO)
- University of Arizona (U of A) Fellowship - Medical Providers from Chile

Provided training to the following groups:

- Clinica Adelante Staff (FQHC)
- People of Color Staff Training
- Arizona Association of Community
- AHCCCS Behavioral Health Services
  Health
- Kathy Fogerly, R.N., Phoenix Children's Hospital

Established and enhanced collaborations with the following entities:

- Phoenix Ranch Market
- Value Options
- Chicanos Por La Causa, Inc.
- Friendly Access Coalition
- National Alliance for Hispanic Health
- National Hispana Leadership Institute
- City of Phoenix Lead Abatement Program
- City of Phoenix Head Start Program
- People of Color, Inc.
- Clinica Adelante

In addition, the Community Relations Coordinator:

- Provided information to OPAC for the Annual State KidsCare Report, Annual CMS KidsCare Report, and the Quarterly Progress Report;
- Met with the City of Phoenix Human Services Department (Head Start) to discuss Medicaid in the Public Schools (MIPS) program and determine how AHCCCS could assist them in encouraging their 14 Head Start contractors to utilize the program. A meeting has been scheduled for AHCCCS and the City's Head Start Program Directors in January;
- Participated in a teleconference with representative from the Inter-University Program of Latino Research to discuss KidsCare and access to health care by Latino children;
- Participated in the "Moving Forward: CHIP for Hispanic Children" conference in Washington, DC held by the National Alliance for Hispanic Health Care;
- Participated in the National Hispana Leadership Institute in Orlando, Florida;
- Provided "master document" for the AHCCCS Medicare Cost Sharing brochure to Sun Health MediSun (Medicare HMO) for them to print on their own. They perform Medicare Cost Sharing outreach on their own;
- Provided KidsCare Power Point Presentation to U of A MSW student to utilize for a class project; and

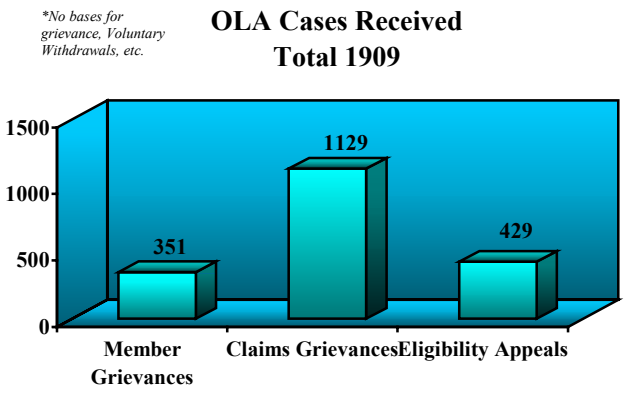
- Attended "Suite Night" at the America West Arena sponsored by Arizona Department of Health Services' Office for Tobacco Education and Prevention Program

Office of Legal Assistance (OLA)

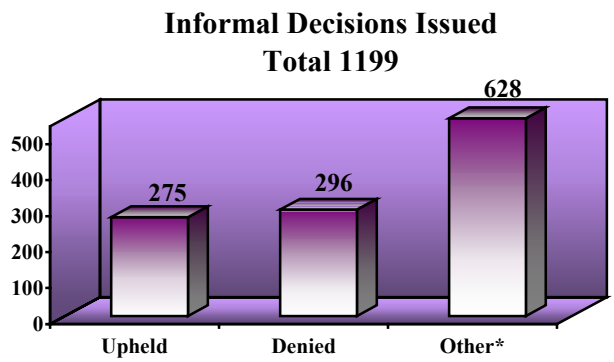
OLA received 1909 cases. Cases fell into one of three types: Member grievances, claims grievances, and eligibility appeals. (Chart 1). Over 59% of the cases filed involved grievances regarding claims. OLA resolved 1199 cases informally, eliminating the need for a formal hearing. (Chart 2). The Director issued 830 decisions. The majority of these decisions concurred with the Arizona Law Judges' findings. (Chart 3). A total of 20 Final Decisions were issued. (Chart 4)

(Chart 1)

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



(Chart 2)



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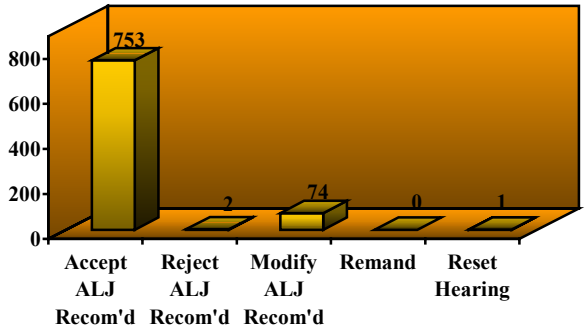

