MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 423-S Statehouse, at 1:30 p.m. on March 16, 1993.

Approved: 3-31-93
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 16, 1993 in Room 423-S of the Capitol.

All members were present except:
Representative Bishop, excused.

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Dr. Robert Harder, Secretary Department of Health and Environment
Mary Kopp, Assistant Director of Kansas State Nurses Association, Chair of Kansas Immunization Task Force
Mark Tallman, Director of Governmental Relations, Kansas Association of School Boards
Kay Farley, Chair of Children/Youth Advocacy Committee, Corporation for Change
Commissioner Robert Epps. Department of SRS
Cheryl DeBrot, Director at large, Kansas Respiratory Care Society
Cheryl Dillard, Public Affairs Manager, Kaiser Permanente, Overland Park, Kansas
Deborah Oringer, Executive Director of Principal Health Care of Kansas City (written only)
Tom Bell, Kansas Hospital Society
Rep. Helgerson

Others attending: See attached list

Chair called the meeting to order, drawing attention to Committee minutes for March 10, 1993, asking members to read them carefully. If there are corrections the Committee secretary should be called by 5:00 p.m. tomorrow, (March 17), otherwise, the minutes will be considered approved as presented.

Chair drew attention to the Agenda, SB 199 , and requested a staff briefing.

Ms. Correll gave a comprehensive explanation of SB 199. She noted this legislation will amend a statute enacted last year that would require immunizations for every pupil being enrolled in school for the first time. SB 199 will amend that law from last year, by requiring each child enrolled in a pre-school or a day-care operated by a school, would be required to have the same immunizations as children enrolled in a school. Ms. Correll noted the omission of this requirement may have been an oversight in the bill enacted last year.

CHAIR OPENED HEARINGS ON SB 199.

Dr. Robert Harder, Secretary of Department of Health and Environment offered hand out, (Attachment No. 1) He noted the Department of Health and Environment has worked with the Kansas Commission on Children, Youth and Families, the Department of Education, the Department of SRS, and many others in providing immunizations to babies 0-2. The goal is to have 100% of babies in Kansas immunized by 1995. By that date, he noted, a tracking system will be in place so that notification to parents for follow-up immunizations for their children may be done. The proposed concept fits in well with the effort to immunize all children, i.e., by adding pre-school programs operated by school districts. He urged support. He noted Operation Immunize dates are set for April 24, 25, 1993.

Mary Kopp, Chairperson of the Kansas Immunization Task Force, spoke in behalf of the Kansas State Nurses Association , (see Attachment No. 2) She stressed the importance of moving the immunizations for children from kindergarten to the first time pre-schoolers enroll for school in licensed day care programs. She indicated a study done by the Department of Health and Environment indicated only half of Kansas two year olds are properly immunized. SB 199 will help to remedy this situation.

Mark Tallman, Director of Governmental Relations, Kansas A sociation of School Boards offered hand out, (Attachment No. 3) He spoke in support of SB 199, and noted as more schools move to provide preschool services, it is the belief that SB 199 is an appropriate measure for encouraging the better health of all children. He noted support for the amendments made by the Senate to remove section (2) from SB 199. He noted HB 2306 is the legislation that would give the schools specific authority to operate day care programs. He noted many school districts currently contract with day care providers to provide such services. He noted there was a bit of ambiguity in SB 199 since HB 2036 had not yet been passed.

Kay Farley, Chair of Children and Youth Advocacy Committee Corporation for Change offered hand out (Attachment No. 4). She indicated SB 199 is a good step toward achieving the goal of early immunization of Kansas children. This legislation will target children attending preschools and day care centers operated by schools. She stated support.

Chair opened the meeting for questions from members of conferees.

Numerous questions were asked, i.e., some school districts currently are providing day care; some school districts are interested in beginning programs to provide day care; it is the understanding that those services contracted for by schools are already regulated by the state. It was noted the enrollment of a child would depend upon compliance regarding immunization requirements.

Dr. Harder was questioned if he thought a smoking ban would discourage family day care providers. Dr. Harder replied, if losing some day care providers were lost on that basis, then those kinds of providers were those that should be lost. Dr. Harder noted in response to a question regarding the state being too intrusive on the rights of families in many cases, stated that without an immunization program in place, there is a high risk of epidemics which then would reduce the freedom of families as they could be faced with unsurmountable medical problems and medical costs which could in many cases involve the state directly with these costs. It was noted that compliance in regard to immunization records, would depend on the licensure of a facility. The Department does rely on a facility to be truthful in their record keeping.

CHAIR CLOSED HEARINGS ON SB 199.

Chair directed attention to SB 119, and requested a staff briefing.

Ms. Correll gave a comprehensive explanation of SB 119, noting this legislation carryies out one of the recommendations of the Joint Committee on Health Care Decisions to direct the Secretary of SRS to enter into a contract for a pilot project to be conducted in two counties in the state during the fiscal year ending June 30, 1995. She noted SB 119 was amended by the Senate after a considerable amount of testimony was given indicating the importance of allowing considerable lead time in respect to the start up of these pilot programs. Ms. Correll noted one county was designated as Sedgwick while the other county would be specified by the Secretary of SRS. She drew attention to new language and noted a Task Force would be appointed by the Secretary.

CHAIR OPENED HEARINGS ON SB 119.

Commissioner Epps, Department of Health and Environment offered hand out (Attachment No. 5), written testimony, (5-A, balloon amendment). He urged support, and noted managed care programs take nearly 2 years to design, develop, and implement. Educational programs at a state and community level are vital; a staff of 2.5 is required for every 1000 recipients. He noted he would request a revised fiscal note. He detailed amendments proposed, i.e., changing "Pilot Project" to "managed care" throughout the bill; on page 1, line 18, to add "may negotiate and enter into contracts for managed care projects to be conducted in two geographic areas as recommended by the SRS task force and determined by the SRS secretary. The managed care projects will be fully operational by July 1, 1995"; page 2, line 19, to insert "to include two physicians, one hospital administrator, one managed care administrator, two consumer advocates, one representative from Healthy Kids Corporation, one SRS area office representative, one medical services representative. He noted other small language changes related to changing verbage to "managed care".

Cheryl DeBrot, Kansas Respiratory Care Society offered hand out (Attachment No. 6). She drew attention to her testimony, and noted there would be information provided later to members regarding Pulmonary Rehabilitation. She spoke in support of SB 119, noting the services provided in the pilot projects of managed care for Medicaid recipients helps to prevent illness and reduce the health care costs of caring for patients with Chronic Obstructive Pulmonary Disease (COPD). She explained the symptoms of individuals at high risk for COPD. She urged support of SB 119.

Cheryl Dillard, Public Affairs Manager, Kaiser Permanente offered hand out , (Attachment No. 7), and drew attention to testimony provided in her hand out from Deborah Oringer, who had given testimony in the Senate Committee but was unable to appear today before the House Public Health and Welfare Committee. Ms. Oringer is experienced with a managed Medicaid program, and her comments, noted Ms. Dillard, would be beneficial to members as they deliberate SB 119. She urged support.

Tom Bell, Kansas Hospital Association (Attachment No. 8,)noted health care costs continue to escalate in spite of the fact many providers, including hospitals have not been given rate increases in recent years. The major problems of rising costs is utilization. What is needed, is a program developed where the incentive is to keep people well so they don't have to use the system so much. By moving toward a system of managed care, the medical assistance program can begin to deal with these problems. He drew attention to the Arizona program, (see Attachment No. 8-A), and noted those involved with this program in Arizona are pleased with its operation and there is an indication of reduction of costs for medical assistance. He stressed the following, i.e., the final product should not be too hastily prepared; it is important to bring all interested parties to the table as plans are formulated; the use of consultants to provide information from other state projects could be beneficial. He noted the amendments made by the Senate have acknowledged these needs.

Rep. Helgerson, (no written testimony provided), noted the SRS Subcommittee had made recommendations that three model pilot projects be implemented by the Department of SRS. He detailed background information; explained why the county of Sedgwick had been chosen, and why it is a good choice;
noted the Appropriations Committee is very much in favor of the program outlined in SB 119; noted the Department of SRS thinks there can be a cost savings of from 5% to 7%.

Chip Wheelen, Director of Public Affairs, Kansas Medical Society (no written testimony), noted the Kansas Medical Society had not established a position on SB 119 because they were awaiting a response to an inquiry from the Sedgwick County Medical Society on their view of this legislation. He then read a letter of support he had just received from the Sedgwick County Medical Society that expressed support.

Alan Cobb, representing four Wichita Hospitals, (no written testimony), concurred with Mr. Wheelen's comments and requested that as members deliberate the bill they give consideration that an area representative should be appointed to the Task Force.

At this time, Chairperson Flower recognized and welcomed a group of young people visiting the Committee from the Kansas Farm Bureau.

Chair opened the meeting for questioning of the conferees on SB 119.

Numerous questions were asked, i.e., it was noted a 5%-7% would be the range of cost avoidance, actually decreasing the rate of increase, not offering a particular savings. Rep. Helgerson noted there could be 2,3,or even 4 programs eventually. There was discussion in regard to the language regarding authority for the Department of SRS being "may" or "shall". It was noted there is not language to direct counties to contribute funding for this project. It was further noted the Arizona plan is moving away from counties contributing to funding of their project. It was noted many states are heavily involved with private contracts for managed care. There were numerous questions in regard to the issue of competitive bids for contracts.

CHAIR CLOSED HEARINGS ON SB 119.

Chair noted if there were no objections, there would be discussion and possible action taken on SB 199, heard earlier today. There were no objections from members.

Rep. Swall moved to report SB 199 favorably for passage, seconded by Rep. Rutledge. Discussion began.

Mr. Furse was asked to give an update on HB 2036 which might perhaps impact SB 199. He did so, noting HB 2036 would require that day care facilities operated in schools to be licensed, and indicated this legislation was requested by Rep. Chronister and Rep. Wagnon, and had been passed out of the House.

Vote taken. Motion carried.

At this point, Rep. Swall asked for an updated report from the Chair on the social worker student loan legislation. He indicated he had talked with Rep. Heineman and Mr. Furse regarding procedures required for a hearing on this bill. He again asked the Chair to update the Committee on the status of this bill. He then asked further if the Chair would entertain a motion to request the bill be re-assigned to this Committee.

The Chair stated she had called Chair Chronister detailing the request made by Rep. Swall and noted Rep. Chronister stated, she took note of this request. Again today, March 16, the Chair stated she had spoken with Rep. Chronister, since Rep. Swall had indicated to the Chair that he had spoken to Rep. Heineman, and Rep. Chronister said that Rep. Heineman had not contacted her at all about the bill in question. Again, Rep. Swall asked the Chair if she would entertain a motion to request the Speaker of the House to re-assign the bill to this Committee. Chair inquired of Mr. Furse if this would be a proper procedure. Mr. Furse indicated the Speaker is the individual that could re-refer the bill, or the Committee where the bill is now assigned could also request it to be re-assigned. Either a written or verbal request would be in order, as bills are re-referred sometimes by request. Chair Flower indicated she would entertain such a motion.

Rep. Swall made a motion the Committee request the Speaker of the House to re-refer Social Work Scholarship bill to this Committee for consideration, seconded by Rep. Nichols. (Rep. Swall did not know the number of the bill.) Mr. Furse stated the number of the bill is HB 2362.

Discussion began. It was noted by some members, there are very few bills being re-referred this year. Rep. Swall noted he wasn't pushing the bill, it is just a request to answer a problem indicated by the Department of SRS regarding a shortage of social workers in rural areas. He just wanted the Committee to know this isn't something he has a real strong personal attachment to. It was noted by some, it would perhaps be better to talk to the Speaker personally, rather than file a letter of request. The Chair indicated she had not personally requested the Speaker thus far to re-refer any bills, so she could not indicate what his preference was to re-referring legislation this year. She offered to speak to Speaker Miller if that is what the Committee wishes her to do. Chair asked Rep. Swall if he had spoken to Rep. Heineman, (sponsor of HB 2362). Rep. Swall stated, he had talked with Rep. Heineman who had indicated he wouldn't push this proposal since he was involved with other things. Chair stated the Speaker had indicated to Committee Chairs, he is hopeful Committees can conclude their business this week. Chair was asked if she felt sufficiently directed to convey this request to the Speaker. The Chair stated she would be happy to convey the request for referral of HB 2362, but she would not push it.

At this point Rep. Swall asked to withdraw his motion because he felt there was not sufficient support from the Committee. Rep. Nichols agreed to withdraw his second.

At this point Rep. Wagle requested the Chair speak personally to the Speaker of the House on this issue under discussion.

Chair adjourned the meeting at 3:03 p.m.

The next meeting is scheduled for March 17, 1993.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-16-1993

NAME	ORGANIZATION	ADDRESS
Bob Williams	KS. Pharmacists Assoc	Topeka
Tom Bell	KHA	Topeka
[illegible]	[illegible]	Topeka
Mark Tallman	KASB	Topeka
Cheryl DeBrot	Ks. Resp Care Society	Topeka
Don Richards	KS Resp Care Society	Topeka
Kay Farley	C4Y Advocacy Committee for Comp. for Change	Topeka
Chip Wheelen	KS Medical Soc	Topeka
Joyce Seagraves	SRS	Topeka
Robert Epps	SRS	Topeka
Michelle Liesten	PMA	Topeka
Karen Catalano	Intern / Rep. Bishop	Lawrence
Sandra Jamerson	KPHE	Topeka
Cheryl Dillard	Kaiser Permanente	Overland Park
[illegible]	Tyson	
HEATHER LANDIS	CHILDREN'S LAW SCIENCE COMM. ON PUBLICATION FOR KS	TOPEKA
Margot G. LENZI	~~MARION~~ Boehringer Ingelheim Pharm Inc	COLUMBIA, MO
HARRY SPRING	HUMANA	KC, MO
Richard F. Hamaker	Sterling Med Center	Sterling

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
[redacted], *Secretary*
Robert C. Harder

Reply to:

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 199

KDHE supports SB 199.

KDHE has teamed up with the Kansas Commission on Children, Youth and Families, Department of Education, SRS and many others in providing immunizations to babies 0-2. We hope to have 100% of the babies immunized by 1995. At that point we would like to have a tracking system in place so we could notify parents of the need for follow-up shots once the baby is born.

This concept fits in well to this legislation because there is an increasing number of children in out-of-home care. With the previous legislation which covered regular day care, this now adds pre-school programs operated by school districts.

SB 199 closes the loop from the standpoint of children in out-of-home placements. This enhances our possibility for 100% immunization of young children in the state.

KDHE urges your support of this legislation.

Testimony presented by: Robert C. Harder
Secretary of Health and Environment
March 16, 1993

PH+W
3-16-93
Attm #1

KSNA

the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT
Mary Kopp MN, RN
Assistant Director
Kansas State Nurses Association
700 SW Jackson, Suite 601
Topeka, KS 66603-3731
(913) 233-8638

SENATE BILL 199

Madam Chairperson and members of the House Public Health and Welfare Committee, my name is Mary Kopp MN, RN and I am the Assistant Director of the Kansas State Nurses Association as well as the Chairperson of the Kansas Immunization Task Force.

