United States General Accounting Office

GAO

Report to the Secretary of Health and Human Services

March 1987

MEDICAID

Lessons Learned From Arizona's Prepaid Program

GAO/HRD-87-14

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-220864

March 6, 1987

The Honorable Otis R. Bowen, M.D.
The Secretary of Health
and Human Services

Dear Mr. Secretary.

This is our report on the lessons learned from the Arizona Health Care Cost Containment System.

This report contains recommendations to you. As you know, 31 U.S.C. 720 requires you to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with HHS's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of the report to the above-mentioned committees, the Governor of Arizona, and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

In 1985, the cost of providing medical care for low-income persons through the federally funded, state-administered Medicaid program was about $38 billion. Resulting financial strains on both the federal and state governments have sparked national interest in ways to constrain these costs.

One experiment to limit Medicaid costs is Arizona's Health Care Cost Containment System, under which the state contracts with prepaid health plans to provide comprehensive medical care for a set monthly fee per patient.

GAO reviewed the program's first 3 years of operation (Oct. 1982 through Sept. 1985) to examine Arizona's approach to

- competitive bidding for procuring health plan contracts,
- collection of utilization data from the prepaid plans on the health care services provided, and
- financial oversight of the prepaid health plans.

Background

The Department of Health and Human Services (HHS) has overall responsibility at the federal level for administering Medicaid. Within HHS, the Health Care Financing Administration is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

The Arizona Health Care Cost Containment System was designed as a 3-year experimental project to provide Medicaid services in Arizona beginning in 1982; HHS granted the program an extension, approving it through September 1987. Before October 1982, Arizona was the only state without a Medicaid program. About 100,000 Medicaid beneficiaries were enrolled in the program as of April 1986. The program cost the federal government about $155 million through the end of fiscal year 1985.

Results in Brief

The Arizona program experienced numerous start-up problems that have prevented an assessment of the effectiveness of its cost containment features. GAO believes other states considering prepaid Medicaid programs can learn from Arizona's problems and solutions. (See ch. 5.)

States planning on using prepaid health programs, should, among other things,

- develop adequate financial and utilization reporting systems and program controls before implementing the program,
- establish penalties for noncompliance with reporting requirements,
- establish requirements to demonstrate the financial viability of prepaid health plans and devote adequate resources to monitoring health plans' performance, and
- design health plan procurements to promote competition

Principal Findings

Effectiveness of Cost Containment Features Unknown

To evaluate the Arizona program's effects on Medicaid costs and beneficiaries' access to quality care, HHS needs information on the medical services provided to beneficiaries.

From its inception, however, the Arizona program has had difficulties in collecting utilization data. By April 1985, the Health Care Financing Administration had concluded that an adequate evaluation of the program's first 3 years could not be conducted because of the problems experienced in implementing the project and the lack of financial and utilization data.

Develop Reporting Systems Before Implementation

In rushing to get the program on line by October 1982, Arizona did not have sufficient time to develop adequate financial and utilization reporting systems. In addition, evaluations of the bidding health plans' ability to collect complete and reliable cost and utilization data were not done before awarding contracts. States need to allow sufficient time to permit development of adequate reporting systems

Establish Penalties to Encourage Reporting

Prepaid health plans have less of a financial incentive to provide utilization and cost information to the Medicaid agency than physicians paid on a fee-for-service basis. Such physicians are generally paid by submitting a claim including both medical service and charge information. Prepaid providers, however, are paid a set amount in advance and have little incentive to report cost and utilization data.

Arizona found that financial penalties were necessary to enforce the reporting requirements. The program designed financial sanctions during its third year to withhold a portion of the plans' payments until

delinquent information was submitted. After the sanctions were implemented, compliance improved. By March 1985, most of the program's plans were submitting financial and utilization data as required.

Assess Plans' Finances

Many participating plans faced financial problems as the program progressed. For example, the largest plan, Arizona Family Physicians Independent Practice Association, filed for financial reorganization under federal bankruptcy laws, but was able to continue providing services. Another large plan, Health Care Providers, however, was terminated in April 1985 because of an inability to pay its debts. Its enrollees were assigned to other plans. A third plan—Western Sun, Inc.—was terminated in July 1985, after it filed for bankruptcy.

To avoid the types of problems encountered by some of the program's plans, other states should thoroughly assess health plans' finances before contract award and monitor their financial performance after contract award.

For its first two procurements, the program did not establish specific financial standards by which the plans' financial position could be evaluated. During the program's third procurement, however, financial performance goals were set and other requirements were expanded.

The program did not perform on-site financial audits of plan operations or analyze financial reports during its first 18 months. During the third year, Arizona increased the audit staff, established a standard audit guide for health plans, and required an annual certified audit of each plan According to the program, financial reviews of all plans were also conducted.

Design Procurements to Promote Competition

The program planned to award multiple contracts in as many locations as possible to give Medicaid beneficiaries a choice of health plans. Arizona also wanted to (1) ensure an adequate backup capacity in case a plan became financially impaired and (2) reduce the chance that one plan could emerge as a monopoly, eliminating future competition.

The program could have achieved these objectives and reduced costs by placing a limit on the number of contracts to be awarded. Because most bidders received contracts regardless of their price, they had less incentive to submit the lowest bid. For example, one health plan received $71 a month for providing services to Medicaid beneficiaries in one county,

while another bidder received $49. Establishing limits on the number of contracts to be awarded during the first-year procurement could have saved the program from $830,000 to $2.36 million, depending on the limits used.

Although the program questioned one of the assumptions GAO made in estimating potential savings, it indicated that changes were made for the fourth year procurement to ensure that plans were not awarded contracts at an unreasonable price. (See p. 21.)

Recommendations

In October 1986, the Congress enacted legislation requiring the Secretary of HHS to review and approve contracts in excess of $100,000 before states award them to entities providing Medicaid services on a prepaid basis.

GAO is recommending actions HHS needs to take in implementing the October 1986 legislation that will help ensure states develop adequate financial and utilization reporting systems for prepaid Medicaid programs.

Agency Comments

HHS generally agreed with the lessons learned from the Arizona program, but did not agree that HHS should develop what it termed "broad and intrusive" guidelines for review and approval of prepaid health plan contracts. Arizona, on the other hand, said that many of GAO's lessons learned could do more harm than good. Like HHS, Arizona cautioned against development of prior approval guidelines.

Neither HHS nor Arizona adequately carried out its responsibility for ensuring program integrity during the Arizona program's first several years. Contracting with a prepaid health plan does not relieve the state or HHS of its responsibility to determine whether federal laws and regulations are followed. GAO's recommended guidelines would not establish "broad and intrusive" new requirements. They would establish internal control procedures to determine whether existing requirements are met. Approving contracts without determining whether the Medicaid agency fulfilled its responsibilities under federal regulations with respect to financial operations, utilization reporting and quality assurance, and procurement procedures unnecessarily places both the Medicaid beneficiaries and other federal taxpayers at increased risk.

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
AHCCCS	Arizona Health Care Cost Containment System
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IPA	Independent Practice Association
MCAUTO	McAuto Systems Group, Inc.
OMB	Office of Management and Budget
RFP	Request for Proposals
SSI	Supplemental Security Income

Introduction

Medicaid is a federally aided, state-administered medical assistance program serving about 22 million low-income people. It became effective on January 1, 1966, under authority of title XIX of the Social Security Act, as amended (42 U.S.C. 1396). Within broad federal limits, states set the scope and reimbursement rates for the medical services offered and make payments directly to the providers who render the services. Generally, persons receiving public assistance under the Aid to Families With Dependent Children (AFDC) and Supplemental Security Income (SSI) programs are eligible for Medicaid assistance. Also, at each state's option, persons who do not qualify for such public assistance but cannot afford the costs of necessary health care may be entitled to Medicaid benefits.

Depending on a state's per capita income, the federal government pays from 50 to 78 percent of the Medicaid costs for health services. In addition, the federal government reimburses the states for 50 to 90 percent of their administrative costs, depending on the functions performed.

The Department of Health and Human Services (HHS) administers Medicaid at the federal level. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

Demonstration Project Waivers

Section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)) allows the Secretary of HHS to waive compliance with standard Medicaid requirements, so that a state Medicaid agency can carry out significant demonstration projects that will further the program's general objectives. All requirements of the Social Security Act and the federal Medicaid regulations apply to a project approved under section 1115(a), unless they are specifically waived.

HCFA provides funds for demonstration projects and research activities that will help resolve major health financing policy and program issues. HCFA's Office of Research and Demonstrations determines which projects will be funded and evaluates their effectiveness. The operation of demonstration projects is monitored by HCFA's regional offices.

Arizona Health Care Cost Containment System

The Arizona Health Care Cost Containment System (AHCCCS), which began operations in October 1982, was initially approved by HCFA to be a 3-year demonstration project. Before AHCCCS, Arizona was the only state without a Medicaid program. In July 1985, HCFA approved an extension of the program, which is now expected to operate through September 1987. SRI International, Inc., is under contract with HCFA to evaluate the AHCCCS demonstration program.

Evolution of the Program

Facing diminishing local tax revenues to fund increased health care costs, Arizona became interested in developing a Medicaid program. Medicaid was also an appealing solution to the uneven and unequal health care treatment available to indigents around the state. Traditionally, Arizona's counties had financed and provided health care services to those unable to pay. As health care costs rapidly increased, the state legislature became interested in establishing a Medicaid program with federal funding. After several attempts to pass and implement Medicaid legislation, Arizona settled on an innovative, competitive health care financing model, which departs in many ways from traditional Medicaid programs.

Program Features

HCFA granted Arizona waivers under section 1115(a) enabling AHCCCS to operate differently from conventional Medicaid programs. The goal of the AHCCCS demonstration project is to develop and test certain innovations designed to contain health care costs. The innovations include using

- competitive bidding to select prepaid health plans,
- prepaid capitated financing[1] of health plans as an alternative to fee-for-service payments,
- primary care physicians as "gatekeepers" to manage and control beneficiaries' access to services,
- restrictions on beneficiaries' freedom of choice in selecting providers, and
- copayments to discourage unnecessary use of services.

AHCCCS provides health care to the federally mandated groups (AFDC and SSI program recipients) and covers all the federally mandated Medicaid

[1]This involves paying a set premium in advance to a health care provider, usually a health maintenance organization (HMO) or similar organization, for comprehensive medical care

services[2] except for skilled nursing facility care, home health care, nurse midwife services, family planning services, and nonacute mental health services.

In addition, AHCCCS provides services to state-defined medically needy and medically indigent people who do not qualify for AFDC or SSI but have inadequate resources to pay for medical care. AHCCCS does not receive federal financial assistance for its medically needy/medically indigent population. Although Medicaid does have a medically needy program, Arizona does not participate.

Through the end of fiscal year 1985, AHCCCS cost the federal government about $155 million As of April 1986, about 100,000 federally eligible beneficiaries were enrolled in AHCCCS.

AHCCCS Program Organization

Originally AHCCCS's day-to-day program operations were carried out by a private contractor. Arizona's Department of Health Services selected McAuto Systems Group, Inc. (MCAUTO), through a competitive procurement, to act as the AHCCCS administrator. The administrator's responsibilities included procuring and monitoring providers, establishing and monitoring medical quality assurance systems, enrolling beneficiaries, maintaining provider relations, providing technical assistance to health plans, and collecting and compiling reports using claim and utilization[3] data.

MCAUTO served as AHCCCS's administrator for about 1-1/2 years, until contract disputes resulted in the severance of this relationship on March 15, 1984. MCAUTO sued Arizona for breach of contract, and the state filed a countersuit. The litigation is currently pending. The state did not hire a replacement administrator, and the AHCCCS Division took over the administrator function. Subsequently, the AHCCCS Division was removed from the Department of Health Services and set up as a separate agency reporting directly to the governor. This report uses "AHCCCS" to describe actions taken by both MCAUTO and the AHCCCS Division.

[2]Including inpatient and outpatient hospital services, laboratory and X-ray services, and physician services

[3]A report of each health care service provided to eligible recipients

Prior GAO Work on AHCCCS

In June 1984, we testified on HCFA's monitoring of certain aspects of the AHCCCS program before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.[4] At that time, we reported that AHCCCS had not generated the program information necessary to render an opinion on the financial performance of contractors, the quality of care provided, or the reasonableness of payments to providers.

Additionally, we reported in November 1985 that many AHCCCS health plans had not complied with federal requirements for disclosure of ownership information.[5] We reported that some AHCCCS plans either had not disclosed direct or indirect ownership interests or had not disclosed officers or directors.

Objectives, Scope, and Methodology

The purpose of this review was to identify "lessons learned" during the first 3 years of AHCCCS that could be applied to other states that are developing or that have expressed an interest in testing similar competitive approaches to Medicaid financing and health care delivery. Specifically, our objectives were to identify lessons learned from AHCCCS's approach to

- competitive procurement of prepaid health plans;
- obtaining complete, accurate, and reliable utilization data; and
- ensuring that health plans are financially viable.

Because of the limited cost and utilization data available, we did not attempt to evaluate access to or quality of care, the actuarial soundness of the payment rates, or the overall cost effectiveness of the AHCCCS concept. AHCCCS's use of a private administrator was not evaluated because of pending litigation between the state and the former administrator.

We did our review at HCFA's Office of Research and Demonstrations in Baltimore, the HCFA Region IX office in San Francisco, the Arizona AHCCCS Administration, and five AHCCCS prepaid health plans.[6] In addition, we visited HHS's Office of Health Maintenance Organizations and

[4]Statement of Michael Zimmerman, Associate Director, Human Resources Division, June 15, 1984

[5]Arizona Medicaid Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov 22, 1985)

[6]Access Patients' Choice, Inc , Health Care Providers of Arizona, Inc , Maricopa County Department of Health Services, Pima County Board of Supervisors, and University Physicians

Arizona's Department of Insurance to identify administrative requirements and procedures for other prepaid health plans. We also obtained information from California's Department of Health Services about experiences with prepaid health care in the 1970's and from the Santa Barbara County, California, Special Health Care Authority about its current experiment with such care.

To assess the effectiveness of AHCCCS's competitive procurement of prepaid health plans, we

- compared the AHCCCS procurement procedures to HCFA's Medicaid procurement guidelines applicable to the AHCCCS program;
- reviewed AHCCCS procurement materials (e.g., Requests for Proposals (RFPs), bid evaluation materials), policies, and procedures;
- analyzed first year (1982-83) and second year (1983-84) contract award prices by eligibility group (AFDC, SSI-Blind, SSI-Aged, and SSI-Disabled) and county;
- reviewed available reports and studies on AHCCCS's competitive procurement by HCFA, HCFA's evaluation contractor, AHCCCS, and others; and
- obtained HCFA contract review forms and discussed the 1982 and 1983 procurements with AHCCCS and HCFA officials.

To evaluate the state's ability to obtain complete and accurate encounter data from AHCCCS health plans, we examined AHCCCS's progress in correcting problems described in our June 1984 testimony We also reviewed AHCCCS's efforts to meet several conditions relating to the submission of utilization and financial reports imposed by HCFA in approving the third program year. We analyzed AHCCCS summaries of data submissions, reviewed an AHCCCS consultant's study of encounter data collection and validation, and discussed the issue with HCFA, AHCCCS, and their consultants.

