

Approved: 3-4-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 24, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Buntin, Committee Secretary

Conferees appearing before the committee:

Tom Hitchcock, Kansas State Board of Pharmacy
Donald A. Wilson, Kansas Hospital Association
Deborah Origer, Executive Director of Principal Health Care of Kansas City
Robert L. Epps, Commissioner, Income Support/Medical Services, SRS

Others attending: See attached list

The Chair opened the hearing on **SB 312** - Uniform controlled substances act schedule I changes.

Tom Hitchcock, KSBP, appeared before the Committee in support of **SB 312** which would bring three chemical entities under the current Drug Enforcement Administration scheduling and such addition in Kansas would bring statutes into compliance with the DEA. Mr. Hitchcock also requested an amendment which would add another section to include KSA 65-4111 with the inclusion of an additional drug, zolpidem, to this section under schedule IV. This drug is approved by FDA as a sedative/hypnotic drug but having a potential for abuse with a depressant effect. (Attachment 1) After Committee discussion, Senator Ramirez made a motion to include the amendment, seconded by Senator Hardenburger. The motion carried. Senator Hardenburger made a motion to recommend SB 312 as amended favorably for passage, seconded by Senator Salisbury. The motion carried.

Hearing on **SB 119** - Pilot project for providing medicaid services in certain areas of the state through a system of managed care.

Don Wilson, KHA, appeared in support of **SB 119** which would deal with the establishment of a managed care plan for medicaid recipients in the city of Wichita and a community with a population under 100,000. A detailed report of the managed care program in Arizona was distributed to the Committee. Mr. Wilson stated his organization had recently met with officials in Arizona, and all involved are pleased with its operation and cost containment. Some suggestions were made that would improve the program, and they are: allow approximately six months to obtain waivers, a need to retain and fund consultants to advise the Secretary on how the program should be established, and a task force made up of those involved in delivery of medicaid services. It was noted an approximate savings of 4% or 5% for one year can be obtained, and currently models are being developed in other states patterned after the Arizona program. A proposed recommendation was made to change the requirement for implementation in FY 1994 to FY 1995. (Attachments 2 and 2a) In answer to a member's question, Mr. Wilson stated the program in Arizona has been in place for 10 years and only to Medicaid eligible residents. Arizona was the last state to implement the Medicaid program, and this is the only program they have ever had. The state regulates the number of plans that will be in each county, and the lower bidder gets the most recipients. There is some freedom of choice for recipients, and when one plan is full, there may be some assignments into the other plan with certain requirements. Start-up costs, effective date of program, and long-term care as a separate program were discussed.

Deborah Origer, Principal Health Care of Kansas City, provided a detailed report to the Committee regarding a general overview of Medicaid managed care programs throughout the country, including operational models, enrollment figures, and program benefits and constraints. (Attachment 3)

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 526-S
Statehouse, at 10:00 a.m. on February 24, 1993.

Robert L. Epps, SRS, appeared before the Committee and submitted written testimony in support of **SB 119**. Mr. Epps stated that managed care exists in the form of the Primary Care Network (PCN), and a Freedom of Choice waiver would be applicable for the managed care pilot project if the recipient participation is mandated as in the PCN program. Significant staff time would be needed to develop a form of managed care that currently does not exist in the Kansas Medicaid system. Necessary steps to initiate this program were given, and an annual fiscal impact of implementing a managed care program in two counties would be approximately \$605,356 (\$254,116 state general funds), and an approximate cost savings of 4% to 5%. (Attachment 4)

The Chair called for consideration of the minutes of February 15, 17, 18, and 19. Senator Salisbury made a motion to approve the minutes as written, seconded by Senator Hardenburger. The motion carried.

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for February 25, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE

DATE: 2-24-93

[illegible]

Kansas State Board of Pharmacy

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STATE OF KANSAS



JOAN FINNEY
GOVERNOR

SB 312 TESTIMONY

SENATE PUBLIC HEALTH & WELFARE COMMITTEE

FEBRUARY 24, 1993

MEMBERS

CHARLOTTE R. BROCK, STERLING
DANA L. CREITZ, JR., PARSONS
HOYT A. KERR, TOPEKA
KATHLEEN M. MAHANNA, HOXIE
BARBARA A. RENICK, GARDEN CITY
MARGARET YOUNG, WICHITA
EXECUTIVE SECRETARY
TOM C. HITCHCOCK
BOARD ATTORNEY
DANA W. KILLINGER

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS TOM HITCHCOCK AND I SERVE AS THE EXECUTIVE SECRETARY FOR THE BOARD OF PHARMACY. I APPEAR BEFORE YOU TODAY ON BEHALF OF THE BOARD IN SUPPORT OF SB 312.

THIS BILL CONSISTS OF THREE (3) CHANGES IN K.S.A. 65-4105 UNDER THE CONTROLLED SUBSTANCES STATUTE. THE THREE CHEMICALS ADDED TO THE ACT MAY BE FOUND ON THE PRINTED BILL IN PAGE 5, LINES 26 AND 27; PAGE 6, LINES 6, 7, AND 8; AND ALSO PAGE 6, LINES 16, 17, 18, AND 19. THE THREE CHEMICAL ENTITIES ARE ALL FOUND IN THE CURRENT DRUG ENFORCEMENT ADMINISTRATION (DEA) SCHEDULING AND SUCH ADDITION IN KANSAS WOULD BRING OUR STATUTE INTO COMPLIANCE WITH DEA. ALL THE DRUGS IN K.S.A. 65-4105 HAVE NO LEGAL MEDICAL PURPOSE AND MAY NOT BE PRESCRIBED NOR MAY THEY BE DISPENSED TO A PATIENT.

ALSO, ATTACHED TO THIS TESTIMONY IS MY REQUEST FOR AN AMENDMENT TO SB 312. THE AMENDMENT WOULD ADD ANOTHER SECTION TO INCLUDE K.S.A. 65-4111 WITH THE INCLUSION ON THE SECOND PAGE OF A ADDITIONAL DRUG, ZOLPIDEM, TO THIS SECTION. I APOLOGIZE FOR REQUESTING THIS AMENDMENT, BUT IT WAS ONLY LAST THURSDAY THAT I WAS INFORMED ABOUT THE ADDITION OF THIS DRUG UNDER SCHEDULE IV BY DEA WHICH WAS EFFECTIVE JANUARY 27, 1993. THIS IS A DRUG APPROVED BY FDA AS A SEDATIVE/HYPNOTIC DRUG BUT HAVING A POTENTIAL FOR ABUSE WITH A DEPRESSANT EFFECT.

THE BOARD OF PHARMACY RESPECTFULLY REQUESTS ADDITION OF THE AMENDMENT AND FAVORABLE PASSAGE OUT OF COMMITTEE SB 312.

THANK YOU.

*Senate PH & W
Attachment #1
2-24-93*

History: L. 1972, ch. 234, § 9; L. 1974, ch. 258, § 4; L. 1978, ch. 257, § 2; L. 1982, ch. 269, § 4; L. 1985, ch. 220, § 3; L. 1989, ch. 200, § 3; L. 1991, ch. 199, § 3; L. 1992, ch. 174, § 3; July 1.

Research and Practice Aids:

Drugs and Narcotics § 66.

C.J.S. Drugs and Narcotics §§ 161, 162.

CASE ANNOTATIONS

1. Appeal from conviction for sale of narcotic drugs; no error in overruling motions for acquittal, continuance or for new trial. State v. Holt, 221 K. 696, 561 P.2d 435.

65-4110.

History: L. 1972, ch. 234, § 10; Repealed, L. 1982, ch. 269, § 9; July 1.

65-4111. Substances included in schedule IV. (a) The controlled substances listed in this section are included in schedule IV and the number set forth opposite each drug or substance is the DEA controlled substances code which has been assigned to it.

(b) Any material, compound, mixture or preparation which contains any quantity of the following substances including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation and having a potential for abuse associated with a depressant effect on the central nervous system:

(1) Alprazolam	2882
(2) Barbitol	2145
(3) Bromazepam.....	2748
(4) Camazepam	2749
(5) Chloral betaine	2460
(6) Chloral hydrate	2465
(7) Chlordiazepoxide.....	2744
(8) Clobazam	2751
(9) Clonazepam	2737
(10) Clorazepate.....	2768
(11) Clotiazepam	2752
(12) Cloxazolam	2753
(13) Delorazepam	2754
(14) Diazepam	2765
(15) Estazolam	2756
(16) Ethchlorvynol.....	2540
(17) Ethinamate	2545
(18) Ethyl loflazepate	2758
(19) Fludiazepam.....	2759
(20) Flunitrazepam	2763
(21) Flurazepam.....	2767
(22) Halazepam	2762
(23) Haloxazolam	2771
(24) Ketazolam.....	2772
(25) Loprazolam.....	2773
(26) Lorazepam	2885
(27) Lormetazepam.....	2774
(28) Mebutamate	2800
(29) Medazepam	2836

CONTROLLED

(30) Meprobamate.....	2820
(31) Methohexital.....	2264
(32) Methylphenobarbital (mephobarbital)	2250
(33) Midazolam	2884
(34) Nimetazepam	2837
(35) Nitrazepam.....	2834
(36) Nordiazepam	2838
(37) Oxazepam	2835
(38) Oxazolam.....	2839
(39) Paraldehyde	2585
(40) Petrichloral.....	2591
(41) Phenobarbital.....	2285
(42) Pinazepam.....	2883
(43) Prazepam	2764
(44) Quazepam.....	2881
(45) Temazepam.....	2925
(46) Tetrazepam.....	2886
(47) Triazolam	2887

(48) Zolpidem 2783

(c) Any material, compound, mixture, or preparation which contains any quantity of fenfluramine (1670), including its salts, isomers (whether optical, position or geometric) and salts of such isomers, whenever the existence of such salts, isomers and salts of isomers is possible.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers (whether optical, position or geometric) and salts of such isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

(1) Cathine ((±)-norpseudoephedrine).....	1230
(2) Diethylpropion.....	1610
(3) Fencamfamin	1760
(4) Fenproporex.....	1575
(5) Mazindol.....	1605
(6) Mefenorex.....	1580
(7) Pemoline (including organometallic complexes and chelates thereof)	1530
(8) Phentermine.....	1640
(9) Pipradrol.....	1750
(10) SPA((-)-1-dimethylamino-1,2-diphenylethane).....	1635

(e) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following, including salts thereof:

(1) Pentazocine.....	9709
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(f) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation containing any of the following narcotic drugs, or their salts

calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below:

- (1) Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit..... 9167
- (2) Dextropropoxyphene (alpha-(±)-4-dimethylamino-1,2-diphenyl-3-methyl-2-propionoxybutane)..... 9278

(g) Butyl nitrite and its salts, isomers, esters, ethers or their salts.

(h) The board may except by rule and regulation any compound, mixture or preparation containing any depressant substance listed in subsection (b) from the application of all or any part of this act if the compound, mixture or preparation contains one or more active medicinal ingredients not having a depressant effect on the central nervous system, and if the admixtures are included therein in combinations, quantity, proportion or concentration that vitiate the potential for abuse of the substances which have a depressant effect on the central nervous system.