There is great wisdom in moving the traditional gatekeeper regarding immunizations status back from kindergarten to the first time preschooler or those in licensed day care programs. To the legislatures credit last year's bill action addressed the thoroughness of immunization recordkeeping within registered home day care. I can not stress enough the need to continue pushing back the dates when the immunization status is evaluated. As you well know a (KDH &E) study indicated that only one half of Kansas 2 year olds are properly immunized. However upon entry into kindergarten compliance, according to some studies reaches 94-99%. It is as if a final immunization alarm sounded. For those who ignored the alarm, children between 2-5 years of age remain at high risk of contracting numerous childhood diseases such as measles and pertussis. Kansas State Nurses Association supports the addition of licensed day cares and preschools as earlier gatekeepers for immunization compliance.

PH&W
3-16-93
Attm #2.

KANSAS ASSOCIATION OF SCHOOL BOARDS

1420 S.W. Arrowhead Rd, Topeka, Kansas 66604
913-273-3600

Testimony on S.B. 199
before the
House Committee on Public Health and Wealth

by

Mark Tallman, Director of Governmental Relations
Kansas Association of School Boards

March 16, 1993

Madam Chairperson, Members of the Committee:

Thank you for the opportunity to comment on S.B. 199. KASB appears today as a proponent of this bill. We support immunization requirements for school children, and last session supported the new requirement that pupils entering school for the first time receive health assessments.

As more schools move to provide preschool services, we believe this bill is an appropriate measure for encouraging the better health of all children.

We also support the Senate amendments which removed section 2 from the bill as introduced.

Thank you for your consideration.

PHealth
3-16-93
Attm #3

SENATE BILL NO. 199
House Public Health and Welfare
March 16, 1993

Testimony of Kay Farley, Chairperson
Children and Youth Advocacy Committee
Corporation for Change

Representative Flower and Members of Committee:

Thank you for the opportunity to appear before you today. I appear in support of Senate Bill No. 199.

"The Blueprint for Investing in the Future of Kansas Children and Families" was adopted by the Special Committee on Children's Initiatives and reported to the 1992 Legislature. The Blueprint places a priority on early immunization of children. (Target IV. A. 1. and 3.).

In response to the Blueprint recommendations, the 1992 Legislature approved House Bill No. 2694 which mandated each child cared for in a registered family day care home to have current immunizations as determined necessary by the Secretary of Health and Environment. This legislation was a good step toward achieving the goal of early immunization of Kansas children.

However, a gap still exists for those children who attend preschools and day care centers operated by schools. Senate Bill No. 199 will close that gap by requiring that these children receive such tests and inoculations as are deemed necessary by the Secretary of Health and Environment.

Target IV. of the Blueprint states "preventive health care is the best investment for Kansans, particularly if targeted to ...immunizations...these programs should reach every Kansas child." For the 1990/91 school year, the state's overall percentage of kindergarten children adequately immunized by age 2 was 51.3%. The passage of Senate Bill No. 199 will assist in improving this statistic and insure that more Kansas children receive early immunizations.

Thank you for the opportunity to support Senate Bill No. 199 on behalf of the Children and Youth Advocacy Committee for the Corporation for Change.

PH&W
3-16-93
Attm #4

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

House Public Health and Welfare Committee
Testimony on Senate Bill 119

March 16, 1993

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SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

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Madam Chairman and members of the Committee, on behalf of Secretary Donna L. Whiteman, I thank you for the opportunity to present you with this testimony.

SRS supports Senate Bill 119.

In response to this bill and a request by the House Appropriations Committee, SRS has consulted with other state Medicaid agencies, met with a Medicaid Managed Care consultant, and developed a preliminary plan to implement at least two managed care models in two geographic areas. Based upon our discussion with these groups, we have learned the following:

1. Successful Medicaid managed care programs take approximately two years to design, develop, and implement.

2. Strong network development and education among provider groups, providers, advocates and recipients at a state and community level.

3. It is estimated that, to implement two to three managed care models, it will require 2.5 staff for every 1000 recipients enrolled and $2 to $3 million in additional expenditures.

4. Managed Care is a long-term investment requiring major changes in how services are provided and reimbursed. This will produce on-going dividends in terms of both cost-efficiency and quality of care.

Based upon the above, we recommend the attached amendments. We will also be submitting a revised fiscal impact statement on this bill.

Robert L. Epps
Commissioner
Income Support/Medical Services
(913) 296-6750

Held
3-16-93
Attm #5

As Amended by Senate Committee

Session of 1993

SENATE BILL No. 119

By Senators Praeger, Bond, Burke, Emert, Frahm, Harris, Kerr, Langworthy, Lawrence, Ramirez, Ranson, Steffes, Tiahrt and Vidricksen

1-28

AN ACT providing for the establishment of a pilot project to provide medicaid services in certain areas of the state through a system of managed care.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Subject to applicable federal guidelines and regulations and the provisions of appropriations acts, the secretary of social and rehabilitation services ~~shall negotiate and enter into contracts with health care providers for a pilot project to be conducted in two counties of this state during the fiscal year ending June 30, 1994 1995. The pilot project under this section shall be conducted in Sedgwick county and in a county having a population of less than 100,000 people as specified by~~ the secretary of social and rehabilitation services *and the task force established under subsection (e)*. The ~~pilot~~ project shall be conducted to provide medicaid services through a system of managed care for Kansas medicaid eligible residents on the basis of a described set of such services to a predetermined population as prescribed by the contracts. No contract entered into under this section shall be subject to the competitive bid requirements of K.S.A. 75-3739 and amendments thereto. The services to be provided for such residents under the contracts shall be provided through a system of managed care as specified in the contracts.

(b) The contract may be entered into by the secretary with a single provider or with a contracting agency to provide such services through a group of qualified health care providers, or both, within the areas of Kansas specified for the ~~pilot~~ project under this section. In determining the location of the ~~pilot~~ project ~~located in a county other than Sedgwick county and the area in which such services shall be provided~~, the secretary *and the task force* shall consider the availability of health care providers and their willingness to participate in such ~~pilot~~ project at the time the ~~pilot~~ project is to commence under the contract.

may negotiate and enter into contracts for managed care projects to be conducted in two geographic areas as recommended by the SRS task force and determined by the SRS secretary. The managed care projects will be fully operational by July 1, 1995.

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Commissioner Epps

P&A&E 3-16-93 Attm # 5-A

P&A&E 3-16-93 Attm # 5

(c) If the secretary of social and rehabilitation services determines that waivers from program or other requirements of the federal government are needed to carry out the provisions of this section and to maximize federal matching and other funds with respect to the ~~pilot~~ project authorized under this section, the secretary shall apply to the federal department of health and human services, or other appropriate federal agency, for such waivers. If the secretary determines that waivers are needed, the ~~pilot program~~ established under this subsection shall not commence until such waivers are granted by the appropriate federal agency.

(d) The secretary shall submit a preliminary report on the ~~results~~ of the ~~pilot~~ project to the committee on ways and means of the senate and the committee on appropriations of the house of representatives at the beginning of the 1994 regular session of the legislature. The secretary shall submit additional reports and information regarding the ~~pilot~~ project as ~~requested by such committees during such legislative session~~.

(e) The secretary of social and rehabilitation services shall appoint a task force to advise the secretary on matters relating to the implementation of the ~~pilot~~ project established under this section. The ~~task force~~ shall make findings and recommendations concerning the ~~pilot~~ project established under this section and shall report such findings and recommendations to the joint committee on health care decisions for the 1990's and to the legislature on or before the commencement of the 1994 legislative session.

Sec. 2. This act shall take effect and be in force from and after its publication in the Kansas register.

managed care

managed care project

progress

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annually for the next four years.

to include two physicians, one hospital administrator, one managed care administrator, two consumer advocates, one representative from Healthy Kids Corporation, one SRS area office representative, and one medical services representative

secretary

managed care

PHEW 3-16-93 Attm # 5-A pg 2

PHEW 3-16-93 Attm # 5-A pg 2

Kansas
Respiratory
Care
Society

P.O. Box 3321 · Kansas City, KS 66103

March 16, 1993

Proponent - Senate Bill 119

TO MEMBERS OF THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE:

I am submitting the attached information on Pulmonary Rehabilitation in support of SB 119 on behalf of the Kansas Respiratory Care Society. Thousands of Kansans are diagnosed and/or developing Chronic Obstructive Pulmonary Disease. One out of every seven smokers will develop either emphysema, asthma, chronic bronchitis, and/or bronchectasis. Farmers as well as individuals from other occupations who are exposed to hazardous respiratory environments are at misk as well.

When the symptoms of COPD develop to the severity that the individual can no longer work, the financial cost is passed onto our state and society at large. That individual can no longer contribute to the tax base, but in fact will attempt to receive from it either through Disability application and/or Medicaid. The cost to all of us is astronomical.

It takes 20 to 35 years for the symptoms of COPD to develop which are cough, weight loss, shortness of breath upon exertion, among others. Early detection of COPD through Pulmonary Function testing would identify the individuals who are unwaringly developing it. This procedure along with Pulmonary Rehabilitative techniques would prevent illness and reduce the health care costs of caring for the patients with COPD.

PH&W
3-16-93
Attn: 6

I would strongly urge you to pass this bill and include the above mentioned services in the pilot projects of managed care for Medicaid recepients.

Respectfully submitted,

Cheryl DeBrot BS RRT
Pulmonary Rehabilitation

Director-at-Large
Kansas Respiratory
Care Society

KAISER PERMANENTE

MEMORANDUM

TO: Chairperson Jo Ann Flower
Kansas House Public Health and Welfare Committee

FROM: Cheryl Dillard CKD
Public Affairs Manager
Kaiser Permanente
Overland Park, Kansas

RE: Senate Bill 119

DATE: March 16, 1993

On behalf of the Kansas Managed Health Care Association, I want to express our support for Senate Bill 119. I have attached the testimony that we provided the Senate Public Health and Welfare Committee for you to review at your convenience.

We obviously believe that among our Association members are people who could make a substantial contribution to the task force created by the legislation.

We'll look forward to working with you.

CKD/lc

Attachment

PHW
3-16-93
Attm#7

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
SENATE BILL #119

FEBRUARY 24, 1993

Good morning Ms. Chairman and members of the Committee. My name is Deborah Origer, and I am the Executive Director of Principal Health Care of Kansas City, a 40,000-member HMO. I am here today on behalf of the Kansas Managed Health Care Association to provide the Committee with a general overview of Medicaid managed care programs throughout the country, including operational models, enrollment figures, and program benefits and constraints. The Kansas Managed Health Care Association consists of 16 member companies operating HMO or PPO networks in 62 Kansas counties and providing care or coverage for 365,000 Kansas residents. The Association is available to serve as consultants to the Committee, should you so desire. We have a great deal of collective expertise, and would be most happy to assist as you struggle through this complex issue.

I was asked to represent the Association due to my experience with a managed Medicaid program. Prior to moving to Kansas City, I served as the Vice President of Marketing for the Johns Hopkins Health Plan, an HMO in Baltimore, Maryland, which is now owned by Prudential. When I joined the plan in 1986, we had 5,000 enrolled Medicaid recipients and 5,000 enrolled commercial recipients. When I left in August of 1991, we provided care to 35,000 enrolled Medicaid members and over 90,000 commercial members.

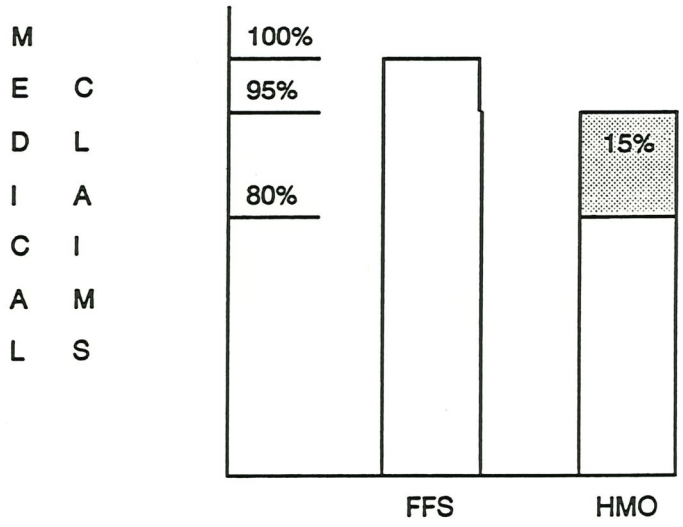
MODELS FOR MEDICAID MANAGED CARE

At the beginning of the Medicaid program, neither private nor public health insurance plans utilized much managed care. By 1972, Medicaid had contracts with only the Health Insurance Plan of Greater New York, Kaiser Permanente, and Group Health Cooperative of Pugent Sound. There was little public attention to Medicaid managed care until California's rapid expansion of prepaid care for Medicaid beneficiaries and the ensuing scandals of the 1970's. Currently, about ten percent of the Medicaid beneficiaries receive care from 214 managed care plans, which can be classified into four types of managed care arrangements:

- **Health Maintenance Organizations (HMOs).** In 1991, 127 state or federally qualified HMOs served over one million enrolled Medicaid recipients in 26 states. HMOs provide comprehensive health services to Medicaid beneficiaries in return for a capitated payment which is based on expenditures for comparable beneficiaries in fee-for-service Medicaid.

PHW
3-10-93
Attm #7
pg. 2 of 14

Typically, the amount that is paid to the HMO ranges from 90 to 100 percent of the estimated fee-for-service equivalent, or the amount that the state would expect to pay for its non-managed recipients. The methodology does not include financial support for administering the program. The limited capitation rates, based exclusively on a percentage of medical costs for the Medicaid fee-for-service program, must also be used to pay for claims processing, utilization review, member services, provider relations, marketing, and general administrative costs, which average around 15 percent of claims for most HMOs. States with low fee-for-service reimbursement levels, and therefore a low starting point, may find no HMO partners. The capitation rate will be insufficient to cover the HMOs' typically higher rates with providers. HMOs simply don't have the volume negotiating power a state Medicaid program has. In Maryland, this critical barrier does not exist, as Maryland's hospital rate setting commission dictates that Medicaid, as well as all other payors, reimburse hospitals at an equal rate. Therefore, cost shifting from the public to the private sector does not exist.



- **Prepaid Health Plans.** In 1991, there were 66 prepaid health plans serving 379,000 enrollees. Prepaid health plans are typically community or public health centers located in medically underserved areas. Any organization, including hospitals or medical groups, may contract with a state Medicaid agency on a capitated basis to provide some Medicaid services, as long as the range of services is not "comprehensive." For example, a hospital that provides inpatient services, but none of the other identified Medicaid benefits, could qualify for this type of risk contract. A clinic could also qualify if it only provides services under the contract from two of the following five categories:

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1) Outpatient hospital services and health clinic services;
2) Other laboratory and x-ray services;
3) Skilled nursing facility services, early and periodic screening, diagnosis and treatment, and family planning;
4) Physician services; and,
5) Home health services.