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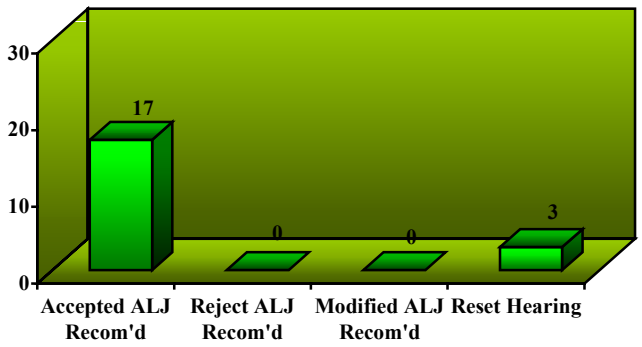

Office of Policy Analysis and Coordination

Native American Activities

The Hopi Tribe and AHCCCS signed an Intergovernmental Agreement (IGA) for the delivery of ALTCS case management services to Hopi Elderly/Physically Disabled ALTCS members. The IGA provides for the full range of benefits under the ALTCS service package.

The Navajo Nation finalized contracts with three Indian Health Service facilities now referred to as a '638 tribal provider. The three tribal organizations which will provide services to approximately 50,000 members and they are:

- Utah Health Care System, Inc.;
- Winslow Indian Health Care Center, Inc.; and
- Tuba City Regional Health Care Corporation.

BBA

AHCCCS developed a team to review the provisions of the BBA and the applicability to the AHCCCS program. This team continued to review current AHCCCS rules, policies, and procedures to determine where changes are needed to comply with the BBA.

Division of Member Services (DMS)

AHCCCS Freedom to Work (FTW) Program

Implementation of FTW, Arizona's Medicaid program under the Ticket to Work and Work Incentives Improvement Act is scheduled for January 1, 2003. AHCCCS finalized policy and application procedures, and developed processes to smoothly transition individuals to FTW when they have earnings or resources that exceed the limits for other Medicaid coverage groups. Employees were recruited from other AHCCCS offices to staff a small, centralized unit to handle the 700 enrollees expected during the program's first two years.

A new database was developed which allows staff to maintain demographic and eligibility information for this population. Additionally, development of a premium billing and collection process was completed. DMS trainers provided an overview of this new program to staff throughout the agency, and trained staff to identify and refer individuals to the new unit.

In November, information and applications were mailed to 258 individuals who were receiving Specified Low Income Beneficiary, Qualified Individual-1, or Qualified Individual-2 benefits and appeared to meet the FTW eligibility criteria. During December, AHCCCS processed applications and approved Medicaid eligibility, beginning January 1, 2003, for 50 individuals with disabilities.

Management Evaluation (ME)

In March 2002, AHCCCS' Quality Compliance Administration began a ME process as part of oversight efforts of the eligibility determinations made by the Arizona Department of Economic Security (ADES). The ME team conducts full reviews of selected local offices and hospital eligibility sites to determine the:

1. Effectiveness of operational processes, including supervisor quality assurance reviews;
2. Accuracy of case approvals, denials, and discontinuances; and
3. Related customer service issues.

If any area of review results in substandard scores, the local offices are required to produce and implement a corrective action plan. A follow-up re-review is then conducted within 90 days to determine the degree of improvement as a result of the corrective action taken. Since implementing this new process, the ME team has conducted 10 full reviews and seven re-reviews as part of this process.

Office of Program Integrity (OPI)

Overview

The AHCCCS Office of Program Integrity coordinates agency-wide efforts to combat fraud and abuse in the Arizona Medicaid program. OPI focuses on strengthening program safeguards, assessing areas of potential vulnerability, and investigating allegations of fraud and abuse. OPI addresses provider fraud, member eligibility fraud, as well as employee fraud and abuse.

OPI strengthens and maintains program integrity by effectively preventing, detecting, and investigating fraud and abuse in partnership with other AHCCCS divisions the Attorney General's (AG's) Office, health plans and program contractors.

OPI continues to improve its effectiveness in identifying fraud and abuse within the AHCCCS program. Activities during this quarter resulted in the recovery of monies received from OPI investigators, settlement agreements, convictions and court orders dollars; referrals to the AG's Office; assessment of civil monetary penalties; disbarment from the program; suspension of provider payments; internal employee investigations; and identifying program overpayments.