History: L. 1972, ch. 234, § 11; L. 1974, ch. 258, § 5; L. 1978, ch. 257, § 3; L. 1979, ch. 204, § 1; L. 1982, ch. 269, § 5; L. 1985, ch. 220, § 4; L. 1986, ch. 241, § 3; L. 1989, ch. 200, § 4; L. 1990, ch. 231, § 1; L. 1991, ch. 199, § 4; April 25.

Research and Practice Aids:

Drugs and Narcotics ⇐ 66.

C.J.S. Drugs and Narcotics §§ 161, 162.

65-4112.

History: L. 1972, ch. 234, § 12; Repealed L. 1982, ch. 269, § 9; July 1.

65-4113. Substances included in schedule V. (a) The controlled substances or drugs by whatever official name, common or usual name, chemical name or brand name designated, listed in this section are included in schedule V.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation containing the following narcotic drug or its salts:

Buprenorphine..... 9064

(c) Any compound, mixture or preparation containing limited quantities of any of the following narcotic drugs which also contains one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

ARIZONA STATE UNIVERSITY
SCHOOL OF HEALTH ADMINISTRATION AND POLICY

AHCCCS
in 1989:
*A Detailed
Analysis*

Analysis by
Bradford Kirkman-Liff, Dr.P.H.
of a Study by
Louis Harris and Associates, Inc.
Distributed by The Flinn Foundation

Senate PH & W
attachment 2
2-24-93

INTRODUCTION

In 1989 Louis Harris and Associates, Inc. was commissioned by the Flinn Foundation to conduct a survey on health care in Arizona. An overview of the results of the survey *Health Care in Arizona: A Profile* has been released by the Foundation, which contains a broad picture of access to health care, satisfaction with health care and barriers to health care in Arizona. Such a panoramic view cannot provide the level of detailed required for many planning and policy efforts. To remedy this problem the Flinn Foundation has developed a series of Supplemental Reports to explore in depth issues relevant to policy-makers in Arizona.

Probably the single greatest change in the health care system of Arizona in the past decade has been the creation of the Arizona Health Care Cost Containment System: AHCCCS. Until 1981, Arizona had been the only state not to participate in the Medicaid program. In that year the Legislature created AHCCCS as an alternative to a traditional fee-for-service Medicaid program.

AHCCCS is designed to provide cost-effective care that avoids excessive costs from over-utilization and poor quality outcomes associated with under-utilization. The program uses capitation and competition to control health care costs. It incorporates both quality assurance and utilization management mechanisms at the level of both the contracting plans and AHCCCS Administration to assure high quality outcomes.

The program has stimulated the development of a state-wide network of capitated, managed care plans. These plans provide medical services to enrolled indigents through primary-care physicians, who act as gatekeepers and coordinate all needed services. Eligible recipients are required to obtain all of their medical care from their selected or assigned plan. The plans competitively bid and negotiate for contracts, and are at financial risk for over-utilization. The ownership of the plans has changed since the creation of the program. After seven years, most of the plans are owned by hospitals which in turn sub-contract with their captive plan. No private sector HMOs currently participate in the program. Although the legislation and the contractual arrangements are intricate, the underlying premise is simple: prepaid care, contracted for competitively---with proper oversight---is the most cost-effective means of providing appropriate care for the State's poor.

The AHCCCS program has been extensively evaluated by SRI International, under a contract from the Health Care Financing Administration. That evaluation focused on the initial years of the program and the recipients whose cost is paid partly by federal funds. The importance of AHCCCS as a sponsor of health care for the poor motivated the Flinn Foundation to include questions specifically for current and past AHCCCS enrollees in the 1989 survey.

This report presents several measures of the AHCCCS program. Some measures come from the perspective of the members themselves. Others examine access to and utilization of care as reported by past and current recipients. The use of survey data from recipients is one approach among many for the evaluation of the program. A full

assessment requires that other evaluation strategies contribute their perspective on this complex and large program.

In the analyses that follow the responses from current and past adult AHCCCS recipients are reported separately from the responses of parents whose children were or are AHCCCS recipients.

The survey also contained information on various household demographic characteristics:

the employment status of the main wage earner in each household: if they were employed, unemployed, or not in the labor force (retired, full-time student, homemaker, or disabled);

residence: Maricopa County, Pima County, or rural Arizona;

the household income: Household income was classified as poor (below the Federal poverty definition), near poor (between Federal poverty and 185% of the Federal poverty line), and non-poor (over 185% of Federal Poverty);

ethnicity: white, Hispanic, black, or Native American;

the education of the adult respondent and the main wage earner in each household: if they had less than a high school education, only a high school education, or more than a high school education;

health status: if the respondent was in excellent or good health at the time of the survey and throughout the twelve months prior to the survey or if they were in fair or poor health at the time of the survey or at some other time during the twelve months prior to the survey; and

age for adult respondents.

One important issue is the extent to which AHCCCS covers the Arizona population. Important data from the program shows the number of enrollees at any one point in time. This does not reveal the true scope of the program, as there are many people who have been in the program in the past, and are either now covered under some other form of insurance or are uninsured. A cross-sectional survey of the state's population, as done in the Louis Harris study, can measure the extent of current and past enrollment in the program.

As seen in Figure 1, 9% of adults in Arizona (250,000), and 20% of children (180,000) have been in AHCCCS at some time. The total of 430,000 is far in excess of the number of current enrollees (303,845 on April 1, 1990) indicating the large number of people who have been enrolled in AHCCCS in the past several years and still live in Arizona.

Of the 500,000 currently uninsured persons in Arizona, some 43,500 adults and 20,000 children were covered by AHCCCS sometime in the past but are not now. However, if these former recipients - or for that matter any of the uninsured - have a catastrophic illness, then they will usually incur sufficient medical expenses to qualify as medically indigent and so obtain AHCCCS eligibility.

Nearly one-third of the adults and one-half of the children in a household with an unemployed main wage earner have been in AHCCCS. People living in a household with an unemployed main wage earner are far more likely to have been enrolled in AHCCCS than those in other households. The same is true for those who are in poverty: more than one-third of the adults and one-half of the children in poor households have been in AHCCCS.

Members of ethnic minorities are more likely to have been in AHCCCS than non-hispanic whites. Adults with less than a high school education and children living in households whose main wage earner has less than a high school education are also more likely to have been in AHCCCS. Adults who are in fair or poor health and those under the age of 40 are also more likely to have been in AHCCCS. There are no meaningful geographical differences in AHCCCS participation for either children or adults.

When the seven measures of employment, residence, income, ethnicity, education, health status and age were compared simultaneously using a maximum likelihood logistical regression model, the six measures for income, age, health status, employment, ethnicity and education were statistically significant for adults but only income, employment and residence were statistically significant for children (Figure 20 in the Appendix presents the results for all of the logistical regression models).

The demographic characteristics of current and past AHCCCS recipients reveal important differences. Figure 2 presents the demographic characteristics for current and past adult recipients. Two out of five current adult enrollees live in a household with an employed main wage earner. These individuals have no or inadequate health insurance, and due to low income or catastrophic medical bills are eligible for the program. Only 70% of current adult enrollees have incomes below the Federal poverty definition. Half of the remainder are near poverty: they have incomes less than 185% of the Federal poverty definition. In this category are included pregnant women and infants who are enrolled in AHCCCS under the SOBRA mandates. The 14% of current enrollees who are non-poor are individuals with catastrophic illnesses who have no or inadequate insurance, and have "spent down" to the state-funded medically indigent component of AHCCCS. This group forms nearly one third of the past recipients, indicating that the medically indigent "spend-downs" are in the program for a short duration. These results indicate that AHCCCS serves as both a source of health coverage for many of the poor and as a safety net for some of the uninsured non-poor and near-poor with catastrophic illnesses.

The finding that nearly two out of three adult recipients are or were in fair or poor health indicates that AHCCCS is covering a population that is far less healthy than the general population.

More than half of the current adult recipients are under the age of 40 and have less than a high school education. While only 15% of current enrollees are over the age of sixty-five, only four percent of past enrollees are this old. This indicates that an elderly person enrolled in AHCCCS is more likely to stay in the program for the rest of their life, compared to the younger enrollees.

Figure 1: Current and Past Coverage By AHCCCS

Percent of Arizonans Who Have Ever Been Covered by AHCCCS

Respondent Characteristics	Adults	Children
Total Arizona Population	9.0%	19.7%
Current Insurance		
Other Insurance	3.3%	5.9%
Uninsured	11.6%	15.0%
Employment Status of Main Wage Earner		
Employed	6.8%	13.9%
Unemployed	31.5%	47.7%
Not In The Labor Force	11.8%	60.2%
Residence		
Urban Arizona	9.2%	19.2%
Maricopa County	9.6%	17.5%
Pima County	7.6%	24.6%
Rural Arizona	8.6%	21.6%
Household Income		
Poor	35.9%	58.3%
Near Poor	9.2%	20.9%
Non-Poor	3.1%	3.9%
Ethnicity		
White	5.3%	9.7%
Hispanic	19.2%	35.9%
Black	21.8%	28.0%
Native American	27.3%	35.9%
Education		
Less Than High School	19.2%	46.5%
High School	7.6%	21.6%
More Than High School	3.4%	7.7%
Health Status		
Excellent or Good	5.2%	17.8%
Fair or Poor	14.8%	22.8%
Age (for Adults)		
17-39	11.3%	
40-64	7.5%	
65 and Older	5.2%	

Figure 2: Characteristics of Adult AHCCCS Recipients

	All Current and Past Recipients (N = 540)	Current Recipients (N = 330)	Past Recipients (N = 210)
Employment Status of Main Wage Earner			
Employed	55.2%	40.6%	72.4%
Unemployed	12.0%	16.3%	6.9%
Not In The Labor Force	32.9%	43.1%	20.7%
Residence			
Urban Arizona	77.7%	82.5%	72.3%
Maricopa County	62.4%	62.4%	62.5%
Pima County	15.3%	20.1%	9.8%
Rural Arizona	22.3%	17.5%	27.7%
Household Income			
Poor	58.1%	69.5%	46.2%
Near Poor	18.9%	16.2%	21.8%
Non-Poor	23.0%	14.4%	32.1%
Ethnicity			
White	49.6%	39.0%	61.0%
Hispanic	32.9%	40.4%	24.8%
Black	6.3%	6.6%	6.1%
Native American	11.2%	14.0%	8.1%
Education			
Less Than High School	51.6%	60.6%	41.5%
High School	35.7%	26.7%	45.7%
More Than High School	12.8%	12.7%	12.9%
Health Status			
Excellent or Good	37.2%	33.5%	41.1%
Fair or Poor	62.8%	66.5%	58.9%
Age			
17-39	63.6%	54.4%	73.9%
40-64	26.9%	31.0%	22.3%
65 and Older	9.5%	14.6%	3.9%

Figure 3 presents the demographic characteristics for current and past child recipients. Half of all children in AHCCCS live in a household with an employed main wage earner. Nonetheless, 77% of the children covered by the program live in poor households, and 18% live in households that are near poverty. Further analysis showed that 31% of the children covered by AHCCCS have parents who are working but are still below the poverty line. Only five percent of the children are from non-poor households: as with the non-poor adults in AHCCCS, these are children with catastrophic illnesses and no or inadequate insurance coverage. While a smaller proportion of children in AHCCCS are in fair or poor health, when compared to adults, the findings show that these children in AHCCCS have more illness than children in the general population.

Some 54% of the children in AHCCCS are hispanic, and only 27% are white. These percentages differ from those for adult recipients due to the underlying demographics of children and adults in the state. Reflecting the findings for adult recipients, more than half of the current child recipients live in a household with a main wage earner who has less than a high school education.

Figure 3: Characteristics of Child AHCCCS Recipients

	All Current and Past Recipients (N = 356)	Current Recipients (N = 246)	Past Recipients (N = 110)
Employment Status of Main Wage Earner			
Employed	62.0%	51.5%	83.1%
Unemployed	13.2%	17.7%	4.2%
Not In The Labor Force	24.8%	30.8%	12.8%
Residence			
Urban Arizona	74.2%	78.0%	66.3%
Maricopa County	51.7%	53.5%	47.9%
Pima County	22.6%	24.5%	18.4%
Rural Arizona	25.8%	22.0%	33.7%
Household Income			
Poor	67.8%	76.6%	50.3%
Near Poor	20.1%	18.1%	24.0%
Non-Poor	24.1%	5.3%	25.8%
Ethnicity			
White	35.7%	26.7%	54.4%
Hispanic	49.1%	54.0%	38.7%
Black	5.5%	7.5%	1.2%
Native American	9.8%	11.8%	5.7%
Education of Main Wage Earner			
Less Than High School	49.5%	54.8%	39.0%
High School	29.9%	28.2%	33.2%
More Than High School	20.6%	17.0%	27.8%
Health Status			
Excellent or Good	56.1%	56.6%	55.0%
Fair or Poor	43.9%	43.4%	45.0%

A key measure of a health program is the overall satisfaction of the recipients with the program. Adults who were in AHCCCS at the time of the survey and had been in it in the past were asked for their satisfaction of the program (Figure 4). Parents of children who were in AHCCCS at the time of the survey or had been in it in the past were asked for their (the parent's) satisfaction with the program for their child (Figure 5). Overall, nearly sixty percent of current and past adult recipients of AHCCCS were completely satisfied, and less than ten percent were dissatisfied with the program.

The findings are more positive for three groups. Those who are currently enrolled are more satisfied than those who are no longer in the program. Those who have been in the program for ten or more months in the previous year are more satisfied than those who were in the program for nine or fewer months. Parents of children who are in the program are more satisfied than adult recipients. Nearly ninety percent of the parents of children who are current AHCCCS recipients and have been in the program for at least ten months in the past year are completely satisfied with the program for their child; none of these parents were dissatisfied.

In 1984 Louis Harris and Associates conducted a national survey on the satisfaction of HMO members with their programs.¹ While it would be preferable to have comparative data from 1989 on satisfaction by Arizona HMO members, such data is not publicly available. Some 91% of adult HMO enrollees in 1984 were completely or somewhat satisfied with their coverage, while 7% were not satisfied with their HMO. This data can be compared to results for adult AHCCCS enrollees who were enrolled at the time of the survey. Some 92% of current enrollees were completely or somewhat satisfied, and only 5% were not satisfied. Compared to national data from 1984 on the satisfaction of HMO members, the AHCCCS program appears to be equivalent to, if not better than, many private HMOs.

Satisfaction with the program is not uniform across all groups. Adult recipients who had a private physician as their usual source of health care prior to joining AHCCCS, are white, have more than a high school education, or are employed are more likely to be dissatisfied and less likely to be completely satisfied than other categories of recipients.

These recipients were probably being treated by fee-for-service private practice physicians prior to entering AHCCCS, developed a financially catastrophic illnesses and spent down to AHCCCS eligibility. These persons find the transition to managed care programs that frequently use hospital-based clinics disruptive to their former patterns of care.

An alternative view of the relatively higher levels of satisfaction among ethnic minorities, those not employed, and the less educated is that AHCCCS is a more comprehensive program with easier access than the alternatives faced by these populations. When all of these respondent characteristics were compared simultaneously, the measures of ethnicity, employment and education had statistically significant relationships with satisfaction.

Similar findings occurred for children. Children who had a private physician as their usual source of health care prior to joining AHCCCS, are white or live in a household with a main wage earner with more than a high school education are more likely to be dissatisfied and less likely to be completely satisfied than other categories of recipients. The cause for this dissatisfaction is probably the same: parents of child recipients with catastrophic illnesses probably find the transition to AHCCCS managed care programs disruptive to their former patterns of care.

When all of these measures were compared simultaneously, ethnicity and employment status of the main wage earner had statistically significant relationships to satisfaction for children.

While it may appear that those adult and child recipients who are poor are more satisfied than those who are not poor, this difference disappears when ethnicity and education are simultaneously considered. There are no significant differences in satisfaction by geographical region of the state or by the health status of the recipient.

It is important to remember that the small percentage who are dissatisfied still refers to a large number of people. These results indicate that there are 24,000 adults who are dissatisfied with their experiences in the program and 15,000 parents who are dissatisfied with the experiences of their child.

1. Louis Harris and Associates, Inc., A Report Card on HMOs: 1908-1984, New York: 1984, pg. 43.

Figure 4: Adult Recipients' Satisfaction with AHCCCS

Respondent Characteristics	Percent of Adults Who Were:		
	Completely Satisfied	Somewhat Satisfied	Not At All Satisfied
All Current and Past Recipients	57.9%	29.3%	9.8%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	65.3%	26.8%	5.3%
Nine Months or Less	56.6%	30.2%	8.6%
Ten Months or More	71.0%	24.7%	3.1%
Not Enrolled Now	49.7%	32.2%	14.8%
Location of AHCCCS Provider			
Physician Office	53.2%	38.1%	8.3%
Hospital Outpatient Clinic	69.4%	20.9%	8.2%
Other Outpatient Clinic	55.4%	33.0%	9.4%
Location of Previous Provider			
Physician Office	41.9%	41.8%	15.7%
Hospital Outpatient Clinic	68.1%	20.8%	11.1%
Other Outpatient Clinic	56.8%	34.6%	7.3%
None Prior to AHCCCS	66.1%	32.9%	8.3%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	46.7%	37.4%	13.7%
Unemployed	78.1%	12.5%	7.9%
Not In The Labor Force	66.2%	24.2%	4.7%
Residence			
Urban Arizona	59.7%	28.2%	9.5%
Maricopa County	62.0%	26.7%	8.7%
Pima County	50.0%	34.1%	13.0%
Rural Arizona	51.9%	33.3%	10.6%
Household Income			
Poor	55.2%	33.2%	8.6%
Near Poor	64.2%	27.8%	6.5%
Non-Poor	49.9%	28.3%	20.3%
Ethnicity			
White	41.0%	44.2%	13.1%
Hispanic	66.9%	23.1%	8.9%
Black	70.6%	14.8%	8.5%
Native American	74.9%	13.5%	2.6%
Education			
Less Than High School	62.4%	24.6%	9.1%
High School	55.5%	35.7%	7.0%
More Than High School	42.3%	33.5%	21.3%
Health Status			
Excellent or Good	56.5%	36.3%	6.0%
Fair or Poor	56.9%	26.5%	12.4%
Age			
17-39	55.9%	31.8%	11.5%
40-64	59.7%	27.7%	6.7%
65 and Older	66.8%	17.3%	6.6%

Figure 5: Parents' Satisfaction with AHCCCS for Their Children

Percent of Parents Who Were:

Recipient Characteristics	Completely Satisfied	Somewhat Satisfied	Not At All Satisfied
All Current and Past Recipients	64.8%	22.7%	8.7%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	72.4%	19.2%	4.1%
Nine Months or Less	53.9%	27.7%	7.5%
Ten Months or More	83.8%	14.0%	2.1%
Not Enrolled Now	48.7%	29.9%	18.4%
Location of AHCCCS Provider			
Physician Office	63.4%	25.9%	7.7%
Hospital Outpatient Clinic	64.7%	21.4%	10.3%
Other Outpatient Clinic	65.9%	21.1%	8.5%
Location of Previous Provider			
Physician Office	43.7%	35.4%	17.1%
Hospital Outpatient Clinic	84.8%	12.4%	0.5%
Other Outpatient Clinic	57.5%	25.7%	11.5%
None Prior to AHCCCS	73.5%	18.8%	5.1%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	59.9%	25.7%	12.0%
Unemployed	75.3%	16.2%	1.8%
Not In The Labor Force	67.0%	21.4%	5.6%
Residence			
Urban Arizona	65.6%	21.3%	9.5%
Maricopa County	66.5%	21.6%	9.6%
Pima County	63.6%	20.4%	9.1%
Rural Arizona	62.6%	26.6%	6.6%
Household Income			
Poor	65.1%	25.1%	6.3%
Near Poor	67.8%	17.6%	12.6%
Non-Poor	42.4%	29.8%	23.9%
Ethnicity			
White	44.3%	32.6%	20.3%
Hispanic	74.0%	17.6%	4.7%
Black	93.1%	6.9%	0.0%
Native American	70.8%	21.7%	0.0%
Education of Main Wage Earner			
Less Than High School	74.2%	17.0%	5.5%
High School	58.8%	20.5%	15.3%
More Than High School	44.0%	42.8%	8.3%
Health Status			
Excellent or Good	66.6%	20.2%	9.8%
Fair or Poor	62.5%	25.8%	7.3%

ACCESS AHCCCS PROVIDER

An important element in any indigent medical care program is the access to medical providers. Recipients who had a usual source of care prior to enrollment in AHCCCS and had to switch to different provider while they were in AHCCCS were asked to compare their access to the two different providers. (Two groups of recipients were not asked this question: those who did not have a usual source of care prior to being enrolled in AHCCCS and those who had a usual source of care prior to being enrolled in AHCCCS but were able to continue to use that provider.) Overall, more than half of the adults said that the AHCCCS provider was easier to get to, while less than one-fifth said that their previous provider was easier to get to.

The findings are even more positive for two groups, as seen in Figure 6. Adults who are currently enrolled were more likely to report easier access to care under AHCCCS than those who are no longer in the program. Two-thirds of current adult recipients who had been in the program for ten or more months in the past year said that their AHCCCS provider is easier to get to than their previous provider; less than one out of ten said that their previous provider was easier to get to.

There are differences among sub-groups of adults on this measure. Adult recipients who are live in a household with an unemployed man wage earner, recipients with a high school education, recipients in fair or poor health and recipients under the age of 40 are those who most frequently report that their AHCCCS provider was easier to get to than their previous provider.

When all of these measures were compared simultaneously, the location of the recipients' provider prior to AHCCCS, the employment status of the main wage earner and the number of months of AHCCCS enrollment in the year prior to the survey were statistically significant.

There are no significant differences in this measure of access by geographical region of the state.

The results are less positive for children. Overall, while more than half of the parents said that their child's AHCCCS provider was easier to get to than the child's previous provider, nearly one-third said that their child's previous provider was easier to get to. The parents of children who are currently enrolled were more likely to report easier access to care under AHCCCS than those parents whose children are no longer in the program. Four out of five parents whose children are currently in AHCCCS and who have been in the program for ten or more months in the past year say that their child's AHCCCS provider is easier to get to than their child's previous provider. Slightly more white parents said that their AHCCCS provider was more difficult to get to than their child's previous provider than reported that the AHCCCS provider was easier to get to than their child's previous provider. However, three-quarters of hispanic parents said that their AHCCCS provider was easier to get to than their child's previous provider, and only one-quarter said that their child's previous provider was easier to get to. These differences are statistically significant.

Figure 6: Access to AHCCCS Provider for Adult Recipients

Respondent Characteristics	Compared To Previous Provider, Percent Who Said AHCCCS Provider Was:		
	Easier To Get To	No Difference	More Difficult To Get To
All Current and Past Recipients	53.27%	25.6%	19.3%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	58.8%	25.4%	15.6%
Nine Months or Less	45.8%	26.2%	27.0%
Ten Months or More	66.2%	24.9%	8.9%
Not Enrolled Now	48.5%	25.9%	22.3%
Location of AHCCCS Provider			
Physician Office	58.2%	26.2%	15.7%
Hospital Outpatient Clinic	41.9%	32.7%	41.7%
Other Outpatient Clinic	59.9%	21.5%	36.3%
Location of Previous Provider			
Physician Office	43.0%	29.0%	28.0%
Hospital Outpatient Clinic	54.1%	33.1%	39.2%
Other Outpatient Clinic	66.7%	16.7%	29.4%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	42.7%	25.5%	28.8%
Unemployed	75.7%	3.4%	19.0%
Not In The Labor Force	50.2%	41.8%	7.5%
Residence			
Urban Arizona	56.4%	26.0%	17.4%
Maricopa County	55.3%	26.3%	18.2%
Pima County	61.6%	24.8%	13.6%
Rural Arizona	40.8%	24.2%	26.3%
Household Income			
Poor	57.3%	20.1%	22.0%
Near Poor	40.1%	29.5%	18.9%
Non-Poor	52.0%	33.1%	14.9%
Ethnicity			
White	40.5%	27.9%	28.0%
Hispanic	34.2%	47.2%	17.9%
Black	40.2%	34.7%	25.1%
Native American	92.3%	0.4%	6.0%
Education			
Less Than High School	62.7%	8.7%	27.8%
High School	37.3%	49.2%	9.1%
More Than High School	60.1%	21.8%	18.1%
Health Status			
Excellent or Good	45.0%	20.3%	34.0%
Fair or Poor	57.0%	28.2%	12.3%
Age			
17-39	64.4%	12.1%	20.6%
40-64	34.6%	44.2%	21.2%
65 and Older	35.8%	56.0%	6.9%

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Figure 7: Access to AHCCCS Provider for Child Recipients

Respondent Characteristics	Compared To Previous Provider, Percent Who Said AHCCCS Provider Was:		
	Easier To Get To	No Difference	More Difficult To Get To
All Current and Past Recipients	58.0%	8.8%	31.3%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	68.3%	7.3%	24.4%
Nine Months or Less	45.4%	15.2%	39.4%
Ten Months or More	84.1%	2.2%	13.7%
Not Enrolled Now	35.6%	12.0%	46.4%
Location of AHCCCS Provider			
Physician Office	57.9%	12.7%	23.3%
Hospital Outpatient Clinic	76.7%	6.7%	6.7%
Other Outpatient Clinic	39.3%	7.6%	53.1%
Location of Previous Provider			
Physician Office	49.0%	11.5%	41.3%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	55.6%	13.1%	28.3%
Not In The Labor Force	49.4%	2.4%	48.2%
Residence			
Urban Arizona	60.3%	7.5%	32.2%
Maricopa County	67.6%	7.5%	24.9%
Pima County	37.1%	7.5%	55.4%
Rural Arizona	44.1%	16.4%	26.5%
Household Income			
Poor	56.5%	5.3%	37.4%
Near Poor	59.4%	3.6%	31.1%
Non-Poor	57.9%	29.7%	12.4%
Ethnicity			
White	35.5%	20.2%	38.9%
Hispanic	73.9%	1.4%	24.7%
Education of Main Wage Earner			
Less Than High School	67.8%	3.1%	28.1%
High School	45.1%	9.1%	40.3%
More Than High School	35.5%	23.4%	41.1%
Health Status			
Excellent or Good	48.6%	10.8%	39.6%
Fair or Poor	66.7%	6.9%	23.6%

ASSESSMENT OF AHCCCS CARE

An equally important element in any indigent medical care program is the quality of care provided to recipients. Survey respondents who had a usual source of care prior to enrollment in AHCCCS were asked to compare their care under AHCCCS to the care that they received prior to AHCCCS. (Recipients who did not have a usual source of care prior to being enrolled in AHCCCS were not asked this question) Overall, nearly half of the adults said that their care under AHCCCS was better than their care prior to AHCCCS, while less than one-fifth said that their previous care was better.

As with the previous two measures, adults who are currently enrolled and adults who have been in the program for ten or more months in the previous year were more likely to report that their care under AHCCCS was better than those no longer in the program or those with less enrollment. Six out of ten current adult recipients who have been in the program for ten or more months in the past year say that their care under AHCCCS is better than their previous care; less than one out of six said that the care from their previous provider was better.

Adult recipients who live in a household with a currently employed main wage earner are significantly more likely to report that the care from their previous provider was better than that they received from their AHCCCS provider. Adult recipients who are in excellent or good health are significantly more likely to report that the care from their AHCCCS provider was better than that they received from their previous provider.

AHCCCS enrollment was more likely to result in a perception that care had improved for those in urban Arizona than for those in rural Arizona. This may be a reflection of the fact that there are fewer AHCCCS plans in rural areas than in urban areas, and the opportunities for AHCCCS recipients to switch to a different provider are more limited. Assessment of care varied by recipient income in an interesting manner. The near-poor (those with household incomes between the Federal poverty definition and 185% of that definition) were least likely to report that there was no difference between their care under AHCCCS and their care under their previous provider.

Simultaneous comparison of all of the respondent measures determined that enrollment, health status and income were statistically significantly related to adults' perceptions of care under AHCCCS.

Overall, only slightly more than one-third of the parents said that their child's care under AHCCCS was better than their child's care prior to AHCCCS, and nearly one-third said that their child's previous care was better. However, current enrollment and the length of enrollment increase the proportion who report that their child's care is better under AHCCCS. Nearly four out of five parents whose children are currently in AHCCCS and who have been in the program for ten or more months in the past year say that their child's care is better under AHCCCS than it was under their child's previous provider. Fewer than one out of fifteen parents in this group report that their child's care was better under their child's previous provider than it was under AHCCCS.

There are significant differences among the various sub-groups of children. The care provided by the AHCCCS provider was rated better than that of the child's previous provider more frequently when the child's current AHCCCS provider or the child's previous provider was located at a hospital outpatient clinic. Further analysis focused on children whose AHCCCS provider and provider prior to AHCCCS were of the same institutional form. Some 57% of parents of children whose AHCCCS and previous provider both were located at a hospital outpatient clinic rated their care better at the AHCCCS provider, compared to 51% for children whose providers were both at physician's offices and 44% for children whose providers were both at free-standing clinics. These findings appear to indicate that the AHCCCS program has motivated a greater improvement in the care provided by hospital outpatient clinics than in other facilities, as measured by parent perceptions.

However, the care provided by the child's previous provider was rated better than that of the child's AHCCCS provider more frequently when the child's previous provider was located at a physician's office. A similar finding occurred for non-poor children, white children, and children who live in a household whose main wage earner has more than high school education. As with the measures of satisfaction, this pattern of findings suggest that the parents of uninsured or underinsured children who had catastrophic illnesses and so spent down to AHCCCS most likely had to change the location of their providers. This shift was more likely to be judged less satisfactory by these parents.

Health status was significantly related to the perception of care. Only one out of four

Figure 8: Assessment of Care by Adult Recipients

Respondent Characteristics	Compared To Previous Provider, Percent Who Said Care Was Better:		
	Under AHCCCS	No Difference	Under Previous Provider
All Current and Past Recipients	46.4%	31.5%	18.6%
<u>AHCCCS-Related Characteristics:</u>			
<u>Enrollment Status</u>			
Enrolled Now	51.8%	26.8%	17.2%
Nine Months or Less	37.4%	32.7%	20.8%
Ten Months or More	60.1%	23.3%	15.1%
Not Enrolled Now	40.7%	36.5%	20.0%
<u>Location of AHCCCS Provider</u>			
Physician Office	47.3%	29.3%	18.0%
Hospital Outpatient Clinic	49.5%	35.9%	12.2%
Other Outpatient Clinic	48.3%	32.3%	19.5%
<u>Location of Previous Provider</u>			
Physician Office	38.5%	32.8%	26.8%
Hospital Outpatient Clinic	56.3%	29.4%	8.5%
Other Outpatient Clinic	47.5%	32.7%	19.5%
<u>Demographic Characteristics:</u>			
<u>Employment Status of Main Wage Earner</u>			
Employed	32.7%	36.1%	27.0%
Unemployed	62.9%	26.2%	8.2%
Not In The Labor Force	56.2%	30.3%	10.3%
<u>Residence</u>			
Urban Arizona	51.7%	27.9%	16.9%
Maricopa County	52.4%	32.0%	14.9%
Pima County	48.0%	8.7%	26.2%
Rural Arizona	28.9%	43.5%	24.1%
<u>Household Income</u>			
Poor	49.6%	32.3%	15.3%
Near Poor	55.0%	11.5%	30.9%
Non-Poor	27.4%	43.9%	22.9%
<u>Ethnicity</u>			
White	27.3%	42.0%	27.3%
Hispanic	49.9%	34.6%	14.8%
Black	65.2%	8.5%	26.3%
Native American	58.7%	17.0%	8.3%
<u>Education</u>			
Less Than High School	44.5%	32.0%	22.4%
High School	52.0%	32.7%	12.8%
More Than High School	39.4%	26.1%	18.7%
<u>Health Status</u>			
Excellent or Good	34.7%	38.2%	18.3%
Fair or Poor	52.3%	28.1%	18.7%
<u>Age</u>			
17-39	44.7%	32.0%	18.7%
40-64	50.0%	28.1%	19.8%
65 and Older	46.5%	37.6%	14.3%

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parents who said that their children were in excellent or good health thought that their AHCCCS provider was better than their previous provider. About half of the parents of children in fair or poor health felt that their AHCCCS provider was better than their

previous provider. The analysis of the child's characteristics showed that the location of child's previous source of care and household income were statistically significant in their relationship to parents' perception of AHCCCS provider care.

Figure 9: Assessment of Care by Parents for Their Child

Respondent Characteristics	Compared To Previous Provider, Percent Who Said Care Was Better:		
	Under AHCCCS	No Difference	Under Previous Provider
All Current and Past Recipients	38.9%	28.6%	29.3%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	52.7%	23.9%	20.8%
Nine Months or Less	15.1%	38.0%	41.6%
Ten Months or More	77.8%	14.1%	7.3%
Not Enrolled Now	14.6%	36.9%	44.2%
Location of AHCCCS Provider			
Physician Office	20.4%	51.4%	25.8%
Hospital Outpatient Clinic	60.1%	12.2%	20.3%
Other Outpatient Clinic	38.6%	19.8%	41.6%
Location of Previous Provider			
Physician Office	9.8%	41.2%	47.1%
Hospital Outpatient Clinic	77.5%	11.7%	2.4%
Other Outpatient Clinic	49.9%	23.6%	24.9%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	31.6%	33.3%	33.7%
Unemployed	47.8%	40.5%	9.4%
Not In The Labor Force	37.5%	15.6%	36.2%
Residence			
Urban Arizona	43.8%	23.8%	28.2%
Maricopa County	45.0%	25.8%	26.0%
Pima County	40.2%	18.0%	34.6%
Rural Arizona	22.9%	44.2%	33.0%
Household Income			
Poor	47.9%	21.4%	26.9%
Near Poor	40.4%	26.5%	33.2%
Non-Poor	0.0%	52.8%	40.7%
Ethnicity			
White	15.2%	33.0%	48.0%
Hispanic	51.1%	29.9%	15.9%
Education of Main Wage Earner			
Less Than High School	59.0%	16.4%	21.9%
High School	12.7%	47.8%	37.6%
More Than High School	14.4%	37.6%	41.6%
Health Status			
Excellent or Good	26.4%	35.5%	35.9%
Fair or Poor	50.4%	22.3%	23.2%

**LOCATION
OF AHCCCS
PRIMARY CARE
PROVIDERS**

A major goal of the AHCCCS program is to assure that each recipient is assigned to a primary care physician, who will serve as their gate-keeper to specialists and hospitals. Respondents were asked to describe the location of their AHCCCS provider, and this information was used to develop four categories for provider location: physician office, hospital emergency room, hospital-based outpatient clinic, and other forms of outpatient clinics, which include among others community health centers, county health department health centers, and Veterans Administration (VA) or Indian Health Service (IHS) clinics.

Community and county health department health centers and other non-hospital-based clinics are the source of primary care for more than one third of AHCCCS adult recipients (see Figure 10). Hospital-based outpatient clinics are the source of primary care for slightly less than one third of AHCCCS recipients, and the traditional physician's office is the location for slightly more than one-quarter of adult and child AHCCCS recipients. Unlike traditional Medicaid programs, in which hospital emergency rooms serve as the primary source of care for as many as one-quarter of Medicaid recipients, less than one out of twenty AHCCCS recipients said that their AHCCCS primary care provider was at a hospital emergency room.

The location of the adult recipient's usual provider of care prior to their enrollment in AHCCCS was significantly related to the location of their AHCCCS provider. Nearly three out of four recipients who had free-standing clinic as their usual source of care prior to AHCCCS had a free-standing clinic as their AHCCCS provider. Almost two out of three recipients who had a physician's office as the location of their previous provider had a physician's office as the location of their AHCCCS provider. More than half of the recipients who had a hospital outpatient clinic as the location of their previous provider had a hospital outpatient clinic as the location of their AHCCCS provider. Recipients who had no usual source of care prior to AHCCCS were distributed across all three locations.

Adults in AHCCCS who were not poor, were white, had more than a high school education, were in excellent or good health or were elderly were more likely to have a physicians' office as the location of their AHCCCS provider than other recipients.

When all of the measures were compared simultaneously, previous source of care and ethnicity were statistically related to location of AHCCCS provider. Individuals tended to have a usual source of care that was of the same type as their previous source of care, (if they had a usual source of care prior to AHCCCS) and white recipients were more likely to have a physician office as their AHCCCS provider, regardless of their previous source of care.

The location of usual provider of care prior to a child's enrollment in AHCCCS was also significantly related to the location of their AHCCCS provider. More than four out of five recipients who had a hospital outpatient clinic as the location of their previous provider had a hospital outpatient clinic as the location of their AHCCCS provider (see Figure 11). More than three out of four who had a free-standing clinic as their usual source of care prior to AHCCCS had a free-standing clinic as their AHCCCS provider. Nearly two out of three who had a physician's office as the location of their previous provider had a physician's office as the location of their AHCCCS provider. Half of the children in AHCCCS who had no usual source of care prior to AHCCCS had a free-standing clinic for their usual source of care, and nearly a third had a hospital outpatient clinic as the location of their AHCCCS provider.

Children in AHCCCS who were white, lived in a household with a main wage earner with more than a high school education or lived in rural Arizona were more likely to have a physicians' office as the location of their AHCCCS provider than other recipients.

When all of the child characteristics were compared simultaneously, only main wage earner education was statistically significant as a predictor of the location of the AHCCCS provider.

Figure 10: Location of AHCCCS Primary Care Provider for Adult Recipients

Respondent Characteristics:	Percent of Adults Who Said That Their AHCCCS Provider Was Located At A:			
	Physician Office	Hospital Emergency Room	Hospital Outpatient Clinic	Other Outpatient Clinic
All Current and Past Recipients	27.2%	3.0%	32.7%	37.1%
<u>AHCCCS-Related Characteristics:</u>				
Enrollment Status				
Enrolled Now	23.6%	0.5%	31.9%	44.0%
Nine Months or Less	19.5%	0.4%	17.7%	62.5%
Ten Months or More	27.1%	0.7%	40.1%	32.1%
Not Enrolled Now	31.3%	5.7%	33.6%	29.5%
Location of Previous Provider				
Physician Office	60.6%	6.8%	23.7%	9.0%
Hospital Outpatient Clinic	21.1%	1.4%	57.4%	20.2%
Other Outpatient Clinic	9.7%	1.4%	17.5%	71.4%
None Prior to AHCCCS	23.7%	2.6%	38.1%	35.6%
<u>Demographic Characteristics:</u>				
Employment Status of Main Wage Earner				
Employed	26.1%	4.4%	30.4%	39.1%
Unemployed	46.6%	3.1%	15.2%	35.0%
Not In The Labor Force	23.7%	0.7%	38.2%	37.3%
Residence				
Urban Arizona	26.6%	2.4%	36.3%	34.7%
Maricopa County	26.9%	2.7%	36.4%	34.0%
Pima County	25.8%	0.9%	36.1%	37.3%
Rural Arizona	29.2%	5.0%	20.1%	45.8%
Household Income				
Poor	24.7%	1.1%	34.2%	40.1%
Near Poor	16.9%	5.2%	39.2%	38.7%
Non-Poor	38.3%	6.7%	33.3%	21.8%
Ethnicity				
White	33.5%	5.0%	28.7%	32.8%
Hispanic	21.3%	1.9%	43.8%	33.1%
Education				
Less Than High School	16.9%	3.4%	39.6%	40.1%
High School	33.6%	2.9%	26.0%	37.5%
More Than High School	45.6%	1.6%	26.6%	26.3%
Health Status				
Excellent or Good	37.4%	3.6%	23.4%	35.6%
Fair or Poor	22.3%	2.7%	35.4%	39.6%
Age				
17-39	31.8%	4.3%	25.5%	38.5%
40-64	20.5%	0.6%	41.9%	37.0%
65 and Older	15.6%	1.0%	55.0%	28.5%

Figure 11: Location of AHCCCS Primary Care Provider for Child Recipients

Respondent Characteristics:	Percent of Parents Who Said That Their Child's AHCCCS Provider Was Located At A:			
	Physician Office	Hospital Emergency Room	Hospital Outpatient Clinic	Other Outpatient Clinic
All Current and Past Recipients	26.4%	0.8%	29.3%	43.5%
<u>AHCCCS-Related Characteristics:</u>				
Enrollment Status				
Enrolled Now	20.9%	1.0%	33.9%	44.3%
Nine Months or Less	36.0%	0.0%	26.5%	37.6%
Ten Months or More	11.3%	1.5%	38.6%	48.5%
Not Enrolled Now	38.1%	0.5%	19.6%	41.8%
Location of Previous Provider				
Physician Office	64.5%	0.0%	15.6%	19.9%
Hospital Outpatient Clinic	12.8%	0.0%	82.3%	5.0%
Other Outpatient Clinic	10.1%	0.0%	13.4%	76.5%
None Prior to AHCCCS	16.7%	1.8%	31.1%	50.5%
<u>Demographic Characteristics:</u>				
Employment Status of Main Wage Earner				
Employed	33.3%	0.6%	27.6%	38.6%
Unemployed	12.6%	2.8%	35.0%	49.6%
Not In The Labor Force	18.8%	0.3%	34.6%	46.3%
Residence				
Urban Arizona	20.1%	0.9%	34.2%	44.9%
Maricopa County	23.2%	0.2%	30.5%	46.2%
Pima County	12.8%	2.5%	42.9%	41.8%
Rural Arizona	44.7%	0.6%	15.2%	39.5%
Household Income				
Poor	23.7%	1.1%	32.5%	42.7%
Near Poor	25.1%	0.0%	34.9%	40.1%
Non-Poor	47.3%	1.3%	17.5%	33.9%
Ethnicity				
White	46.8%	0.5%	19.1%	33.6%
Hispanic	16.0%	1.3%	43.1%	39.6%
Education of Main Wage Earner				
Less Than High School	17.2%	1.2%	34.9%	46.7%
High School	31.6%	0.3%	30.1%	38.0%
More Than High School	45.1%	0.7%	19.4%	34.8%
Health Status				
Excellent or Good	28.7%	0.8%	26.0%	44.6%
Fair or Poor	23.6%	0.8%	33.6%	42.0%

The role of the primary care provider in AHCCCS is to serve as the usual source of care for the recipient and to act as a gatekeeper to and a coordinator of specialty and inpatient care. Respondents were asked if their AHCCCS provider was their usual source of care, if another provider was their usual source of care, or if they had no usual source of care (while they were in the program).

Overall, nearly three out of four adult AHCCCS recipients reported that their usual source of care while they were in the program was their assigned AHCCCS provider. As with several of the previous measures, those who were enrolled at the time of the survey and those who had ten or more months of enrollment during the year prior to the survey were more likely to report that their usual source of care was their AHCCCS provider. However, one out of ten adult enrollees said that they had no usual source of care while they were in the program.

The location of the AHCCCS provider is significantly related to whether or not they are the recipients' usual source of care. Only 61% of adults whose provider was located at a physician office reported that this provider was their usual source of care, and 17% of this group reported that they had no usual source of care while they were in the program. However, four out of five recipients whose provider was at a free-standing clinic (such as a county health department or a community health center) reported that their provider was their usual source of care, and only 7% said that they had no usual source of care while in the program. Less than two-thirds of recipients who did not have a usual source of care prior to AHCCCS said that their AHCCCS provider was their usual source of care, and 16% of this group said that they did not have a usual source of care while in the program.

Adult recipients who were employed, non-poor, white, had more than a high school education and were in excellent or good health were more likely than other recipients to report that they had no usual source of care when they were in AHCCCS. When compared simultaneously, employment and the number of months of program enrollment were the only two measures that were statistically significant. Adult recipients who were employed and those with fewer months of enrollment were more likely to report that they did not have a usual source of care while they were in the program.

Overall, nearly nine out of ten parents of children in AHCCCS reported that their child's usual source of care while they were in the program was their assigned AHCCCS provider. Again, those who were enrolled at the time of the survey and those who had ten or more months of enrollment during the year prior to the survey were more likely to report that their usual source of care was their AHCCCS provider. Less than one out of twenty child enrollees had no usual source of care while they were in the program.

The location of the AHCCCS provider is not significantly related to the whether or not they were the child's usual source of care. Child recipients who were white were more likely than hispanic recipients not to have a usual source of care when they were in AHCCCS, and were less likely to use their AHCCCS provider as their usual source of care. However, the statistical analysis of all of the child measures showed that enrollment status (enrolled at the time of the survey or not enrolled at the time of the survey but previously enrolled) and the number of months of enrollment in the twelve months prior to the survey were significantly related to whether or not the AHCCCS provider was the child's usual source of care while they were in the program.

AHCCCS PRIMARY CARE PROVIDER AS THE USUAL SOURCE OF CARE

Figure 12: Relationship with AHCCCS Primary Care Providers for Adult Recipients

Respondent Characteristics	Percent Who Said That Their Usual Source of Care While They Were In AHCCCS Was:		
	AHCCCS Provider	Another Provider	No Usual Source
All Current and Past Recipients	73.2%	16.4%	10.4%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	79.1%	13.5%	7.5%
Nine Months or Less	74.3%	15.7%	10.0%
Ten Months or More	81.9%	12.5%	5.6%
Not Enrolled Now	66.6%	19.7%	13.7%
Location of AHCCCS Provider			
Physician Office	61.4%	21.5%	17.1%
Hospital Outpatient Clinic	74.9%	17.7%	7.3%
Other Outpatient Clinic	80.8%	11.9%	7.3%
Location of Previous Provider			
Physician Office	75.2%	16.4%	8.4%
Hospital Outpatient Clinic	84.2%	13.6%	2.2%
Other Outpatient Clinic	78.2%	15.9%	5.9%
None Prior to AHCCCS	65.7%	18.1%	16.2%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	63.1%	21.5%	15.5%
Unemployed	87.8%	9.1%	3.1%
Not In The Labor Force	83.5%	11.6%	5.0%
Residence			
Urban Arizona	71.6%	17.8%	10.6%
Maricopa County	74.1%	15.8%	10.1%
Pima County	61.5%	25.9%	12.7%
Rural Arizona	78.7%	11.5%	9.8%
Household Income			
Poor	86.3%	7.0%	6.7%
Near Poor	52.9%	35.7%	11.5%
Non-Poor	69.5%	11.6%	18.9%
Ethnicity			
White	68.1%	15.7%	16.3%
Hispanic	78.3%	16.2%	5.5%
Black	85.1%	10.0%	4.9%
Native American	65.6%	28.3%	6.1%
Education			
Less Than High School	81.6%	10.0%	8.4%
High School	64.5%	23.3%	12.2%
More Than High School	62.6%	23.3%	14.1%
Health Status			
Excellent or Good	64.3%	14.4%	21.3%
Fair or Poor	81.6%	14.1%	4.4%
Age			
17-39	71.8%	17.0%	11.3%
40-64	72.3%	18.1%	9.5%
65 and Older	85.5%	7.5%	7.1%

Figure 13: Relationship with AHCCCS Primary Care Providers for Child Recipients

Percent of Parents Who Said That Their Child's Usual
Source of Care While The Child Was In AHCCCS Was:

Respondent Characteristics	AHCCCS Provider	Another Provider	No Usual Source
All Current and Past Recipients	87.2%	9.1%	3.8%
<u>AHCCCS-Related Characteristics:</u>			
<u>Enrollment Status</u>			
Enrolled Now	92.5%	4.8%	2.7%
Nine Months or Less	87.3%	8.3%	4.5%
Ten Months or More	95.6%	2.7%	1.6%
Not Enrolled Now	76.1%	17.9%	6.0%
<u>Location of AHCCCS Provider</u>			
Physician Office	80.4%	15.7%	3.9%
Hospital Outpatient Clinic	89.5%	8.6%	1.9%
Other Outpatient Clinic	89.9%	5.2%	5.0%
<u>Location of Previous Provider</u>			
Physician Office	82.6%	16.2%	1.2%
Hospital Outpatient Clinic	88.5%	4.8%	6.7%
Other Outpatient Clinic	85.2%	11.8%	3.0%
None Prior to AHCCCS	91.5%	6.0%	2.6%
<u>Demographic Characteristics:</u>			
<u>Employment Status of Main Wage Earner</u>			
Employed	85.3%	11.4%	3.3%
Unemployed	91.0%	5.1%	3.9%
Not In The Labor Force	88.3%	6.5%	5.2%
<u>Residence</u>			
Urban Arizona	87.8%	8.4%	3.7%
Maricopa County	87.4%	9.4%	3.3%
Pima County	88.9%	6.3%	4.7%
Rural Arizona	85.3%	10.8%	3.9%
<u>Household Income</u>			
Poor	88.7%	6.7%	4.7%
Near Poor	89.3%	8.1%	2.7%
Non-Poor	78.6%	21.4%	0.0%
<u>Ethnicity</u>			
White	78.8%	14.8%	6.4%
Hispanic	93.4%	3.7%	2.9%
<u>Education of Main Wage Earner</u>			
Less Than High School	89.4%	7.4%	3.2%
High School	86.4%	8.1%	5.5%
More Than High School	81.0%	15.8%	3.2%
<u>Health Status</u>			
Excellent or Good	91.4%	4.9%	3.6%
Fair or Poor	81.8%	14.3%	3.9%

APPLYING FOR AHCCCS

Recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and Food Stamps are automatically enrolled in AHCCCS; all other recipients must first apply for eligibility. All survey respondents (not just those who were or had been covered by AHCCCS at the time of the survey) were asked if they had ever applied for AHCCCS coverage. Those who had applied were asked for their perception of the difficulty of the application process. One out of four applicants for AHCCCS coverage reported that the application process was very difficult, while one out of three felt that the process was not at all difficult.

Not surprisingly, a higher proportion of adults who applied for coverage but were never enrolled in the program perceived the application process to be very difficult than those who applied and were deemed eligible.

Hispanic respondents were more likely to report that the application process was very difficult, compared to white respondents. However, when all of the respondent's characteristics were considered simultaneously, only enrollment status was significant.

As with adult applicants, a higher proportion of parents who applied for AHCCCS coverage for their child but whose children were never enrolled in the program perceived the application process to be very difficult than those parents who applied for a child who was deemed eligible. Nearly two out of three parents of children currently enrolled in AHCCCS report that the application process was not difficult. Parents who were employed found the application process more difficult. When all variables were considered at the same time, enrollment status and main wage earner employment were statistically significant.

Figure 14: Difficulty of AHCCCS Application Process for Adults Applying For Themselves

Respondent Characteristics	Percent Who Said Application Process Was:		
	Very Difficult	Somewhat Difficult	Not At All Difficult
All Applicants	25.4%	30.3%	36.4%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	18.5%	29.4%	48.0%
Not Enrolled Now	14.4%	43.3%	33.1%
Never Enrolled	41.5%	24.9%	33.6%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	32.0%	26.2%	34.8%
Unemployed	6.9%	51.3%	41.8%
Not In The Labor Force	16.5%	29.6%	41.5%
Residence			
Urban Arizona	26.2%	32.9%	35.5%
Maricopa County	28.3%	33.7%	32.9%
Pima County	19.1%	30.1%	44.4%
Rural Arizona	22.9%	22.1%	39.1%
Household Income			
Poor	21.5%	30.1%	38.3%
Near Poor	33.9%	33.6%	25.7%
Non-Poor	23.8%	27.5%	40.8%
Ethnicity			
White	17.8%	29.5%	40.7%
Hispanic	42.1%	20.7%	31.2%
Black	21.8%	51.9%	25.8%
Native American	24.5%	31.9%	43.6%
Education			
Less Than High School	27.9%	31.0%	31.3%
High School	18.3%	27.8%	47.8%
More Than High School	32.1%	33.8%	28.1%
Health Status			
Excellent or Good	22.6%	32.3%	37.8%
Fair or Poor	24.6%	30.2%	36.9%
Age			
17-39	23.1%	33.6%	35.0%
40-64	33.4%	21.8%	37.7%
65 and Older	19.2%	32.2%	41.4%

**Figure 15: Difficulty of AHCCCS Application Process for Parents
Applying For Their Children**

Respondent Characteristics	Percent Who Said Application Process Was:		
	Very Difficult	Somewhat Difficult	Not At All Difficult
All Applicants	27.6%	24.9%	46.0%
<u>AHCCCS-Related Characteristics:</u>			
Enrollment Status			
Enrolled Now	10.8%	27.3%	60.8%
Not Enrolled Now	31.6%	27.1%	38.0%
Never Enrolled	37.8%	22.2%	39.0%
<u>Demographic Characteristics:</u>			
Employment Status of Main Wage Earner			
Employed	32.4%	23.8%	42.3%
Unemployed	11.3%	25.4%	63.4%
Not In The Labor Force	11.5%	30.7%	55.3%
Residence			
Urban Arizona	30.4%	23.5%	45.6%
Maricopa County	32.6%	24.5%	42.9%
Pima County	24.8%	20.9%	52.5%
Rural Arizona	18.8%	29.2%	47.2%
Household Income			
Poor	19.5%	32.5%	46.5%
Near Poor	34.0%	16.2%	47.8%
Non-Poor	16.2%	30.6%	51.0%
Ethnicity			
White	19.3%	30.3%	47.6%
Hispanic	37.7%	18.6%	42.8%
Black	52.4%	19.7%	27.9%
Native American	30.2%	34.1%	35.7%
Education of Main Wage Earner			
Less Than High School	39.9%	12.0%	46.2%
High School	18.0%	34.9%	44.8%
More Than High School	20.8%	30.5%	48.7%
Health Status			
Excellent or Good	21.76%	27.6%	49.1%
Fair or Poor	33.1%	22.5%	43.1%

An analysis of AHCCCS must include some comparison of the utilization of medical care by children with the utilization patterns of those with other forms of insurance, as well as those who are uninsured. Four measures were examined for adults and children: the percent with one or more ambulatory care visits, the average number of ambulatory care visits, the percent with one or more emergency room visits, and the percent with one or more hospital stays. All of these measures involve statistical adjustments to control for variations in the health status and demographic characteristics of the various insurance groups. The development of these methods is described in the Appendix.

Nearly three out of four adult AHCCCS recipients had one or more ambulatory care visits in a year (Figure 16). This is significantly higher than those who were covered by Medicare or indemnity insurance. HMO and PPO members were also more likely to have seen a provider than those with Medicare or indemnity insurance. Individuals who were uninsured had significantly less access to care: only slightly more than half of the adults in this group had one or more ambulatory care visits.

Adult AHCCCS enrollees had significantly more visits than all other individuals. There were no significant differences among those with other forms of insurance coverage. However, the uninsured adults had significantly fewer visits than those with insurance.

AHCCCS recipients, those eligible for services from the VA, the IHS or the military, and HMO members were more likely to have had one or more emergency room visits than those with Medicare, in PPOs, or indemnity insurance. This is an interesting finding. It is generally expected that managed care providers will have lower utilization of emergency rooms. The results may be a reflection of the impact of the high deductibles and copayments found in PPOs, Medicare, and indemnity insurance on deterring emergency room utilization. Managed care providers reduce their members' out-of-pocket costs for emergency care, and hope to achieve lower utilization through appropriate case management. While recipients in conventional Medicaid programs frequently use emergency rooms for the majority of the health care, AHCCCS appears to have obtained an emergency care utilization rate equivalent to that for private sector HMOs.

Those who were covered by AHCCCS, Medicare, or had access to Veterans Administration, Indian Health Service or military providers were more likely to have had a hospitalization than others. Interestingly, there were no statistically significant differences in this measure between HMO, PPO or indemnity insured.

Children in AHCCCS were more likely to have had one or more ambulatory care visits in a year than children with other forms of insurance (Figure 17). Children who were uninsured had significantly less access to care.

Children enrolled in AHCCCS were significantly higher than all other children in their number of ambulatory care visits and in their likelihood of having one or more emergency room visits. There was no difference among any of the groups of children in their likelihood of having a hospitalization.

Overall, these self-reported measures of the utilization of medical services indicate that **AHCCCS has been somewhat successful in substituting ambulatory care for care provided in hospital emergency rooms.** The utilization patterns within AHCCCS are not dissimilar from those seen in HMOs and other forms of insurance, after adjustment for the demographic and health status characteristics of recipients. However, the absence of significant cost-sharing on the part of recipients requires that AHCCCS plans actively be involved in case management.

Some of these models revealed that the number of months of AHCCCS enrollment in the twelve months prior to the survey had a strong effect on three utilization measures. As seen in Figure 18, the average number of ambulatory care visits increases with the number of months of enrollment. Individuals who are in the program for a short period of time have more visits per month than those with a full years' enrollment. This may indicate that the utilization management aspects of AHCCCS work to control long-term utilization of services, after an initial period of high utilization. The likelihood of a child having an ambulatory care visits increases with the number of months of enrollment. This may reflect the efforts by AHCCCS plans to get all enrolled children through a health screening examination during their enrollment. Lastly, the likelihood of a child having one or more emergency room visits increases with the number of months of enrollment, but this probability is only one-third higher for a child with twelve months of enrollment than a child with one month of enrollment.

Figure 16: Utilization of Medical Services by Adults

Insurance Status	Utilization Measures			
	Percent With One or More Ambulatory Care Visits	Average Number of Ambulatory Care Visits	Percent With One or More Emergency Room Visits	Percent With One or More Hospital Stays
AHCCCS	73%	11.3	20%	8%
Medicare	68%	7.4	15%	11%
HMO	78%	6.8	19%	5%
PPO	76%	6.8	15%	5%
VA/IHS/Military	67%	7.2	20%	8%
Family-Purchased Indemnity	71%	6.9	15%	5%
Employer-Provided Indemnity	67%	6.7	15%	6%
Uninsured	53%	4.4	15%	5%

Figure 17: Utilization of Medical Services by Children

Insurance Status	Utilization Measures			
	Percent With One or More Ambulatory Care Visits	Average Number of Ambulatory Care Visits	Percent With One or More Emergency Room Visits	Percent With One or More Hospital Stays
AHCCCS	87%	5.9	19%	5%
HMO	77%	4.4	14%	5%
PPO	86%	4.4	14%	5%
VA/IHS/Military	79%	4.4	15%	5%
Family-Purchased Indemnity	77%	4.4	14%	5%
Employer-Provided Indemnity	76%	4.4	14%	5%
Uninsured	63%	4.4	15%	5%

Figure 18: Variations in Utilization by Months of AHCCCS Enrollment

Number of Months of AHCCCS Enrollment	Utilization Measures		
	Average Number of Ambulatory Care Visits for Adults in AHCCCS	Percent of Children in AHCCCS With One or More Ambulatory Care Visits	Percent of Children in AHCCCS With One or More Emergency Room Visits
1	5.9	76%	15%
2	6.6	76%	15%
3	7.2	77%	16%
4	7.8	78%	16%
5	8.4	79%	17%
6	9.1	81%	17%
7	9.7	82%	18%
8	10.3	84%	19%
9	10.9	86%	19%
10	11.5	87%	20%
11	12.2	89%	20%
12	12.8	91%	21%

AHCCCS is a very complex program that involves a variety of mechanisms to provide care at a reasonable cost to eligible recipients. This analysis of self-reported information revealed that:

more than one-third of the adults and one-half of the children in poor households in Arizona have been enrolled in AHCCCS;

Nearly sixty percent of current and past adult recipients of AHCCCS were completely satisfied with the program, and less than ten percent were dissatisfied with the program;

Nearly ninety percent of the parents of children who are current AHCCCS recipients and have been in the program for ten or more months in the past year are completely satisfied with the program for their child: none of these parents were dissatisfied with the program.

More than half of the adults who had a usual source of care prior to joining AHCCCS said that their AHCCCS provider was easier to get to, while less than one-fifth said that their previous provider was easier to get to.

Four out of five parents whose children are currently in AHCCCS and who have been in the program for ten or more months in the past year say that their child's AHCCCS provider is easier to get to than their child's previous provider.

Nearly half of the adults who had a usual source of care prior to joining AHCCCS said that their care under AHCCCS was better than their care prior to AHCCCS, while less than one-fifth said that their previous care was better.

More than four out of five parents whose children had a usual source of care prior to joining AHCCCS, were in AHCCCS at the time of the survey and who had been in the program for ten or more months said that their child's care was better under AHCCCS than it was under their child's previous provider. Fewer than one out of twenty parents in this group report that their child's care was better under their child's previous provider than it was under AHCCCS.

Less than one out of twenty AHCCCS recipients said that their AHCCCS primary care provider was at a hospital emergency room. However, the location of the adult recipient's usual provider of care prior to their enrollment in AHCCCS was significantly related to the location of their AHCCCS provider.

Less than one out of twenty AHCCCS recipients said that their AHCCCS primary care provider was at a hospital emergency room.

Nearly three out of four adult AHCCCS recipients reported that their usual source of care while they were in the program was their assigned AHCCCS provider. However, one out of ten adult enrollees said that they had no usual source of care while they were in the program.

Nearly nine out of ten parents of children in AHCCCS reported that their child's usual source of care while they were in the program was their assigned AHCCCS provider. Less than one out of twenty child enrollees had no usual source of care while they were in the program.

AHCCCS appears to have successfully substituted non-emergency ambulatory care for care provided in hospital emergency rooms.

The program is not without faults. Significant numbers of recipients who have been in the program for a short period of time, are white, have more than a high school education, are non-poor, or who had a usual source of care prior to joining AHCCCS are less satisfied with the program than other recipients. These recipients are most likely the Medically Indigent/Medically Needy recipients who have spent down to AHCCCS due to catastrophic eligibility. The program may need to find appropriate mechanisms to smooth the transition to a managed care program for those individuals who previously experienced fee-for-service medicine.

The cost-effectiveness of AHCCCS over conventional Medicaid has been repeatedly demonstrated in earlier studies; this effort shows that recipient satisfaction and access to care is very high. These benefits of AHCCCS need to be expanded, through broader eligibility for pregnant women and children, through expansion of the Health Care Group to provide insurance for small employers, and through the creation of an AHCCCS buy-in program in which individuals with pre-existing conditions who cannot obtain adequate private health insurance could pay a portion of the costs for the enrollment in an AHCCCS plan. Together these changes could go far to reducing the number of uninsured in Arizona, estimated to be nearly 500,000.

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APPENDIX

The Survey Methodology

This study surveyed Arizona residents about their use of, satisfaction with, and attitudes toward health care services. The survey was conducted by Louis Harris and Associates, Inc., working closely with Bradford L. Kirkman-Liff, Dr.P.H., of the School of Health Administration and Policy of Arizona State University.

The survey, comprising 4,217 interviews, was designed to provide reliable information about a representative cross section of adults and children who are residents in all parts of the State of Arizona, excluding persons living on Indian reservations, military bases, in prisons, nursing homes, college dormitories, and mental institutions.

Of the total 4,217 interviews, 4,073 were conducted by telephone from the Harris firm's headquarters in New York from February through May of 1989. Also included in the sample were 144 in-person interviews conducted in households without telephones -- 100 with adults about themselves and 44 with adults about their children. A total of 3,104 randomly selected adults, age 17 and over, were interviewed about themselves, and 1,113 adults provided information about a randomly selected child, age 0 to 16, living in the household. Interviews were conducted in English or Spanish.

The survey focused on residents' use of health care services, including doctors, hospitals, and other medical facilities; on whether they had access to needed medical care (and the reasons they did not have such access); on their satisfaction with health services used; and on their perceptions of health care priorities and problems in their communities.

In order to provide sufficient data about various subgroups within the population, two kinds of oversampling were used. Rural areas were oversampled to provide better data about less populated areas, while Maricopa County, with over half the population of the state, was undersampled. (This oversampling and undersampling was corrected by weighting). The state, apart from the Indian reservations, was divided into six "areas":

- Pima County inside the City of Tucson
- Pima County outside the City of Tucson
- Maricopa County inside the City of Phoenix
- Maricopa County outside the City of Phoenix
- Towns with populations of 10,000 or more

Rural areas (the rest of the state, including towns of less than 10,000 population).

An oversample of low-income families was interviewed in order to gather reliable information about low-income residents. (The data collected from this oversample were weighted to bring the sample into line with the latest Census Bureau population figures for Arizona.)

The 4,073 telephone interviews were conducted in two stages. In stage one, interviews were conducted with representative cross sections of 2,000 adults and on behalf of 705 children. In stage two, additional telephone interviews were conducted with 1,004 adults and on behalf of 364 children at or below the poverty level. This oversample of poor people was obtained by "screening" additional households drawn from the same bank of telephone numbers in which poor people had been found in the cross section. A household was "screened out" and was not interviewed if its income exceeded the poverty level. This oversampling of poor households was also corrected by weighting.

The total sample was weighted to the U.S. Census Bureau's latest population parameters on region, education, sex, race, and age. This weighted adjusted these key variables, where necessary, to their actual proportions in the population. The sample of adults was also weighted by the number of adults in the household, and the sample of children was weighted by the number of children in the household.

A total of 540 adults and 356 children were identified through the survey who either were an AHCCCS recipient at the time of the survey or had been an AHCCCS recipient at some time prior to the survey. The raw number of AHCCCS respondents according to each of the various demographic variables is displayed in Figure 19. As described above, all of the tabular analyses were performed using weighted observations, in order to correct for the oversampling of rural and low-income respondents.

The results achieved from all sample surveys are subject to sampling error. Sampling error is defined as the difference between the results obtained from the sample and those that would have been obtained had the entire relevant population been surveyed. The size of the sampling error varies both with the size of the sample and with the percentage of respondents giving a particular answer. Taking into account both these variables, errors in this study do not exceed 3 percent at the 95 percent confidence level.

All Louis Harris and Associates surveys are designed to adhere to the Code of Standards of the Council of American Survey Research Organizations (CASRO) and the Code of the National Council of Public Polls (NCPPI).

Statistical significance of the differences between sub-groups for the reported measures was tested using a variety of procedures. Differences involving dependent categorical variables (in Figures Two through 15) were tested using chi-square statistics for each independent categorical variable (such as source of care prior to AHCCCS, ethnicity, income or residence). Maximum likelihood logistical regression models were developed which simultaneously tested the significance of all of the independent categorical variables. This process involved both forwards and backwards model construction, to control for possible all confounding due to the presence of independent categorical variables that were themselves significantly related to each other. The results of these models are seen in Figure 20.

The analysis of measures of utilization of medical services involved a somewhat different approach. The average number of non-emergency ambulatory care visits was obtained through the development of separate multivariate ordinary least squares (OLS) regression models for adults and children, using a stepwise methodology to find the strongest model in which all of the parameters were statistically significant. These models included quadratic components for all quantitative variables. Both the adult and the child model incorporated nine measures of health status and nine measures of health insurance. The adult model also included thirteen demographic measures (covering gender, age, education, income, ethnicity, and employment status of main wage earner) and seven interaction terms involving membership in AHCCCS combined with selected demographic measures. The child model also included eleven demographic measures (covering gender, age, education, income, ethnicity, and employment status of main wage earner) and five interaction terms.

The percent of adults and children with one or more non-emergency ambulatory care visits, emergency ambulatory care visits, and hospital stays were obtained through the development of separate multivariate maximum likelihood logistical regression models. These models incorporated the same health status, demographic, insurance, interaction and quadratic terms as used in the multivariate OLS regression models. A forward selection methodology was used to develop a model in which all of the parameters were statistically significant. Based upon these models point estimates were developed which used the mean values of the health status and demographic measures to control for those factors. The results presented in Figures 16, 17 and 18 therefore represent estimates of the utilization of medical services, if populations with identical health status and demographic characteristics were covered by the different forms of insurance.

A 95% confidence level was used in all of the statistical tests. All statistical analyses were performed using the Statistical Analysis System (SAS).

Acknowledgements

Data analysis and text were provided by Bradford Kirkman-Liff of the Arizona State University School of Health Administration and Policy. James J. Wallace, Jr. provided computer programming assistance. Original design was created by Ann Hermanson. Susan Mulera, Ann Salisbury, and Dan Grigg prepared the final camera-ready copy.

Figure 19: Number of AHCCCS Respondents

Respondent Characteristics	Adults	Children
Total AHCCCS Respondents	540	356
Employment Status of Main Wage Earner		
Employed	201	194
Unemployed	94	70
Not In The Labor Force	241	90
Residence		
Urban Arizona	300	181
Maricopa County	191	114
Pima County	109	67
Rural Arizona	240	175
Household Income		
Poor	430	293
Near Poor	41	25
Non-Poor	30	18
Ethnicity		
White	226	132
Hispanic	197	144
Black	47	27
Native American	42	30
Education		
Less Than High School	281	163
High School	143	109
More Than High School	107	81
Health Status		
Excellent or Good	193	200
Fair or Poor	343	156
Age (for Adults)		
17-39	285	
40-64	166	
65 and Older	89	

Figure 20: Maximum Likelihood Logistical Regression Models

Models and Significant Independent Variables	Chi-Square	p
Current or Past Coverage By AHCCCS - Adults		
Income	203.02	.0001
Age	77.73	.0001
Health Status	50.76	.0001
Employment Status of Main Wage Earner	21.27	.0001
Ethnicity	14.57	.0001
Education	8.39	.0038
Current or Past Coverage By AHCCCS - Children		
Income	178.91	.0001
Employment Status of Main Wage Earner	20.72	.0001
Residence	4.01	.0453
Recipients' Satisfaction with AHCCCS - Adults		
Ethnicity	14.00	.0002
Employment Status of Main Wage Earner	11.60	.0007
Education	6.78	.0092
Recipients' Satisfaction with AHCCCS - Children		
Ethnicity	12.78	.0004
Employment Status of Main Wage Earner	8.26	.0041
Access to AHCCCS Provider - Adults		
Employment Status of Main Wage Earner	6.28	.0122
Location of Previous Provider	4.59	.0321
Months of Enrollment	4.32	.0378
Access to AHCCCS Provider - Children		
Ethnicity	6.12	.0134
Assessment of Care - Adults		
Enrollment Status	9.53	.0020
Health Status	5.50	.0190
Income	3.88	.0487
Assessment of Care - Children		
Location of Previous Provider	11.85	.0006
Income	5.45	.0196
Location of AHCCCS Primary Care Provider - Adults		
Location of Previous Provider	8.66	.0033
Ethnicity	3.86	.0493
Location of AHCCCS Primary Care Provider - Children		
Education of Main Wage Earner	5.56	.0184
AHCCCS Primary Care Provider Relationship - Adults		
Employment Status of Main Wage Earner	12.89	.0003
Months of Enrollment	12.33	.0004
AHCCCS Primary Care Provider Relationship - Children		
Enrollment Status	10.92	.0010
Months of Enrollment	6.03	.0140
Difficulty of AHCCCS Application Process - Adults		
Enrollment Status	32.35	.0001
Difficulty of AHCCCS Application Process - Children		
Enrollment Status	9.33	.0023
Employment Status of Main Wage Earner	4.96	.0260

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Memorandum

February 23, 1993

Donald A. Wilson
President

TO: Senate 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. As such, SB 119's requirement for implementation in FY 1994 should be changed to FY 1995. Second, it is very important to bring everyone to the table in developing a plan. We recommend that a task force of agency representatives, providers, client representatives and others with expertise in this area be included. 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.

Senate PH&W #20
Attachment
2-24-93

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.

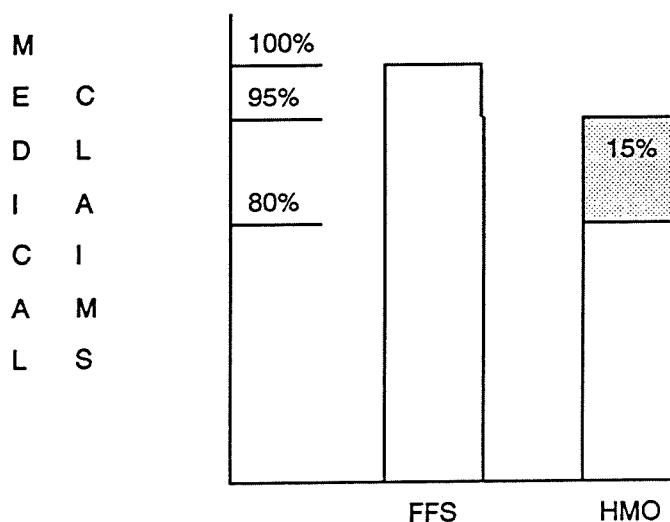
MODELS FOR MEDICAID MANAGED CARE

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 Puget 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.

*Senate PH&W
Attachment #
2-24-93 3*

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:

- 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.

TABLE 1

TYPE	1991 # PLANS	1991 ENROLLMENT	PAYMENT METHODOLOGY	PROVIDERS AT <u>RISK</u>
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

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.

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

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.

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

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	MEDICAID
STATE	POPULATION	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%

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.

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.

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

Senate Public Health and Welfare Committee
Testimony on Senate Bill 119

February 24, 1993

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."

Madam Chairman and members of the committee, on behalf of the Secretary of SRS, I thank you for the opportunity to present you with this testimony.

SRS supports Senate Bill 119.

Currently in Sedgwick and six other counties in Kansas (Shawnee, Saline, Douglas, Johnson, Leavenworth and Wyandotte), managed care exists in the form of the Primary Care Network (PCN). A Freedom of Choice waiver would be applicable for the managed care pilot project if recipient participation is mandated as in the PCN program. The Health Care Financing Administration approved the Freedom of Choice waiver required for the PCN program after we supplied HCFA with justification and cost-effectiveness of the program. Since this Freedom of Choice waiver already exists in the above counties, it's anticipated an application to HCFA for an additional waiver would not be necessary.

It will take significant staff time to develop a form of managed care that currently does not exist in the Kansas Medicaid system. First of all the cost-effectiveness of a new managed care program would need to be demonstrated to the Health Care Financing Administration (HCFA). Necessary steps to initiate a managed care project include, but are not limited to, the following:

1. Research of the federal regulations, state laws and other state programs to determine criteria necessary for this project.
2. Procure actuarial services to establish the capitation rate that meets HCFA's upper limit criteria. Rate setting is a contentious issue, and the extent and type of risk the state is willing to take in a prepaid Medicaid initiative is a key consideration.
3. Define which Medicaid-eligible population will be in the pilot project. Commonly, the AFDC Medicaid population is targeted for managed care. An option might be to target the pregnant women and children population.
4. Develop a medical benefits package for the managed care project.
5. Acquire HCFA approval of contract, rates and State Plan changes.

Senate PH & W
Attachment 4
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6. Develop internal and fiscal agent systems to accommodate enrollment, disenrollment, payment and informational report needs.
7. Hire and train staff to monitor/manage the program.
8. Enroll and train providers and recipients.
9. Time for finalization and data testing.
10. Signing of a contract and training/mailing of clients/providers.

The annual fiscal impact of implementing a managed care program in two counties would be approximately \$605,356 (\$254,116 State General Funds). This cost includes at least three staff who would be needed to research, implement and oversee the project, the costs of the actuarial and marketing contracts, and the modifications to the Medicaid Management Information System. An option for SRS would be to contract for the above mentioned administration and operations of the managed care program.

Managed care programs have achieved five percent savings in medical costs. Due to Kansas's low reimbursement rate and existing cost-containment programs such as reimbursement to hospitals through the Diagnostic-Related Groups, it is unknown whether Kansas can achieve a five percent savings.

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