There are several Kansas City, Missouri "prepaid health plans" participating in Missouri's managed care program.

- **Primary Care Case Management Programs (PCCM).** In 1991, 16 Primary Care Case Management programs provided care to 888,241 beneficiaries. PCCM programs are the fastest growing model for managed Medicaid. Under PCCM arrangements, a primary care physician coordinates and approves all non-emergency care, tests and drugs. In most PCCM systems, the physician is paid a case management fee (typically $3 per beneficiary per month) and regular fee-for-service payments for the services provided, while in others, the physician is placed at financial risk for some services (usually outpatient care). The physician may determine the level of his/her Medicaid case load up to the state's limit. For some physicians these arrangements are attractive because the number of beneficiaries can be limited and the physician can provide services in a fashion that ensures continuity of care. The State of Kansas has offered a PCCM program in seven Kansas counties since 1989. Kansas has over 50,000 enrollees in its program. The program is mandatory, meaning recipients in those counties must select one of the 371 participating case managers.

- **Health Insuring Organizations.** In 1991, HIOs represented five plans enrolling 150,000 Medicaid recipients. HIOs pay for services of subcontracting providers and assume all financial risks in exchange for a premium. Typically, the providers are paid on a fee-for-service basis. HIOs organize a network of providers with preauthorization and utilization review, similar to independent practice associations. They include all physicians willing to abide by a specified contractual arrangement, and all Medicaid beneficiaries who reside in a designated area. The usefulness of this model was limited due to certain restrictions imposed on HIOs in the mid-80's, therefore, I will not mention it further today.

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TABLE 1

TYPE	1991 # PLANS	1991 ENROLLMENT	PAYMENT METHODOLOGY	PROVIDERS AT RISK
HMOs	26	1,037,000	Capitation	Full - Comprehensive Services
PHPs	66	379,000	Capitation	Partial - Limited Services
PCCMs	16	888,240	Case Management Fee; typically $3/month	No

In order for a state Medicaid agency to establish any of these models, the state must apply to the Health Care Financing Administration (HCFA) for a "Freedom of Choice waiver (2175 waiver)." This application process is extremely burdensome, both in terms of the initial approval process and ongoing reporting. Congress and HCFA are currently looking for ways to relieve this burden, thereby reducing some of the disincentives currently facing States considering these initiatives.

CURRENT ENROLLMENT STATISTICS

Managed care has grown rapidly in Medicaid during the last few years -- from only 282,000 beneficiaries in 1985 to 2.4 million beneficiaries in 1991. More rapid growth is expected over the next several years due to recent state actions. For example, New York has committed to enrolling one half of its Medicaid beneficiaries in managed care plans by 1995. Maryland now requires all AFDC beneficiaries to enroll in either HMOs or PCCM programs. Michigan is planning to expand its three mandatory managed care options to all counties and is developing specific managed care products for beneficiaries with special health problems, such as AIDS and chronic mental illness.

Nevertheless, Medicaid beneficiaries are less likely to be in managed care plans than the general population. For example, only about five percent of Medicaid beneficiaries are enrolled in HMOs, compared to 15 percent of the population. Nearly all states' proportion of the general population enrolled in HMOs exceeds the proportion of Medicaid beneficiaries enrolled in HMOs (Table 2). Only about 19 percent of HMOs have Medicaid contracts.

Additionally, access to managed care varies considerably by state (Table 3). Twenty states have no beneficiaries in managed care. Utah, New Mexico, Colorado and Arizona have more than 50 percent in managed care; Michigan and Wisconsin have between 25 and 50 percent. States with a high proportion

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of Medicaid beneficiaries in managed care have some degree of mandatory enrollment.

Advocates for managed care have described its potential advantage for beneficiaries by improving access and quality of care, and for states by controlling costs. From the perspective of the beneficiary, managed care organizations strengthen physician/patient relationships by coordinating care, improve preventive care, and assure the quality of care. Around the clock access to physicians, which managed care entities commit to provide, guarantees a contact point for the treatment of acute problems. This decreases the use of hospital emergency departments and assures continuity of care.

From the government's perspective, managed care controls the growth and volume of services that has plagued the fee-for-service sector and, under capitated managed care plans, assures predictable expenditures.

FINANCIAL, OUTCOME AND SATISFACTION STUDY RESULTS

Research studies on Medicaid managed care, on balance, demonstrate that managed care organizations provide care that is at least equivalent to fee-for-service Medicaid, slightly improves preventive care, reduces emergency room use, guarantees access, and lowers costs. These outcomes have been shown consistently by extensive studies of the Medicaid Competition Demonstrations, the Arizona Health Care Cost Containment System (AHCCCS), and other programs. The Medicaid Competition Demonstrations occurred in six sites which tested innovative delivery systems including capitation and primary care case management. The AHCCCS provides medical services to 330,000 beneficiaries through providers who are selected on the basis of competitive bidding and they are paid a capitated rate. Beneficiary satisfaction with these programs appears to be high, even though much of the enrollment was mandated, although in comparison with fee-for-service, the results are mixed. Over 78 percent of AHCCCS beneficiaries were satisfied with care, but some measures of satisfaction were higher in the fee-for-service comparison site. In the Medicaid Competition Demonstrations, beneficiary satisfaction was lower in managed care sites when compared to fee-for-service sites, but again most managed care beneficiaries were satisfied with their care. In contrast, managed care beneficiaries in Rochester, New York had higher satisfaction than they had previously with fee-for-service care.

Managed care reduces the use of hospital emergency departments. Across all Medicaid Competition Demonstrations, there were significant reductions in emergency department use by both children and adults. Based on medical records, adult acute and chronic care was equivalent in Medicaid Competition Demonstrations and comparison sites. Children were more likely to have basic childhood immunizations in the managed care sites.

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Studies conducted by many states show that managed care plans decrease expenditures. For example, the Michigan Physician Sponsor Plan (PSP), which is a mandatory primary care case management plan for Wayne County, for 1990-91 cost about 14 percent less than fee-for-service, even though the health status of PSP enrollees prior to enrollment appeared to be worse. Minnesota estimated that it saved about ten percent on its prepaid managed care program in 1989. Kentucky's primary care case management program saved $25 million, and Wisconsin logged savings of six percent.

QUALITY ASSURANCE

Despite the advantages, some experiences with managed care have been unsuccessful. Some prepaid capitated contractors have abused the system. In the early 1970's, California encouraged managed care for Medicaid beneficiaries. There was deceitful marketing, favorable selection, disenrollment upon sickness, financial irregularities, poor quality or non-existing care, conflict of interest, etc.

Fraud, abuse, and under service are often associated with a lack of adequate oversight of managed care programs in some states. A review in 1988 by Medicaid officials concluded that many managed care arrangements were deficient because they had vague contracts without detailed standards for benefits and provider qualifications, protocols for treatment, quality controls, and referral guarantees.

In order to safeguard against the possibility of Medicaid recipients receiving substandard care, the federal government implemented Section 1903(M)(2)(A) of the Social Security Act which said that no more 75 percent of the health plans' enrollment can be Medicaid or Medicare recipients. The other 25 percent, presumably, will be commercial enrollees. The concept behind the "enrollment composition rule" is to restrict Medicaid enrollment to those HMOs that maintain standards of care high enough to satisfy major employers, and to attract and retain their employees in the plan. Congress also guaranteed Medicaid beneficiaries the right to enroll and disenroll voluntarily. In 1984, Congress softened this restriction by permitting states to limit disenrollment without cause from all federally qualified HMOs for six months after enrollment (known as a lock-in provision).

To improve Medicaid quality assurance policy, HCFA has developed a Quality Assurance Reform Initiative (QARI) for Medicaid managed care. Through a collaborative effort with the National Academy of State Health Policy Work Group on Medicaid and Managed Care -- a group representing federal and state policymakers, industry leaders, and advocacy groups established by HCFA -- standards will be developed for quality assurance.

Finally, within the HMO model, there are several controls in place to assure recipients a high quality of

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care and service. HMOs are licensed by the State in which they operate, and are therefore subject to state oversight of their grievance procedures and quality assurance programs. Kansas HMOs must undergo review by an outside agency every three years. Given all these controls and the maturation of the HMO industry, the 75/25 composition rule is now considered by many policymakers to be unnecessary.

BARRIERS TO PARTICIPATION - PRACTICAL APPLICATION

There are significant barriers to the development of Medicaid managed care programs under the models which I presented. I would like to review how, in a practical sense, each of these models might work and what barriers may exist to both the State of Kansas, as well as to participating HMOs/providers.

- **Primary Care Case Management Fee-for-Service Plans.** In this model, a "case manager" is paid a monthly fee to serve as a gatekeeper, and direct the members' care. Case managers can be individual physicians, physician groups, hospital clinics, etc. This model may be the most appropriate, or only, alternative for the State of Kansas, particularly if the fee-for-service equivalent capitation level is too low to be financially viable to an HMO.

  Currently, the State's PCCM plan design is such that non-emergency care must be preauthorized by the case manager. If a recipient presents in an emergency room without a life threatening emergency, the recipient is required to call their case manager for authorization. The State must have mechanisms in place to deny claims that are not authorized (unless they are medical emergencies). This requires additional claims payment expertise, and payment editing capabilities. In addition, the State may need to modify its computer system in order to assign each Medicaid recipient a case manager. Hospitals can then call into the State's eligibility verification system to obtain the name of the case manager, should the member present without an ID card.

  Even with these controls, the State may find that its savings are limited under this model. First, case managers have no real incentives to manage care. The payment level is low ($2/month), and there is no financial risk. If a member calls a provider at 11:00 p.m. on a Friday night requesting an ER visit, it is probably easier to approve the visit than to discuss medical necessity. In addition, the elaborate quality assurance and utilization review programs which HMOs have in place are nonexistent in a physician's office. There are no standards for care, peer review, or reporting mechanisms to help providers identify whether or not their members could/should utilize fewer or alternative services.

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From the State's perspective, other than the administrative complexity of reporting to HCFA, it is relatively easy to implement this model. There are usually sufficient providers willing to serve as case managers, since there is no financial risk, and some managed care is certainly better than no managed care.

- **Prepaid Health Plans.** This model typically pays either a capitation to a hospital for hospital services or to a physician for physician services. To implement a PHP model, the State would have to develop a capitated payment arrangement which is acceptable to potential participating providers. Community or public health centers are excellent candidates for participation. Typically, they are located within the underserved Medicaid community, and possess a critical ingredient for success -- they have philosophically committed and have purposefully sought out to serve the Medicaid population. Community or public health centers have the necessary outreach programs to deal with the distinct characteristics of this population, including the social problems which so often affect their health problems.

  However, these organizations are also constrained by their lack of experience in a capitation environment, and its inherent risks. They might not have the actuarial and underwriting knowhow to evaluate the State's payment offer, and typically lack the necessary management information systems critical to an HMO's success. Systems are needed to track eligibility and enrollment, to audit the State's payments against their enrollment, to pay claims for services for which they are at risk, and to determine whether or not the capitation is fair and adequately covers their expenses. In addition, the utilization review and quality assurance mechanisms typical in HMOs that help reduce costs and render capitation "profitable" may be nonexistent in community health organizations.

- **HMOs.** HMOs have historically had limited interest in contracting with state Medicaid programs. There are several critical barriers.

  Due to the nature of the Medicaid system, marketing an HMO product can be time consuming and expensive. First, states generally can not provide HMOs with direct access to Medicaid beneficiaries' names and addresses, so any marketing by an HMO is done largely on an individual basis. An HMO must hire a large staff of representatives who market the program door-to-door. The State can be a great help by educating its

case workers about the benefits of HMO enrollment, as well as by allowing the HMO access to potential members at the eligibility offices. A mandatory Medicaid enrollment program will correct this major obstacle. Marketing is further complicated because, unlike HMO commercial enrollment which is annual, Medicaid enrollment is on a day-to-day basis. Some states "guarantee eligibility" up to a period of six months. In other words, once a member is enrolled, the state will guarantee to pay the HMO for six months regardless of whether or not the member loses their eligibility. In addition, the State may allow for a mandatory lock-in of enrollment -- meaning a newly enrolled member must remain in the HMO for a period of six months. Current regulations allow the lock-in provision for members of federally qualified HMOs only. Finally, the state could allow a rolling eligibility guarantee. Should a member lose eligibility and then regain it within a period of X months (that period was nine months in Maryland), the State can automatically re-enroll the member into the HMO. Finally, a process which automatically enrolls newborns of Medicaid recipients will help to ease the marketing costs.

Without a mandatory provision, the incentives for a Medicaid recipient to enroll in an HMO are close to nonexistent. In the commercial sector, members select an HMO either for a greater level of benefits, or for lower out-of-pocket costs. In the Medicaid environment, recipients have comprehensive benefits at no cost. At Hopkins, we developed elaborate and costly community service programs to help encourage enrollment, including food giveaways, community events, and free cab transportation for office visits. Important features such as access, personalized care, continuity of care, and prevention are largely intangible, particularly to the Medicaid population. Among recipients, taking away the right to visit the local emergency room is not necessary perceived as a benefit.

The other major obstacle, which I reviewed earlier, is the payment mechanism. If the State's current fee-for-service equivalent is very low, due to either low reimbursement rates or a good case management program which has effectively reduced over-utilization, then the capitation rate may simply be insufficient.

CONCLUSION

Although there are many states benefiting from various managed care models, the unique circumstances of each state must be considered. Is Kansas' current PCCM program effective? How do costs and utilization rates compare to those of other states? I don't think anyone will argue that HMOs have been the most cost effective model, but could the State's payment level, which to a certain extent is limited by

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HCFA, be sufficient to attract an HMO partner? Are there community health centers willing to share the risk, perhaps with an HMO, so that both entities benefit from the other's unique expertise? Would the State commit the resources to develop a program with features such as mandatory enrollment, rolling eligibility, and guaranteed eligibility?

This topic is receiving significant attention at the State, as well as the Federal, level. Last Year, Senator Moynihan introduced S. 2077 "Medicaid Managed Care Improvement Act," which addressed many of the constraints, and would allow Medicaid agencies to contract with various managed care entities without first going through the Federal waiver process. Senator Moynihan intends to reintroduce the bill again this year.

I hope we have given you some insights into the complexity of this topic. Thank you.