Major Activities

An individual completed an application for ALTCS benefits for his elderly father and intentionally withheld crucial financial information that would have rendered the client ineligible for Long Term Care benefits. OPI has received full restitution in excess of $29,000 to cover the monies spent for this client.

A Licensed Nurse Practitioner (LPN) was indicted for two counts of forgery for filing two separate applications to become an AHCCCS Provider, which contained false statements. The provider was disbarred from the AHCCCS program after an investigation by OPI, and assessed $173,948 in civil monitory penalties for filing false claims.

A provider billing under incorrect CPT Codes and incorrect billing of discharge services was referred to the Attorney General's Office.

OPI evaluated 34 fraud referrals and from the referrals received, criminal investigations were opened on several providers relating to the following:

- Billing for services not provided,
- Billing for services performed by others,
- Overpayments, and
- Utilizing unqualified personnel.

Two AHCCCS employees were found guilty of illegally placing their children onto the KidsCare program by entering the data into the eligibility computer system. Both employees were terminated and as a part of their probation, prohibited from working for any Medicaid agency or provider for a period of five years. In addition, they will be required to make full financial restitution to the agency. AHCCCS initiated corrective action to prevent this activity from happening in the future.

Office of Managed Care (OMC)

HIPAA

OMC staff worked with the AHCCCS internal teams and consultants in assessing AHCCCS' and its contractors' readiness to comply with HIPAA regulations, to identify gaps in current compliance, and to development action plans and timelines for reaching full compliance.

Balanced Budget Act (BBA) Revised Rules - Analysis and Implementation Project Teams

OMC staff continued an in-depth analysis of the revised BBA managed care regulations to identify gaps between current practices, policies, contract language, and to develop, for those areas identified as gaps, a detailed compliance implementation plan.

Operational and Financial Reviews (OFRs)

Behavioral Health Unit (BHU)

The BHU participated in OFRs of the four Acute Care and Long Term Care contractors scheduled during the reporting period. The behavioral health portion of the OFRs utilized review tools based on contract standards that were developed for the Acute Care and ALTCS contractors.

The review tool for Acute Care contractors included the following behavioral health related content areas:

- Behavioral health policies and procedures,
- Communication with members (e.g., member handbooks),
- Coordination of care with behavioral health providers,
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) / behavioral health screening follow-up, and
- Monitoring of Primary Care Providers' (PCP) medical management of behavioral health disorders.

The review tool for ALTCS contractors included the following behavioral health related content areas:

- Adequacy of the behavioral health provider network;
- Contractor mechanisms for ensuring coordination of behavioral health services with the member's primary care provider;
- EPSDT / behavioral health screening and follow-up;

- Quality of behavioral health care, including a standard to assess the contractor's inclusion of the member/parent/guardian in treatment planning decisions, and
- Timeliness of behavioral health screening, referral, and provision of services.

BHU staff also reviewed and provided feedback to ADHS/Division of Behavioral Health Services (ADHS/DBHS) management on its proposed Administrative Review Tool for use in conducting the annual OFRs of the contracted Regional Behavioral Health Authority (RBHA). Staff participated in ADHS' staff training for conducting the reviews, and accompanied ADHS on one of the reviews as one mechanism to assess ADHS' performance in monitoring its contractors. ADHS has moved increasingly from a review of structure (policies, procedures, etc.), to one of assessing actual contractor performance against policies and contractual requirements.

ALTCS Unit

The ALTCS Review Team began OFRs for Contract Year Ending 2003 (CYE 03). One contractor was reviewed in November and one was reviewed in December. Reviews are scheduled monthly through May 2003.

The CYE 03 reviews differ from past reviews in several areas due to AHCCCS' desire to make the reviews more out-come oriented. There is also increased emphasis on analysis of the program contractors' corrective action plans from the CYE 02 reviews. This follow-up provides better assurances that the program contractors have appropriately and consistently implemented their corrective actions.

Program Contractor Strategic Planning Session

In October, OMC and the Office of Medical Management (OMM) met with the ALTCS program contractors for a half-day strategic planning session. The main topics of the session were:

- Improving the Monitoring of Members in HCBS Settings,
- Medicare/Medicaid Dual Enrollees, and
- Provider Relations.

As a result of the session, a decision was made to conduct more detailed forums on the issues of Medicare/Medicaid dual eligible enrollees, and member issues regarding behavioral health needs.