To assess AHCCCS's efforts to ensure contracting health plans' financial viability, we

- compared AHCCCS's financial standards and insolvency provisions for bidding health plans to standards used by other agencies, such as Arizona's Department of Insurance and HHS's Office of HMOs,
- reviewed AHCCCS health plans' compliance with federal disclosure requirements;
- analyzed AHCCCS health plans' financial reports and other related information; and

- monitored AHCCCS health plans' compliance with state and federal financial reporting requirements.

Our work was done in accordance with generally accepted government auditing standards.

AHCCCS Could Increase Price Competition

One of AHCCCS's principal objectives is to demonstrate the cost effectiveness of competitive bidding for prepaid health plan contracts. Although AHCCCS was able to obtain enough bidders to provide a choice of health plans for most beneficiaries, procurement procedures did not maximize price competition among the bidders Price competition was reduced because

- AHCCCS did not limit the number of contracts to be awarded, lessening the bidders' risk of nonselection, and
- limited data on the use and cost of medical services for Arizona's indigent care population were available to assist potential bidders in calculating competitive rates.

State law precluded price negotiation between AHCCCS and the health plans. To achieve cost savings without negotiating individually with each health plan, AHCCCS asked bidders in some counties to voluntarily reduce bid prices. While this process resulted in reductions in bid prices, we believe additional savings could have been achieved by seeking price reductions from all AHCCCS health plans. In addition, because there was little risk of nonselection, bidders had less incentive to voluntarily reduce bid prices.

AHCCCS's Procurement Process Results in Choice of Health Plans for Most Beneficiaries

Statewide procurement of a broad array of health services for AHCCCS beneficiaries through fixed-price prepaid contracts is the most innovative feature of the AHCCCS demonstration project. While other state Medicaid agencies have begun programs of selective contracting with hospitals or competitive bidding for selected services, AHCCCS is the first system to implement a comprehensive competitive procurement statewide for Medicaid services AHCCCS procured health plan contracts through statewide bidding in 1982, 1983, and 1985.[1]

In 1982, AHCCCS received 113 bids from 50 separate organizations in response to an RFP. AHCCCS required the organizations to submit monthly prices at which they would provide Medicaid services to AHCCCS patients. Each bid was required to include individual bid prices for five patient categories: AFDC, SSI-Blind, SSI-Aged, SSI-Disabled, and the state-sponsored medically needy/medically indigent population. Separate bids were required for each service area.

[1]AHCCCS did not conduct a statewide procurement in 1984 A 1983 contract provision allowed a 1-year extension of second-year contracts (through Sept 1985) if agreeable to both the health plans and AHCCCS Eighteen of the 19 health plans awarded second-year contracts agreed to renew their AHCCCS contracts for the third year (1984-85)

The 113 bids were primarily evaluated on:

- Technical qualifications.
- Composite bid price—an average of the bid rate for each patient category weighted by the estimated number of AHCCCS eligibles in each category (e.g., AFDC).

AHCCCS rejected 74 of the 113 bids because the bidders lacked the technical qualifications to provide Medicaid services or had bid to provide only partial services, such as hospital care. After evaluating the remaining 39 bids, AHCCCS awarded one or more first-year contracts in each of the state's 14 service areas. A total of 32 contracts were awarded to 7 physician-sponsored, 6 clinic-based, and 4 hospital-based health plans. Most of the health plans had no prior experience in providing services on a prepaid basis; only 2 of the 17 organizations receiving contracts were federally qualified HMOs.

Thirteen of the 19 bidders awarded contracts in the second year had participated in the program's first year.

As shown by table 2.1, AHCCCS's first- and second-year procurements resulted in over 80 percent of the federally eligible beneficiaries having a choice of two or more health plans from which to receive medical benefits. Although beneficiaries in six counties in 1982-83 and four counties in 1983-84 did not have a choice of health plans, they constituted less than 18 percent of the population.

Table 2.1: Results of AHCCCS Procurements: Percentage of Categorically Eligible Beneficiaries With Choice of Health Plans

	Number of counties[a]	Number of beneficiaries served	Percentage of total beneficiaries
Oct 1982-Sept 1983			
One plan (no choice)	6	16,370	17 8
Two plans	4	6,851	7 5
More than two plans	4	68,685	74 7
Oct 1983-Sept 1984			
One plan (no choice)	4	9,771	8 9
Two plans	5	11,526	10 4
More than two plans	6	89,085	80 7

[a]The number of counties in Arizona increased from 14 to 15 in 1983

Limit on Multiple Contract Awards Could Enhance Price Competition

Because AHCCCS's procurement design did not establish limits on the number of contracts to be awarded in a service area, bidders had little risk of not obtaining a contract and little incentive to submit the lowest bid. Establishing a limit on the number of contracts to be awarded could have reduced AHCCCS's cost by $830,000 to $2.36 million in the first program year (1982-83).[2]

AHCCCS planned to award multiple contracts in as many service areas—usually counties—as possible to give beneficiaries a choice of health plans whenever possible. Other reasons for awarding multiple contracts, according to AHCCCS, were to provide a backup health plan capacity in case a plan became financially impaired and to reduce the chance that one plan in a large service area would emerge as a monopoly, eliminating the framework for future competition among health plans.

AHCCCS's goal of awarding multiple contracts within service areas, however, limited the effectiveness of competitive bidding. Bidders generally have an incentive to submit the lowest possible bid because only one contract will be awarded and they will not get the contract if their bid is too high. AHCCCS officials pointed out that awarding bids at too low a price could increase plan failures and cause disruptions to service.

Competitive bidding can also be used to award multiple contracts, but in order to maintain the incentive to submit the lowest bid, there should be more bidders than contracts to be awarded. We believe AHCCCS could have accomplished its goals of giving beneficiaries a choice of health plans and adequate backup capacity and still increased competition by establishing a limit on the number of contracts to be awarded in each service area.

Most qualified bidders received AHCCCS contracts, however, even when bid prices varied significantly. AHCCCS rejected 7 of the 39 technically qualified bids on the basis of price in 1982-83 and 8 of 41 technically qualified bids in 1983-84. No technically qualified bidders were rejected in Arizona's most populous county (Maricopa), where five or more contracts were awarded each year. According to the AHCCCS director, health plans had an incentive to submit the lowest bid because they could increase their share of enrollment by being the low bidder. He said that most AHCCCS enrollees who did not choose a health plan were assigned to the lowest priced plan.

[2]This estimate is explained in detail on p 20

Contract prices varied substantially within the same geographic area. For example, in the program's second year, AHCCCS awarded multiple contracts within 11 counties at different prices for the same beneficiary category. We found that monthly rates for AFDC beneficiaries varied an average of almost 12 percent. For the three other federal beneficiary categories, the average variance ranged from 16 to 29 percent. To give two examples:

- In one county, a plan served AFDC beneficiaries for a fixed monthly fee per individual of $71, while a second plan received $49.
- In another county, a plan received $246 per month for each enrolled SSI-Blind or SSI-Disabled beneficiary, while a second plan received $167.

AHCCCS said that the wide variation in bid prices was due in part to its awarding contracts during the first 2 program years based on composite bids rather than individual bid prices. In addition, AHCCCS said that the low bidders in the two counties cited were county health departments subsidized by the county.

We identified instances where the low bidder was not a county-based health plan, and a wide variation occurred in composite bid prices. For example, four health plans submitted first-year bids in Pinal County. Three of the bidding health plans had adequate capacity to serve the entire county's Medicaid population. Two of the health plans, Arizona Family Physicians Independent Practice Association (IPA) and Pinal General Hospital, submitted composite bids of $75.26 and $78.42 per beneficiary per month, respectively. The third plan, Health Care Providers, submitted substantially higher bids for each category, and had a composite bid of $95.59 per beneficiary per month. AHCCCS awarded contracts to all three bidders.

In another four counties, AHCCCS awarded two contracts when only two bidders were competing. For example, Arizona Family Physicians submitted a first-year bid of $45.31 per beneficiary per month to serve the SSI-Aged population in Yavapai County, while Northern Arizona Family Health Plan submitted a bid of $101.48 to serve the same beneficiary population. Both health plans were initially awarded contracts contingent upon their ability to contract with enough providers to adequately serve the Medicaid population.[3]

[3]Arizona Family Physicians IPA's contract was later withdrawn because some physicians serving the county refused to sign contracts with the health plan

By limiting the number of contracts awarded in a service area to the two lowest qualified bidders, AHCCCS could have increased price competition among health plans by putting them at risk of not getting a contract if their bid was too high. In instances where there were only two technically qualified bidders, both bidders were essentially assured of an AHCCCS contract, and there was less price competition between them. In such cases, we believe price competition could be increased by (1) awarding only one contract unless bid prices were comparable or (2) awarding a second contract if the health plan agrees to provide services at the level of the lowest priced bid.

Increasing emphasis on price competition could have reduced AHCCCS costs by as much as $2.36 million in the 1982-83 program year. For instance, we developed an alternate strategy, which generally gave beneficiaries a choice of provider but placed a limit on the number of contracts awarded. Using 1982-83 AHCCCS enrollment figures and actual contract prices, by patient category and county, we estimated contract costs if AHCCCS had used the alternate strategy and compared them to AHCCCS's actual costs under its own award procedures. Using varying assumptions of beneficiary enrollment, AHCCCS's potential savings ranged from about $830,000 to $2.36 million.

We used the following assumptions in estimating savings under the alternate strategy:

1. In the six counties with more than two bidders, we awarded contracts to the two lowest priced bidders only— and assumed either that beneficiaries enrolled to the extent possible in the lowest priced plan or that half of the beneficiaries would enroll in each of the two lowest priced health plans.

2. In the four counties with two bidders only, we awarded contracts to both bidders at the level of the lowest bid. We assumed that the lower bids were reasonable and viable and that the higher priced bidders would be willing to participate at the lower bid.

AHCCCS officials disagreed with our assumption that the low bid was reasonable and that other bidders would be willing to participate at that price According to AHCCCS, the lower bids were submitted by county-subsidized health plans, and other bidders would not have been willing to participate at the county-subsidized bid rate. County-sponsored health plans, however, submitted bids in only 3 of the 14 service areas;

only 1 submitted the lowest composite bid price in a service area. Nevertheless, even if the higher priced bidders in the four counties were not willing to participate at the lower bid, the low bidder had the capacity to serve the entire Medicaid population. Only about 6,900 beneficiaries (7 5 percent) would have been affected.

According to the AHCCCS director, AHCCCS developed actuarial ranges by eligibility category and county for the fourth program year to ensure that plans were not awarded a contract at an unreasonably low or high price. He said that multiple contracts at a proper price level promote viable health plans that are true competitors over the long term. Additional health plans are ready to enter the program during the next contract cycle, the AHCCCS director said.

Limited Cost and Utilization Data May Have Reduced Competition

Another factor that may have limited competition among AHCCCS bidders was the absence of sufficient local cost or utilization data to help potential bidders calculate competitive rates.

We have previously reported that the lack of financial and utilization information can limit competition by inhibiting bidders' ability to develop responsible contract proposals and by causing some offerors not to bid because they believe the venture to be too risky.[4] For example, our review of prepaid Medicaid insuring agreements[5] disclosed that several states failed to provide sufficient financial and eligibility data that were necessary for proposal development. In one state, a successful bidder's actuary estimated that he underpriced his company's contract by 25 to 30 percent because the Medicaid data provided were not representative of a month's experience. In another state, some firms did not submit proposals because the Medicaid agency did not provide information on the number of users or related costs by type of beneficiary.

Although AHCCCS required bidders to quote a bid price for each beneficiary category based on cost and utilization estimates, it did not give potential bidders data on Arizona's health care cost or utilization. For

[4]Medicaid Insurance Contracts—Problems in Procuring, Administering, and Monitoring (HRD-77-106, Jan 23, 1978), North Carolina's Medicaid Insurance Agreement, Contracting Procedures Need Improvement (HRD-76-139, July 1, 1976)

[5]Under these agreements, the contractor is responsible for paying all valid claims for covered services received by eligible persons in exchange for a predetermined per capita premium The contractor is at risk because, if the costs of paying claims exceed premium payments, the contractor could suffer a loss

the first year's procurement, AHCCCS attempted to obtain data from Arizona's county health systems, which previously served the medically indigent. After examining data from three county health systems, AHCCCS's actuaries determined that reliable local data were not available. Instead, AHCCCS turned to actuarily determined cost and utilization data based on other states' programs

In the second- and third-year RFPs, actual utilization data from the program were not provided because AHCCCS was unable to collect reliable utilization data from all participating health plans. AHCCCS officials pointed out that additional services were added to the program for the second year and no utilization data were available from the first year. (See ch. 3) Bidders were expected to generate financial and utilization data independently.

The actuarial estimates were equitable for first-year bidders because all bidders had equal, though limited, knowledge of the costs of delivering Medicaid services in Arizona. However, bidders in later AHCCCS procurements who had not previously participated in the program were at a competitive disadvantage due to the lack of local program cost and utilization data. For instance, some of AHCCCS's health plans have participated in the program during all 3 years, gaining 3 years of AHCCCS financial and program benefit experience. Compared to these plans, new bidders for AHCCCS contracts face greater difficulty in preparing contract proposals.

Voluntary Price Reductions Could Have Been More Effective

Because state law precluded direct negotiation with bidding health plans, AHCCCS attempted to achieve lower priced contracts in the first and second program years by requesting bidders to voluntarily reduce their bid prices Although this action resulted in bid price reductions, its effectiveness was limited because

- original and revised bids were made public, as required by state law;
- the risk of not obtaining a contract was too little to encourage maximum price competition among bidders; and
- voluntary price reductions were not sought in eight Arizona counties for the first program year despite significantly varying bid prices in some of these counties

Because first-year bids in six counties and second-year bids in all counties were considered too high, AHCCCS asked these bidders to voluntarily reduce their prices in both years after the original bids had been made

public. AHCCCS sought voluntary price reductions after it was advised by the state attorney general that state law precluded price negotiation[6] between AHCCCS and health plans.

In 1982, bidders in the six counties where voluntary price reductions were requested lowered their bid prices an average of 6 percent. AHCCCS estimated that these reductions resulted in savings of $4 million to $5 million. In 1983, voluntary price reductions were requested in all counties, but resulted in acceptable bid prices in only two counties. Bids in the other 13 counties were rejected and a new RFP was issued, which resulted in price reductions.

AHCCCS estimated that the voluntary price reductions saved about $25 million in the second program year. However, this estimate may be overstated. According to HCFA's evaluation contractor—SRI International, Inc.—second-year bidders, expecting a request for voluntary price reductions, may have inflated their initial bid prices.

Because most bidders in the six counties where voluntary price reductions were sought, including those who submitted the low bid, reduced their prices, AHCCCS might have achieved additional first-year savings by requesting price reductions in the other eight counties. In particular, we believe AHCCCS should have requested voluntary price reductions where bid prices varied widely. For example, Arizona Family Physicians IPA submitted the low bid ($45.31) for the SSI-Aged population in Yavapai County. Although Northern Arizona Family Health Plan submitted a bid ($101.48) over twice as high, AHCCCS awarded both bidders a contract without seeking a voluntary price reduction.[7]

HHS Required to Review and Approve Future Contracts

In October 1986, the Congress, through the Omnibus Budget Reconciliation Act of 1986, required that the Secretary of HHS review and approve contracts in excess of $100,000 before states award them to entities providing services to Medicaid beneficiaries on a capitated or risk basis.[8] The requirements were made effective on enactment and apply to contracts entered into, renewed, or extended after the end of the 30-day

[6]Price negotiation, a routine component of federal procurements, would have permitted AHCCCS to reach agreement on prices through a series of exchanges with bidders

[7]Arizona Family Physicians IPA's contract was later withdrawn for other reasons

[8]HHS regulations contained a similar requirement before 1983, but it was eliminated by revisions spurred by the Office of Management and Budget's regulatory reforms

period beginning on enactment. In effect, the act requires that HCFA review and approve future contracts with AHCCCS health plans.