TABLE 2
PERCENT IN HEALTH MAINTENANCE ORGANIZATIONS, 1990

STATE	STATE POPULATION	MEDICAID BENEFICIARIES
Alabama	5.3%	0.7%
Alaska	0.0%	0.0%
Arkansas	2.2%	0.0%
California	30.7%	9.9%
Colorado	20.0%	4.5%
Connecticut	19.9%	0.0%
Delaware	17.5%	0.0%
District of Columbia	72.9%	9.3%
Florida	10.6%	5.6%
Georgia	4.8%	0.0%
Hawaii	21.6%	3.1%
Idaho	1.8%	0.0%
Illinois	12.6%	11.2%
Indiana	6.1%	
Iowa	10.1%	1.5%
Kansas	7.9%	0.0%
Kentucky	5.7%	0.0%
Louisiana	5.4%	0.0%
Maine	2.6%	0.0%
Maryland	14.2%	13.2%
Massachusetts	26.5%	6.4%
Michigan	15.2%	12.3%
Minnesota	15.2%	6.4%
Mississippi	0.0%	0.0%
Missouri	10.5%	5.3%
Montana	1.0%	0.0%
Nebraska	5.1%	0.0%
Nevada	8.5%	7.9%

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New Hampshire	9.6%	1.7%
New Jersey	12.3%	0.7%
New Mexico	12.7%	0.0%
New York	15.1%	2.3%
North Carolina	4.8%	0.1%
North Dakota	1.7%	0.0%
Ohio	13.3%	9.7%
Oklahoma	5.5%	0.0%
Oregon	24.7%	23.3%
Pennsylvania	11.5%	11.6%
Rhode Island	20.6%	0.4%
South Carolina	1.9%	0.0%
South Dakota	3.3%	0.0%
Tennessee	3.7%	2.5%
Texas	6.9%	
Utah	13.9%	12.4%
Vermont	6.4%	0.0%
Virginia	6.1%	0.0%
Washington	14.6%	4.1%
West Virginia	3.9%	0.0%
Wisconsin	21.7%	28.6%
Wyoming	0.0%	0.0%

Source: Adapted from Interstudy 1991 and HCFA 1991.

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Table 3. MEDICAID ENROLLEES IN MANAGED CARE PROGRAMS, 1991

State	Managed Care Enrollees	Percent of State Beneficiaries
Alabama	18,287	5.7
Alaska	0	
Arizona	216,202	95.0
Arkansas	0	
California	357,504	10.7
Colorado	98,109	51.4
Connecticut	0	
Delaware	0	
District of Columbia	8,681	8.8
Florida	58,374	6.7
Georgia	0	
Hawaii	2,600	2.8
Idaho	0	
Illinois	119,271	11.4
Indiana	1,065	0.3
Iowa	38,937	17.3
Kansas	87,528	49.5
Kentucky	196,836	45.7
Louisiana	0	
Maine	0	
Maryland	43,520	13.5
Massachusetts	37,670	6.5
Michigan	293,893	26.3
Minnesota	25,278	7.8
Mississippi	0	
Missouri	86,947	21.4
Montana	0	
Nebraska	0	
Nevada	3,699	9.0
New Hampshire	743	2.1
New Jersey	4,252	0.8
New Mexico	76,000	67.2
New York	53,833	2.4
North Carolina	37,978	7.8
North Dakota	0	
Ohio	118,292	10.4
Oklahoma	0	
Oregon	52,889	24.8
Pennsylvania	136,624	12.4
Puerto Rico	0	
Rhode Island	442	0.4
South Carolina	12,100	4.4
South Dakota	0	
Tennessee	18,779	3.5
Texas	0	
Utah	56,039	59.4
Vermont	0	0.0
Virgin Islands	0	
Virginia	0	
Washington	18,321	4.3
West Virginia	0	
Wisconsin	112,547	28.0
Wyoming	0	
TOTAL	2,393,240	10.1

Source: HCFA.

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KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Memorandum

March 16, 1993

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: **SENATE BILL 119**

The Kansas Hospital Association appreciates the opportunity to comment on the provisions of SB 119. This bill directs SRS to implement a pilot program of managed care for Medicaid recipients in two Kansas counties.

Legislators are well aware of the increasing costs of the medical assistance program in Kansas. These costs continue to escalate in spite of the fact that many providers, including hospitals, have not been given rate increases in recent years. This phenomenon suggests that the major culprit in the cost problem is utilization. In other words, the more the system is utilized, the greater the cost. What needs to be developed is a system where the incentive is to keep people well, so they don't have to use the system.

By moving toward a system of managed care, the medical assistance program can begin to deal with this problem. We think that a comprehensive, well thought out plan can help to restrain the growth of costs in the medical assistance program. We have recently had discussions with officials in Arizona about this type of approach. It appears that all involved in that system are happy with its operation and that it has acted to reduce the rate of increase in costs.

We think several concepts should guide the implementation of a managed care approach in Medicaid. First, the final product should not be hastily prepared or it will fail. The Senate Committee recognized this and moved the implementation date to FY 1995. Second, it is very important to bring everyone to the table in developing a plan. Senate Committee amendments also recognized this and directed the formation of a task force to develop a plan. Third, it is equally important to make use of consultants experienced with Medicaid managed care models. Such consultants can certainly provide information from other State projects that could be helpful.

As national health reform efforts move toward a focus on managed care, we think similar State initiatives in Medicaid are timely and appropriate. Thank you for your consideration of our comments.

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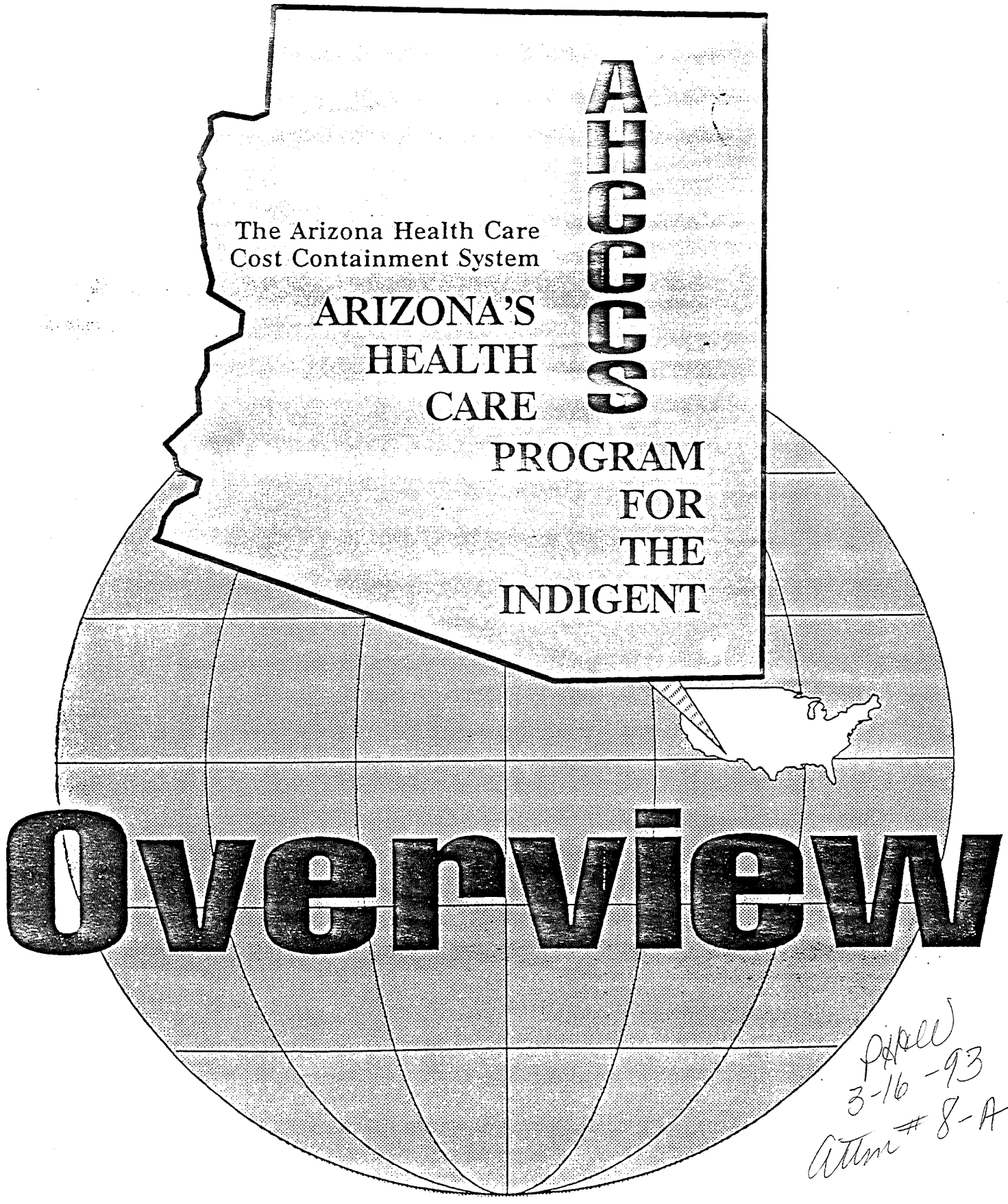

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10th Anniversary

AHCCCS

Mission Statement

AHCCCS is a state agency that administers an innovative program to assure delivery of quality health care to eligible members by regulating and monitoring qualified providers. Providers are chosen through competitively bid, risk-sharing, prepaid capitated contracts.

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AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System, Arizona's health care program for the needy, is now 10 years old. The state's Medicaid program has undergone continual change in the past decade and is looking ahead to even more change as budget funds dwindle, the cost of health care increases and the AHCCCS population continues to grow. In ten years AHCCCS has come a long way, from a system that was ridiculed in the early years to one that has caught the attention of government officials, health care professionals, the media and the public across the country. The reason: The program has demonstrated that, in comparison to other Medicaid systems, it saves money and provides excellent health care. The program also has shown that it is possible to provide effective health care for the needy through a partnership between state government and the private sector.

AHCCCS began Oct. 1, 1982. The program now serves more than 455,000 people, mostly mothers, children and elderly persons. Among these are 17,029 people who have qualified for services under the Arizona Long Term Care System, a program for the developmentally disabled, elderly and physically disabled that began in January 1989.

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THE EARLY YEARS

Since 1864, health care for Arizona's low-income population was provided by the counties through county hospitals and clinics, or through contracted providers. One hundred years later, in the mid-1960's, Congress enacted the federal Medicaid program to serve the poor across the country, and by 1972 all states had joined the system -- all except Arizona. For various reasons, including a dislike of federal interference, Arizona remained the lone holdout, serving the indigent through a disjointed system of county-run health care programs. While a statute was enacted in 1974 to bring Medicaid into the state, it was subsequently challenged in court and was declared unconstitutional. Responsibility for indigent health care remained with the counties. Arizonans, through their taxes, continued to support a nationwide Medicaid system without Medicaid money benefiting the state.

By 1981, the state's counties were facing a financial crisis because of escalating health care costs and because the Legislature had enacted a measure limiting the growth in county income. Caught in the middle of these conflicting forces, the counties appealed to the state for relief. One thing quickly apparent was the disparity of health care available in each county, which had set its own income and resource guidelines within certain minimum standards set by the state. The range of services also varied from county to county. Some provided only the bare minimum of services while others offered a number of additional benefits.

In response to this fiscal crisis, Arizona considered several options to provide support for county programs. Among these were:

-- Implement a traditional Medicaid program, which would require the

Arizona Legislature to develop standards for such a program and submit a plan to the federal government.

-- Establish an "excess medical cost fund" to provide emergency funds for counties that exceeded their indigent health care budgets. The option would allow Arizona to reimburse counties for cost overruns and, in some cases, to help with "catastrophic health care" costs.

-- Establish a statewide catastrophic health insurance program for all residents of the state.

-- Establish a prepaid capitation program to provide health care services to certain indigent populations. This would be a new approach to traditional Medicaid and would incorporate cost-containment elements. Arizona would then seek matching funds from the federal government.

The Arizona Legislature chose the fourth option. In the spring of 1982, AHCCCS was approved as a three-year demonstration project (under Section 1115 of the Social Security Act) by the Health Care Financing Administration, the federal agency that oversees the program. AHCCCS officially began operating Oct. 1 that year. HCFA has since given AHCCCS repeated extensions to continue operating and receiving federal funds under demonstration status. In late November 1988, HCFA approved a five-year extension until Sept. 30, 1993, at which time the program may become permanent or it may continue under experimental status or some other authority. Arizona, on the other hand, gave AHCCCS permanent status in 1987.

The goal of the AHCCCS project was to develop and test a new delivery and payment system for providing health care services, facilitate cost containment, improve patient access and, at the same time, encourage quality care and efficient treatment. The original program design called for a

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private contractor to serve as the day-to-day administrator. The administrator's responsibilities included enrollment functions, health plan oversight, audit and compliance functions, claims processing, medical quality assurance, and grievance and appeals.

Soon after it began, AHCCCS ran into problems. Not enough time had been set aside to start the program correctly and efficiently, and there were few administrators on board with managed-care experience. AHCCCS found itself under tough scrutiny by the press and public officials, who questioned whether the program would survive. In 1984, not two years after it began, typical headlines around the state read:

"AHCCCS crisis needs answers"

"Poor find the path to AHCCCS a hard one"

"State program beyond salvage"

The turmoil resulted in the termination of the private administrator's contract less than halfway through the term. In March 1984, the state took over the operation and the program was structured to assume a strong, regulatory position. New challenges included:

-- Performing financial and contractual compliance reviews of 19 contracting health plans.

-- Quality control review of the county eligibility systems.

-- Medical quality-of-care audits of the health plans, some of the most thorough medical reviews of any Medicaid program.

-- Increased staffing for the audits, compliance and utilization review functions.

After the state assumed administration of the program, two health plan contracts were terminated due to plan insolvency and another plan with new management was successfully reorganized under the federal bankruptcy statutes. AHCCCS was then, and remains today, the only statewide prepaid Medicaid system in the country. The improvements have been dramatic, both in the care AHCCCS gives and the way it delivers it. These improvements have been well-documented by SRI International, a research organization that was commissioned by the federal government to study the first five years of the program (see Page 25). Other studies, such as those conducted by the Flinn Foundation of Phoenix, also show the effectiveness of the AHCCCS program today. It is clear that because of its success, the AHCCCS health care delivery system has become one possible solution to the national problem of providing and paying for adequate health care.

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FUNDING

AHCCCS is funded by a combination of state, county and federal contributions, in addition to some revenue from third-party liability recoveries, usually listed as miscellaneous. The chart on Page 7 shows AHCCCS expenditures by major revenue source since Fiscal Year 1982-83. Before FY 1988-89, the percentage of funds contributed by the state continued to grow partly because of the addition of the Children's Care Program, which is 100 percent state-funded (this program includes Eligible Assistance Children and Eligible Low Income Children -- see Page 14). Because the counties' contribution has been fixed and because the federal government limits its risk-sharing with the states, the State General Fund has absorbed a number of program cost increases. Nonetheless, there have been increases in the federal percentage over the past three years because the AHCCCS Administration has aggressively pursued more federal matching funds and because more federal funds have become available as Congress has expanded federally matched eligibility under Medicaid for more pregnant women and children.