Operations Unit

OFRs of Acute Care contractors continued this quarter. OMC, in conjunction with OMM, conducted reviews at CIGNA Community Choice and Arizona Physicians Independent Physicians Association (APIPA). The final report for Mercy Care Plan for CYE 02 was mailed to the health plan in December.

Behavioral Health Unit

Contractor Technical Assistance and Collaboration - Network Development

BHU continued to meet regularly with ADHS/DBHS staff to develop strategies to enhance the network of behavioral health providers; particularly for Therapeutic Foster Care, Personal Assistance, Family Support, and Respite services.

Extensive assistance was provided by BHU to ALTCS contractors in the development of a behavioral health provider network, focusing on the above behavioral health covered services and in developing appropriate community placement options for members who are in inpatient psychiatric settings.

Coordination of Care - Grant Application

BHU staff prepared a grant proposal to conduct a feasibility study to determine the potential opportunities and resources that would be required to develop a limited integrated patient information system. The new system would allow the sharing of key patient information between a member's PCP and their behavioral health provider. AHCCCS submitted the grant in November 2002, and is awaiting a decision from the foundation grant review board.

Regional Collaboration To Enhance Coordination of Care

BHU staff continued to participate in regularly scheduled meetings with each RBHA, the health plans serving members in that geographic area, providers, and representatives of ADHS/DBHS. The meetings are designed to facilitate regional collaboration and problem solving to enhance coordination of member care between the PCP and the behavioral health provider.

Survey of State Medicaid Programs With A Behavioral Health Carve-Out

During July through September, BHU sent a survey to 14 state Medicaid programs that have a behavioral health carve-out model. The survey was designed to identify other states' best practices in coordination of care between the physical and behavioral health provider systems. AHCCCS received responses from 11 of the states. Staff developed a matrix of responses and presented the preliminary summary of responses to the Integration of Care Committee on September 27, 2002.

During this quarter, staff contacted a number of the states that had indicated some progress in improving coordination of care, to engage them in more detailed conversations about their experiences, and as applicable, best practices in this area. Staff will present the findings to both the AHCCCS Medical Director and the Integration of Care Committee for discussion and potential adoption/modification for use in the AHCCCS system.

Encounter Processing, Analysis, and Rate Setting Unit

Encounter Validation Study

Feedback from contractors regarding Contract Year 1999/2000 Encounter Data Validation Study preliminary results were received and analysis underway. It is expected that final results will be sent to contractors during the next quarter. For Contract Year 2000/2001 Encounter Data Validation Study, contractors have been contacted to begin the initial step of medical record and/or file collection process.

Encounter Operations

Encounter and report transmissions between AHCCCS and contractors continue via File Transfer Protocol - an Internet application that allows the transfer of files between one computer and another computer on the Internet. As a result of the approaching HIPAA transaction implementation deadline, the Operations area is working with contractors to significantly reduce both new and aged

pended encounters. One goal is to reduce total pended encounter volume of submitted encounters. A low pend volume should help our contractors during the HIPAA transaction transition period.

Ratesetting

- Federal Fiscal Year (FFY) 2002 disproportionate share hospital payments were made,
- The first FFY 03 critical access hospital payments were made, and
- Transportation rates for January 1, 2003, were frozen at their previous levels.

Finance Unit

Prior Period Coverage (PPC) Reconciliation

Under a provision of the Acute Care Contract, AHCCCS offers a reconciliation process for health plans with total PPC cost experience that is more than the break-even reimbursement associated with PPC. AHCCCS will reimburse 100% of a contractor's excess reasonable costs and will recoup profits in excess of costs. The reconciliation is done in stages to ensure full encounter data reporting. AHCCCS completed the final stage of the PPC reconciliation for CYE 01 in December 2002. The net amount of the reconciliation was an additional payout to the health plans of $229,938, for a total payout of $10,468,839. The final reconciliations were given to the health plans for their review and approval, and if approved, the final payments will be made by February 2003.

BBA

AHCCCS formed a team to review the provisions of the BBA and the applicability to the AHCCCS program. During the quarter ending December 31, 2002, this team continued to review current AHCCCS rules, policies and procedures to determine where changes are needed to comply with the BBA.

Rate Adjustments

Capitation rates effective October 1, 2002, were adjusted for inflation and utilization changes. The PPC reconciliation was eliminated for CYE 03 and the KidsCare capitation rates were blended with the 1931/SOBRA capitation rates.

Operations Unit

CYE '04 Request for Proposal (RFP)

OMC, in conjunction with OMM, and the Division of Business and Finance, continued developing processes and teams for the CYE '04 RFP for Acute Care Services. It is expected that the RFP will be released to the public in early February 2003. The RFP teams continue to develop the document, scoring criteria, and submission requirements, as well as review any necessary policy changes.

Division of Business and Finance (DBF)

Contracts

During the period of October 1, 2002, through December 31, 2002, AHCCCS initiated, awarded or amended the following contracts/agreements:

- Issued amendment #20 for the Behavioral Health agreement with ADHS to amend the Quality Performance standards section;
- Awarded HIPAA Translator Software & Consulting Services to Mercator Software, Inc. of Wilton, Connecticut;
- Issued amendments for all nine Acute Care contracts to add rates for HIFA II parents;
- An amendment was issued for Banner Health Systems' Transplant contract to increase their rate on bone marrow transplants by 2.8%;
- Medicaid Eligibility Verification System RFP entered evaluation this quarter;
- Completed the revised IGA for Comprehensive Medical and Dental Program to ADES (filed with the Secretary of State in December);
- Finalized the Memorandum of Understanding to establish a digital signature procedure for AHCCCS;
- Produced the final draft of the Third Party Liability Recovery Services RFP, pending issue early January 2003;
- Renewed both Health Care Group contracts for an additional twelve months.
- Renewal amendments were issued for our Flagstaff and Show Low janitorial contracts renewing them through 2003; and
- The AHCCCS Copiers, Mail Service and Warehouse Service contract with IKON, Inc. was renewed.

Work continues on a new Acute Care RFP for health plan contracts effective October 1, 2003. Separate teams are working on their portion of the draft RFP and will be pulling together the document during the next quarter.

Claims Unit

The Claims Unit is still dealing with problems initiated by implementing new imaging software at the end of August. Over 25,000 claims were omitted from September to December, but have now been entered into the system.

A new Electronic Claims Submission process was implemented in December. Providers are encouraged to submit claims electronically.

AHCCCS' partnership continues with APIPA to resolve many MIPS program claim issues and system incompatibilities.

The HIPAA Privacy and Security requirements for Claims are being reviewed, as well as ongoing requirements for the claims transactions and formats.

The Reinsurance and Provider Registration Units have been transitioned from DBF/Claims to OMC and OMM respectively, effective January 1, 2003.

Division of Information Systems

HIPAA

This 1996 Administrative Simplification Act standardizes the administrative and financial health care transactions in order to reduce the costs and administrative burden of health care. 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.

Transactions and Code Sets: The mapping documents are nearly completed for the transactions, and design work has begun. A contract was awarded to the transaction translator, Mercator, on December 23, 2002.

Privacy and Security: A detailed assessment was completed based on a staff survey (42% response) regarding the use of protected health information and further investigations in each department. The report of this assessment along with the recommendations has been developed for review. Materials and a training work plan and has been completed and computer based training, as well as other training sessions are being finalized.

Hawaii/Arizona PMMIS Project

Hawaii and Arizona have entered into an agreement to implement the AHCCCS PMMIS for the State of Hawaii Medicaid program, through a joint effort of Hawaii Department of Human Services and AHCCCS. Both states expect to benefit from the enhancements that are required to support Hawaii, and together they will share the ongoing maintenance and operation of the system.

The Fee-for-Service claims system was successfully implemented for Hawaii in November 2002, with three years of claims converted. Staff members were trained on inquiry functions, prior authorization, and medical review. Similar to Arizona, the system handles Medicare crossover claims, and providers can submit their claims electronically.

AHCCCS Customer Eligibility (ACE)

A DMS eligibility redesign team re-engineered the entire eligibility determination process, defining 27 functional requirements. Some of the new functionality is already being implemented into manual processes, while other requirements will be implemented together with the ACE system.

The proposed system has the following objectives:

- Dramatically improve customer service by a substantial reduction in paper, quick entry into services, increased assistance to clients needing verification;
- Easily integrate new eligibility programs, as required, such as, 100% FPL, KidsCare, Premium Sharing;
- Integrate new concepts, such as the Universal Application; and
- Streamline the eligibility process to increase productivity, improve the quality of eligibility determinations and reduce the time it takes to determine eligibility through easier data entry, reduction in manual processes, and utilization of knowledge management principles.

The pilot office implementation is on target for February 2003. Process testing has been completed successfully, and integration testing was wrapping up with no significant issues that

would impact the pilot implementation. Including the pilot office in the integration testing, allowed staff to enter current cases into the system and compare the results to the existing system, and by doing so they were able to uncover problems that the other testers did not. This form of testing ensured that the pilot office was more prepared for the actual implementation.