Summary

Although one of AHCCCS's principal objectives is to demonstrate the cost effectiveness of competitive bidding for prepaid capitated contracts, several parts of AHCCCS's procurement design conflicted with this objective and may have limited competition. For example, one aspect of the procurement design was to give beneficiaries a choice of health plans wherever possible. However, because AHCCCS awarded more contracts than necessary to serve the Medicaid population and awarded them at varying prices, bidders had little risk of not receiving a contract and little incentive to submit the lowest bid, decreasing the competitiveness of the procurement. We believe that AHCCCS's costs could have been reduced and the procurement competition increased by awarding fewer contracts.

Also, the limited local cost and utilization data increased bidders' risks. Finally, because Arizona statutes prohibited direct negotiation with bidders, AHCCCS had to substitute a voluntary price reduction method after publicizing bids, which may have resulted in less competition because initial bid prices were known to all bidders.

Utilization Data Unavailable to Evaluate AHCCCS

HCFA needs utilization data—information on medical services provided to AHCCCS beneficiaries—to assess whether AHCCCS is effective in containing health care costs, a major program goal. Because complete and accurate utilization data were not available, HCFA could not evaluate the effectiveness of AHCCCS's cost containment features of competitive bidding, prepaid capitation payments, gatekeeping, and copayments over its first 3 years. By the program's third year, HCFA and AHCCCS had begun several initiatives to collect needed data in the future.

Slow Progress in Collecting Utilization Data

AHCCCS has had difficulties in collecting utilization data from the program's inception In September 1983, a year after the program began, the state reported that two of the largest prepaid health plans, treating 65 percent of AHCCCS's enrollees, had not submitted any utilization data. AHCCCS estimated that as of July 1983, only 13 percent of the expected statewide services had been reported. Although AHCCCS reported significant progress in collecting utilization data during the second year of the program, there were continuing problems with the quality of the data submitted.

In April 1984, HCFA reported on the problems in obtaining utilization data, estimating that only one-third of the needed data had been processed by AHCCCS. HCFA advised the state that it would not approve the third year of AHCCCS unless the state produced complete and accurate utilization data before June 30, 1984. However, we testified in June 1984 that, according to a HCFA official, the accuracy and completeness of utilization data the state submitted to HCFA in response to the April request would be difficult to verify until the state analyzed provider information systems to determine how the providers count and record the particular data.[1]

Subsequently, HCFA and AHCCCS took several steps to improve the reporting of utilization data. As a condition for approval of AHCCCS's third program year (Oct. 1984-Sept. 1985), HCFA required AHCCCS to (1) analyze the integrity of contracting health plans' utilization data systems, (2) analyze the accuracy and completeness of data already submitted, (3) recommend changes to assure quality data in the future, (4) provide technical assistance to the plans to assure that required changes were implemented and tested before October 1984, and (5) monitor the accuracy, completeness, and timeliness of the data submitted.

[1]Statement of Michael Zimmerman, Associate Director, Human Resources Division, June 15, 1984

In response, AHCCCS devoted increased efforts toward utilization data collection in its third year. Specifically, AHCCCS (1) contracted with a private firm to assess AHCCCS health plans' utilization data systems and the reliability of the data they submitted, (2) established timeliness criteria for data submissions, and (3) established and levied penalties for failure to submit timely or accurate data.

AHCCCS's actions have resulted in increased utilization data submissions and in utilization data being received from all health plans. However, the accuracy and completeness of data submissions were questionable. Summaries of monthly utilization data submissions showed that the volume of services reported has fluctuated considerably. For example, one AHCCCS plan reported about 69,000 services in February 1985, but almost 190,000 the next month. Another plan reported 7,400 services in December 1984 but only 120 the following month. AHCCCS officials said there is less fluctuation in the number of services by date of service than date of submission. This supports our view that data submissions were sporadic

By April 1985, HCFA had concluded that an adequate evaluation of the program's first 3 years could not be conducted because of problems experienced in implementing the demonstration project and the lack of financial and utilization data. HCFA also noted that the lack of utilization data had made it impossible to tell if the cost containment features of the AHCCCS program—competitive bidding, prepaid capitation payments, gatekeeping, and copayments—were working effectively. The actions taken by the state resulted in utilization data being received from all AHCCCS plans, but in HCFA's opinion, significant problems still existed. HCFA said that not all of the plans had corrected deficiencies in their utilization data reporting systems and that plans still needed training in order to report their data completely and correctly.

In June 1985, when granting funding for the AHCCCS demonstration project to continue for another year, HCFA imposed several additional requirements on AHCCCS to help assure more successful utilization data collection. HCFA required AHCCCS to develop a methodology to assess utilization data received from the health plans on an ongoing basis. First, AHCCCS will determine whether a health plan's data submissions are 20 percent below the expected level. If so, AHCCCS is to review a statistically valid sample of the health plan's medical records. If the health plan underreported more than 10 percent of medical services, financial penalties are to be imposed on the plan. AHCCCS was also to commit at least six

full-time staff to the utilization data collection efforts and was required to submit monthly reports on progress made in collecting the data.

Improved Oversight Should Alleviate Data Collection Problems

Problems in obtaining complete utilization data during the program's first 3 years stemmed from three major weaknesses in AHCCCS's oversight of the health plans. Specifically, AHCCCS did not

- establish specific data submission requirements and assess health plans' capability to provide accurate and complete data before awarding contracts,
- provide sufficient technical assistance to health plans, and
- establish and use penalty provisions for noncompliance with the submission requirements.

AHCCCS has made significant improvements in each of these areas to collect reliable and consistent utilization data.

AHCCCS's Procurement Process Did Not Ensure That Health Plans Could Produce Adequate Data

During its health plan procurements in 1982 and 1983, AHCCCS did not thoroughly analyze bidding health plans' ability to generate utilization data and submit them to the state in a usable format. Although AHCCCS initially defined the type of data that would be required, it did not develop technical standards on which the bidders' proposals would be evaluated.

In neither the 1982 nor the 1983 procurement did AHCCCS give bidders explicit minimum standards necessary for the plans to develop management information systems that could generate utilization data. AHCCCS's procurement materials defined an adequate information system as one that would meet contractors' needs to manage the risk and responsibility associated with AHCCCS participation and to meet AHCCCS's reporting requirements. However, AHCCCS did not include minimum technical requirements, provide information on how the data should be formatted, or state how frequently they were to be submitted.

AHCCCS did not report, during preaward site visits conducted in the first year, whether health plans were able to provide utilization data. In the second year, no site visits were conducted to ensure that the bidding organizations were capable of implementing the information systems or providing the required information described in their bid proposals. After reviewing second-year health plan contracts' descriptions of information and reporting systems, HCFA found no consistency in the types of

data health plans were to report to the state. HCFA recommended in September 1983 that each contract be reviewed to assure that the necessary data could be submitted. An AHCCCS official told us, however, that such reviews were not conducted before or after second-year contracts were awarded.

Several factors prevented AHCCCS from fully assessing the health plans' ability to provide compatible utilization data. From the outset, AHCCCS's administrator—MCAUTO—had problems implementing the computer system for AHCCCS. Because the system to process utilization data was not operational when the program began, AHCCCS could not give health plans technical requirements before contracts were awarded.

Also, because seven health plans were new organizations formed solely to participate in AHCCCS, their information systems were in development and had not been tested.

Because AHCCCS did not have time to pilot-test the utilization data system before the program began, many start-up problems caused delays in data collection. For example, AHCCCS noted in its second annual report that the utilization data forms were not filled out the way the state had intended. In most plans, rather than being completed by individual physicians, they were based on adjudicated claims payments or internal systems. Also, because many health plans found paper forms cumbersome to complete, the system offered the option of submitting data via electronic means. However, lack of specific training in data form completion and subsequent computer coding conversion problems led to high rates of rejected utilization data in the program's first 18 months.

Inadequate Technical Assistance Provided to Health Plans

AHCCCS provided limited technical assistance to the health plans in developing data reporting systems. Until July 1984, almost 21 months after the program's start, AHCCCS did not have staff specifically assigned to monitor and assist health plans in submitting data.

During the program's first and second years, inadequate technical assistance provided by the AHCCCS administrator— MCAUTO—hindered the plans' ability to improve their data submissions. Utilization data submitted during AHCCCS's first 18 months were rejected, for failing computerized edits, at a high rate. The state attributed this problem to a lack of training in completing the utilization forms and a lack of specific

instructions given to the health plans for correcting and resubmitting the data failing initial edits.

A review conducted at health plans' sites by AHCCCS's staff initiated in May 1984 revealed additional data problems. According to the site reviewer.

- AHCCCS's management information system was incorrectly rejecting reported services.
- AHCCCS's providers did not have instructions for resubmitting corrected data, and AHCCCS did not have a method for tracking services originally denied
- Many AHCCCS plans had still not developed guidelines for data collection.
- A definition of what services should be reported had not been developed and shared with the health plans.

AHCCCS officials attributed problems to the slow development of the management information system. Originally, AHCCCS's entire system was to be installed as early as March 1983 and be reviewed by HCFA in order to certify it for federal matching funds. However, AHCCCS requested that HCFA postpone its review due to schedule slippage and utilization data collection problems. According to AHCCCS officials, the fee-for-service and member file have now been certified. AHCCCS officials said that the uncertified systems, which account for about 40 percent of the management information system, are the prepaid systems for which HCFA lacks certification standards. The officials said that they are working closely with HCFA in developing the prepaid management information systems.

AHCCCS reported that the system's development was further hindered when AHCCCS terminated its contract with MCAUTO. After the state took over the administrative responsibility of program operations, most of MCAUTO's systems analysts were not hired by AHCCCS. AHCCCS staff could not easily assist health plans with utilization data problems because the state employees were inexperienced with the system and there was a general lack of documentation for the Medicaid Management Information System MCAUTO had been developing.

Not until the third year of the program did AHCCCS's oversight of health plans' utilization data submissions improve substantially. AHCCCS began generating analyses of monthly utilization data submissions of each plan. These analyses, used for both monthly statistical reports to HCFA and feedback to the plans, indicate the

- total number of services reported,
- percentage of data approved and identified for review,
- types of edits causing data to be questioned, and
- time lag between the date of service and date of reporting to AHCCCS.

Penalties Were Not Established

Because prepaid health plans are not paid on the basis of claims submitted, they lack the incentive to submit complete and accurate utilization data that would be present in a traditional fee-for-service Medicaid program. Accordingly, special contract provisions were established to encourage such health plans to comply with submission requirements. The lack of sanctions in the AHCCCS program hindered AHCCCS's ability to collect quality data in a timely fashion during the program's initial years. As the program progressed, AHCCCS made contracts more specific and established financial sanctions.

In the program's first year, health plan contracts stipulated that utilization data would be provided to AHCCCS, but did not condition receipt of monthly premium payments on data submission.

In the program's second year, the contract language was more specific. Monthly premium payments to health plans were conditioned on the state's receipt of accurate and complete monthly reports, including utilization data. However, according to the assistant director of audits and compliance, AHCCCS did not withhold payments to noncompliant health plans.

In October 1984, AHCCCS amended health plan contracts to require that plans submit timely, complete, and accurate data, generally within 2 months of receiving service information from providers. Further, effective December 1984, penalty provisions allowed the health plans to be fined a percentage of their total monthly capitation payments if they do not comply with these contractual requirements. Separate penalties exist for untimely, incorrect, or incomplete data and are recoverable if the plan corrects problems within 2 months. In January 1985, AHCCCS notified two health plans that penalties would be levied unless complete and accurate utilization data were submitted within established time frames. However, according to AHCCCS's encounter unit manager, by the time AHCCCS determined submissions were late, the health plans had submitted data.

Not until the fourth contract year did HCFA condition federal funding on AHCCCS's imposing penalties on health plans that underreport services by more than 10 percent.

Summary

The problems that AHCCCS experienced in obtaining complete and accurate utilization data during the first 2 program years indicate that HCFA should require that, before implementing any prepaid Medicaid program, the state Medicaid agency (1) specify data requirements, (2) evaluate the plans' capabilities to produce needed data, (3) provide technical assistance, and (4) establish penalty provisions for noncompliant plans.

AHCCCS Was Initially Weak in Assessing and Monitoring Health Plans' Financial Performance

Financial difficulties experienced by AHCCCS health plans underscore the need for effective financial oversight by state agencies administering prepaid health care programs. Over the first 3 years of operation, three AHCCCS health plans filed for reorganization under federal bankruptcy laws, and others had significant financial problems. During the first 2 years of the program, AHCCCS exerted limited oversight of the health plans' financial performance and did not

- thoroughly assess the financial viability of health plans bidding on AHCCCS contracts,
- enforce compliance with financial reporting and disclosure requirements, or
- conduct periodic audits of health plans.

During the third and fourth program years, HCFA and AHCCCS increased their efforts to assess and monitor the health plans' financial performance, and their compliance with disclosure requirements improved.

Monitoring AHCCCS Prepaid Health Plans' Finances Is Important

Monitoring the health plans' financial performance is important to assure the AHCCCS program's stability. During the program's first 3 years, health plans assumed financial liability for all emergency and inpatient medical expenses for enrolled AHCCCS beneficiaries up to $20,000 per person, as well as a percentage of such costs exceeding $20,000. In return, the health plan received a uniform monthly payment for each beneficiary enrolled. If a plan does not manage its finances responsibly, providers may not be paid and eventually AHCCCS may be forced to terminate the plan's contract.

One financial management problem for prepaid health plans is maintaining sufficient working capital. Plan income is received on a regular basis, but plan expenses vary from month to month. Many plans pay for services delivered by hospitals and specialty physicians on a fee basis. Typically these bills are received by plans after the service is delivered, resulting in a lag between a month's income and the payment for services delivered that month. This lag between income and bills can make inexperienced plan management feel cash rich and result in too much money being tied up in long-term investments When bills come due, the plan may not have sufficient cash to pay its short-term debts.

A plan must not only manage its cash flow, but also have sufficient assets to cover unforeseen claims. Unless the plan owners or operators have some substantial investment (or equity) in the plan, bankruptcy

involves little personal risk. When owners have made little personal investment, the principal losers from health plan termination are the debtors—those the health plan owes money. In a prepaid health plan, the largest debts often involve hospital and other medical services. Should these bills go unpaid, the program loses credibility among its principal suppliers. As a result, enrollees may have trouble getting services.

Most of AHCCCS's prepaid health plans had no previous experience in providing medical services on a prepaid basis, so financial oversight was important. Only 2 of the 17 first-year AHCCCS plans had previously provided health care services as private sector prepaid health plans. Seven of the health plans were organized solely to participate in the AHCCCS program.