The AHCCCS Administration is reimbursed by the federal government under a methodology called "real time" reimbursement. Real time reimbursement essentially means that AHCCCS is reimbursed on actual costs incurred during the current fiscal year, reported quarterly. Previously, the federal government made capitation payments to AHCCCS based on actual costs that were two years old, adjusted for inflation and program changes. The end result was that the agency was forced into a catch-up mode, never quite receiving enough funds to cover current costs. AHCCCS administrators vigorously sought the

Total AHCCCS Expenditures

(000)

SFY	State	Federal	Other*	Total
1983	22,050	37,800	55,300	115,150
1984	81,270	57,063	80,457	218,790
1985	124,621	66,772	65,271	256,664
1986	141,311	70,120	62,912	274,343
1987	127,822	87,148	72,162	287,132
1988	187,193	111,983	78,050	377,226
1989	244,260	192,720	95,725	532,705
1990	267,220	357,087	123,827	748,134
1991	330,701	490,766	152,999	974,466
1992	369,946	589,886	159,232	1,119,064

* Primarily county funds

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change in 1990, arguing that AHCCCS needed a more equitable reimbursement methodology. "Real time" is used by Medicaid programs in all other 49 states. The methodology became effective for AHCCCS on Oct. 1, 1990, the start of Federal Fiscal Year 1991.

The annual county contributions for the acute care portion of the program are fixed by statute at 50 percent of the lesser of what they budgeted or spent on health care in FY 1980-81, which resulted in an annual contribution of $63,073,476. A change was made to Pima County's contribution in 1986 based on a re-evaluation of their 1980-81 indigent health care expenditures by the Auditor General. The only change made to the statutory formula since the inception of the program also reduced Pima County's contribution. That change to the county contribution formula (per Laws 1986, Chapter 380, Section 19) limited the amount of county contributions beginning with FY 1987 to 33 percent of the amount that AHCCCS expended in that county for FY 1984. That change affected only Pima County's contribution, which was reduced by $3,403,130 to $12,737,224.

The chart on Page 9 shows the history of the counties' annual contributions to the acute care AHCCCS program. The chart illustrates that while the AHCCCS program has grown significantly, the county contribution to acute care has actually decreased.

It is important to note that the startup of the long term care program in FY 1989 increased the counties' contribution to the program. The counties' contribution is to cover the entire local share of the long term care program costs for the elderly and the physically disabled. However, as discussed later, the counties' contribution to long term care was capped according to

Annual County contributions to AHCCCS acute care program

(000)

	FY 84 FY 85 Contribution	FY 86 Contribution	FY 87 - 91 Contribution
Apache	262,476	262,476	262,476
Cochise	2,161,200	2,161,200	2,161,200
Coconino	724,956	724,956	724,956
Gila	1,379,280	1,379,280	1,379,280
Graham	523,044	523,044	523,044
Greenlee	186,108	186,108	186,108
La Paz	207,000	207,000	207,000
Maricopa	32,933,076	32,933,076	32,933,076
Mohave	1,207,956	1,207,956	1,207,956
Navajo	302,964	302,964	302,964
Pima	17,378,112	16,140,357	12,737,224
Pinal	2,649,756	2,649,756	2,649,756
Santa Cruz	471,288	471,288	471,288
Yavapai	1,393,260	1,393,260	1,393,260
Yuma	1,293,000	1,293,000	1,293,000
Total	$63,073,476	$61,835,721	$58,432,588

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statute for FY 1989 and FY 1990. During its 1990 session, the Legislature approved a $96 million county contribution for Fiscal Year 1991. The county contribution for FY 1992 was $87.5 million, and for FY 1993 it was $92.3 million.

ELIGIBILITY GROUPS

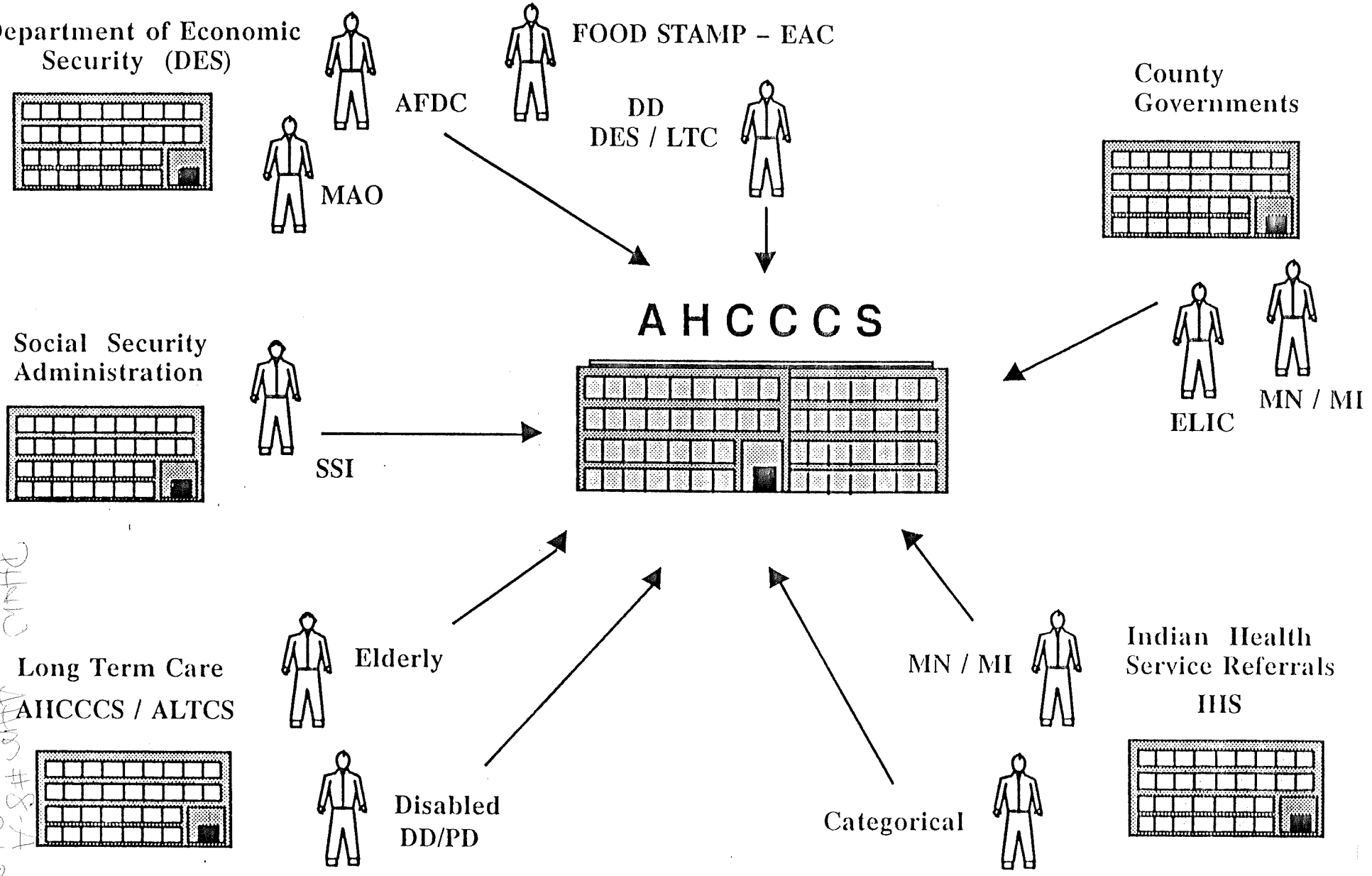
AHCCCS provides services to several different eligibility groups that are classified as either categoricals or state-funded-only. Categoricals are those people who enter AHCCCS through a program for which federal matching funds are available. Examples are persons who are receiving Aid to Families with Dependant Children (through the Department of Economic Security) or Supplemental Security Income (through the Social Security Administration). Other eligible groups that are defined by Arizona statute only -- such as the Medically Needy/Medically Indigent, who enter AHCCCS through the counties -- receive no federal matching funds and their medical expenses are handled solely by the state. A chart showing the income levels for each eligibility group can be found in Appendix A.

Eligibility groups are briefly described below:

1. Categorically eligible

By federal law, these groups must be covered by AHCCCS. A person may qualify for AHCCCS benefits through the Aid to Families with Dependent Children (AFDC) program, through the AFDC-related Medical Assistance Only (MAO) group, or through the Supplemental Security Income (SSI) program and

AHCCCS ELIGIBILITY GROUPS



SSI-related MAO groups. Federal regulations define these groups. The Arizona Department of Economic Security (DES) performs eligibility determinations for AFDC-related applications. The Social Security Administration, a federal agency, performs eligibility determinations for the aged, blind and disabled SSI applicants. The AHCCCS Administration itself does not qualify people for acute -- or medical -- benefits. The Administration does, however, qualify people for the long term care program.

As of Jan. 1, 1988, Arizona also implemented the provisions of the Sixth Omnibus Budget Reconciliation Act (S.O.B.R.A.), which Congress passed in 1987 to help the nation's needy pregnant women, infants and children. This statute allows the state to receive federal financial aid for this group, which includes children ages 6 and under.

Eligibility criteria for the S.O.B.R.A. group includes many of the same requirements for other MAO groups. Only income is considered, not assets. A woman remains eligible under S.O.B.R.A. for 60 days after the date of delivery, then must re-apply under another category, such as AFDC. Either DES or the counties can take an application, but DES does the eligibility determination.

The income level for S.O.B.R.A. initially was set at 100 percent of federal poverty level, rather than at the lower AFDC income limits. States had the option of expanding the income eligibility limit up to 185 percent of poverty. During the 1989 session, the Arizona Legislature approved an expansion of S.O.B.R.A. to include women and children up to 130 percent of poverty. The effective date was to be July 1, 1990. However, Congress in the meantime approved its own mandatory expansion to 133 percent of poverty, to

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take effect April 1, 1990. The congressional action superseded the Legislature's approval and the expansion had to take place three months early. More recently, the 1990 legislative session approved an expansion of S.O.B.R.A. eligibility to 140 percent of the federal poverty level for women and infants up to age one. Other children up to age six remained at 133 percent of poverty.

2. Medically Needy/Medically Indigent

These people are eligible for AHCCCS benefits as defined by Arizona state statute only. The federal government does not participate in funding these benefits, nor do federal regulations apply. Arizona statute defines one group as "indigent" (A.R.S. 11-291, et seq.) and the other group as "medically needy" (A.R.S. 36-2901, et seq.). At this time there is no difference in the medical services rendered or the eligibility process between these groups. The Medically Needy population ("MN") and the indigent population (referred to as Medically Indigent, or "MI") are determined eligible by the counties.

There is a provision within state statute that allows an applicant to subtract the previous year's medical expenses from the applicant's annual income in order to qualify for the program. While an individual cannot earn more than $3,200 a year and still qualify (a couple cannot earn more than $4,266 and a family of three cannot earn more than $4,810 -- See Appendix A), an income of $10,000 minus medical expenses of $7,000 would put the individual within the income limit. This process, known as "spend down," allows AHCCCS to act as a safety net for the uninsured people who may be over the income limits but who accumulate significant medical debts within a given year. Generally, MN/MI eligibility is redetermined every six months.

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An extended eligibility period is allowed for pregnant MN/MI women, who remain on AHCCCS until one month after the month of delivery. Because the focus is on the delivery of healthy babies, a child born to a woman who is MN/MI will be covered under the mother's health plan for a least 30 days after birth. The child may then qualify for health care as long as the household remains eligible. It should be noted that counties must first attempt to qualify a pregnant woman under the S.O.B.R.A. program. The extended eligibility mentioned above applies to women who don't qualify under S.O.B.R.A. but are eligible under MN/MI status.

3. Children's Care Program

The Children's Care Program is funded by state dollars only. The program was passed by the Legislature in 1986 because of increasing evidence that children were going without preventive services necessary to their good health and development. The program began in January 1987 with coverage for children ages 5 and under. Coverage was expanded to include children ages 13 and under on Oct. 1, 1988.

There are two different populations within this category: Eligible Assistance Children (EACs) and Eligible Low Income Children (ELICs). Eligible Assistance Children, also known as "food stamp children," are those children ages 13 and under in families certified by DES for the Federal Food Stamp Program. These children are automatically eligible for AHCCCS benefits. Eligible Low Income Children are determined eligible through a process similar to the MN/MI eligibility system. This category is for children in families that do not receive food stamps but whose incomes exceed state MN/MI levels and are not greater than federal poverty guidelines. State law requires that EAC and ELIC children apply for eligibility under a federally funded category

in order to remain eligible for AHCCCS. If they are denied categorical eligibility they will remain on the program as Eligible Assistance Children.

PRESENT POPULATION

The number of eligibles in AHCCCS has grown significantly since the beginning of the program. At the end of the first program year in September 1983, there were approximately 160,000 members. As of Dec. 1, 1992, AHCCCS had 455,859 members. The current numbers include 17,029 long term care recipients, 271,177 AFDC/SSI/MAO members, 48,807 MN/MI members, 16,260 Eligible Assistance Children, 5,011 Eligibile Low Income Children, 3,043 in the Children's Medical Program, and 94,532 S.O.B.R.A. women and children.

COVERED SERVICES

Because AHCCCS still operates as a demonstration project, the services covered or excluded can differ from those offered in states that have fee-for-service Medicaid. Originally, Arizona had waivers from providing services for the chronically mentally ill, home health services, family planning services, and the room-and-board component for long term care populations. The counties and DES were responsible for providing these services to eligible populations (by state statute, the counties have ultimate responsibility for the health care of the indigent in Arizona if they do not qualify for AHCCCS). With the advent of family planning services and the

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Arizona Long Term Care System (ALTCS), both of which were approved by the 1988 legislative session and which became effective Oct. 1, 1988, and Jan. 1, 1989, respectively, AHCCCS now offers all services available through a traditional Medicaid program except full mental health services for adults. However, the first phase of the adult mental health program -- for the seriously mentally ill (SMI's) -- is scheduled to begin Nov. 1, 1992. On Oct. 1, 1990, AHCCCS began mental health services for children under 18 who were categorically eligible and had serious mental health problems that required 24-hour supervision. Services for children with other mental health problems and/or substance abuse disorders began April 1, 1991. It is a goal of AHCCCS that by 1993, the mental health program will include all services for adults.

Unlike other states, AHCCCS does not have limitations such as paying for only a specified number of days in a hospital. Services covered by AHCCCS include:

- Outpatient health services
- Laboratory and medical services
- Pharmacy services
- Medical supplies, medical equipment, and prosthetic devices
- Inpatient hospital services
- Emergency services
- Emergency ambulance and medically necessary transportation
- Emergency dental care and extractions
- Medically necessary dentures

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- A children's program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- As of Oct. 1, 1985, certain oral surgery for children under the age of 18
- Podiatry services as of Oct. 1, 1985
- As of Oct. 1, 1988, family planning services
- As of January 1989, home health care services
- Medically necessary kidney, cornea and bone transplants and immuno-suppressant medications (available to all populations under AHCCCS); as of Oct. 1, 1987, medically necessary heart transplants for categorical members only; as of Oct. 1, 1988, liver transplants for categorically eligible children; as of Oct. 1, 1989, autologous (from own body) bone marrow transplants for categorical members; and, during the 1992 session, the Legislature approved allogeneic (donor) bone marrow transplants for categorical members.
- As of April 1, 1991, mental health services for children under age 18

  Tentatively, as of Nov. 1, 1992, mental health services for adults who are seriously mentally ill.

SERVICE DELIVERY

Services are provided to eligible populations through health plans that

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are selected by competitive bidding. Bids are awarded on a county-by-county basis. Enrollment in a prepaid health plan is mandatory for all members except American Indians, who may choose the Indian Health Service as a provider of medical care. Health plans are reimbursed on a prepaid, capitated basis. In late summer 1992, AHCCCS finalized contracts with 14 health plans statewide for a two-year period ending Sept. 30, 1994. Two new health plans, AHCCCS Select (Intergroup) and Arizona Health Concepts, joined the program. Two existing plans -- University Famli-Care and Northern Arizona Family Health Plan -- dropped out. In La Paz County, which had been served on a fee-for-service basis since 1990, a contract was awarded to Arizona Physicians IPA. The newly contracted plans began serving members Oct. 1. Underscoring the success of the AHCCCS contracting was an editorial in the Arizona Republic on Aug. 7. The editorial said the contracts between AHCCCS and the health plans "have turned out to be the best bargain in a long time." The editorial went on to suggest that because AHCCCS could keep costs down through market competition, state workers should also be served through the AHCCCS plans.

The formation of AHCCCS gave rise to private sector involvement in indigent health care and, at the same time, presented a vehicle for the involvement of county-operated hospitals.

All of the private AHCCCS plans, including AHCCCS Select, Intergroup's plan for AHCCCS members, were formed to bid on AHCCCS contracts. In addition, Maricopa, Pima and Pinal counties, plus the University of Arizona Medical Center, reorganized themselves into prepaid health plans to bid on AHCCCS contracts (later, Pinal opted not to continue as an AHCCCS plan and University Famli-Care also dropped out).

In order to be considered for a contract award, a health plan must

demonstrate that it has the proper administrative experience, structure, resources and controls to manage the risks associated with a prepaid capitatedcontract. Requests for proposals not only require the plans to bid by county, but by rate code of eligibility. Thus, contracts are awarded based on rate codes that include eligibility under AFDC, SSI, MN/MI, Children's Care Program and S.O.B.R.A. -- and whether persons in the SSI and MN/MI categories have Medicare coverage.

AHCCCS re-insures the plans at levels that vary according to member category, by plan size and by diagnosis, such as for AIDS and the higher-cost transplant procedures. For emergency inpatient and outpatient services provided to AHCCCS-eligible persons in special catastrophic categories and approved transplant recipients, the health plan is liable for a $1,000 deductible, and a continuing share of 10 percent of the costs of care. There is also a deferred liability program for members hospitalized on the day of enrollment. In the case of sick newborns, the responsibility runs to the date of discharge.

AHCCCS also has a fee-for-service exposure. This occurs when a person is first declared eligible but has not yet joined a health plan. AHCCCS pays non-hospital providers directly based on a maximum allowable charge set by the AHCCCS Administration. Hospitals currently are reimbursed based on a percentage of billed charges fixed by Arizona state statute. Discounts on these adjusted billed charges are also allowed by statute based on timeliness of payment. A new hospital reimbursement system has been approved by the Legislature and will go in effect March 1, 1993. The new system, based on seven major levels of care, will replace the ABC method. Under this system, each of the levels will have a basic reimbursement amount, with some readjustment for individual hospitals.

QUALITY OF CARE

Documenting quality health care delivery has proved difficult in a prepaid setting. There are a few such measuring sticks in the private sector, and this led AHCCCS to develop a system of its own. This system was based on audits performed annually by out-of-state physicians who examined AHCCCS patient records maintained by primary care physicians.

Medical quality of care audits have been conducted annually and indicate that care for AHCCCS members is being provided within generally accepted medical practice criteria. These audits also indicate that AHCCCS members are being mainstreamed into the general health care delivery system. This mainstreaming is evidenced by the fact that approximately 70 percent of Arizona's licensed physicians (MD's and DO's) are registered as AHCCCS providers.

SRI International, a California research facility who has studied AHCCCS for the federal government, also conducted a satisfaction survey of the program's members during the summer of 1985. Results of that study showed members had about the same access to care, service utilization and satisfaction level as Medicaid patients in other states. A later SRI study would show better access to care and lower service utilization (see SRI evaluation, Page 25).

The SRI member survey confirmed an independent study conducted in 1984 by Louis Harris and Associates, funded by the Robert Wood Johnson Foundation and the Flinn Foundation. The survey found AHCCCS members had a high level of satisfaction with their health care, and their access to health care had improved over the previous county system. In late 1989, the Flinn Foundation

released a study that painted a grim picture of health care in Arizona but pointed at AHCCCS as a program that was reaching its target population. The report also said that the overwhelming majority of AHCCCS enrollees were either satisfied or completely satisfied with the program, and only 5 percent were dissatisfied with the services they were receiving.

More recently, Laguna Research Associates has been evaluating the long term care program under AHCCCS. Results of that evaluation will be presented in later updates of the Overview.

HEALTH CARE GROUP

(Coverage of the "notch group")

Since AHCCCS is the safety net for uninsured health care, it is experiencing an increasing problem with the "notch group," which AHCCCS defines as anyone -- regardless of income - - who makes too much money to qualify for AHCCCS benefits but who does not have health insurance. The working uninsured represent a major, growing problem in Arizona and across the nation. This lack of insurance presents a problem not only to the people who are "going bare," but to health care providers and taxpayers.

When uninsured people become ill, the burden falls on the medical community and taxpayers. The impact of the uninsured is regularly felt by AHCCCS. Some people qualify for the program who are not "indigent," according to the classic definition of that term. They might earn $20,000, or $30,000, or even more, but they become eligible for AHCCCS health care because they "spend down" their incomes to sub-poverty levels -- that is, their medical

bills can be subtracted from their incomes to meet the eligibility standards. Many people enter the program at the most expensive point in the course of their health care treatment.

In response to the growing notch-group problem, AHCCCS developed a small-business product designed exclusively for small businesses in Arizona. The Health Care Group of Arizona (HCG), an AHCCCS program, was developed under an initial grant of $346,000 from the Robert Wood Johnson Foundation of Princeton, N.J., in 1986. Designed as a self-sufficient health care plan for small businesses, the Health Care Group offers medical coverage to companies of 40 or fewer employees who currently do not have group insurance.

Four benefit options are available, all covering physician visits, hospital and surgical procedures, laboratory and X-ray services, prescriptions and emergency care. HCG does not exclude any industries from coverage. Employer contributions are encouraged, but not required.

More than 230,000 Arizona workers could be eligible for HCG coverage. When added to the number of eligible dependents, the potential membership could be more almost 600,000 Arizonans.

In the fall of 1989, the Robert Wood Johnson Foundation and the Flinn Foundation of Phoenix approved more than $450,000 in additional grant money for the continuation of the Health Care Group. The funds were for administrative costs to enable the project to operate until the end of 1991. Then, during the 1991 session, the Arizona Legislature approved $198,000 in administrative state funds so the program could continue operating until it becomes self-sufficient through member premiums.

The Health Care Group is intended to be a statewide project. Eligible carriers must have AHCCCS contracts in order to bid on providing HCG coverage.

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COMPARISON OF AHCCCS TO FEE-FOR-SERVICE MEDICAID

Medicaid expenditures, whether for AHCCCS or for a traditional program, are affected by three major factors: the number of people eligible for the program (population), the use of services by each person (utilization), and the cost of each service (unit cost).

Population

As is the case for any Medicaid program, AHCCCS expenditures are affected by the size of the population the program services. AHCCCS has seen the number of its AFDC-related enrollees rise from approximately 65,000 enrolled members on Oct. 1, 1983 -- after one year of operation -- to more than 210,000 on Oct. 1, 1992. Since 1986, the AHCCCS rolls have been increased substantially by three new populations: Eligible Assistance Children, S.O.B.R.A. women and children, and recipients under the long term care system.

Because AHCCCS follows federal- and state-defined eligibility rules, the same number eligible for AHCCCS would be eligible for a fee-for-service program. Thus, the central question in comparing AHCCCS to a fee-for-service program is the degree to which utilization and/or unit costs are reduced by the prepaid model.

Utilization

AHCCCS has several features to control the utilization of medical services. Contracted health plans receive a fixed capitation payment regardless of the number or type of services provided; therefore, they have an incentive to control utilization. Traditional programs lack these cost containment features. In a traditional program, the physician has an

incentive to increase utilization, because Medicaid pays a physician each time a service is provided. Traditional programs experience a high use of expensive emergency room and hospital care.

Unit Cost

AHCCCS controls and makes more predictable the cost of medical services through prepaid contracting. Competitive procurement of health care services is designed to contain costs. Health plans can negotiate discounts from hospital rates in return for referring patients to particular hospitals.

Total cost comparison

AHCCCS compares favorably with fee-for-service programs. SRI International has compared AHCCCS costs with what a traditional program would have cost Arizona. Results show that for FY 1983 to FY 1985, AHCCCS saved between $1.3 million and $12.1 million. The savings variances result from the use of different cost calculation methods. The most striking result is AHCCCS' slower rate of per-capita cost increase for the same time period: 3.8 percent compared to 18.6 percent for the fee-for-service program.

SRI in 1989 released a five-year study which in part compared AHCCCS program costs to traditional programs from October 1982 through 1987 (the results are discussed in detail below). Again, the findings were positive. In looking at the per capita costs, this report indicated that traditional Medicaid program costs during this period increased by 37.3 percent while AHCCCS program costs increased 23.1 percent.

5-YEAR EVALUATION BY SRI INTERNATIONAL

Researchers from SRI International in Menlo Park, Calif., released a $4 million, five-year study of AHCCCS in early March 1989. The massive study was conducted for HCFA, the federal agency that oversees AHCCCS. It evaluated the period from October 1982 through 1987. SRI found that AHCCCS was less expensive, provided a higher quality of care for children and had better access to routine care than traditional Medicaid. In addition, the study indicated that member satisfaction with AHCCCS was high, hospital utilization was lower than it would be under traditional Medicaid, and quality assurance was a well developed system.

Researchers summarized their findings under four major categories:

- Cost. Over the program's first five years, the average per capita costs for AHCCCS increased at a rate of 23.1 percent while those for traditional Medicaid increased 37.3 percent.
- Utilization. Hospital utilization under AHCCCS was lower than traditional Medicaid and indicated a significant savings.
- Quality of care. Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics.
- Access and satisfaction. Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.

In addition, researchers said AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance, and the study supports the "stimulation of AHCCCS-type Medicaid innovations in other states."

AHCCCS program savings and cost increase compared to a traditional Medicaid program

Federal fiscal years 1983 - 1987

Savings	$30,435,386

Per capita cost increase:

AHCCCS	23.1 percent
Traditional	37.3 percent

AHCCCS has lower hospital use than a traditional Medicaid program

	Hospital days per thousand
California	1,529
Michigan	1,620
New York	2,500
AHCCCS	1,260

LONG TERM CARE

The Arizona Long Term Care System (ALTCS) is a program of institutional and home health care services for the indigent elderly, physically disabled and developmentally disabled in Arizona. Services for the developmentally disabled began Dec. 19, 1988, and for the elderly and physically disabled on Jan. 1, 1989. As of Oct. 1, 1992, the program was serving 16,688 people.

The Program Model

The state built on the concept of the prepaid capitated acute care program by expanding Medicaid service coverage to include long term care. Senate Bill 1418, the enabling legislation for ALTCS, was passed by the Legislature and signed by the governor May 21, 1987. Consistent with enabling legislation, the state proposed that Medicaid long term care services be delivered and financed through a system that incorporates the major elements of the current AHCCCS program and at the same time builds upon the success of Arizona's counties and the Department of Economic Security in delivering quality long term care services in a cost-effective manner. ALTCS uses a prepaid capitated approach with its incentives to control the risk of the volume and cost of services, thereby providing an alternative to the runaway long term care costs that have plagued other states. ALTCS provides a continuum of services that focuses on less intensive and less expensive services than the institutional services upon which other states rely.

Traditional Medicaid programs are biased toward the use of high cost institutional services because eligibility is tied to institutional status. ALTCS provides less costly alternatives to institutionalization in the form of Home and Community Based Services (HCBS) to the full extent agreed to by the

federal government. In addition, acute and long term care services are bundled -- that is, anyone eligible for ALTCS will also be eligible for all other medical services available through AHCCCS - - thereby providing incentives for delivery of cost-effective and appropriate services. A case manager acts as a gatekeeper to ensure that the most appropriate and cost-effective services are provided.

Under the new law, the state's two largest counties, Maricopa and Pima, are required to act as providers for both acute and long term care services to the elderly and physically disabled. The other 13 counties have the option to do the same. In any county where the county government elects not to participate as a provider, AHCCCS will seek competitive bids. Reimbursement is primarily on a prepaid, capitated basis. The state Department of Economic Security, which administers programs for the developmentally disabled, is responsible for care to that population by contracting with AHCCCS.

As of Oct. 1, 1992, the federal government has limited the availability of HCBS to 30 percent of the total elderly and physically disabled populations under ALTCS. This limit has been eased several times since 1990; Project SLIM, Gov. Fife Symington's program to improve efficiency in government, has recommended an even higher percentage of HCBS availability to save money that is currently being spent on institutional care. Because AHCCCS requires that a person be at risk of institutionalization to enter ALTCS, it is questionable whether a higher percentage of members could avail themselves of home health services.

From the beginning of the program, the developmentally disabled population has received both institutional and HCBS care not held to any percentage limit. Thus, the cost-effectiveness of the capitated model where

less costly HCBS substitutes for more expensive institutional care can be demonstrated more fully with the developmentally disabled than with the elderly and physically disabled.

In addition to the cost control incentives inherent in capitation, ALTCS used a tightly defined pre-admission screening (PAS) process to ensure that only individuals who are determined to need the necessary levels of care will receive these services. The screening is conducted either by a registered nurse or an ALTCS social worker, in consultation with a doctor, to determine the best method of treatment for the individual's well being.

Eligibility

The long-term care eligibility of individuals who apply must be based on SSI, AFDC or S.O.B.R.A. eligibility requirements. Income and resource limits differ with the aid category (AFDC or SSI) under which an individual is determined eligible. Generally, however, the gross income limit is set at 300 percent of the SSI benefit rate for an individual. There is no "spend down" provision for long term care eligibility; that is, an individual cannot offset his or her income with incurred medical expenses in order to qualify for the program.

Furthermore, as has been indicated, only those individuals who are determined to be at risk of institutionalization are eligible.

Services

Long term care services include:

- Skilled nursing facilities
- Intermediate care facilities
- Intermediate care facilities for the mentally retarded
- Home and community based services (home health care, respite care, transportation, meals-on-wheels, hospice, etc.)
- Acute medical services

MENTAL HEALTH

After implementation of ALTCS, behavioral health coverage was the only major element of a traditional Medicaid program that remained outside the AHCCCS range of services. In late 1989, congressional action mandated that Medicaid programs pay for the cost of mental health and substance abuse services necessary to treat children for conditions identified in the EPSDT screening. The initial implementation date was to be April 1, 1990, but AHCCCS asked for and received an extension because there was no workable network in Arizona for such services.