AHCCCS Health Plans Encounter Financial Difficulties

As the AHCCCS program progressed, many health plans faced financial problems. An analysis conducted by Peat, Marwick, Mitchell and Company (Peat Marwick) under an AHCCCS contract showed that for the 18 months ended March 1984, excluding CIGNA Health Plan of Arizona, the health plans' aggregate expenses exceeded their revenues.[1] Five of the 19 health plans surveyed, treating about 33,000 AHCCCS enrollees, had net losses totaling about $5 million. Fifteen of the health plans had less than 1 month's payments in reserve, while the amount of claims they owed equaled 3 months of expected future state payments. AHCCCS officials said that the start-up problems experienced by AHCCCS plans were not unlike those experienced by new HMOs during their first years of operation.

More extensive financial difficulties were faced by three AHCCCS health plans. In September 1984, the plan with the most AHCCCS members, Arizona Family Physicians IPA, filed for financial reorganization under federal bankruptcy laws because it was not able to pay its debts as they became due. AHCCCS allowed the company to continue to provide services to AHCCCS enrollees.

Another large health plan—Health Care Providers—had its contract terminated by AHCCCS in April 1985 because of an inability to pay its debts. There were indications that Health Care Providers had been

[1]CIGNA Health Plan of Arizona, Inc., was excluded from this aggregate analysis because of its large size in comparison to other AHCCCS plans. CIGNA is a federally qualified HMO. Only 1 percent of its members were AHCCCS enrollees. Moreover, its revenues were equal to almost 50 percent of the remaining AHCCCS health plans' aggregate revenues.

plagued by financial difficulties for some time. In March 1984, AHCCCS reported the results of a limited financial review of the plan, identifying several areas of concern. AHCCCS suspended enrollment into the plan for 1 month while Health Care Providers attempted to correct deficiencies. In September 1984, another public accounting firm reported that an examination of the plan's financial statements indicated that the plan might be unable to remain in existence. Also, Peat Marwick's financial review showed that, as of March 1984, Health Care Providers' expenses exceeded its revenues by about $2.3 million, possibly a conservative estimate because the plan did not have sufficient data to identify the extent of its outstanding claims Rather than allowing this plan to continue participating after it reorganized under bankruptcy laws, AHCCCS terminated its contract on April 1, 1985, and enrolled affected beneficiaries in other health plans available in the applicable geographic areas.

A third health plan—Western Sun, Inc.—also filed for bankruptcy due to financial management difficulties. In July 1985, AHCCCS terminated its contract and enrolled affected beneficiaries in other health plans.

According to AHCCCS officials, AHCCCS enrollees never faced difficulties in obtaining services when plans were terminated because of efforts to transfer the enrollees into other plans.

Health Plans' Finances Not Thoroughly Assessed Before Contract Award

In evaluating health plan proposals to participate in the program's first and second years, AHCCCS did not establish specific standards or criteria to assess their ability to perform in a financially responsible manner. AHCCCS neither required sufficient financial information from health plans to be able to evaluate their financial condition nor established criteria by which to judge their financial soundness. In its fourth-year procurement, AHCCCS improved its ability to evaluate health plans' financial viability by setting financial goals for prospective bidders and requiring bidders to submit more information on their financial condition.

Little Financial Information Required of Bidders

AHCCCS did not require that bidding health plans be certified as prepaid health plans or federally qualified HMOs. Instead, AHCCCS's procurement process, including evaluating proposals and ranking bids according to price, served as the means by which bidders were determined to be qualified providers. According to AHCCCS officials, the emphasis during the first 2 program years was on development of networks to deliver health care services.

For its first two procurements of health plans, AHCCCS required less information on financial performance and capability than other organizations that evaluate health care service organizations. For example, AHCCCS did not require as much information as either HHS's Office of HMOs, which qualifies HMOs for federal aid and participation in various programs, or Arizona's Department of Insurance, which certifies health care service organizations[2] to operate businesses in the state.

To evaluate first- and second-year bidders' financial viability, AHCCCS required them to submit a financial plan, "proof of adequate financial resources," and a description of risk sharing and compensation arrangements with subcontractors. Bidders were also required to provide evidence of professional liability insurance and a description of reinsurance arrangements

The Office of HMOs and Arizona's Department of Insurance required more specific data from organizations in order to evaluate their financial condition. Such data included

- a description of financing arrangements,
- statements of accounting and budgeting standards and procedures, and
- a copy of certified financial statements

In addition to the above, these agencies require applicants to show how they will (1) account for costs that are incurred but not reported, (2) market services, and (3) provide services in the event of financial insolvency. The Office of HMOs also requires certified annual statements of guarantors and lendors.

Standards Not Set

AHCCCS did not establish financial standards for bidding health plans in either the first- or second-year procurements. For example, although AHCCCS cited financial viability as one criterion by which plans would be evaluated, the bid evaluation materials did not include standards or definitions of financial viability Similarly, although the solicitation stated that bidders must demonstrate that they have sufficient financial resources and an adequate financial plan, bid evaluation materials included no criteria to assess the adequacy of financial resources or plans. For example, the bid evaluation materials set no limits or ranges,

[2]A health care service organization is one that contracts with private sector employers to provide health care services on a prepaid basis

such as minimum capital required, by which a plan's financial position could be evaluated

To illustrate further, a 1982 bid evaluation checklist required each member of the bid evaluation team to examine a bidder's financial information and analyze whether it indicated any potential financial difficulties during the contract period However, the checklist did not provide criteria to be used in evaluating revenue and expense projections. Similarly, the 1983 bid evaluation checksheet asked if the bidder's proposal provided evidence that its financial resources were acceptable for participating in the AHCCCS program, but did not indicate what level of financial resources would be considered acceptable.

Past Performance Not Considered in Awarding Second-Year Contracts

AHCCCS decided not to use information about providers' first-year performance in its evaluation of second-year proposals. AHCCCS did this in order to give health plans not participating in the first year an incentive to bid However, as a result, AHCCCS did not use information that may have helped it evaluate the financial information in the proposals and the reasonableness of proposed bid rates. Also, AHCCCS's auditors, who had responsibility for assuring the financial solvency of contracting health plans, did not participate in the bid evaluation process. From both a financial and a contract compliance perspective, they may have provided useful input to the bid evaluation process.

Financial Standards and Information Requirements Improved for Fourth-Year Procurement

AHCCCS expanded the criteria by which it evaluated fourth-year health plans' financial status by setting financial performance goals and increasing information requirements. Each bidder must now use several financial measures to summarize its financial condition based on its most recent audited financial statement. Bidders must also submit a written description of their planned improvements to their performance over the 2-year contract period. AHCCCS set several financial measures and target levels, as shown in table 4.1.

Table 4.1: AHCCCS Financial Measures and Target Criteria

Measure	Target criteria
Working capital ratio[a]	At least 0 60
Equity per enrollee	At least $100
Medical costs as a percentage of capitation revenues	Not more than 90%
Administrative costs as a percentage of capitation revenues	Not more than 10%
Lag between receipt of subcontractor claim and health plan payment	Not more than 90 days

[a]A working capital ratio is current assets divided by current liabilities The ratio is an approximate measure of a company's liquid resources and can constitute a margin of safety for paying short-term debts

In addition, AHCCCS required bidders to submit

- copies of the most recent financial statements, if available;
- a description of accounting procedures for costs that are incurred but not reported;
- an explanation of factors used to develop bid rates; and
- an explanation of key aspects of their accounting systems.

AHCCCS also required that bidders submit financial data for subcontracting with management firms. AHCCCS officials believe that the measures will provide enough information so that the financial condition of the health plans can be assessed before contract award and monitored throughout the contract period.

Noncompliance With Financial Reporting Requirements

Financial reports needed for AHCCCS to monitor health plans' financial performance were not generally submitted by plans during the first 2 years of the program. The state has taken a series of actions to address this problem. By the spring of 1985, compliance had improved substantially.

Financial Reporting Requirements

For the first 7 months of the program, AHCCCS did not set specific financial reporting requirements for contracting health plans. Although the 1982 RFP required health plans to submit financial information to AHCCCS, it did not specify what the format of reports was to be or when they were to be submitted.

In May 1983, AHCCCS began requiring contracting health plans to submit periodic financial statements. Patterned after HHS's reporting requirements used to collect information on HMOs' fiscal performance and financial operations, the statements require:

- quarterly and annual statements of revenues and expenses, balance sheets, and statements of changes in financial position;
- quarterly statements of lags in physician, hospital, and other medical service charges;
- annual ownership and financial disclosure statements; and
- annual independently audited financial statements.

Compliance With Reporting Requirements Is Improving

In June 1984, we testified that AHCCCS's health plans had not generally complied with the financial reporting requirements. For example, plans had submitted only 37 percent of required quarterly financial statements for the first year and 46 percent for the second.

Since then, AHCCCS has improved its oversight of health plans' compliance with financial reporting requirements. For example, AHCCCS's fourth-year contracts specify the plans' financial reporting requirements, as well as the financial penalties for failure to meet them. Also, in January 1985, AHCCCS began issuing reminders and warnings to plans that had not submitted all required financial reports.

By the spring of 1985, compliance had improved substantially. For example, as of March 1985, all but 4 of 18 plans had submitted certified financial statements for first-year operations. Nine of the 18 third-year AHCCCS plans promptly submitted the certified financial statements that were due by December 31, 1984. By March 1985, 13 of 18 plans had submitted required quarterly financial statements, and 17 had submitted claims aging reports.

To further improve compliance, AHCCCS designed a financial sanction for noncompliant plans. Beginning in October 1985, AHCCCS said it would withhold 10 percent of each month's payment for plans delinquent in filing financial reports until the data were submitted. Plans would not be entitled to receive interest on the withheld amounts.

Analysis and Audits Needed to Monitor Plans' Performance

AHCCCS has acted to increase its oversight of health plan financial operations. Until the Peat Marwick financial and compliance review was released in August 1984, AHCCCS did not have sufficient information to target areas for specific analysis. In 1985, AHCCCS began to systematically follow up with health plans and planned to conduct contract compliance audits to assure that plans meet their contractual obligations and maintain their financial viability.

Need for Analysis of Financial Reports and Periodic Audits

In January 1985, AHCCCS began to analyze financial reports received from health plans to monitor their financial status and to target areas for future review Because of health plans' poor compliance with reporting requirements and because AHCCCS did not conduct periodic audits of health plans,[3] the Peat Marwick report completed under a state contract in August 1984 gave AHCCCS its first comprehensive picture of the magnitude of the financial difficulties being experienced by many AHCCCS health plans. Until January 1985, AHCCCS's audits and compliance division had tracked health plans' compliance with financial reporting requirements (i.e., how many health plans submitted required reports) but had not used the reports' information to identify problems or monitor financial trends.

According to Peat Marwick's review of the 19 health plans contracting with AHCCCS during its first 2 years of operations,

- 11 had insufficient budgeting systems,
- 10 had insufficient accounting systems,
- 7 had untimely and incomplete financial data, and
- 11 had improper methods of estimating incurred but not recorded liabilities.

Responding to these findings in January 1985, AHCCCS required its health plans to submit corrective action plans and began to systematically follow up with the plans to determine whether problems were being corrected. AHCCCS also increased the staff of its audits and compliance division and rewrote its rules and regulations to require the plans to submit certified annual audits.

HCFA Acts to Improve State Oversight

We previously reported that some AHCCCS health plans did not comply with federal disclosure requirements intended to determine the appropriateness of ownership and control arrangements and related-party transactions.[4] Of the 19 health plans awarded AHCCCS contracts in the second year (1983-84), 3 did not disclose direct or indirect ownership, and 3 did not disclose officers or directors. Further, 18 contracts were renewed for the third program year without assuring compliance with disclosure requirements. We also found that AHCCCS plans did not disclose 64 percent of related-party transactions requiring disclosure under

[3]Only one on-site health plan audit was conducted during the program's first 18 months

[4]Arizona Medicaid Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov 22, 1985)

federal regulations. Only 4 of the 11 plans that submitted financial disclosure statements disclosed all of the related-party transactions that should have been disclosed.

In June 1985, we briefed HCFA officials on AHCCCS's continued problems in enforcing compliance with financial reporting and disclosure requirements and the limited review and audit of financial performance Subsequently, HCFA conditioned approval of a 1-year extension of the AHCCCS program on AHCCCS's agreeing, among other things, to

- submit quarterly progress reports to HCFA on submission of financial reports by AHCCCS plans;
- impose financial penalties on individual health plans not complying with the data collection requirements;
- obtain from each provider, before contracting, full disclosure of ownership and control and related-party transactions in order to receive federal funding;
- conduct annual financial audits of plans; and
- submit the results of these audits to HCFA immediately upon completion.

Summary

Financial oversight by HCFA and the state was not adequate in the early years of the AHCCCS program. In particular, AHCCCS plans neither complied with federal financial disclosure requirements nor filed state-mandated financial reports. As a result, HCFA and the state had little assurance that AHCCCS plans were financially qualified to deliver the needed health services. Eventually, two plans reorganized under federal bankruptcy laws, and another's contract was terminated.

Lessons Learned in Arizona: Implications for Other Prepaid Health Programs

Experiments with prepaid health care are not limited to Arizona's AHCCCS program. Other states, including Kentucky, California, Wisconsin, and Pennsylvania, have experimented with prepaid health care, and still others, such as Nevada, have considered establishing prepaid health care systems. While AHCCCS is currently the only statewide Medicaid prepaid health program, Pennsylvania's recently established health insuring organization in Philadelphia is expected to serve about the same number of Medicaid beneficiaries as AHCCCS

The problems Arizona faced in developing and implementing AHCCCS will likely confront other states developing prepaid health programs As a result, AHCCCS provides a good case study of the lessons learned in the development of a Medicaid prepaid health program that should prove useful to HCFA and other states in developing and monitoring similar programs. This chapter summarizes the problems discussed in chapters 2 through 4 and additional problems identified during this and our earlier work on the AHCCCS program. As financial and utilization data become available to permit an assessment of AHCCCS's cost effectiveness and effect on Medicaid beneficiaries' access to quality health care, additional lessons will likely be learned

Lesson 1: Develop Program Controls Before Implementation

Sufficient time should be allowed between program authorization and implementation to permit development of adequate financial and utilization reporting systems and program controls.

Arizona went from having no Medicaid program to having a statewide prepaid health program in 10 months, a significant accomplishment. The private administrator was selected only 4 months before the program began. MCAUTO and Arizona staff did not have sufficient time to develop adequate financial and utilization reporting systems or requirements. AHCCCS did not conduct evaluations of whether bidding health plans were capable of providing utilization data. The program began while the management information system was still in early development. Further, because of limited time, AHCCCS awarded several contracts contingent upon correction of contractor deficiencies—such as too few physician specialists If Arizona had allowed more time between authorization and implementation, it could have waited to award contracts until health plans had corrected the deficiencies—helping to ensure that contractors were responsive and able to provide a full range of services

Lesson 2: Anticipate Failures and Develop Contingency Plans

Plan failures should be anticipated and contingency plans developed to provide uninterrupted services to Medicaid beneficiaries.

During the first 3 years of the AHCCCS program, three prepaid health plans, including two of the largest, experienced extensive financial difficulties. Financial problems are not uncommon in new HMOs. AHCCCS terminated the contracts of two of the plans and enrolled their beneficiaries in other plans According to AHCCCS officials, this was accomplished with no interruption of services because adequate backup capacity was ensured through the procurement process and contingency plans had been developed to permit a smooth transition.

Lesson 3: Design Procurements to Maximize Competition and Savings

Health plan procurements should be designed to promote maximum competition and cost savings

Arizona obtained the physician community's participation in AHCCCS by awarding multiple contracts in most service areas. According to AHCCCS officials, the program has achieved its goal of increasing Medicaid beneficiaries' access to the mainstream delivery system by achieving a much higher physician participation rate (67 percent) than in other states (20 percent). The awarding of multiple contracts, however, complicated the use of sealed-bid procurement. Normally under a sealed bid procurement, bidders have an incentive to submit the lowest possible bid because only one contract will be awarded. AHCCCS, however, awarded multiple contracts at significantly varying prices to different health plans treating the same beneficiary population in the same county. Because AHCCCS did not establish limits on the number of contracts to be awarded, bidders had little risk of not receiving a contract and had less incentive to submit their lowest possible bids. Moreover, because Arizona requested bidders to voluntarily reduce their prices and publicized all original bids, bidders had an incentive to inflate their bids in future years in anticipation of such a request.

Lesson 4: Establish Requirements for Financial Viability

Minimum requirements should be established to demonstrate the financial viability of prepaid health plans

AHCCCS did not establish specific financial standards, such as limits or ranges by which the plans' financial positions could be evaluated. A number of AHCCCS health plans faced financial difficulties, and a financial review revealed that most of these organizations did not have adequate accounting and budgeting systems. For the third procurement,

AHCCCS set several financial performance goals and expanded its informational requirements to help ensure that health plan operations are financially able to weather the risks of prepaid health care

Lesson 5: Penalize Plans Violating Reporting Requirements

Penalties for noncompliance with financial and utilization reporting requirements should be established and administered

Prepaid health plans have less of a financial incentive to provide medical utilization information than physicians or hospitals providing care on a fee-for-service basis. Fee-for-service physicians are generally paid by submitting a claim that includes both medical service and charge information. In contrast, prepaid providers are paid a set amount in advance, regardless of the type and amount of medical services they are providing.

In the program's first 18 months, AHCCCS's health plans generally did not submit financial and utilization information promptly, if at all Accordingly, Arizona found that financial penalties were necessary to enforce reporting requirements. Although the state could withhold a plan's entire payment for reporting noncompliance, this was a last resort and could interfere with health care delivery. AHCCCS designed financial sanctions to withhold a portion of capitation payments, recoverable when delinquent information was submitted. Rather than a fixed dollar amount, the penalty is a fixed percentage of the total capitation payment so that small plans are not disproportionately penalized. After workable financial sanctions were in place, compliance improved. as of March 1985, most health plans were submitting financial reports and utilization data as required.

Lesson 6: Evaluate Propriety of Financial Arrangements

The appropriateness of ownership and control arrangements and related-party transactions should be determined to prevent the diversion of program funds from their intended purpose—the provision of health care.

In 1977, the Congress enacted Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, to prevent and detect fraud and abuse in government health care programs Specifically, sections 1124 and 1902(a)(38) of the Social Security Act were added to strengthen disclosure requirements and provide an additional audit tool for project managers and auditors to help control program payments involving related organizations.

These statutory provisions were enacted after our reviews of a prior Medicaid experiment with prepaid health plans in California disclosed that nonprofit, tax-exempt health plans were subcontracting with related for-profit providers, enabling funds to be diverted from the provision of needed health care.[1] In that program, many of the prepaid health plans were nonprofit corporations that contracted for needed services with for-profit corporations that were created by, or involved ownership interests on the part of, directors or officers of the nonprofit entities

Related-party transactions within these corporate structures can enable health plans to divert capitation funds from their intended purpose—the provision of health care. They can lead to unnecessary administrative costs and excessive profits. Underservicing of the Medicaid population may occur if capitation payments are used to pay unnecessary administrative costs or excessive profits to related parties rather than to provide medical care services For example, we reported in 1976 that a California prepaid health plan retained 5 percent of the Medicaid funds for internal expenses, while the remainder flowed to affiliated for-profit firms. One firm, which provided administrative and management services to the plan, derived about 41 percent of its revenues from the plan and realized an 18 5-percent profit on its revenues.

HCFA regulations state that a Medicaid agency must require health care providers to identify each person with an ownership or control interest in a health plan Information on certain related-party transactions must also be disclosed to the state or HCFA upon request. In our November 1985 report we stated that some AHCCCS health plans did not comply with these requirements although they conducted significant financial transactions with related parties. HCFA and AHCCCS did not enforce compliance with disclosure laws Specifically, they did not terminate contracts or withdraw federal funding from contractors who did not disclose relationships or financial transactions with related parties

Lesson 7: Monitor Financial Performance

Adequate resources should be devoted to monitoring the financial performance of prepaid health plans, including assigning staff to fraud and abuse investigations.

[1]Better Controls Needed for Health Maintenance Organizations Under Medicaid in California (B-164031(3), Sept 10, 1974), Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program (MWD-76-15, Aug 29, 1975), and Relationships Between Nonprofit Prepaid Health Plans With California Medicaid Contracts and For-Profit Entities Affiliated With Them (HRD-77-4, Nov 1, 1976)

We noted ownership and control arrangements in participating AHCCCS plans similar to those identified in the California experiment previously mentioned. For example, one AHCCCS health plan that did not disclose ownership and control arrangements, Health Care Providers of Arizona, Inc., was tied to 10 other firms in which its owners had a controlling interest. AHCCCS terminated the contract with Health Care Providers in April 1985 because the plan could not meet its outstanding liabilities

In response to our November 1985 report, Arizona took several actions to ensure that health plans made full disclosure in the fourth year (Oct 1985-Sept. 1986). Specifically,

- the RFP addressed the federal disclosure requirements,
- all health plans were required to complete ownership and control and related-party transaction forms before receiving a contract,
- the state attorney general's office agreed to perform a criminal-history check on every owner and executive of an AHCCCS plan, and
- AHCCCS audit staff have been directed to visit each health plan in the beginning of the new contract year to review related-party transactions.

In AHCCCS's first 18 months, financial data on health plan contractors were not promptly submitted or analyzed. Periodic on-site audits were not conducted to identify and correct problems in health plan financial operations. Subsequently, Arizona increased the audit professional staff, established a standard audit guide for health plans, and required an annual certified audit from each health plan. AHCCCS also established a fraud and abuse investigation unit, staffed with law enforcement professionals.

The 1985 annual report prepared by the Arizona attorney general's AHCCCS fraud investigation and prosecution unit states that the unit is pursuing allegations of fraud in the operation of three AHCCCS health plans. According to the report, the investigations are primarily focused on patterns of criminal activity involving kickbacks, embezzlement, false claims to the government, willful concealment from the government, and illegal control of an enterprise (racketeering).

According to the annual report:

"The AHCCCS Fraud Unit's largest and most complex case involves the State's largest health plan, with 30 to 35 million dollars in losses Our evidence indicates that certain highly placed corporate officials of the health plan used their positions to divert corporate funds into various accounts of corporations owned or controlled

by those officials These funds were distributed to the officials and to others, sometimes under the guise of consulting fees, and sometimes as outright embezzlements A sizeable portion of these funds were paid to the principals as kickbacks, in a fashion similar to racketeering activities surrounding the Teamsters Welfare Fund and its health care related business "

Lesson 8: Establish Procedures for Prompt Enrollment

Procedures should be established for prompt enrollment of Medicaid beneficiaries in a health plan.

Although the eligibility and enrollment processes are closely related, they are handled by separate agencies and frequently take place at different times. Arizona's department of economic security determines AFDC eligibility. The Social Security Administration determines SSI eligibility. Those eligible for AFDC or SSI benefits are automatically eligible for AHCCCS benefits, but are not enrolled in an AHCCCS health plan until information is relayed to the AHCCCS administrator and the patient chooses, or is assigned to, a health plan.

Arizona's counties determine eligibility for AHCCCS's state-sponsored medically needy/medically indigent population based on an applicant's income and assets. The information is then given to AHCCCS, which begins its enrollment procedure. Until May 1984, AHCCCS allowed medically needy/medically indigent individuals to choose a health plan. In May, AHCCCS began to assign medically needy/medically indigent eligibles to a health plan through a computerized algorithm to expedite health plan enrollment.

In Arizona the delay between eligibility and enrollment was substantial. During the program's first year, AHCCCS bore a heavy cost burden for the medically needy/medically indigent population partly due to a significant lag between the beneficiaries' eligibility determination and their health plan enrollment—an average of 46 days in fiscal year 1983. The delays were caused by the number of entities participating in the eligibility and enrollment processes· counties, state, and federal agencies all had a role in determining eligibility and/or enrollment.

Although AHCCCS has succeeded in decreasing the length of time between eligibility and enrollment, the delay for SSI and AFDC recipients remains significant. Pilot-testing of the enrollment system should enable other states to minimize delays.

Lesson 9: Budget for Fee-Basis Costs Before Enrollment

Fee-basis costs should be budgeted for during the period between application for Medicaid coverage and enrollment in a prepaid health plan.

After a beneficiary is enrolled in a prepaid health plan, Arizona's liability is limited to a constant monthly premium, unless medical expenses exceed $20,000 per year. However, between the time a beneficiary applies for Medicaid and the time he or she is actually enrolled in a prepaid health plan, the state remains liable for the beneficiary's health care costs. Such costs are paid on a fee basis.

AHCCCS paid $35.8 million, or about 33 percent of its total program expenditures, in fee-basis claims during fiscal year 1983. Medically needy/medically indigent beneficiaries are high users of care around the time eligibility is determined. AHCCCS officials believe that the costs of the medically needy population are high because they apply for state assistance for immediate medical needs—many are already receiving emergency medical services. In contrast, AFDC and SSI beneficiaries become Medicaid eligible because they qualify for the cash assistance provided by those programs, not because of immediate medical needs The resulting cost to the state is substantial. For example, in September 1984, AHCCCS paid Medicaid providers an average of $7.81 per day, or about $234 a month, in fee-for-service claims for each medically needy/medically indigent individual. It paid Medicaid providers an average of $1.19 a day, or about $36 a month, in fee-for-service claims for each federally eligible beneficiary.

Over the first 2 years of the program, AHCCCS paid about $17 million in fee-basis claims for federally eligible beneficiaries, partly because of delays in eligibility determinations beyond its control. For example, AHCCCS could not control the lag between application for AFDC or SSI eligibility and the eligibility determination, an average of 45 days for AFDC beneficiaries, 25 days for SSI-Aged, and 75 days for SSI-Disabled and SSI-Blind. However, AHCCCS was liable, on a fee basis, for medical care costs incurred during these time periods.

Another portion of AHCCCS's fee-basis liability was due to a federal requirement that Medicaid coverage extend to AFDC and SSI beneficiaries who incurred medical expenses during the 90 days before applying for benefits and would have been eligible for benefits during that time AHCCCS does not maintain statistics on the amount of fee-basis claims attributed to this retroactive eligibility. However, an eligibility

researcher at the Social Security Administration estimated that 15 percent of SSI applicants in Arizona apply for retroactive eligibility to pay medical claims.

Lesson 10: Adapt the Medicaid Management Information System to Detect Underservicing

The Medicaid Management Information System should be adapted to provide utilization data necessary for monitoring a prepaid health program.

Under a fee-for-service Medicaid program, the information system is based on paid claims data showing both the services provided and the charges for those services. As stated on page 30, providers have an incentive to submit prompt and accurate claims in order to obtain payment. Because the incentives under a fee-for-service system are to overuse services to increase reimbursement, the information system is geared primarily toward detecting unnecessary services.

In a prepaid health program, however, providers have opposite incentives. They receive a fixed monthly payment regardless of the types and number of services provided. Accordingly, the Medicaid Management Information System should be directed toward detecting underservicing. As of July 1986, however, HCFA did not have standards for a prepaid information system, and AHCCCS was encountering many difficulties in trying to develop one. Only the fee-for-service portion of AHCCCS's system has been certified. The prepaid portion is being redeveloped, and AHCCCS does not expect it to be fully operational until June 1988

Lesson 11: Design Adequate Systems to Report Utilization Data

An utilization data reporting system adequate to obtain consistent, accurate data from contracting health plans should be designed

During its first 3 years, AHCCCS did not test the accuracy and completeness of utilization data Because AHCCCS did not have a means to estimate how many services each health plan should have provided, data completeness was unknown. Furthermore, AHCCCS did not perform reviews to determine whether the data received were reliable and consistent. At HCFA's urging, AHCCCS contracted with a private consulting firm to conduct a thorough review of data collection activities. The firm constructed a data validation method that AHCCCS plans use periodically to determine data accuracy and reliability.

Conclusions, Recommendations, and Agency Comments

Conclusions

In October 1986, the Congress enacted legislation requiring the Secretary of HHS to review and approve contracts over $100,000 before states award them to entities providing services to Medicaid beneficiaries on a capitated or risk basis. To help ensure that the lessons learned from AHCCCS are applied to future prepaid health plan contracts, HCFA should review such contracts to determine, among other things, whether the Medicaid agency has (1) provided for adequate price competition in the procurement process, (2) set adequate financial and utilization reporting requirements and penalty provisions for nonreporting, (3) reviewed the contractors' financial solvency, (4) enforced compliance with federal requirements for disclosure of ownership information, and (5) reviewed the contractors' ability to meet reporting requirements and provided technical assistance to contractors when needed.

Recommendations

We recommend that the Secretary of HHS, in establishing regulations to implement the preapproval provisions of the Omnibus Budget Reconciliation Act of 1986, develop criteria to be used in evaluating the adequacy of price competition and the reasonableness of contract prices.

We also recommend that the Secretary develop guidelines for reviewing contracts that provide for an assessment of, among other things, whether the Medicaid agency has

- adequately specified utilization and data reporting requirements,
- evaluated prepaid health plans' capabilities to produce timely and accurate utilization data,
- established procedures for providing technical assistance to health plans in meeting the reporting requirements,
- established adequate penalties for noncompliance with the reporting requirements,
- specified routine financial reporting and disclosure requirements in the contract,
- reviewed the financial qualifications of the proposed contractors, and
- determined that federal financial disclosure requirements have been met.

In addition, the guidelines should condition renewal or extension of contracts on adequate financial oversight of the contractors by the state Medicaid agency.

HHS Comments and Our Evaluation

Overall Comments

HHS (see app I) agreed that there are many lessons to be learned from the mistakes in administration and start-up that were experienced by AHCCCS and said that, except for a few minor issues, it agrees with the lessons learned presented in chapter 5. HHS said, however, that it found major noteworthy problems with the bulk of the rest of the report. HHS said our report

- relies on the experience of an experimental program in Arizona to draw conclusions and make recommendations for other states that have very different experiences and rules for operating prepaid programs;
- recommends the establishment of broadened, and in its view "intrusive," standards for regulating state prepaid programs; and
- does not recognize the efforts by HCFA and the state to review the AHCCCS program.

We disagree fundamentally with HHS's characterization.

Drawing Conclusions Based on AHCCCS

HHS said that our findings concerning the AHCCCS program do not provide a sound basis for recommending changes in policies for approving prepaid health plan contracts in other states. The report's recommendations are made, according to HHS, without the benefit of specific and factual comparisons to actual experience in other states.

Medicaid rules and regulations governing the areas covered by our recommendations—procurement, utilization reporting, and financial viability—were not waived for the AHCCCS program, but they were not always followed. While our report does not provide specific data on the experience with prepaid health plans in other states, the prior approval requirements of the Omnibus Budget Reconciliation Act of 1986 apply to contracts with prepaid health plans in all states. Our recommendations are intended to help HHS fulfill its responsibilities under the act by identifying those Medicaid requirements that HHS should focus on during the review process. The lessons learned, which HHS agrees other states should consider in establishing prepaid health plans, address the same areas covered by the review guidelines we recommend. In applying the guidelines, HHS would, in effect, be determining whether other states

have learned from the problems experienced in Arizona. Applying the knowledge gained through an experimental program to other programs is, in our opinion, the ultimate objective of an experiment. Implementation of our recommendations should accomplish that objective

Finally, we agree with HHS's position that some of the problems experienced in Arizona could have been avoided had it not waived many of the rules and regulations governing other prepaid health plans. The rules and regulations governing prepaid health plans that were waived for AHCCCS did not, however, include those dealing with procurement standards, utilization and financial reporting, and financial disclosure—the problems discussed in this report.

Establishment of Prior Approval Requirements

According to HHS, our recommendations repeatedly suggest that HHS tak action to implement the prior approval requirements of the Omnibus Budget Reconciliation Act of 1986 by using broadened and "intrusive" standards for regulating the state operating systems and policies. Many of our recommendations would, HHS maintains, unduly burden state flex ibility to contract with prepaid entities, increase costs, and create obsta cles to cost-effective contracting arrangements within states HHS also said that some of the recommendations may exceed the authority the Congress gave HCFA to establish standards for organizations contracting under Medicaid.

Contracting for Medicaid services on a prepaid basis does not relieve either HCFA or the state Medicaid agency of its basic responsibility to ensure that federal funds are not misspent and that Medicaid recipients have access to quality care. Our recommendations are intended to help HHS fulfill its responsibilities under the new prior approval requirement of the Omnibus Budget Reconciliation Act, not to establish new requirements for contracts with prepaid health plans. The problem in Arizona was not that existing requirements were not adequate but that they were not followed. Our recommendations are intended to establish an internal control system so that future prepaid health plan contracts are awarded in accordance with federal requirements.

Medicaid contracting and financial disclosure regulations specify that the state Medicaid agency is responsible for ensuring that prepaid health plan contractors

- are financially responsible and have adequate protection against insolvency,

- are subject to a system of medical audits that collect management data on the use of Medicaid services,
- provide assurances that they are furnishing health services required by enrolled recipients,
- are paid on an actuarially sound basis,
- comply with federal ownership and control disclosure requirements, and
- are awarded contracts in accordance with OMBprocurement standards.

These requirements were not waived for the AHCCCS program.

HCFA has an oversight responsibility to determine whether the state has adequately fulfilled its responsibilities under contracts with prepaid health plans. The prior approval requirements for the Omnibus Budget Reconciliation Act of 1986 require that HHS review prepaid health plan contracts in excess of $100,000 before they are awarded.

The Federal Managers' Financial Integrity Act of 1982 requires executive agencies to establish and maintain systems of internal controls to reasonably ensure that

- obligations and costs comply with applicable law;
- all assets are safeguarded against waste, loss, unauthorized use, and misappropriation; and
- revenues and expenditures applicable to agency operations are recorded and accounted for properly so that accounts and reliable financial and statistical reports may be prepared and accountability of the assets may be maintained.

The internal control standards we developed for executive agencies to follow include a requirement that the internal control systems provide reasonable assurance that the systems' objectives will be accomplished. Reasonable assurance equates to a satisfactory level of confidence under given considerations of costs, benefits, and risks

In our opinion, approving contracts with prepaid health plans without first determining whether the Medicaid agency fulfilled its responsibilities under the regulations with respect to financial operations, utilization reporting and quality assurance, and procurement procedures does not provide the reasonable assurances called for under the act. The review guidelines we recommend would provide a framework for making such determinations.

Recognizing HCFA and State Efforts

HHS said our report was developed without recognizing the extensive efforts by HCFA, the state of Arizona, and HCFA's evaluation contractor t conduct a rigorous review of the AHCCCS program. HHS said that while the report indicates at times that the state took corrective action, overal it is unfairly biased and misleading in that it fails to acknowledge HCFA's effort to correct deficiencies in Arizona and to issue reports on its findings.

We recognize throughout the report the actions HCFA and Arizona have taken to improve the AHCCCS program For example, on page 26, we note that HCFA and AHCCCS began several initiatives to collect needed utilization data; on page 30, that AHCCCS officials were working closely with HCFA in developing the prepaid management information system, on page 32, that HCFA conditioned federal funding for AHCCCS's fourth contract year on its imposing penalties for underreporting of utilization data; on page 34, that HCFA and AHCCCS had increased their efforts to assess and monitor health plans' financial performance, and on page 41 that HCFA had acted to improve state oversight of compliance with federal ownership and control disclosure requirements

It should be noted, however, that most of the significant actions taken t improve oversight occurred after we testified in June 1984 that accurat and complete utilization and financial data were not being reported and after we reported in November 1985 on the nondisclosure of ownership information by AHCCCS health plans.

Evaluating Price Competition

Concerning our recommendation that it develop criteria to evaluate the adequacy of price competition and the reasonableness of prices, HHS sai that it agreed that fostering price competition is a reasonable objective and that the Secretary should develop criteria to evaluate the adequacy of procurement systems. HHS said that it did not agree, however, that always limiting award of contracts to the lowest bidder is the best way to achieve this goal. AHCCCS, HHS said, established as few barriers to potential bidders as possible to (1) promote development of AHCCCS health plans in rural areas where there was concern that few, if any, bids would be received; (2) provide beneficiaries and providers as muc freedom of choice as possible; and (3) foster the long-term competitive market.

We agree with the AHCCCS program's goal of promoting maximum healt plan participation and freedom of choice and did not suggest that contracts be awarded only to the lowest bidder As stated on page 20, the

alternate strategy we developed for setting a limit on the number of contracts to be awarded generally gave beneficiaries and providers a choice of health plan. The primary difference between our approach and that taken by Arizona is that we would condition participation by a second (or third) contractor on their willingness to provide services at a price comparable to that submitted by the lowest qualified bidder. We do not believe AHCCCS should award contracts at a rate above the equivalent fee-for-service costs, if other contractors are available to provide services to the Medicaid population at rates below the fee-for-service equivalent.

The Medicaid requirement that risk-based contracts with prepaid health plans not be awarded at a rate that exceeds fee-for-service costs was, however, waived for the AHCCCS program. As a result, 6 of the 32 first year contracts were awarded at a composite rate that exceeded the costs Arizona said it would have experienced under a fee-for-service program. In five of the six cases, all other qualified bidders in the counties involved were awarded contracts at composite rates below the projected fee-for-service costs In the sixth case, only one qualified health plan submitted a bid and was awarded the contract at a rate that exceeded projected fee-for-service costs.

In 9 of the 15 Arizona counties, recipients and providers had a choice of only one (four counties) or two (five counties) health plans during the second program year HHS's comments did not, however, mention the limited freedom of choice offered to recipients and providers in those counties

Finally, while awarding contracts at prices that exceed estimated fee-for-service costs may encourage the development of new health plans to take advantage of the government's generosity, it does not, in our opinion, help develop a competitive market. In a competitive market, providers have an incentive to keep their costs low in order to remain competitive. That incentive was essentially lacking in Arizona.

HHS further stated that our recommendations relating to price competition seem to ignore the regulations of 42 C.F.R. 434, which already reference requirements for competitive bidding. They also ignore, HHS said, the requirements that contracts with HMOs and other prepaid entities must be cost effective under Medicaid, based upon upper payment limits that appear at 42 C.F.R. 447.361 and 447.362.

As noted above, HHS has a responsibility to determine whether Medicaid agencies are fulfilling their responsibilities under federal regulations. The Omnibus Budget Reconciliation Act of 1986 requires that HHS review prepaid health plan contracts in excess of $100,000 before they are awarded. Our recommendations are intended to help HHS focus its review efforts on those requirements most important to the success of a prepaid health plan. They are intended not to establish new requirements for Medicaid agencies, but to establish guidelines to determine whether existing regulations have been followed.

HHS said that the report fails to note that AHCCCS plans did have an incentive to submit low bids to maximize the number of counties in which their bids were accepted and that the lowest bidders were assigned a larger share of program beneficiaries who did not select plan and could thus increase their market share.

We recognized on page 18 that health plans could achieve a larger market share by submitting the lowest bid This incentive may have been lessened, however, because the low bidder received a larger share of recipients from all program categories, including those considered to be high risk. We also stated on page 18 that most qualified bidders received contracts even when bid prices varied significantly As a result bidders could maximize the number of counties in which their bids were accepted without submitting low bids. For example, Health Care Providers had both of its first-year bids accepted, but did not submit the low bid in either county where it received contracts

According to HHS, most states, unlike Arizona, use negotiated contractin methods to engage in prepaid contracting under Medicaid once they determine the maximum cost-effective prices HHS said that our report provides no useful information from which to measure the adequacy of price competition in situations where states competitively bid for services.

We agree that the absence of direct negotiation limited price competitio in AHCCCS (see p. 22). We do not agree, however, that this limits the usefulness of the report's findings with respect to setting limits on the number of contracts awarded in order to preserve price competition States will not, in our opinion, be in a good bargaining position during negotiations if bidders know in advance that they have little or no risk of being denied a contract if they do not reduce their bid prices.

Assessment of Utilization Reporting Provisions

HHS said that it disagreed with the four recommendations concerning utilization reporting because (1) they exceed the authority mandated by the Congress with respect to contracting requirements for HMOs and other prepaid health plans under section 1903(m) of the Social Security Act, (2) they encroach on the flexibility of states to manage the Medicaid program, and (3) they overlap with existing requirements for operation of a Medicaid Management Information System, which require states to maintain utilization data on Medicaid recipients.

As previously stated, our recommendations do not suggest that HHS establish any new requirements for prepaid health plans or Medicaid agencies. Rather, they recommend establishing guidelines to implement the prior approval requirements of the Omnibus Budget Reconciliation Act of 1986. Accordingly, we do not believe that our recommendations exceed the authority mandated by the Congress under 1903(m). HHS provided no explanation of why it believes the recommendations would exceed its legislative authority.

The guidelines we recommend would provide guidance for assessing compliance with existing requirements in accordance with the intent of the Omnibus Budget Reconciliation Act. The terms and conditions of HHS's approval of the AHCCCS program required that the program gather utilization data and conditioned fourth year (Oct. 1985-Sept. 1986) funding on establishing adequate penalties for noncompliance with the reporting requirements by the health plans. The procurement standards in OMB Circular A-102, which apply to all contracts with prepaid health plans, require an assessment, before contracts are awarded, of potential contractors' ability to meet contract requirements. An important part of ensuring that health plans can provide needed data is providing training and instruction on the data requirements and how to meet them.

As noted on page 55, Medicaid agencies are required to obtain assurances from prepaid health plans that they are furnishing needed health care services. However, as discussed on page 30, HCFA has not developed certification standards for management information systems for prepaid health care programs. Until certification standards are developed, HCFA should more closely monitor prepaid health plan contracts to determine whether adequate utilization data are being developed. Our recommended guidelines would encroach on a state's flexibility only where HCFA's review found that the state was not operating a prepaid program in accordance with federal requirements.

Assessment of Financial Reporting and Disclosure

HHS agreed with the intent of our recommendations concerning financial management of prepaid health plans and said that its ongoing financial management of the Medicaid program contains similar requirements. These requirements, as HHS may modify them to reflect the prior approval requirements, will, HHS believes, ensure adequate oversight by Medicaid agencies and HCFA.

As stated on page 23, the prior approval requirements were made effective on enactment in October 1986 and apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on enactment. HHS's comments, however, establish no time frame for implementing the recommendation, nor do they indicate how its ongoing financial management of the Medicaid program will be modified Accordingly, they do not meet the internal control standard for prompt resolution of audit findings.

Arizona Comments and Our Evaluation

Arizona said that some of our lessons learned are not, in the long run, viable and could cause more harm than good. Moreover, Arizona blamed many of the problems AHCCCS experienced during the program's first 2 years on its private administrator and cautioned against implementation of our recommended prior approval requirements. Most of Arizona's comments centered, however, on its belief that the AHCCCS program provided adequate price competition.

Problems Attributed to Private Administrator

Our report describes, according to Arizona, many of the problems experienced during the program's first 2 years, when the private administrator, MCAUTO, was operating the program The report does not, Arizona said, clarify MCAUTO's actions and the state's action during this period.

Contracting with MCAUTO to perform certain AHCCCS functions, such as procuring and monitoring providers, establishing quality assurance systems, and enrolling beneficiaries, did not relieve the state of its primary responsibility to guard against fraud and abuse of Medicaid services and provide Medicaid beneficiaries access to quality care.

As discussed on page 54, Medicaid regulations state that the Medicaid agency is responsible for ensuring that prepaid health plans are financially sound, furnish needed health care services, comply with ownership disclosure requirements, and are awarded contracts in accordance with OMB's procurement standards. Although the Medicaid agency can delegate individual functions to a contractor, it cannot delegate its

responsibility under the regulation. Accordingly, the state and MCAUTO share responsibility for the problems discussed in this report.

Under Medicaid regulations (42 C.F.R. 434.70), HCFA can withhold federal financial participation for any period during which either party to a contract substantially fails to carry out the terms of the contract or the state fails to fulfill its responsibilities with respect to administration of the contract. As noted on page 12, MCAUTO and Arizona have filed countersuits for breach of contract. Regardless of the outcome of the suits, HCFA may, under its regulations, be able to withhold federal financial participation for contract costs.

According to Arizona, the report erroneously notes that the Arizona program was implemented, and many of the information systems were installed, in 10 months. Many of the problems described in the report are, Arizona maintains, due to the misrepresentation by MCAUTO that systems would be implemented in a timely fashion. Arizona said the program was clearly not fully operational in 10 months. Because of the pending litigation with MCAUTO, Arizona said that it neither admits nor denies the findings of fact and conclusions of our report.

The AHCCCS program was implemented on a statewide basis 10 months after receiving approval from HHS. We did not, as Arizona maintains, suggest that many of the information systems were installed at that time. As we noted on page 44, the program began while the management information system was still in early development. We discussed the problems Arizona and MCAUTO had in developing an adequate management information system on page 30

Establishing Prior Approval

Arizona said that because of the complexity of the prepaid health care business, it would caution us against making recommendations to HHS regarding the prior approval of prepaid contracts. HHS must, according to Arizona, guard against a "cookbook" approach to regulatory oversight of programs such as AHCCCS because contracting health plans require close monitoring of many local factors that may not be possible to "prior approve" through a national and regional office. Arizona cautioned that implemented incorrectly, our prior approval recommendations may have a chilling effect on competition, on the viability of health plans, and on recipient choice, satisfaction, and quality of care.

As discussed on page 23, the law requires HHS to review contracts with prepaid health plans before their award. The complexity of prepaid

health care cited by Arizona and the limited experience most state Medicaid agencies have had with prepaid health care led us to conclude that HCFA's oversight is needed prior to contract award. Such prior approval is needed so that other states can avoid the types of problems AHCCCS faced during the first 2 years of operation In the case of AHCCCS, neither HCFA nor the state carried out its responsibility for ensuring that contracting health plans were financially sound, that Medicaid beneficiaries received needed services, and that health plans were paid a reasonable price for the services provided.

Limiting Contract Awards

Arizona said that limiting award of contracts to the lowest bidder is not always the best way to promote price competition. Our suggestion that contract awards be limited on the basis of low prices alone is, Arizona said, "simplistic" and could be highly misleading to other state officials. An emphasis on low prices must, according to Arizona, be balanced against other critical factors, including the financial viability of the contractors, the participation of providers, and the backup capacity needed to ensure the delivery of health care services.

Contract awards made at too low a price are, according to Arizona, made at the expense of areas critical to the success of a prepaid health care program. Arizona said that it is for this reason that AHCCCS examines the contracting plan's provider network, the quality of medical care, the capacity to deliver health services, and financial viability.

We did not suggest that contract awards be limited on the basis of low prices alone. Rather, as we stated on page 20, we suggested that contracts be awarded to the lowest qualified bidders. As discussed on page 36, the report emphasizes the need to thoroughly assess health plans' finances before contracts are awarded and to award contracts only to plans that are determined to be financially viable.

Providing Freedom of Choice

Arizona said that purchasing health care services is different from purchasing hard goods. Setting a limit of two on the number of contractors may be acceptable for the purchase of "aircraft coffee pots," but poses serious problems for the purchase of health care services, Arizona maintains. Many Medicaid recipients have established patient-physician relationships and, Arizona said, both physicians and patients have a right to make freedom-of-choice demands. According to Arizona, awarding as many contracts as possible tends to reduce restrictions on freedom of choice.

Arizona did not express concern about the program's inability to provide greater freedom of choice to beneficiaries and providers in the nine counties where only one (four counties) or two (five counties) contracts were awarded. As discussed on page 20, the alternate strategy we developed would give beneficiaries and providers as much or more freedom of choice as beneficiaries in those nine counties

Awarding contracts by recipient category "smacks of discrimination," according to Arizona, and would distribute a large number of high-risk recipients (e.g., Supplemental Security Income-Aged) into some health plans and not into others. The plans would, Arizona said, bid for the low-risk rate groups but not bid in earnest for the high-risk groups by proposing an unacceptably high rate. It is entirely conceivable, according to Arizona, that there would be separate health care plans for each category of recipients. Under such a scenario, the recipients would not receive "mainstream" medical care, and their freedom to choose health care providers would be severely limited, if not abolished, Arizona said According to Arizona, an important feature of the AHCCCS program is the risk-spreading attained by requiring health plans to service all rate categories.

While Arizona requires bidders to service all rate categories, it does not require them to service them at a reasonable price. Under the current contract award procedures, bidders have an incentive to submit a low bid for the rate categories they want to serve in order to capture a larger market share. They have an incentive not to submit the low bid for the high-risk rate categories they do not want to serve to avoid being assigned a higher market share For example, as discussed on page 19, Northern Arizona Family Health Plan was awarded a contract to serve the SSI-Aged population in Yavapai County at $101.48 per beneficiary per month, while Arizona Family Physicians was awarded a contract at $45 31 Under AHCCCS's assignment policy, Arizona Family Physicians would have been assigned a larger market share of these high-risk beneficiaries. However, because Arizona Family Physicians' contract was later withdrawn, Northern Arizona Family Health Plan was assigned the entire SSI-Aged population at a rate that exceeded estimated fee-for-service costs by about $36 per beneficiary per month.

We agree that Arizona should continue to condition participation in AHCCCS on agreement to service all rate categories. However, we do not believe health plans should be awarded contracts that would result in payments for recipients in any rate category that would greatly exceed the estimated fee-for-service costs.

Ensuring Adequate Backup Capacity

According to Arizona, awarding as many contracts as practical provides a "safety net" in the event a health care plan goes out of business or its contract is terminated due to poor quality of care or financial misfeasance. It would make little difference if one of two "aircraft coffee pot" manufacturers went out of business, Arizona said, because another manufacturer could be lined up in due course. In health care, however, there must, Arizona said, be a safety net to meet the needs of patients for immediate care.

Under our analysis each health plan had the capacity to serve the entire Medicaid population in the service area in order that an adequate safety net be available in the event of plan failure or termination. Additional assurance that Medicaid beneficiaries will not be left without services in the event of plan termination or failure is provided through the insolvency plans that contractors are required to develop to ensure continuation of services and an orderly transition to either another health plan or fee-for-service care.

Incentive to Submit Low Bids to Increase Market Share

Arizona said that the AHCCCS program provides an incentive for plans to be price sensitive by assigning recipients not exercising a choice of health plans into the lowest price health plan. They said that this rewards the lowest priced bidders with a greater market share.

We had previously noted (see p. 18) the AHCCCS director's comments regarding the plans' incentive to submit the lowest price bid. The assignment policy is based, however, on the lowest bid by rate category, not the lowest composite bid. Accordingly, while it may provide an incentiv to submit the low bid for those rate categories a plan wants to service, it provides the opposite incentive for other rate categories where a high bid will avoid assignment of unwanted high-risk beneficiaries. In the second program year, about 40 percent of the categorically eligible beneficiaries did not select a health plan and were assigned to the low bidder

As we stated on page 18, most qualified bidders received contracts even when bid prices varied significantly. As a result, bidders could maximiz the number of counties in which their bids were accepted without submitting low bids. For example, Health Care Providers had both of its first-year bids accepted but did not submit the low bid in either county.

Differences in Delivery Methods

Awarding only two contracts assumes, according to Arizona, that any difference in price resulting from methods of production is secondary to

other considerations. Arizona said that this is not a valid assumption for the procurement of health services, where costs within prepaid health care are as much a function of the method by which services are delivered as the services delivered. Costs can vary among group model HMOs, staff HMOs, individual practice associations, and hospital-based plans, Arizona said. Awarding only two contracts will, in the long run, stifle competition, according to Arizona, as health plans frustrated in the past simply will not bid.

As noted on page 11, one of the goals of the AHCCCS program was to test competitive bidding as a method for containing health care costs. In a competitive environment, bidders have an incentive to provide goods or services in the most cost-effective way in order to effectively compete for a contract. If a provider is unable to provide services at a competitive price, that provider should be driven to develop more cost-effective methods in order to become competitive, not rewarded for inefficiency with a higher contract price.

Furthermore, as discussed on pages 21 and 22, one of the primary deterrents to competition in AHCCCS has been the lack of sufficient local cost and utilization data. AHCCCS did not provide cost and utilization data on AHCCCS operations to all potential bidders during the second- and third-year contracting process. In our opinion, this increases the risk for new bidders and may, in the long run, stifle competition.

Changes in Contracting Process

According to Arizona, several changes have been made in the contracting process since the early program period documented in our report. Arizona said that price is examined carefully and balanced against critical factors during the contracting process. AHCCCS uses actuarial ranges based on expected utilization to ensure that the bid rate is neither too high nor too low, Arizona said. According to Arizona, some of the low priced bidders cited in our report were not financially viable The use of actuarial ranges, Arizona said, guards against the possibility that a bidder with too low a price will experience bankruptcy and disrupt the delivery of health services.

We agree that the use of actuarial ranges based on expected utilization will help AHCCCS ensure that future AHCCCS contracts are not awarded to health plans at a rate that is too low to enable the plan to remain financially viable. This additional program control, coupled with the improved oversight of health plans' finances discussed in chapter 4, not present during the first two contract awards, should provide greater

assurance that contracting health plans remain financially viable Accordingly, while Arizona's concerns that limiting contract awards to the lowest qualified bidders could increase plan failures may have been valid during the early program years when financial oversight was inadequate, such limits should not create undue risk with adequate financial oversight before and after contract award.

Furthermore, as previously stated, the financial difficulties experienced by some health plans cannot be attributed solely to bids that were too low, as Arizona implies. For example, as noted on page 19, Health Care Providers, a plan that was terminated from the AHCCCS program because it was unable to pay its debts, was paid $20 per recipient more than the two other plans in Pinal County and received a higher payment per recipient than the other four health plans in Maricopa County, the only other county in which it competed for a contract

Contract Negotiations

Arizona said that AHCCCS negotiates with bidders through a "best and final" process to ensure an equitable price. According to Arizona, we erroneously noted that state law precluded negotiation A legal interpretation, not the law, precluded negotiation during the program's first 2 years, Arizona said.

As stated on page 23, AHCCCS was advised by the state attorney general that state law precluded price negotiation between AHCCCS and health plans. While AHCCCS has asked some bidders to voluntarily reduce bid prices and submit a "best and final" offer, it has not used direct price negotiation in which agreement is reached on prices through a series of exchanges with bidders.

Incorporation of Earlier Comments

Arizona said that our report incorporates some of the comments it had previously provided, but said that those comments were either downplayed or discounted altogether.

We incorporated all of the comments previously provided by the AHCCCS director. Where we disagreed with him, or the information he provided was inaccurate, we explained the reasons for our disagreement in the report. For example, the AHCCCS director said that the lowest bids were submitted by county-subsidized health plans We incorporated his comment on page 20, but pointed out that county-sponsored health plans submitted bids in only 3 of the 14 service areas and that only one submitted the lowest composite bid.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington D C 20201

DEC 24 1986

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicaid: Lessons-Learned from Arizona's Prepaid Program." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report "Lessons - Learned from Arizona's Prepaid Program"

Overview

GAO undertook its review of Arizona's Health Care Cost Containment System (AHCCCS) to determine if the program encountered problems that could be avoided by other States developing similar prepaid programs. In particular, GAO reviewed the Arizona program's first 3 years of operation (October of 1982 through September of 1985) focusing on its approach to: competitive bidding for procuring health plan contracts; collection of utilization data from the prepaid plans on the health care services provided; and, financial oversight of the prepaid health plans.

GAO notes that Arizona's program was implemented just 10 months after receiving departmental approval. GAO believes this is particularly significant in view of the fact that Arizona previously had no statewide indigent care program. However, GAO reports that the program experienced numerous start-up problems that have prevented an assessment of the effectiveness of its cost-containment features. As such, GAO believes other States considering prepaid Medicaid programs can learn from Arizona's problems and solutions.

Specifically, GAO explains that States planning on using prepaid health programs should, among other things, develop adequate financial and utilization reporting systems and program controls before implementing the program. In addition, States should establish penalties for noncompliance with reporting requirements. GAO also believes States should establish requirements to demonstrate the financial viability of prepaid health plans and devote adequate resources to monitoring health plans' performance. Finally, GAO reports that States should design health plan procurements to promote competition.

We agree that there are many lessons to be learned from the mistakes in administration and start up that were experienced by Arizona's program. These lessons are described in the last eight pages of the report. Except for a few minor issues, we agree with this portion of the report. We have found, however, major noteworthy problems with the bulk of the report. These problems fall into three areas:

1. The report relies upon the experience of an experimental program in Arizona to make recommendations and reach conclusions for setting policies nationally for the rest of the States which have very different experiences and rules for operating prepaid programs. Many of the rules and

regulations governing these other State programs did not apply to Arizona and would therefore have potentially avoided some of its problems. In addition, the report's recommendations are made without the benefit of specific and factual comparisons to actual experience in other States.

2. The report's recommendations repeatedly suggest that the Department take action to implement the Omnibus Budget Reconciliation Act of 1986 (OBRA) requirement that prior approval of contracts with prepaid entities be performed by the Federal government using broadened and, in our view, intrusive standards for regulating the State operating systems and policies. Many of these recommendations would unduly burden State flexibility to contract with prepaid entities, increase costs, and would both delay and create obstacles to cost-effective contracting arrangements within States. Further, we find that some of these recommendations may exceed the authority that Congress itself provided to the Health Care Financing Administration (HCFA) to establish standards for organizations contracting under Medicaid.

3. This report was developed without recognition of the extensive efforts by HCFA, the State of Arizona, and HCFA's evaluation contractor to closely monitor the Arizona program. While at times the report indicates that the State took corrective action, overall the report fails to acknowledge HCFA's own effort to correct deficiencies in Arizona and to issue reports on its findings.

GAO Recommedation

That the Secretary of HHS, in establishing regulations to implement the preapproval provisions of the Omnibus Budget Reconciliation Act of 1986, develop criteria to be used in evaluating the adequacy of price competition and the reasonableness of contract prices.

Department Comment

The report concludes that the process used by AHCCCS may have limited competition among the bidding providers. The decision to give beneficiaries a choice of health plans wherever possible led to the award of more contracts than were absolutely necessary to serve the Medicaid population. The report suggests that limiting the number of contracts and awarding to the lowest bidders would have saved more money. The report also concludes

that there was little incentive to reduce bid prices since most bids were accepted and provides as support for this conclusion the large variations in bid prices among providers. In addition, the report notes that the unavailability of local cost and use data increased the risk bidders would undertake and therefore the bids were higher than necessary. The use of voluntary price reductions rather than direct negotiation were activities that also decreased competition.

Although the recommendation stops short of requiring the competitive bidding process, it does suggest that the Secretary evaluate the adequacy of price competition and the reasonableness of contract prices in the preapproval process.

We would agree that fostering price competition is a reasonable objective and that the Secretary should develop criteria to evaluate the adequacy of procurement systems. We do not agree, however, that always limiting award of contracts to the lowest bidder, in all situations, is the best way to achieve this goal.

Prior to the implementation of the AHCCCS demonstration, indigent health care in Arizona was provided by the county health department. There was a limited number of private health care groups who had provided services to a Medicaid population and there were only two federally qualified Health Maintenance Organizations (HMOs) in the State. There was considerable concern that few, if any, bids would be received, especially for some of the rural counties. In addition, an important goal of the AHCCCS program was to have as many plans as possible available to program beneficiaries. The purpose of having numerous plans from which to select was to afford beneficiaries some freedom-of-choice and opportunity to change plans if dissatisfied with the care they received and to involve as many Arizona providers as possible into the program so that beneficiaries had access to the mainstream of Arizona health care services. Finally, having more bidders available would foster the long range competitive market. These concerns led AHCCCS to establish as few barriers to potential bidders as possible, concentrating more on plan ability to establish the provider networks necessary to deliver the required services and to allow more plans than were absolutely necessary to be awarded contracts.

The report fails to note that plans did have incentive to submit low bids to maximize the number of counties in which their bids were accepted and that the lowest bidders were also assigned a larger share of program beneficiaries who did not select plans and could thus increase their market share.

GAO's recommendation seems to ignore the regulations at 42 CFR 434 which already reference the requirements for competitive bidding. It also ignores the requirements that contracts with HMOs and other prepaid entities must be cost-effective under Medicaid based upon upper payment limits which appear at 42 CFR 447.361 and 447.362. This report provides no useful information from which to measure the adequacy of price competition in4 situations where States competitively bid for services. Unlike the State of Arizona, most States use negotiated contracting methods to engage in prepaid contracting under Medicaid, once they determine the maximum cost effective price.

GAO Recommendation

That the Secretary of HHS, in establishing regulations to implement the preapproval provisions of the Omnibus Budget Reconciliation Act of 1986, develop guidelines for reviewing contracts that provide for an assessment of, among other things, whether the State Medicaid agency has (1) adequately specified utilization data reporting requirements, (2) evaluated prepaid health plans' capabilities to produce timely and accurate utilization data, (3) established procedures for providing technical assistance to health plans in meeting the reporting requirements, and (4) established adequate penalties for noncompliance with the reporting requirements.

Department Comment

We disagree with these recommendations for the following reasons: (1) they exceed the authority mandated by Congress with respect to contracting requirements for entities under secton 1903(m); (2) they encroach on the flexibility of States to manage the Medicaid program; and (3) they overlap with existing requirements for operation of a Medicaid Management Information System which requires States to maintain utilization data on Medicaid recipients.

GAO Recommendation

That the Secretary of HHS, in establishing regulations to implement the preapproval provisions of the Omnibus Budget Reconciliation Act of 1986, develop guidelines for reviewing prepaid health plan contracts that provide for an assessment of, among other things, whether the State Medicaid agency has (1) specified routine financial reporting and disclosure requirements in the contract, (2) reviewed the financial qualifications of the proposed contractors, and (3) determined

that Federal financial disclosure requirements have been met. In addition, the guidelines should condition renewal or extension of contracts on adequate financial oversight of the contractors by the State Medicaid agency.

Department Comment

We agree with the intent of this recommendation. Our ongoing financial management of the Medicaid (TEFRA) program contains similar requirements. We believe that these requirements, as we may modify them to reflect the OBRA changes, will ensure adequate oversight by Medicaid agencies and HCFA. However, we have the following additional comments.

HHS Technical Comments and GAO Evaluation

The HHS technical comments on the following pages have been extracted verbatim from its December 24, 1986, letter. Each section of the HHS comments is followed by our evaluation. Page references in the HHS comments have been changed to correspond with the final report

HHS Comments

1. On page 3 of the executive summary, the report suggests that Arizona establish financial penalties to encourage reporting of utilization and encounter data. The report further suggests that reporting to the State was deficient for this reason. The "findings" seem to overlook the fact that the State was not paying for the cost of data collection from prepaid health plans, as part of the ratesetting method used for setting premium rates. Further, since the ratesetting system was without the benefit of a fee for service system's cost experience, any new system was subject to substantial guesswork determining cost-effective rates I GAO believes that such data is necessary to evaluate the costs and quality of care, a better alternative may be for the State to fund such data collection efforts, as it will under the new provisions of the 1986 OBRA [Omnibus Budget Reconciliation Act legislation for Peer Review Organizations' and Quality Review Organizations' review of Medicaid prepayment programs.

GAO Evaluation

AHCCCS health plans are being paid for the cost of data collection Utilization data requirements are specified both in the AHCCCS contracts and in the special terms and conditions of the waiver. HHS's comment ignores the position HCFA has taken throughout the AHCCCS program—that health plans must submit utilization data on all services provided to Medicaid beneficiaries. HHS's approval of the AHCCCS program has been conditioned each year on the submission of complete and accurate utilization data. As stated on page 32, HCFA conditioned federal funding of the AHCCCS program on AHCCCS's imposing penalties on health plans that underreport services by more t. an 10 percent.

HHS Comments

2. Chapter 2 of the report suggests that AHCCCS could have increased price competition by limiting the number of contracts to be awarded an because only limited data on use and cost of medical services was available regarding Arizona's indigent care population. These viewpoints are limited in helping to understand the nature of the Arizona marketplace For example, the report does not discuss how many federally qualified HMOs chose to participate in the Arizona program and how many of the

successful bidders underpriced the cost of care in their bids It also does not address the historical problems that have existed in other States, where many mainstream HMOs have chosen not to contract with Medicaid because of the risk and because of the low payment rates allowed The risk assumption for a new program without fee-for-service program experience from which to establish data for pricing care to the indigent was a handicap to obtaining a price elastic competitive market in Arizona

GAO Evaluation

As discussed on page 17, only 2 of the 17 organizations receiving AHCCCS contracts during the first program year (Oct. 1982-Sept. 1983) were federally qualified HMOs. Only one federally qualified HMO participated in AHCCCS during the second program year (Oct. 1983-Sept. 1984). We did not discuss how many qualified bidders underpriced the cost of care in their bids because adequate utilization and financial data were not available to determine the reasons for plans' financial problems. (See chs 3 and 4) As we discussed in our November 1985 report on nondisclosure of ownership information by AHCCCS health plans, related-party transactions within the complex corporate structures of some AHCCCS health plans can enable health plans to divert program funds from their intended purpose—the provision of health care. Accordingly, until Arizona and HHS complete a review of the related-party transactions of AHCCCS health plans and generate complete and accurate utilization and financial data, the actual cost of providing care to AHCCCS beneficiaries will not be known. Finally, we noted on page 21 that the limited cost and utilization data available on Arizona's county-based health care system may have limited competition among AHCCCS bidders.

HHS Comments

Further, since financial and organizational barriers exist for entry by new prepaid plans, it would have been risky for Arizona to limit contracts to one or two contractors per area and later discover that they failed to perform without having alternative contractors available to replace them either in the middle of a contract or in subsequent years.

GAO Evaluation

Under our analysis each health plan had the capacity to serve the entire Medicaid population in the service area in order that an adequate safety net be available in the event of plan failure or termination. Additional assurance that Medicaid beneficiaries will not be left without services in

the event of plan termination or failure is provided through the insolvency plans that contractors are required to develop to ensure continuation of services and an orderly transition to either another health plan or fee-for-service care.

HHS Comments

3. On page 19, we find the discussion of the composite bid prices confusing and points to weaknesses in the methodology used First, it cites wide differences in the bids submitted, which is usually indicative of problems in the competitive market.

GAO Evaluation

We agree that there were problems in the competitive market in Arizona. As stated on pages 21 and 22, the absence of sufficient cost or utilization data to help bidders calculate competitive rates may have limited competition. All bidders had equal, though limited, knowledge o the costs of delivering Medicaid services in Arizona during the first-yea procurement. However, bidders in later AHCCCS procurements who had not previously participated in the program were at a competitive disadvantage due to the lack of local cost and utilization data. Further, as discussed on pages 18 to 20, bidders had little risk of not getting a contract if their bids were too high.

HHS Comments

Second, it fails to address the long-range effect of these variations in contracting prices on the future competition and long term effect of holding down expenses as compared with the operation of a fee-for-service system.

GAO Evaluation

Until complete and accurate financial and utilization data are available it is not possible to determine whether AHCCCS costs more or less than a traditional fee-for-service program and whether the limited price competition in AHCCCS will result in steadily increasing health care costs because of the limited incentives to contain costs.

HHS Comments

Finally, it fails to analyze the effect that the very low price of the cited plan, Arizona Family Physicians, had on its subsequent withdrawal from the program.

GAO Evaluation

Until adequate data are available on the percentage of the payments made to Arizona Family Physicians that were spent on the delivery of health care services, it is not possible to determine whether the bid rate was too low. It should be noted, however, that it was the responsibility of Arizona and HHS to assess the financial viability of bidding health plans and to reject those bidders who submitted bids that were too low AHCCCS, with HCFA's concurrence, sought, and obtained, voluntarily price reductions from Arizona Family Physicians during both the first and second contract year.

HHS Comments

4. On page 20, GAO cited potential savings of between $830,000 and $2.36 million which were foregone by not limiting contracts in each area to the two lowest bidders that had the capacity to serve the entire Medicaid population While these estimates, which were not documented, may be theoretically true, we would argue that the program could not have accomplished its goals, as already stated in our comments regarding Chapter 2, (see comment #2).

GAO Evaluation

Continuing to award contracts to prepaid health plans at prices that exceed normal fee-for-service Medicaid costs may encourage the development of new health plans to take advantage of the government's generosity but will not, in our opinion, foster competition to develop a more cost-effective health care system. If competition is to be an important cost containment feature of the AHCCCS program, bidders must have some risk of not getting a contract in order to encourage price competition.

If, on the other hand, Arizona and HHS view the goal of encouraging the development of new health plans to be more important than price competition, they should abandon the current competitive bidding process and allow any qualified health plan to participate in the AHCCCS program at a predetermined payment rate based on some percentage of the estimated fee-for-service costs, such as the 95 percent HCFA has used in setting payment rates for other prepaid health plans.

Our report describes, on pages 20 and 21, the methods used in developing our savings estimates. While the detailed calculations for each health plan are not included in the report, the bid prices and enrollment figures needed to duplicate our analysis are available in HCFA records.

HHS Comments

5. On page 35, and in Chapter 4, the report comments on the symptoms of financially weak organizations which contracted with the Arizona AHCCCS program. The report does not address the fact that many of these contracting plans were not serving diversified populations, such as State employees, commercial enrollees and non-Medicaid individuals Arizona had certain waivers of requirements of section 1903(m) with regard to the composition of enrollment of its plans. We believe that these factors may be the root cause of financial difficulties of these plans.

GAO Evaluation

The uniqueness of the health plans contracting with AHCCCS, and the exemptions granted by HHS from normal Medicaid requirements, provide strong arguments for monitoring health plan finances aggressively both before and after contract award. Such monitoring was lacking at both the federal and state levels during AHCCCS's first 2 years.

HHS Comments

Further, this criticism of the financial viability of these plans seems to be inconsistent with earlier comments about contracting with only the lowest bidders. If the State had contracted only with the lowest bidders, who later withdrew because they were financially least viable, then more serious problems may have occurred in delivering care to Medicaid recipients.

GAO Evaluation

With proper oversight, contracting with the lowest qualified bidders should not increase the risk of financial insolvency. Further, it should be noted that many of the low bidders in AHCCCS remained financially viable, while Health Care Providers and Western Sun, the highest bidders in the counties in which they competed, did not

HHS Comments

Further, it should be noted that in many States that contract with non-federally qualified HMOs, the State has its own licensing law which includes financial solvency and periodic review of plan financial capability. In Arizona, the State elected to exempt these plans from meeting State HMO licensing requirements.

GAO Evaluation

We noted on page 37 that Arizona did not require AHCCCS health plans to meet the financial requirements established by Arizona's Department of Insurance for health care service organizations.

Comments From the State of Arizona

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BRUCE BABBITT
Governor

DONALD F. SCHALLER M.D.
Director

December 9, 1986

Mr. Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Gov. Bruce Babbitt asked me to comment on the most recent draft copy of the report titled: "Medicaid: Lessons Learned from Arizona's Prepaid Program." I have several major concerns with this latest draft, which is not much different from the first one. In the long run, some of your lessons learned are not viable and could cause more harm than good in this complex and dynamic environment. I will try to explain why.

In the first place, the recommendation that contract awards be limited on the basis of low prices alone is simplistic and could be highly misleading to other state officials. An emphasis on low prices must be balanced against other critical factors. These factors include the financial viability of the contractors; the participation of providers and, consequently, a recipient's choice of provider, satisfaction and quality of care; and the backup capacity needed to ensure the delivery of health care services. Contract awards at too low a price are clearly made at the expense of areas critical to the success of a prepaid health care program. It is for this reason that the AHCCCS Administration examines the contracting plan's provider network, the quality of medical care, the capacity to deliver health services, and financial viability.

Purchasing health care services is different from purchasing hard goods. While setting a limit of two on the number of contractors may be okay for the purchase of aircraft coffee pots, it poses severe problems for the purchase of health care services. In many cases, Medicaid recipients have established patient-physician relationships. As human beings, both patients and physicians have a right to make freedom of choice demands. Awarding as many contracts as practical tends to reduce restrictions on freedom of choice.

801 East Jefferson • Phoenix Arizona 85034 • (602) 234-3655
PO Box 25520 • Phoenix Arizona 85002

Awarding only two contracts includes one major assumption -- that any difference in price resulting from methods of production is secondary to other considerations. For the procurement of health services, this is not a valid assumption. Costs within prepaid health care are as much a function of the services delivered as the method by which those services were delivered. Thus, costs can vary among group model HMO's, staff HMO's, IPA's, and hospital-based plans.

It would make little difference if one of two aircraft coffee pot manufacturers went out of business. Another manufacturer could be lined up in due course. Not so in health care. For patients in need of immediate care, there must be a safety net in the event a health care plan goes out of business or its contract is terminated due to poor quality of care or financial misfeasance. Awarding as many contracts as practical provides such a safety net.

Finally, awarding only two contracts in the long run will stifle competition. Over a period of time, health care plans frustrated in the past simply will not bid.

Furthermore, awarding contracts to the lowest price offerer for certain recipient catagories and not others as the report implies would distribute a large number of high-risk recipients (e.g. SSI aged) into some health plans and not into others. The plans will bid for the low-risk rate groups but not bid in earnest for the high-risk groups by proposing an unacceptably high rate. An important feature of the AHCCCS program is the risk spreading attained by requiring health plans to service all rate categories.

Awarding contracts by rate code category smacks of discrimination. It is entirely conceivable that there would be separate health care plans for AFDC members and for members of each of the three SSI rate code categories (aged, blind and disabled). Under such a scenario, the members would not receive "mainstream" medical care and their freedom to choose health care providers would be severely limited, if not abolished.

Several changes have been made to the contracting process since the early program period documented in the report. Price is examined carefully and balanced against critical factors during the contracting process. The Administration uses actuarial ranges based on expected utilization to ensure that the bid rate is neither too high nor too low. Some of the low-priced offerers cited in your report were not financially viable. Actuarial ranges guard against the possibility that an offerer with too low a price will experience bankruptcy and disrupt the delivery of health services. The Administration negotiates with offerers through a best and final process to ensure an equitable price. Your report erroneously notes that state law precluded negotiation. A legal interpretation rather than the law precluded negotiation during the program's first two years.

Finally, the AHCCCS program provides a major incentive for plans to be price sensitive while assuring that critical areas are met by assigning recipients not exercising a choice into the lowest priced health plan. This awards low-priced offerers with a greater market share.

Due to the complexity of the prepaid health care business, we caution GAO against making recommendations to DHHS regarding the prior approval of prepaid contracts. DHHS must guard against a "cookbook" approach to regulatory oversight of programs such as AHCCCS. We have found that contracting health plans require close monitoring of many local factors that may not be possible to prior approve through a national and regional office. Implemented incorrectly, the prior approval recommendations may have a chilling effect on competition, on the viability of health plans, on recipient choice, satisfaction and the quality of care.

The report describes many of the problems that were experienced during the program's first two years when the private administrator, McAuto Systems Group Inc., was operating the program. The report does not clarify McAuto's actions and the state's actions during this time period. Furthermore, the report erroneously notes that the Arizona program was implemented in ten months and that many of the information systems were installed. Many of the problems that the report describes are due to the misrepresentation by McAuto that systems would be implemented in a timely fashion. Clearly, the program was not fully operational in ten months. As a result of pending litigation with McAuto and with providers, the state neither admits nor denies the findings of fact and conclusions of the GAO report.

In conclusion, this latest draft of the report incorporates some of the comments we sent you in a previous review. Unfortunately, the comments either were downplayed or discounted altogether. Our number one concern is that public officials from other states will embrace this report as a prescriptive package and consequently fail with their own programs. I urge you to consider the comments in this letter and include them in your final report. I also ask you to reproduce this letter in full with that report.

Sincerely,

Donald F. Schaller, M.D.
Director

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