The new program began Oct. 1, 1990, for children with problems serious enough to require 24-hour supervision. Services for eligible Title XIX children with other mental health needs or substance abuse problems began April 1, 1991. The guiding principals of the new program include coordination of acute and long term care and behavioral health services, centralized diagnosis and screening, and involvement of both AHCCCS and the Department of Health Services in its development. A child's needs are identified through the EPSDT process and the child is then referred to a DHS administrative entity, which acts as a "broker" and contracts with providers for the behavioral health services. More than 5,500 children were being treated under this program as of Oct. 1, 1992.

Up to now, AHCCCS has covered only limited acute mental health services in crisis situations for adults. However, the first phase of adult mental health services began Nov. 1. The program, which received the Arizona Legislature's approval during the 1992 session, offers services to seriously mentally ill (SMI) AHCCCS members who are ages 21 and older. Legislators

also approved services for people in ALTCS who are disabled and are ages 65 and older, but that phase is not scheduled to begin until sometime between Feb. 1 and July 1, 1993. Still to be included under AHCCCS is the non-SMI population, which requires legislative approval. Services for the SMI population will include inpatient hospitalization; partial care; emergency crisis, behavior management and psychosocial rehabilitative services; evaluation and case management; and mental health-related services such as laboratory work, radiology and medication.

OTHER CHANGES AND CHALLENGES

Recently, AHCCCS has had to face more changes, all of which have a serious impact on costs. The Arizona Legislature, as stated earlier, has expanded S.O.B.R.A. eligibility to include pregnant women up to 140 percent of the federal poverty level. The current poverty level is $6,816 for one person, or $11,580 for a family of three. At 140 percent, the levels rise to $9,540 for an individual and $16,200 for a family of three. In addition, the Welfare Reform Act passed by Congress in September 1988 has impacted both the cash assistance and related Medicaid benefits offered in Arizona. Beginning April 1, 1990, Arizona was required to offer welfare benefits to two-parent families in which the principal wage earner was unemployed. Also, while most elements of the Medicare Catastrophic Coverage Act of 1988 were repealed by Congress in late 1989 after a storm of protests by Medicare recipients over the cost of financing the program, Congress kept those elements that affect Medicaid programs such as AHCCCS. AHCCCS must pay the premiums, deductibles

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and co-insurance for Medicare recipients -- called Qualified Medicare Beneficiaries -- whose incomes fall below the federal poverty level and whose assets are below twice the SSI resource level. And finally, on Oct. 1, 1991, AHCCCS began covering members through age 20 under the EPSDT program. While other states have had coverage up through this age, AHCCCS has had a waiver and has only covered through age 17. The expansion to include these additional ages will have an impact on costs and on other areas of the AHCCCS program, such as mental health.

The AHCCCS Administration is responsible for the purchase of hundreds of millions of dollars in acute medical goods and services in Arizona. These goods and services are purchased from the same providers who are serving employees of the major corporations and small businesses, government employees, and Medicare beneficiaries. Both government and private purchasers of health care coverage have seen a dramatic increase in their costs.

According to industry analysts, excessive health care inflation is here with a vengeance. Health insurance experts have predicted premium increases of 15 percent to 25 percent in the private sector for the foreseeable future. Nationally, health insurance now outranks both Social Security and private pension plans as the most expensive employee benefit. Experts cite two primary reasons for cost increases in the health care industry: Both hospital and outpatient service expenses are increasing due in part to the cost of high technology, inflation and malpractice insurance; and there has been an increase in utilization -- particularly in the more expensive outpatient areas such as ambulatory surgery.

It is within this environment that the AHCCCS program must work. Increases to the AHCCCS health plans have been small in the past three years.

Compared to the private sector industry, AHCCCS typically treats sicker clients and yet medical cost increases have been substantially less compared to private carriers.

While AHCCCS is still a relatively new program and is paralleling the usual steps that accompany organizational evolution, considerable progress has been made. Costs have been controlled without a reduction in quality and a system has been developed to assess and monitor quality health care. For the first time since the mid-1860's, federal funds have been brought into the state for indigent health care. The health plans are maturing and continue to develop creative contractual arrangements with the direct providers of care. Elements of competition and risk-sharing have been introduced into the indigent health care delivery system. Members have been given access to mainstream medical care.

A year ago, the New York Times took a look at AHCCCS and determined that the program was leading the way as a Medicaid system (see Appendix D). Not only New York, but other states are looking at AHCCCS to restructure their Medicaid programs. What is of importance is that Arizona has developed a system that can be used by other states to implement a prepaid, managed health care program without the pitfalls AHCCCS encountered in its early stages of development.

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APPENDIX A

Annual Income by Household Size

Household Size	AFDC	Medically Needy	Food Stamp	Federal Poverty Level (FPL)
1	$ 2,448	$ 3,200	$ 6,624	$ 6,816
2	$ 3,300	$ 4,266	$ 8,880	$ 9,192
3	$ 4,164	$ 4,810	$11,148	$11,580
4	$ 5,016	$ 5,354	$13,404	$13,956
5	$ 5,868	$ 5,898	$15,660	$16,332

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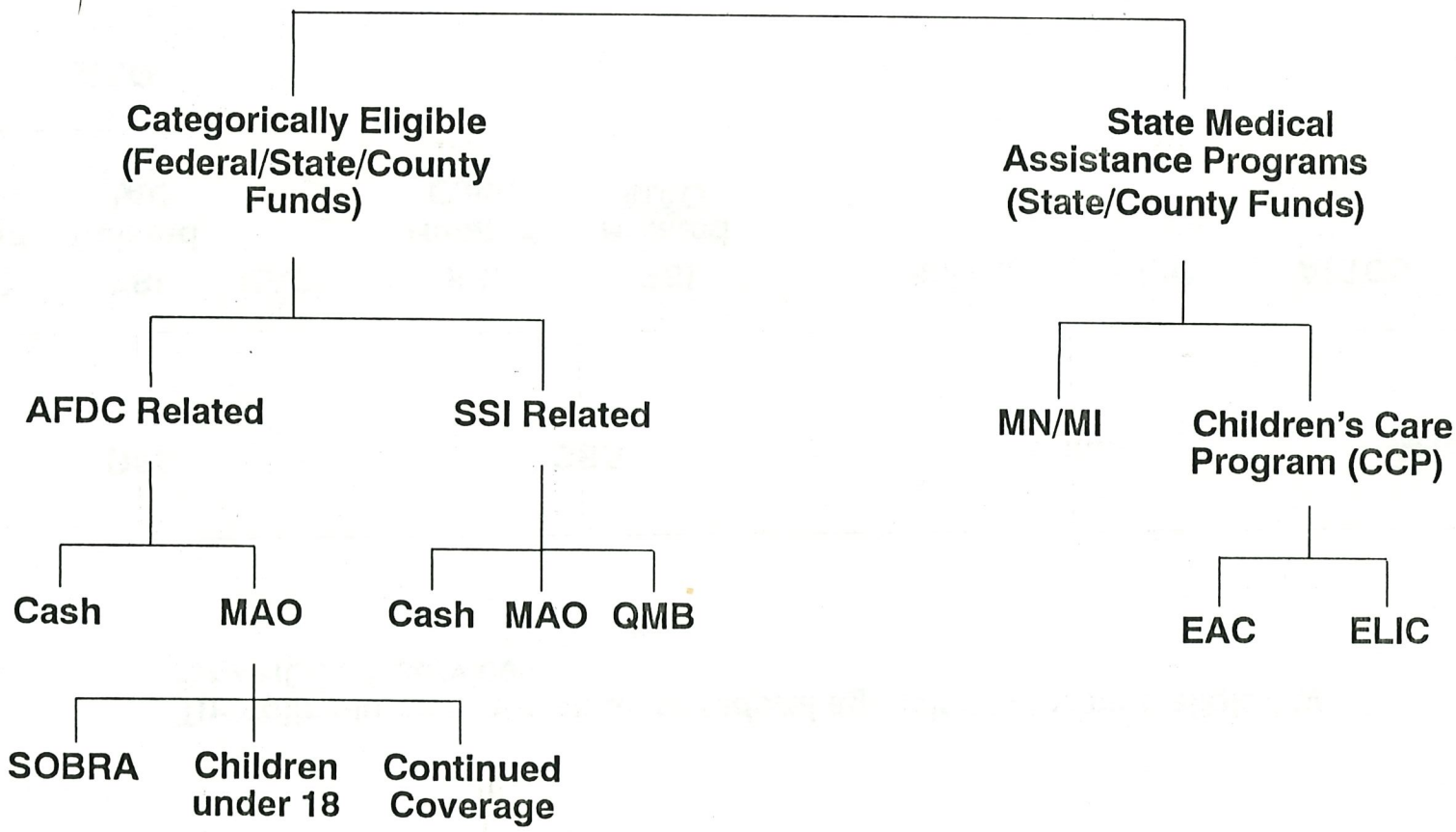
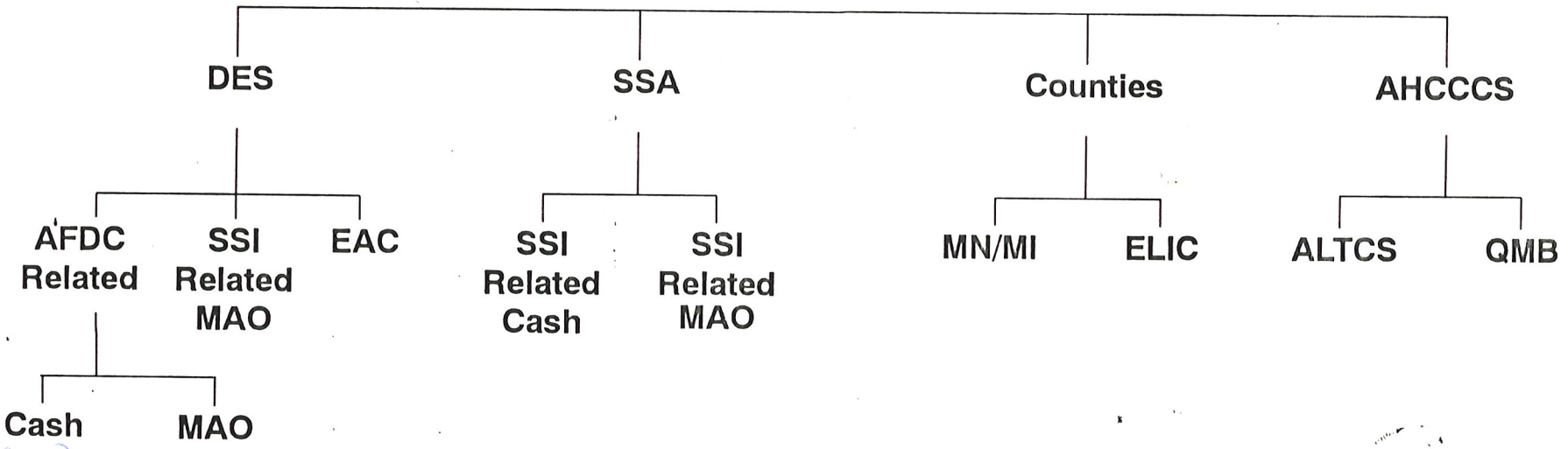
APPENDIX B

AHCCCS Eligibility Groups



AHCCCS Eligibility Process

The following county, state, or federal agencies determine eligibility for AHCCCS services:



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APPENDIX C

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GLOSSARY OF TERMS

AHCCCS - - The Arizona Health Care Cost Containment System, made up of the administration and service contractors (or some other arrangement) to provide health care services to eligible people. The term "AHCCCSA" is used when referring to the administration.

ABCs (ADJUSTED BILL CHARGES) - - The reimbursement rates paid by AHCCCS to hospitals, based on a formula outlined in the Arizona Revised Statutes 36-2903 and 36-2904. The ABC system will become obsolete March 1, 1993, and will be replaced by a new tiered system of reimbursement.

AFDC - - Aid to Families with Dependent Children, a cash assistance program under the Social Security Act. A person receiving AFDC from the Department of Economic Security is automatically eligible for AHCCCS benefits.

ALTCS - - Pronounced "All-tecs". The Arizona Long Term Care System, which provides long-term care services to the developmentally disabled, the elderly and the physically disabled. All segments of the program were in operation by Jan. 1, 1989.

CAPITATION - - Fixed monthly payments which AHCCCS gives in advance to its contractors (health plans) for the full range of medical benefits available to each AHCCCS member.

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CATEGORICALLY ELIGIBLE - - Those individuals - - such as recipients of Aid to Families with Dependent Children or Supplemental Security Income - - who are mandatorily eligible for AHCCCS according to Title XIX (Medicaid) of the Social Security Act. These individuals are eligible for federal matching funds.

CERTIFICATION PERIOD - - The period for which a person is certified as eligible for AHCCCS benefits.

COMPETITIVE BID PROCESS - - The state procurement system used by AHCCCS to select providers (health plans) of covered services on a geographic basis.

CONTRACTOR - - A person, organization (health plan) or other entity that contracts with AHCCCS to provide services to AHCCCS members.

CO-PAYMENT - - An amount of money specified by the AHCCCS director which the AHCCCS member pays at the time covered services are rendered.

DEFERRED LIABILITY - - A payment policy under which AHCCCS may, for set periods of time, reimburse a portion of a contractor's medical costs for a newly enrolled member of AHCCCS.

EAC - - Eligible Assistance Children (also known as food stamp children).

ELIC - - Eligible Low Income Children.

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EPSDT SERVICES - - Early and periodic screening, diagnosis and treatment services for persons under 20 years of age.

ELIGIBILITY WORKER - - An employee of a county, the Social Security Administration, the Department of Economic Security or the Arizona Long Term Care System designated to conduct eligibility interviews and determinations for AHCCCS. The AHCCCS Administration itself does not make people eligible for the program, except for ALTCS recipients.

ENCOUNTER DATA - - Records of medical services provided to an AHCCCS member, which must be submitted monthly by each contractor.

ENROLLMENT SITES - - Locations throughout the state where individuals eligible for AHCCCS must go to choose a contractor (health plan).

FEE-FOR-SERVICE PROVIDERS - - Registered providers who deliver services after a person becomes eligible for AHCCCS but before that person is enrolled with a contractor (health plan). Also, a fee-for-service provider can operate in areas of the state not being served by a health plan.

GATEKEEPER - - A primary care provider - - generally a physician - - who is primarily responsible for all medical treatment of an AHCCCS member. The provider makes referrals to specialists, as necessary, and monitors the patient's treatment throughout.

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GRIEVANCE - - A complaint arising from an adverse action, decision or policy by a contractor, a subcontractor, a non-contracting provider, a county or the AHCCCS Administration, presented by an individual or entity.

HCBS - - Home and Community Based Services, a category of service under the Arizona Long Term Care System. This category provides a variety of long-term care services at the member's home or in a community setting.

HCFA - - The Health Care Financing Administration, a federal organization which is under the U.S. Department of Health and Human Services and which oversees the AHCCCS program.

HEALTH PLAN (AHCCCS) - - One of 14 entities that contract with AHCCCS to provide health care services to AHCCCS members. Although AHCCCS monitors the plans for proper delivery of care, they are private entities and AHCCCS does not run them.

ICF - - Intermediate Care Facility under the Arizona Long Term Care System.

ICF/MR - - Intermediate Care Facility for the Mentally Retarded.

MAO - - Medical Assistance Only. This is a special category of recipients who do not qualify for cash assistance under AFDC or SSI but for whom U.S. law provides entitlement to Medicaid (or AHCCCS) benefits.

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MEDICAID - - A federal/state program under Title XIX of the Social Security Act. It provides federal matching funds for medical care to recipients of federal public assistance, SSI benefits or other specified aid. Certain minimal populations and services must be included to receive federal matching funds. AHCCCS is Arizona's Medicaid program.

MEDICALLY NEEDY/MEDICALLY INDIGENT (MN/MI) - - A category of AHCCCS recipients funded by state and counties only. The state receives no federal matching funds for these people. Eligibility is determined by counties according to AHCCCS standards.

MEDICARE - - A federal program under Title XIX of the Social Security Act which provides health insurance for persons aged 65 and older and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

NOTCH GROUP - - Generally refers to a segment of the working population whose income is too high to qualify for AHCCCS but too low to afford health insurance. People working for employers who do not provide health insurance are also considered to be in the "notch group".

OPEN ENROLLMENT - - A period of time - - usually beginning in August - - during which all current members of AHCCCS may switch membership to another contractor (health plan) when such a choice is available.

PAS - - Pre-Admission Screening, the medical process necessary to qualify for The Arizona Long Term Care System.

PMMIS - - The Prepaid Medical Management Information System. This is a new computer system designed specifically to handle AHCCCS's managed care approach to Medicaid.

PRIMARY CARE PHYSICIAN - - See GATEKEEPER.

QUALITY ASSURANCE - - A methodology used by AHCCCS to assess the degree of conformance to desired medical standards and practices. It also involves activities designed to improve and maintain quality service and care.

REDETERMINATION - - The process by which an AHCCCS member reapplies for a new eligibility period before the current eligibility period expires.

SNF - - Skilled Nursing Facilities, under the Arizona Long Term Care System.

SSI - - Supplemental Security Income (for the blind, aged, or disabled) through the Social Security Administration. A person who is eligible for SSI benefits is automatically eligible for AHCCCS.

S.O.B.R.A. - - Sixth Omnibus Budget Reconciliation Act, part of a series of major Medicaid maternal and child health reforms passed by Congress this decade. S.O.B.R.A. provides states with funding to expand their Medicaid eligibility groups to include pregnant women and children with family

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incomes up to 133 percent of the federal poverty level (mandatory). States have the option of covering incomes up to 185 percent of FPL, and Arizona has opted for coverage at 140 percent of FPL. The act took effect in 1987 and Arizona implemented the S.O.B.R.A. standards January 1, 1988. The state Department of Economic Security determines eligibility and AHCCCS monitors the delivery systems so that the state is in compliance with federal regulations.

SPEND DOWN - - The process by which an individual or a family can subtract medical expenses from annual income to meet eligibility income limits. As an example, a person earning $10,000 a year with incurred medical bills (for one year previous) of $7,000 can subtract the bills from the income to reach the eligibility limit for an individual, which is $3,200 a year. The spend down process, sometimes erroneously called "spin down," applies to the Medically Needy/Medically Indigent category only and not to AFDC, SSI or other categories that receive federal matching funds.

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APPENDIX D

"All the News That's Fit to Print"

The New York Times

National Edition
Southern California: Still unusually cool, cloudy at the coast. Hot, sunny inland. Rockies, afternoon clouds and storms. Weather map and forecasts for other areas appear on page B4.

VOL. CXL . . . . No. 48,685 WEDNESDAY, AUGUST 7, 1991

Printed in California 75 CENTS

Late Starter in Medicaid, Arizona Shows the Way

By ERIK ECKHOLM
Special to The New York Times

TUCSON, Ariz. -- When Sandra Bejarano's 7-year-old son, Santiago, had headaches and a fever on a recent morning, she took him to their family doctor at an attractive midtown clinic. The doctor took a blood count, and through he suspected a routine viral infection, he had them return the next day for another test just to make sure.

For most Americans, an ordinary medical encounter. And that is what was so exceptional: Ms. Bejanro, who is 28 and unemployed, and her two sons are patients in Arizona's version of Medicaid, the Federal-state medical program for poor people.

"The medical care is mainstream. Patients are happy, doctors are happy and costs per patient are about 5 percent lower than in other states where the quality of care is often worse."

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"All the News That's Fit to Print"

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For most Americans, an ordinary medical encounter. And that is what was so exceptional: Ms. Bejanro, who is 28 and unemployed, and her two sons are patients in Arizona's version of Medicaid, the Federal-state medical program for poor people.

"'It may save a little money, but more important, they are getting something worthwhile for what they are spending,' said Gail Wilensky, head of the Federal Health Care Financing Administration in Washington. Her agency, which pays just over half of Medicaid bills here and nationwide, hopes to see much wider use of managed care."

THE NATION'S NEWSPAPER

USA TODAY

FRIDAY, AUGUST 16, 1991 A GANNETT NEWSPAPER

Gardner health-care plan gleans other states' ideas

Washington Gov. Booth Gardner and aide Bob Crittenden cribbed some of their best ideas for health care reforms from other states:

"Arizona, last state to join the Medicaid program, has a plan dubbed AHCCCS that functions like a health maintenance organization but is administered by the state. If the federal government approves, AHCCCS would replace Medicaid."

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U.S. News & WORLD REPORT
AUGUST 26--SEPTEMBER 2, 1991 $2.50

SPECIAL DOUBLE ISSUE

THE BEST OF AMERICA

Real health-care fixes

ARIZONA

■ **Major reform:**

"Arizona has ended the two-tier system of care for rich and poor. The state sends Medicaid patients to private doctors and hospitals, instead of to 'Medicaid mills' and separate clinics for the poor."

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U.S. News & WORLD REPORT
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THE BEST OF AMERICA

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ARIZONA

■ **Major reform:**

"... because Arizona entered (Medicaid) two decades after most states, it was also able to learn from the mistakes of others. If Medicaid were to be reinvented today, it would look a lot like Arizona's program."

The Phoenix Gazette

NOVEMBER 28, 1989 STREET FINAL 35c

Study paints bleak picture of health care for poor

By Brad Patten
The Phoenix Gazette

The most extensive survey in history of Arizona's health care system finds good care for the weathly, the white, and those with health insurance, but a much worse health care system for the poor, minorities and the uninsured.

"We have a story of two po... the well-served majority ... underserved minority," ... Taylor, president of ... Associates, which ... the survey. "It is really like ... untries."

The $35 ... Arizo... pr... 200

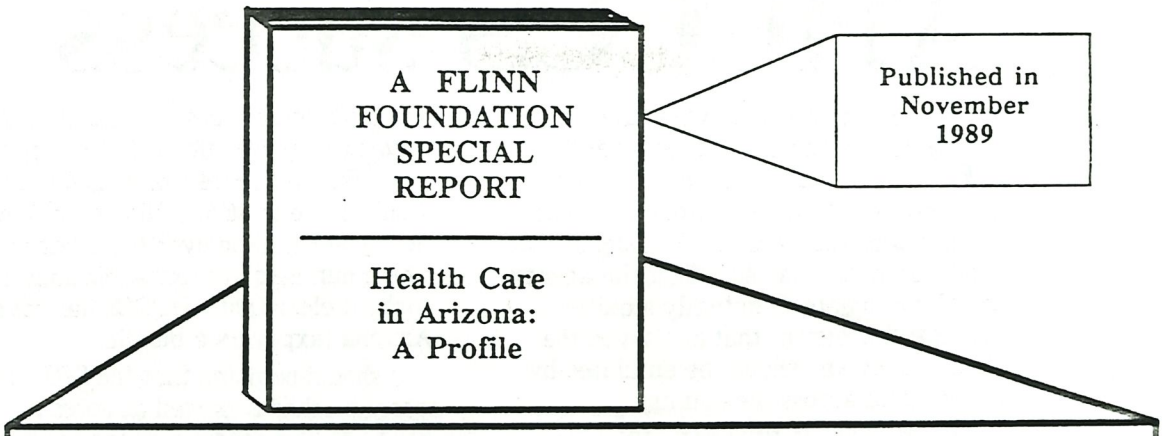
... national average.

"The findings reveal a paradox," John Murphy, executive director of The Flinn Foundation, said. The report will be released today. "Clearly, the majority of ...izonans can obtain medical care if they ... -- and they are satisfied with it. ...stantial segment of the popula... ...ealth care difficult to obtain ...ied with it."

... Survey, A-6

One bright spot, Taylor noted, was the impact of the 7-year-old experimental Arizona Health Care Cost Containment System. The often over-budget and much-maligned AHCCCS program appears to be serving the people most in need, those with the most disease and disability, who need to visit the doctor or hospital most often, and the portion of the population most likely to need emergency care.

"You have to give the people who designed AHCCCS credit for reaching the people most in need," Taylor said.



HEALTH CARE FOR THE POOR

One Arizona health care investment which seems to be accomplishing its objectives is AHCCCS, the state's health care program for the poor and medically indigent. This program, launched in 1982 to provide quality health care services to low-income, uninsured families with significant unmet health needs, is reaching its targeted audience -- the poorest of the poor.

Most importantly, the overwhelming majority of AHCCCS enrollees (65 percent) say they are completely satisfied with the program. Only 5 percent say they are dissatisfied with the care they receive.

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March 7, 1989

Tempe Daily News
Tribune

Editorials

AHCCCS success

What do you do when the whipping boy turns out to be a hero? Arizona's more ultra-conservative legislators had to be taken aback this week by an independent report showing that AHCCCS, the agency they love to hate, is actually a quite successful program that has saved the state money and should be emulated by other states across the country.

The Arizona Health Care Cost Containment System is, according to the report by SRI International, apparently living up to its name. The report was ordered and paid for by the federal Health Care Financing Administration, in an independent effort to look for better, cheaper ways to fund health care for the poor.

Because the cost of AHCCCS has been steadily increasing, an increasing number of legislators have panned the agency and the whole concept of the state undertaking indigent health care without the aid of Medicaid. What the report shows, however, is that costs would have been going up much faster had Arizona opted for Medicaid.

Between 1982 and 1987, the AHCCCS per-patient average cost went up by 23.1 percent. Although that's quite a jump in a fund that demands such a large chunk of the state budget, at about 4.6 percent a year it's really just slightly above the general inflation rate for the same period.

More importantly, the increase in per-patient costs for states with Medicaid programs has been nearly 38 percent during the same time frame. That's an annual increase of about 7.5 percent. For a program spending more than a quarter of a billion dollars a year, the difference in the cost increase rates is substantial.

The AHCCCS budget calls for serving about 263,000 people at a cost of some $284 million next year. That's just under $1,100 per person. If AHCCCS costs had been as high as Medicaid cost increases, that would amount to an additional $32 per person per year. With a clientele of 263,000, that would come to $8.5 million every year, nearly $43 million over the 5-year period. These numbers are extrapolations, but they make it clear that AHCCCS has saved Arizona taxpayers a bundle.

It should be noted that the SRI report tossed brickbats as well as roses at AHCCCS. The report said the health care program isn't doing enough for pregnant women or those who need emergency room care. In general, the report says that AHCCCS hasn't managed to provide the state's poor a sufficiently high level of health care.

In short, the SRI report said the agency is not doing enough but is being exceptionally thrifty in the process.

What's really interesting about the report is that it may well flush some ultra-conservative legislators out from the cover of complaints about the agency's fiscal performance. Without the cost issue, indeed in the face of documented evidence that the system is saving great gobs of money in providing health care for the poor, those legislators might be forced to expose their real objection to AHCCCS — the very notion that it is the state's job to provide health care for the poor.

The report, for instance, decries the fact that under AHCCCS, rates "of care overall are below what is generally thought to be acceptable," and says that the level of health care for the poor is too far below that of the rest of the state's residents. We know at least a few legislators who would scoff at the very idea of poor people getting the same level of care as those who can afford their own medical care, legislators to whom the notion of government paying for health care for the poor is no less than the first installment of a communist state.

THE WALL STREET JOURNAL.

VOL. CXXVI . . . . No. 8 Western Edition MONDAY, JANUARY 13, 1992 Riverside, California 75 CENTS

Bush Administration Considers Proposal on Health-Care Costs

Another important feature of any plan will be incentives to encourage people to enroll in health maintenance organizations or other prepaid health care providers, people with knowledge of the talks say. Such systems, where people receive all medical services from a group of doctors for a prenegotiated fee, are less costly than traditional "fee-for-service" care.

Administration officials are discussing numerous incentives to encourage use of HMOs and other forms of managed care in the Medicare and Medicaid programs, primarily to save money. They aim to encourage states to run their Medicaid programs like Arizona, which alone among the states assigns each Medicaid beneficiary to a managed care provider...

Administration officials are discussing numerous incentives to encourage use of HMOs and other forms of managed care in the Medicare and Medicaid programs...They aim to encourage states to run their Medicaid programs like Arizona, which alone among the states assigns each Medicaid beneficiary to a managed care provider.

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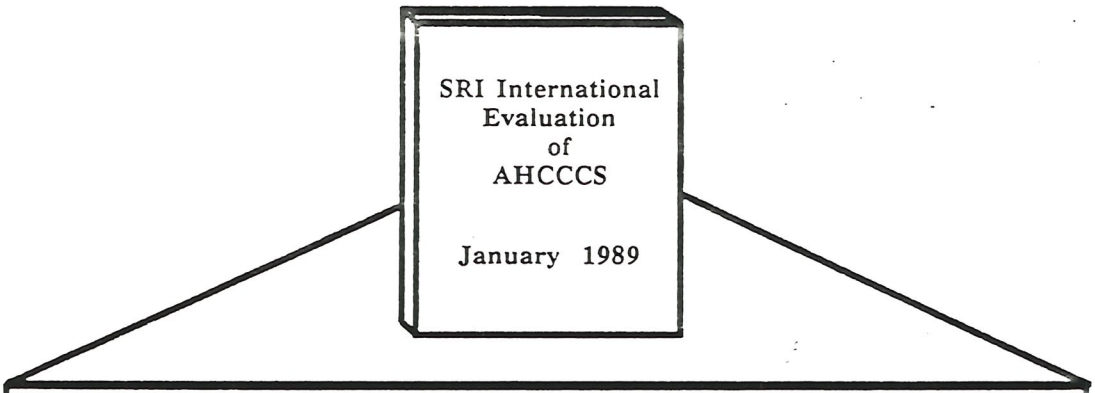

Summary of Findings

COST: Over the program's first five years, the average per capita costs for AHCCCS increased at a rate of 23.1 percent while those for traditional Medicaid increased 37.3 percent.

UTILIZATION: Hospital utilization under AHCCCS was lower than traditional Medicaid and indicated a significant savings.

QUALITY OF CARE: Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics.

ACCESS AND SATISFACTION: Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.

In addition, . . . AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance.