



A REPORT  
TO THE  
ARIZONA LEGISLATURE

Performance Audit Division

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Performance Audit

# Arizona Health Care Cost Containment System—Coordination of Benefits

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April • 2012  
REPORT NO. 12-01



**Debra K. Davenport**  
Auditor General

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AUDITOR GENERAL

**STATE OF ARIZONA**  
OFFICE OF THE  
**AUDITOR GENERAL**

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DEPUTY AUDITOR GENERAL

April 5, 2012

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Tom Betlach, Director  
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, *A Performance Audit of the Arizona Health Care Cost Containment System (AHCCCS)—Coordination of Benefits*. This report is in response to an October 26, 2010, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, AHCCCS agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on April 6, 2012.

Sincerely,

Debbie Davenport  
Auditor General

Attachment

**REPORT  
 HIGHLIGHTS**  
 PERFORMANCE AUDIT

**Our Conclusion**

The Arizona Health Care Cost Containment System (AHCCCS) has established various processes to help meet federal and state requirements for identifying members with other health insurance, ensuring these other insurers first pay for a member's medical costs, and recovering monies from other liable parties after members' healthcare costs have been paid. However, AHCCCS can further help ensure that it pays for medical benefits only after other responsible parties have first paid their share by implementing additional oversight procedures and using additional federal data. Further, AHCCCS should establish an additional oversight procedure of its post-payment recovery contractor, document decisions to accept less than the settlement amount recommended by its contractor, and seek additional data-sharing agreements to enhance its recoveries.



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**Coordination of benefits is an important part of Arizona's  
 Medicaid program**

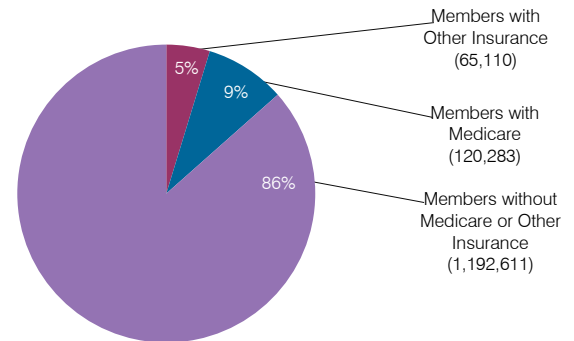
**Majority of AHCCCS program  
 operates under managed care  
 model**

Medicaid is a federal healthcare program for certain low-income individuals and families that is jointly funded by federal and state governments. AHCCCS is Arizona's state program that provides these benefits to eligible persons primarily through a managed care system. Under this system, AHCCCS contracts with health plans, which coordinate and pay for the medical services AHCCCS members receive from healthcare providers. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive monthly capitation payments for each enrolled member.

**Coordination of benefits**—Federal regulation and state laws require that AHCCCS pay for medical benefits only after other responsible parties have first paid their share, making AHCCCS the payor of last resort. This process is called coordination of benefits. Coordination of benefits involves two key areas—*cost avoidance* and *post-payment recovery*.

To perform *cost avoidance*, AHCCCS has processes to determine at the time of enrollment whether the person has Medicare or private health insurance. If the member has such coverage, the AHCCCS-contracted health plan must ensure that Medicare or the private health insurance covers the cost of the medical care before the health plan uses its capitation payment to pay the claim. For fiscal

Number and Percentage of Medicaid Population with Medicare or Other Insurance as of September 2011



year 2011, AHCCCS reported that its contracted health plans avoided more than \$838 million in claims costs.<sup>1</sup>

Although the State does not recover any of those avoided medical costs, it benefits from reduced capitation rates. Those rates are adjusted at least annually, taking into consideration the health plans' reduced medical costs from the coordination of benefits.

For about 10 percent of its members, AHCCCS pays healthcare providers directly on a "fee-for-service" basis, rather than making capitation payments to health plans. The costs avoided when AHCCCS determines these members have Medicare or other health insurance represent actual dollar savings for AHCCCS. For fiscal year 2011, about \$90 million in fee-for-service healthcare costs were paid by Medicare or other insurance instead of AHCCCS.

The other type of coordination of benefits is *post-payment recovery*. This is money recovered after AHCCCS or its health plans have paid for a member's medical services and later discover that there is a

<sup>1</sup> According to AHCCCS, this amount does not include an additional \$307 million in claims costs that its contracted health plans also reported avoiding. The health plans incurred no financial obligation for these costs because they were entirely the responsibility of a third party and were not submitted to AHCCCS for processing.

party responsible for such medical costs. These responsible parties are discovered through questionnaires sent to members with trauma-type injuries, by matching data with national insurance coverage databases, and by receiving information from the member's attorney. Any post-payment recoveries that AHCCCS receives related to its fee-

for-service members are returned to the federal government and the State General Fund, and used to pay AHCCCS' contractor, Health Management Systems, Inc. (HMS), who helps with this function. AHCCCS' managed care health plans that receive post-payment recoveries are allowed to retain them under certain circumstances.

## AHCCCS should implement additional oversight procedures and use additional federal data

AHCCCS has processes in place that help it comply with federal regulation and state laws requiring that it be the payor of last resort. For example, it receives data from the federal government to identify whether members have Medicare, and it has a contract with HMS to match its members with a national health insurance database. Although it has an informal process in place to monitor HMS, AHCCCS should develop and implement written procedures to monitor HMS' efforts to identify members with other insurance.

AHCCCS should also use data from the U.S. Departments of Veterans Affairs and Defense and

Office of Personnel Management to determine if there are veterans' benefits or federal healthcare coverage that should be used to avoid costs.

### Recommendations:

AHCCCS should:

- Develop and implement written procedures to monitor HMS' efforts to identify members with other insurance.
- Reactivate plans and establish procedures to develop and implement data searches using additional federal information and track and calculate those costs avoided.

## AHCCCS should implement additional procedures and data-sharing agreements

When it is discovered that an AHCCCS member is involved in an incident where a third party is responsible for the member's healthcare expenses, such as a car accident, AHCCCS' contractor, HMS, prepares case settlement information that includes the healthcare expenses paid, the settlement offer, and the formulas required to determine the appropriate settlement amount. AHCCCS reviews the settlement document, verifies HMS' calculated value of the healthcare costs paid, and approves the settlement amount. However, AHCCCS does not review those cases where HMS recovers from a liable third party the full amount AHCCCS paid. Also, in some cases, AHCCCS might accept less than the settlement amount that HMS has recommended—for example, when the legal costs to pursue the recommended settlement would outweigh the additional monies it might receive.

AHCCCS should pursue other sources of information that would help post-recovery. A data-sharing

agreement with the Motor Vehicle Division to obtain motor vehicle accident data would help AHCCCS identify members involved in car accidents. Similarly, a data-sharing agreement with the Industrial Commission would help AHCCCS identify members who are receiving workers' compensation for work-related illnesses and injuries.

### Recommendations:

AHCCCS should:

- Review a sample of cases where the liable third party paid in full to ensure that HMS included all healthcare costs and valued the case properly.
- Document reasons for accepting less than the recommended settlement amount and have HMS include that information in the case file.
- Establish data-sharing agreements with the Motor Vehicle Division and the Industrial Commission.

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# INTRODUCTION

## Scope and Objectives

The Office of the Auditor General has conducted a performance audit of the Arizona Healthcare Cost Containment System (AHCCCS) pursuant to an October 26, 2010, resolution of the Joint Legislative Audit Committee. This audit is the first in a series of audits conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and addresses whether AHCCCS is meeting state and federal requirements for coordinating healthcare benefits and collecting monies from other responsible parties. The second audit will focus on whether the State's Medicaid eligibility determinations meet federal and state requirements, and the third report will examine AHCCCS' processes for managing Medicaid fraud cases. A fourth report will address the statutory sunset factors.

# Coordination of benefits is an important part of Arizona's Medicaid program

## Majority of AHCCCS program operates under managed care model

AHCCCS was established to administer Arizona's Medicaid program, which provides healthcare for certain low-income individuals and families living in Arizona. Medicaid is a federal healthcare program for low-income individuals and families that is jointly funded by the federal and state governments. AHCCCS was implemented in October 1982 as the nation's first state-wide Medicaid program designed to provide medical services to eligible persons primarily through a managed care system. Under a managed care system, AHCCCS contracts with entities, known as health plans, which coordinate and pay for the medical services AHCCCS members receive from registered AHCCCS healthcare providers, such as physicians and hospitals. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive monthly capitation payments (see textbox).

**Capitation payment**—A fixed monthly amount paid in advance to AHCCCS' contracted health plans for each enrolled member. At least annually, based on information such as the historical use and cost of medical services provided and inflation data, capitation payment amounts are determined using mathematical and statistical methods. Monthly capitation amounts paid to AHCCCS' contracted health plans can vary by individual based on factors such as age, gender, geographical service area, and program (see examples below):

Examples of average <b>Acute Care</b> monthly capitation rates <sup>1</sup>					Average <b>Arizona Long Term Care System</b> monthly capitation rate <sup>1</sup>
Age <1 Male/Female	Age 1-13 Male/Female	Age 14-44 Female	Age 14-44 Male	Age 45+ Male/Female	
\$460	\$97	\$222	\$138	\$347	\$3,000

<sup>1</sup> See page 2 for explanation of Acute Care and Long Term Care programs.

Source: Auditor General staff analysis of AHCCCS information contained in its contracts, actuarial certifications, and Acute Care and Arizona Long Term Care System rates effective October 1, 2011.



Approximately 90 percent of AHCCCS' members are enrolled with its contracted health plans in managed care. For the remaining members, known as fee-for-service members, AHCCCS reimburses registered healthcare providers directly.<sup>1</sup> According to the Kaiser Family Foundation, as of October 2010, 47 states and the District of Columbia used managed care programs to some degree, but only 9 states, including Arizona, had 80 percent or more of their members enrolled in comprehensive managed care programs.<sup>2,3</sup>

AHCCCS members receive a full range of medical services under the following three primary programs:

- **Acute Care**—As shown in Table 1 (see page 3), the majority of AHCCCS' members are enrolled in its Acute Care program. This Medicaid program provides a wide range of healthcare services, such as inpatient and outpatient hospital services, physician services, immunizations, and laboratory and x-ray services to children, pregnant women, and other low-income adults.
- **Arizona Long Term Care System (ALTCS)**—A small percentage of members receive services under ALTCS. The ALTCS program provides acute care, behavioral health, long-term care, and case management services to individuals who are elderly, physically disabled, or developmentally disabled and meet the criteria for institutionalization.
- **KidsCare**—Children under age 19 may receive medical services under KidsCare, the name given to Arizona's federal Children's Health Insurance Program. Children may qualify for KidsCare if their family's income exceeds the limit allowed for Medicaid, but is still below the federally established amount for this program. Children enrolled in KidsCare receive the same medical services available under Arizona's Acute Care program. However, new enrollment in the KidsCare Program has been frozen since January 1, 2010, due to lack of funding, and AHCCCS has established a waiting list of applicants.

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<sup>1</sup> AHCCCS reimburses providers on a fee-for-service basis for (1) AHCCCS members who have been determined eligible, but have not yet selected a contracted health plan, (2) individuals receiving services under the Federal Emergency Services program, or (3) Native American members who choose to receive services through a tribal fee-for-service contractor.

<sup>2</sup> Comprehensive managed care is defined as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally Qualified Center services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment services; (7) family planning services; (8) physicians' services; and (9) home health services.

<sup>3</sup> Kaiser Family Foundation. (2010). *Medicaid enrollment in comprehensive managed care as a share of total Medicaid enrollment, October 2010*. Retrieved January 31, 2012, from [www.statehealthfacts.org](http://www.statehealthfacts.org)

Table 1: AHCCCS Enrollment by Program  
At July 1, 2009, 2010, 2011, and February 1, 2012  
(Unaudited)

Program	2009	2010	2011	2012
Acute Care	1,174,598	1,272,118	1,300,674	1,253,073
Arizona Long Term Care System	48,673	50,241	51,314	51,813
KidsCare	51,838	30,445	17,649	12,149
Total	<u>1,275,109</u>	<u>1,352,804</u>	<u>1,369,637</u>	<u>1,317,035</u>

Source: Auditor General staff analysis of the AHCCCS July 1, 2009, 2010, and 2011, and February 1, 2012, *Population Highlights* reports.

AHCCCS receives federal monies along with state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program. As shown in Table 2 (see page 4), during fiscal year 2012, AHCCCS estimates that its revenues will total more than \$8.4 billion, with approximately \$5.66 billion coming from the federal government, approximately \$2.16 billion from the State, about \$341 million from the counties, and \$275 million from other sources. AHCCCS' estimated expenditures for fiscal year 2012 total nearly \$8.4 billion, with about \$6.4 billion, or 76 percent, going toward capitation payments. AHCCCS' estimated revenues and expenditures for fiscal year 2012 are each approximately \$1.2 billion less than fiscal years 2010 and 2011 because some changes were made to Arizona's Medicaid program during the 2011 legislative session. For example, enrollment in Arizona's Medicaid program for some individuals, such as childless adults, is no longer being accepted.<sup>1</sup> In addition, the federal matching rate returned to its typical level starting in fiscal year 2012. Specifically, the American Recovery and Reinvestment Act of 2009 and additional federal legislation increased the federal matching rate from approximately 66 percent to between 71 and 76 percent from October 1, 2008 through June 30, 2011. This change and the changes to the Arizona Medicaid program resulted in the fiscal year 2012 estimated federal government revenues being approximately \$1.4 billion lower. However, the State's estimated revenue did not show a similar decrease, in part due to the reduction in the federal matching rate that required the State to contribute more of each dollar spent.

AHCCCS receives federal, state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program.

## Coordination of benefits is required

Federal regulation and state laws require that AHCCCS be the payor of last resort for covered medical services. This means that federal and state Medicaid monies should not be used to pay for members' covered services until all other sources of payment have been exhausted. Therefore, AHCCCS and its contracted health plans must identify and collect payments from other responsible parties such as private health

<sup>1</sup> In December 2011, the Arizona Court of Appeals upheld the State's decision to stop new enrollment for childless adults, indicating that it was a political decision that was not subject to judicial resolution. In February 2012, the Arizona Supreme Court refused to review the Appeals Court's decision.

**Table 2: Schedule of Revenues, Expenditures, and Changes in Fund Balance<sup>1</sup>**  
**Fiscal Years 2010 through 2012**  
(In Thousands)  
(Unaudited)

	<b>2010</b> <b>(Actual)</b>	<b>2011</b> <b>(Actual)</b>	<b>2012<sup>2</sup></b> <b>(Estimate)</b>
<b>Revenues:</b>			
Federal government <sup>3</sup>	\$ 7,229,797	\$ 7,077,440	\$ 5,663,201
State government <sup>3</sup>	1,720,054	2,012,179	2,163,412
County government <sup>3</sup>	247,043	277,663	341,131
Other <sup>4</sup>	302,363	272,449	275,024
Total revenue	<u>9,499,257</u>	<u>9,639,731</u>	<u>8,442,768</u>
<b>Expenditures and transfers:</b>			
<b>Capitated payments—</b>			
Acute care	4,181,191	4,163,405	3,150,673
Long-term care	1,940,629	1,957,650	1,959,774
KidsCare	91,795	55,095	36,068
Mental health and Children's Rehabilitation Services <sup>5</sup>	1,413,917	1,422,241	1,234,025
<b>Fee-for-service—</b>			
Acute care	847,605	874,121	759,836
Long-term care	119,705	127,138	134,366
Other <sup>6</sup>	685,871	805,577	898,318
Administrative	177,092	163,936	180,616
Total expenditures	<u>9,457,805</u>	<u>9,569,163</u>	<u>8,353,676</u>
Transfers to the State General Fund	2,699	1,268	1,244
Net transfers to other state agencies <sup>7</sup>	<u>39,213</u>	<u>38,184</u>	<u>41,928</u>
Total expenditures and transfers	<u>9,499,717</u>	<u>9,608,615</u>	<u>8,396,848</u>
Net change in fund balance	(460)	31,116	45,920
Fund balance, beginning of year	<u>685</u>	<u>225</u>	<u>31,341</u>
Fund balance, end of year	<u>\$ 225</u>	<u>\$ 31,341</u>	<u>\$ 77,261</u>

<sup>1</sup> The table includes all AHCCCS financial activity except the Healthcare Group. The Healthcare Group provides medical coverage primarily to small, uninsured businesses and is managed as a self-supporting operation.

<sup>2</sup> The estimates for fiscal year 2012 revenues and expenditures are significantly less than fiscal years 2010 and 2011 because multiple changes were made to the Medicaid program and the State's contribution during the 2011 legislative session that affected fiscal year 2012. See page 3 for additional information.

<sup>3</sup> Consists of all monies that originally came from the federal, state, or county governments, including monies passed through other entities, such as other state agencies.

<sup>4</sup> Amounts primarily consist of monies that were authorized for use on AHCCCS expenditures by the Legislature or voters, such as tobacco litigation monies, gaming revenues, and tobacco tax monies administered by AHCCCS. For example, Proposition 204 (November 2000) authorized the use of tobacco settlement monies to increase the number of people eligible for coverage in AHCCCS. Similarly, Proposition 202 (November 2002) provides a portion of gaming revenues to be used for a trauma and emergency services program.

<sup>5</sup> Amounts consist of capitated mental health and Children's Rehabilitation Services expenditures that were passed through to the Arizona Department of Health Services. Beginning in fiscal year 2012, the Children's Rehabilitation Services appropriation was moved to AHCCCS; therefore, AHCCCS no longer passes through these monies to the Department and instead makes payments directly to the providers.

<sup>6</sup> Amounts consist of various other expenditures that were not paid as capitated payments or fee-for-service. For example, reinsurance, a stop-loss program for partial reimbursement after a deductible is met, is included in this category.

<sup>7</sup> Amounts primarily consist of monies transferred to the Arizona Departments of Health Services and Economic Security for monies appropriated by the Legislature to these agencies. Specifically, the Legislature appropriated over \$35 million each year in fiscal years 2010 through 2012 to the Department of Health Services for behavioral health services from the tobacco tax monies AHCCCS administers. Similarly, approximately \$3 million each year was appropriated to the Department of Economic Security in fiscal years 2010 through 2012 from county contributions for administration costs for Proposition 204 (November 2000) implementation.

Source: Auditor General staff analysis of the AHCCCS fiscal year 2010 and 2011 financial statements audited by an independent certified public accounting firm and AHCCCS-prepared fiscal year 2012 estimates dated January 24, 2012, that are primarily composed of fiscal year 2012 appropriations.

insurance, workers' compensation, or automobile insurance if an automobile injury. This process is called coordination of benefits.

## Coordination of benefits encompasses two key areas

Coordination of benefits involves two key areas. First, AHCCCS and its contracted health plans work to identify other responsible parties and attempt to avoid paying for those healthcare claims costs that are the responsibility of these other parties. This first step in the coordination of benefits process is called **cost avoidance**. Second, when claims are paid before another responsible party is identified, AHCCCS or its contracted health plans must recover these costs once the other responsible party is identified. This second step is referred to as **post-payment recovery**.

Coordination of benefits begins with cost avoidance—Cost avoidance involves identifying other parties who are responsible for covering all or part of AHCCCS members' medical costs. For example, an AHCCCS member may have Medicare coverage or other health insurance coverage, and AHCCCS' contracted health plans must ensure that Medicare or the other health insurance company pays first before using their capitation payments to pay the claim. AHCCCS has established various processes for identifying whether members have other insurance, including:

- **Requesting information about other health insurance during the eligibility determination process**—Federal regulations require AHCCCS to collect insurance information from applicants and members during the eligibility determination and redetermination process, and AHCCCS does so.
- **Determining whether members have Medicare**—To help ensure AHCCCS is the payor of last resort, AHCCCS works to determine whether their members have Medicare. To identify AHCCCS members who receive Medicare benefits or have Medicare benefits changes, AHCCCS coordinates with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the federal agency that administers both programs.
- **Determining whether members have private health insurance**—Federal regulations and state law require AHCCCS to determine and verify whether AHCCCS members have private health insurance. AHCCCS contracts with Health Management Systems, Inc. (HMS), a national firm that provides coordination of benefits services to most states, to identify whether members have private health insurance (see textbox).

### Health Management Systems, Inc.—

According to its Web site, HMS focuses on providing coordination of benefits, program integrity, and other cost containment solutions services to healthcare payors nation-wide. According to HMS, it provides coordination of benefits services to 41 agencies in 39 states and the District of Columbia, including Arizona. These services include:

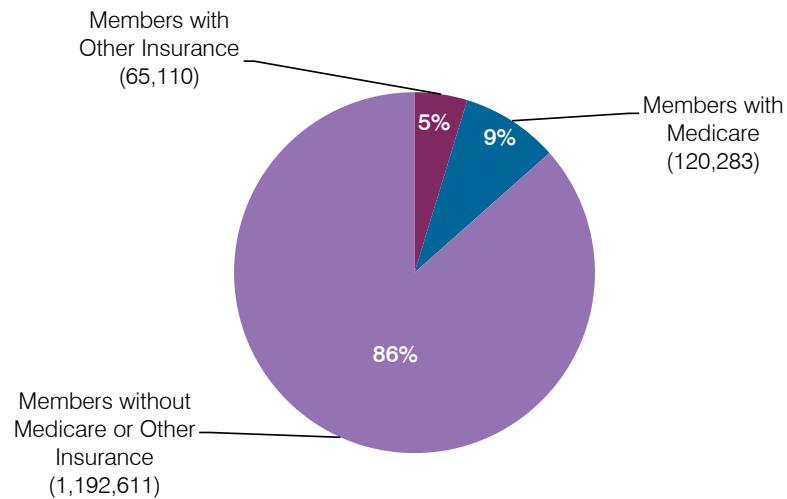
- Identifying Medicaid members who have other private healthcare insurance, and
- Recovering money from responsible third parties.

Source: Auditor General staff analysis of information provided by HMS and available on its Web site as of February 18, 2012.

- Requiring health plans to report other insurance**—A.R.S. §§36-2903(B) (10) and 36-2946(A) allow AHCCCS to require that contracted health plans help the State meet its coordination of benefits requirements. As a result, AHCCCS requires its contracted health plans to take reasonable measures to determine legally liable parties and to cost avoid claims. For example, contracted health plans are required to report to AHCCCS the liable third-party information that they obtain. AHCCCS then sends this information to HMS to verify. In addition, AHCCCS can financially sanction its contracted health plans for not participating in cost-avoidance activities.

These efforts have produced results: almost 14 percent of AHCCCS members have other insurance, and hundreds of millions of dollars is cost avoided annually. As shown in Figure 1, as of September 2011, about 185,000 of the nearly 1.4 million AHCCCS members had Medicare or other insurance. Additionally, as shown in Table 3 (see page 7), in fiscal year 2011, AHCCCS reported that more than \$928 million in claims costs were paid for by Medicare or other insurance.

Figure 1: Number and Percentage of Medicaid Population With Medicare or Other Insurance As of September 2011 (Unaudited)



Source: Auditor General staff analysis of the membership information provided by AHCCCS as of September 2011.

**Table 3: Managed Care and Fee-for-Service Cost-Avoidance Amounts Fiscal Years 2009 through 2011<sup>1</sup> (Unaudited)**

	2009	2010	2011
<b>Managed Care</b>			
Medicare	\$ 667,138,951	\$ 694,122,546	\$ 727,500,357
Other	70,625,113	92,080,667	110,600,824
Total	<u>737,764,064</u>	<u>786,203,213</u>	<u>838,101,181</u>
<b>Fee-For-Service</b>			
Medicare	79,690,721	87,038,836	87,566,008
Other	2,309,388	2,612,108	2,400,648
Total	<u>82,000,109</u>	<u>89,650,944</u>	<u>89,966,656</u>
<b>Total Cost Avoidance</b>	<u>\$ 819,764,173</u>	<u>\$ 875,854,157</u>	<u>\$ 928,067,837</u>

<sup>1</sup> Cost-avoidance totals reported by AHCCCS for the fiscal year actually reflect June through May activity, not July through June activity. AHCCCS reports June through May activity in its fiscal year totals for consistency in reporting all coordination of benefits activities, including post-payment recoveries (see pages 8 through 10 for more information on post-payment recoveries).

Source: Auditor General staff analysis of AHCCCS internal reports for fiscal years 2009 through 2011.

The majority of costs avoided were for managed care members enrolled in contracted health plans. Specifically, in fiscal year 2011, AHCCCS reported more than \$838 million in claims costs that were the responsibility of Medicare or other insurance.<sup>1</sup> Both the contracted health plans and the State benefit from efforts to coordinate benefits and avoid costs. Since contracted health plans are paid a monthly capitation amount, when some or all of a member’s medical costs are paid for by Medicare or other insurance, the health plans avoid these costs. Although the State does not actually recover any of the avoided medical costs, it benefits from reduced capitation rates. Specifically, according to AHCCCS, costs avoided reduce the capitation rates it pays to contracted health plans, which are reviewed and adjusted at least annually, because capitation rates are driven in part by the amounts health plans pay for services after avoiding costs. For example, when the allowed amount for a service is \$90, and Medicare pays \$80, the \$10 paid by the contracted health plan is used in developing future capitation rates.

In addition to its members who are enrolled with the contracted health plans in its managed care system, AHCCCS avoids medical costs for its fee-for-service members. The amount of costs avoided for AHCCCS’ fee-for-service members is smaller because only about 10 percent of its members are fee-for-service members. However, the costs avoided for these members represent actual dollar savings for AHCCCS because AHCCCS pays the providers directly for the medical services provided. During fiscal year 2011, as shown in Table 3, approximately \$90 million in

According to AHCCCS, costs avoided reduce the capitation rates it pays to its contracted health plans.

<sup>1</sup> According to AHCCCS, the more than \$838 million in total claims costs avoided does not include an additional \$307 million in claims costs that its contracted health plans also reported avoiding. The contracted health plans incurred no financial obligation for these claims costs because they were entirely the responsibility of a third party and were, therefore, not submitted to AHCCCS for processing.

fee-for-service healthcare costs were paid by Medicare or other insurance instead of AHCCCS.

Coordination of benefits sometimes involves post-payment recovery of money—Although cost avoidance is preferable, AHCCCS sometimes must recover monies when a responsible third party is identified **after** AHCCCS or its contracted health plans have paid for a member’s medical services. This sometimes occurs when a member has suffered an injury, such as in an automobile accident. Therefore, after claims have been paid, AHCCCS and its contractors are continuously involved in identifying and collecting payments from responsible third parties. These activities take two main forms, as follows:

- **Requiring health plans to conduct post-payment recovery**—To help ensure that AHCCCS is the payor of last resort, A.R.S. §§36-2903(B)(10) and 36-2946(A) allow AHCCCS to require its contracted health plans to participate in identifying and recovering members’ medical costs from liable third parties. AHCCCS has established specific post-payment recovery activities that the health plan contractors must perform, including analyzing members’ healthcare cost data to look for specific diagnostic codes that indicate a member has suffered a specific type of injury, identifying liable third parties, and recovering costs when the payments for healthcare services rendered are partially or wholly the responsibility of a liable third party.
- **Contracting for additional post-payment efforts**—AHCCCS’ contract with HMS, the company that provides cost-avoidance services, includes provisions for post-payment recovery efforts as well. Specifically, AHCCCS contracts with HMS to identify other responsible parties, and collect post-payment recoveries for fee-for-service member cases and for managed care member cases where AHCCCS has paid reinsurance costs. Reinsurance is a part of AHCCCS’ managed care system. Reinsurance costs occur when AHCCCS partially reimburses the contracted health plans for managed care member services costs that exceed a specific amount in any one contract year. For example, if an ALTCS member without Medicare is hospitalized and has medical costs above \$20,000 in one contract year, AHCCCS’ reinsurance will cover 75 percent of the medical costs above that amount.<sup>1</sup> Reinsurance payments are in addition to the monthly capitation payments.

HMS identifies other responsible parties in several ways:

- **Analyzing members’ service data**—HMS uses information from AHCCCS’ payment management system to identify paid claims for members who have suffered a trauma-type injury, such as broken bones. HMS sends these members a questionnaire to determine if there is a liable third party.

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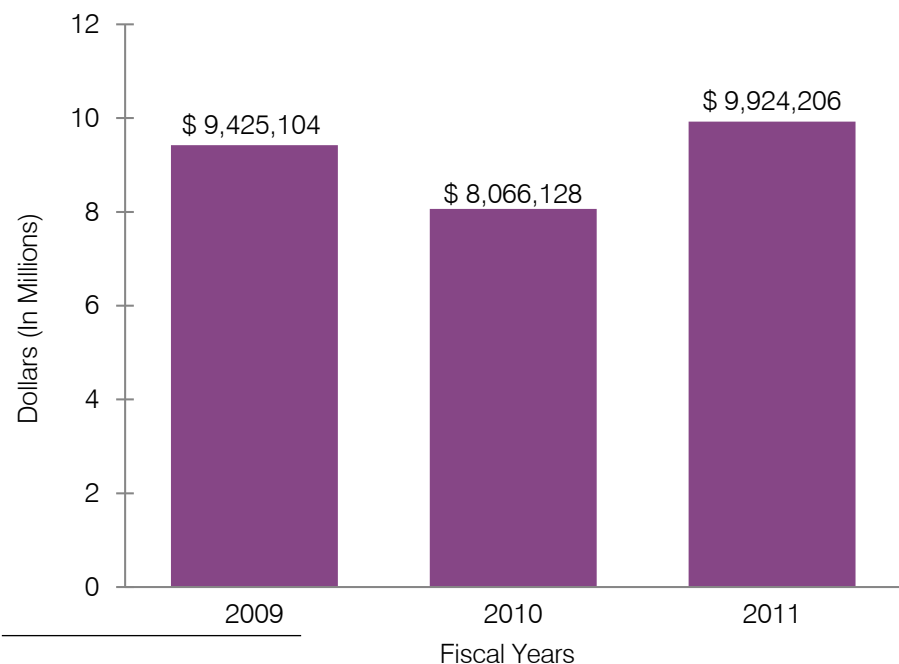
<sup>1</sup> This amount applies to ALTCS health plan contractors who have up to 1,999 members. If an ALTCS health plan contractor has 2,000 or more members, the medical costs must exceed \$30,000 before AHCCCS’ reinsurance coverage begins.

- **Using data matching**—HMS also monthly matches AHCCCS member information against its national insurance coverage database. Although the member information match occurs monthly, HMS’ national database is continuously updated and, therefore, HMS provides new insurance information to AHCCCS daily. This matching process is used to identify members with other insurance before claims are paid, but sometimes identifies insurance coverage that was unknown at the time a claim was paid.
- **Obtaining information from others**—HMS sometimes receives other responsible party information from an attorney representing the AHCCCS member. According to A.R.S. §36-2915, the AHCCCS member’s legal representatives are required to provide written notice to AHCCCS to establish the liability of any third party. In addition, contracted health plans are also required to report probable liable third parties they identify to AHCCCS. AHCCCS then provides this information to HMS for verification.

Monthly, AHCCCS is required to report to the Legislature the recoveries collected from liable third parties. AHCCCS reports recoveries for fee-for-service members and claims involving reinsurance in its monthly Appropriation Status Report. As shown in Figure 2, AHCCCS reported recovering between \$8 million and nearly \$10 million annually in fiscal years 2009 through 2011. Because Medicaid is jointly funded, recovered amounts are returned to the federal government, the State, and other entities that have helped pay for the medical costs. For example, in fiscal year 2011, of the approximately \$9.9 million that AHCCCS recovered in medical costs, it returned \$5.8 million to the federal government and returned \$1.6 million in state funds, including State General Fund monies, and paid \$1.5 million to HMS for its coordination of benefits activities.

AHCCCS’ contracted health plans may also recover

Figure 2: Annual Fee-for-Service and Reinsurance Third Party Liability Recoveries Fiscal Years 2009 through 2011<sup>1</sup> (Unaudited)



<sup>1</sup> Third party liability recoveries reported by AHCCCS for the fiscal year actually reflect June through May activity, not July through June activity. AHCCCS reports June through May activity in its fiscal year totals for consistency in reporting all coordination of benefits activities, including cost-avoidance totals (see pages 5 through 7 for more information on cost avoidance).

Source: Auditor General staff analysis of AHCCCS internal reports for fiscal years 2009 through 2011.



monies from liable third parties and retain the amounts recovered under certain circumstances. Specifically, according to its health plan contracts, for claims where there are no AHCCCS payments related to fee-for-service, reinsurance, or administrative costs, contracted health plans can identify and collect the costs they paid for members' services as long as the collections received do not exceed the amount of the contractor's financial liability for the member and recovery is not prohibited by state or federal law. Quarterly, AHCCCS' contracted health plans are required to report recovery amounts to AHCCCS. During fiscal year 2011, the contracted health plans reported to AHCCCS that they recovered \$14 million from liable third parties. According to AHCCCS, this information is considered during the capitation rate-setting process; however, the amounts have been too small to significantly impact capitation rates.

## Staffing and expenditures

Coordination of benefits activities are performed by AHCCCS, HMS, and its contracted health plans. Specifically, AHCCCS uses its staff to update its payment management system with Medicare and other insurance information, prepare reports related to coordination of benefits activities, and oversee HMS' and contracted health plans' coordination of benefits activities. As indicated earlier, contracted health plans and HMS are also involved in conducting coordination of benefits activities including identifying other liable third parties. As shown in Table 4, the total cost of these activities ranged from about \$1.8 million to more than \$2 million annually in fiscal years 2009 through 2011. The largest expense—between approximately \$1.35 million and more than \$1.6 million annually—has been payments to HMS for cost-avoidance and cost-recovery services (see textbox, page 11). The personal services and related benefits expenses shown in the table are for the four AHCCCS staff who work on coordination of benefits activities full-time and are responsible for overseeing HMS. Finally, AHCCCS has paid CMS slightly more than \$100,000 each year for providing data to AHCCCS for cost-avoidance purposes.

**Table 4:** Expenditures for Cost-Avoidance and Post-Payment Recovery Activities  
Fiscal Years 2009 through 2011  
(Unaudited)

	2009	2010	2011
Personal services and related benefits	\$ 289,441	\$ 297,376	\$ 240,507
CMS fees <sup>1</sup>	106,874	110,888	115,657
HMS contract fees <sup>1</sup>	1,630,932	1,355,436	1,470,218
Total	<u>\$ 2,027,247</u>	<u>\$ 1,763,700</u>	<u>\$ 1,826,382</u>

<sup>1</sup> See Introduction, page 10, for more information.

Source: Auditor General staff analysis of expense information provided by AHCCCS for fiscal years 2009 through 2011.

### **HMS' coordination of benefits activities paid for by post-payment recoveries—**

Effective October 1, 2008, HMS is paid a percentage of the costs it recovers. Although HMS still performs the same cost-avoidance and post-payment recovery benefit activities as it did in the previous contract, including identifying and verifying members' other insurance coverage, AHCCCS changed the contractor payment method. The prior contract paid specific dollar amounts for other insurance data as well as between 10 to 12 percent of recoveries. The current contract pays 15 percent of recoveries with no separate payment for other insurance leads. According to an AHCCCS internal tracking report, during contract year 2011, this new payment approach saved over \$2 million in contract costs, indicating this method is more cost-effective.

Source: Auditor General staff analysis of contract documents and an internal report provided by AHCCCS.



## FINDING 1

The Arizona Healthcare Cost Containment System (AHCCCS) can enhance its efforts to help ensure that it is the payor of last resort by implementing additional oversight procedures and using some additional federal data. AHCCCS' processes help it to meet federal and state requirements and identify thousands of members with other health insurance. However, using some additional federal data could help AHCCCS identify other insurance available to members that could be used to cover some costs before Medicaid dollars are used.

# AHCCCS should implement additional oversight procedures and use additional federal data to further help ensure it is the payor of last resort

## AHCCCS' processes help meet federal and state requirements and identify members with other health insurance

Federal regulation and state laws require that AHCCCS be the payor of last resort. This means that federal and state Medicaid monies should not be used to pay for members' covered healthcare services until all other sources of payment have been exhausted. AHCCCS has established processes that help it meet requirements related to identifying members' other health insurance and coordinating benefits. Auditors' examination of these processes indicate they are working as intended (see Introduction, pages 5 through 8, for a more complete explanation of the processes). For example:

- **Requesting information about other health insurance during the eligibility determination process**—Auditors reviewed AHCCCS' benefits applications and a sample of initial and renewal eligibility determinations and confirmed that applicants are requested to provide this information. If an applicant supplies information about other health insurance, this information is sent to AHCCCS' contractor, Health Management Systems, Inc. (HMS), for verification.
- **Determining whether members have Medicare**—Monthly, AHCCCS receives an electronic file from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). This file identifies AHCCCS members who are enrolled in Medicare, a change in the member's Medicare entitlement, or errors in the member's information, such as a birth date or social security number mismatch. Auditors confirmed that AHCCCS has a reconciliation process that includes researching these discrepancies and correcting them in its management information system. This system is used by AHCCCS and its contracted health plans to help ensure that Medicare pays for AHCCCS members' claims costs first.

- **Determining whether members have other health insurance**—These activities, carried out by AHCCCS' contractor, Health Management Systems, Inc. (HMS), cover most insurance carriers that had a verified insurance policy for one or more AHCCCS members within the past 3 years. Specifically, according to AHCCCS' 2011 Insurance Carrier Compliance report, HMS has data-sharing agreements to obtain insurance coverage information with 259 of the 308 health insurance carriers that had a verified insurance policy for one or more AHCCCS members.<sup>1</sup> Further, these 259 insurance carriers' policies comprised 99.4 percent of the medical insurance policies in place for AHCCCS members as of September 30, 2010, or terminated within the past 3 years. Auditors reviewed HMS' files for 31 of 308 health insurance carriers identified in the 2011 Insurance Carrier Compliance report and found that for all 31, HMS either obtained and maintained data-sharing agreements or made continued efforts to obtain agreements from noncompliant or nonresponsive health insurance carriers.

Auditors also reviewed the data-matching process HMS uses to identify health insurance coverage that enrolled members may have but was not identified during AHCCCS' eligibility process and found that (1) on a monthly basis, HMS matches AHCCCS member information against its national database, and (2) on a daily basis, HMS is providing other verified health insurance information to AHCCCS for updating AHCCCS' management information system. AHCCCS then forwards this verified health insurance data to its contracted health plans. The contracted health plans are required to use this information to coordinate benefits prior to processing claims.

AHCCCS oversees contracted health plans' and HMS' coordination of benefit efforts—AHCCCS has also developed oversight processes to ensure its contracted health plans and HMS comply with their contractual requirements for coordination of benefits. For health plans, this oversight takes two main forms:

- **Reporting potential insurance**—AHCCCS' contracts require the health plans to report the existence of a potentially responsible party within 10 days of discovery. Auditors examined the summaries of all the findings from AHCCCS' 2010 health plan compliance reviews, and these reviews reported that all but one of the health plans were in compliance with the requirements relating to identifying other insurance.
- **Checking to ensure benefits are coordinated**—AHCCCS' management information system reprocesses the claims paid by its contracted health plans and employs several edits to help ensure contracted health plans are

<sup>1</sup> Arizona Revised Statutes (A.R.S.) §36-2923 requires healthcare insurance carriers to provide their enrollment information to AHCCCS to determine whether a Medicaid-eligible person or that person's spouse or dependents are also covered by the healthcare insurer and the nature of that coverage. Although AHCCCS has no authority to enforce compliance with the statute, HMS is continuously working to bring noncompliant insurance carriers into compliance by telephoning and sending correspondence requesting that the carriers provide information on their Arizona-enrolled members.

AHCCCS' contractor, HMS, matches AHCCCS member information against its national database on a monthly basis and provides daily updates on member health insurance information to AHCCCS.

appropriately coordinating benefits. For example, when AHCCCS' management information system indicates that a member has other health insurance coverage, the system will reject claims for that member if the other insurer information is missing. Auditors reviewed four system claim printouts showing that AHCCCS' management information system appropriately denied them because they were missing other insurance information.

In addition to monitoring its contracted health plans, AHCCCS has an informal process in place to ensure HMS is meeting its cost-avoidance contractual requirements. Although AHCCCS has not established formal procedures, AHCCCS monitors trends in data provided by HMS, such as the number of members HMS is identifying as having other health insurance. According to AHCCCS, it handles any concerns with HMS' performance verbally, but would handle concerns in a more formal manner if necessary. To ensure that HMS is effectively meeting its contract requirements, AHCCCS should develop and implement written procedures for monitoring HMS' efforts to identify members with other insurance. The procedures should include a description of AHCCCS' monitoring process and methods for documenting the results of its oversight and any corrective actions taken.

AHCCCS should formalize its process for monitoring HMS' efforts to identify AHCCCS members with other insurance.

## AHCCCS should use additional federal data to ensure it is payor of last resort

Although AHCCCS has a substantial array of cost-avoidance practices in place, it can take additional actions to help ensure Medicaid is the payor of last resort for its members' medical costs. These actions involve using additional federal data to check for other insurance. The federal government requires states to participate in the Public Assistance Reporting Information System (PARIS), which contains data that can help states identify whether their Medicaid program members are also enrolled in other state Medicaid programs or have or are eligible for other federal healthcare benefits, such as military health insurance. AHCCCS uses only one of the three data matches available and should develop and implement procedures for using the other two sources of data.

**AHCCCS required to participate in federal data exchange**—Effective October 1, 2009, AHCCCS modified its State Plan to indicate that it would participate in the PARIS data matches (see textbox). This change was federally required as a condition of receiving Medicaid funding for automated data systems, including Medicaid management information systems. These matches can potentially identify other income and/or medical benefits for which the AHCCCS member may be entitled. There are three types of PARIS matches in which states can participate:

**State Plan**—The State Plan is a comprehensive written contract between AHCCCS and CMS that describes the nature and scope of the State's Medicaid program. The State Plan describes specific methods and procedures AHCCCS performs in order to ensure compliance with federal regulations for coordination of benefits, including the frequency and type of data exchanges.

Source: Auditor General staff analysis of 42 CFR 430.10 and AHCCCS' State Plan.

- **Interstate match**—When this match is performed, public assistance members' social security numbers are submitted by participating states and matched with data from all other participating states to determine if participants are inappropriately enrolled in two or more state Medicaid programs.
- **Veterans Affairs match**—This match provides states with information on enrolled members' eligibility for veterans' benefits and also allows states to confirm if their Medicaid clients are receiving income and medical assistance payments from the U.S. Department of Veterans Affairs. Veterans' benefits and other assistance should be used to cover enrolled members' medical costs before Medicaid monies are used.
- **Federal match**—This match ties state data with information from the U.S. Department of Defense and the U.S. Office of Personnel Management to determine if members are receiving income from any of these sources or are eligible for federal healthcare coverage. Similar to veterans' benefits, federal healthcare coverage should be used to cover enrolled members' medical costs before Medicaid monies are used.

According to the PARIS Web site, as of November 2011, 43 of 50 states, including Arizona, plus Puerto Rico, participated in the interstate and Veterans Affairs matches, and 38 of 50 states, including Arizona, plus Puerto Rico, participated in the federal match.

**AHCCCS should develop procedures to analyze additional federal data**—Although AHCCCS receives data from PARIS for all three matches, it analyzes data from only one of the matches. According to AHCCCS, it started using the PARIS interstate match in February 2007, but not the Veterans Affairs or federal matches.<sup>1</sup> AHCCCS officials said they postponed analysis of the PARIS Veterans Affairs data because the file format was undergoing changes, and AHCCCS was waiting for new instructions from the PARIS project team. AHCCCS planned to develop a process for analyzing the Veterans Affairs data when the new instructions were issued to state Medicaid agencies. AHCCCS officials also explained that although it has been their intent to work with all three matches, their plan was to start with the interstate match and then move to the Veterans Affairs and federal matches as system and staff resources become available.

The PARIS project team issued new Veterans Affairs instructions in December 2011. Therefore, AHCCCS should reactivate its postponed plans to develop a process to analyze the Veterans Affairs match, and it should establish procedures to analyze the federal match as well. AHCCCS officials said they could not determine how many additional personnel, if any, would be required to perform these matches until the volume of work from the additional matches is identified. However, AHCCCS' goal is to try to automate the PARIS data match analyses as

<sup>1</sup> AHCCCS began this match in advance of modifying the State Plan effective October 1, 2009, to indicate that it would participate in the PARIS data matches.

AHCCCS receives data from PARIS for three types of matches, but uses data from only one of these matches.

much as possible in order to reduce the need for additional personnel. In developing its processes, AHCCCS could make use of materials available on the PARIS Web site, including manuals and best practices from other states. For example, according to the PARIS manual, procedures such as the following could be established:

- **Aid & Attendance Allowance (Veterans Affairs data match file)**—The Veterans Affairs data match file may help identify other insurance that could be used to pay for some Arizona Long Term Care System (ALTCS) costs. Specifically, this data match identifies veterans who are receiving or may be eligible for the aid and attendance allowance. This allowance is for some veterans who need the regular assistance of a caregiver.<sup>1</sup> This allowance is added to the veteran’s regular compensation payment amount, but may not be considered income for Medicaid eligibility purposes. However, CMS considers the allowance as other insurance that could be applied toward the cost of Medicaid long-term care services. Using the Veterans Affairs data match, AHCCCS could identify veterans receiving long-term care services who are also eligible for the aid and attendance allowance, and ensure that this allowance is used first to pay for ALTCS claims before using Medicaid dollars.
- **Veterans’ health benefits eligibility (Veterans Affairs data match file)**—The Veterans Affairs data match file could be used to identify veterans who are enrolled in AHCCCS who may be eligible for U.S. Department of Veterans Affairs medical benefits. A person who served in the active military and who was discharged or released under conditions other than dishonorable may qualify for these healthcare benefits, which could be used to pay for some ALTCS costs before using Medicaid dollars.
- **Military health insurance eligibility (federal data match file)**—The federal match file could be used to identify AHCCCS members eligible for military health insurance, also known as TRICARE. This insurance is the U.S. Department of Defense’s world-wide healthcare program for active duty and retired uniformed service members and their families. If an AHCCCS member was determined to have TRICARE, then AHCCCS’ contracted health plans would be required to bill TRICARE before paying for healthcare claims with Medicaid dollars.

In addition to developing procedures on how to use the additional PARIS data, AHCCCS should develop a method to calculate and track costs avoided from using the PARIS data matches to report on the benefits achieved.

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<sup>1</sup> The U.S. Department of Veterans Affairs has established regulations to determine the need for an aid and attendance allowance, which include one or more of the following criteria: living in a nursing home because of mental or physical incapacity, inability to dress or undress, or having an incapacity that requires care and assistance on a regular basis.



## Recommendations:

- 1.1 AHCCCS should develop and implement written procedures for monitoring HMS' efforts to identify members with other insurance. The procedures should include a description of AHCCCS' monitoring process and methods for documenting the results of its oversight and any corrective actions taken.
- 1.2 AHCCCS should reactivate plans to develop and implement a process to analyze the PARIS Veterans Affairs data and establish procedures to analyze the federal match file. In developing its procedures, AHCCCS could make use of materials available on the PARIS Web site, including manuals and best practices from other states.
- 1.3 AHCCCS should develop and implement a method to calculate and track costs avoided from using the PARIS data matches to report on the benefits achieved.

## FINDING 2

Although the Arizona Healthcare Cost Containment System (AHCCCS) has established various processes to meet federal and state requirements for identifying and recovering payments from other persons or entities that are liable to pay for all or part of AHCCCS members' medical expenses, including overseeing the contractors that assist with these efforts, it should enhance these processes. First, AHCCCS should establish an additional oversight procedure of the post-payment recovery activities that its contractor, Health Management Systems, Inc. (HMS), performs to identify and recover monies from other liable parties. AHCCCS should also document its decisions to accept less than the settlement amount recommended by HMS. Finally, AHCCCS should ensure that it meets federal requirements to obtain motor vehicle and work-related accident data by establishing data-sharing agreements with the Arizona Department of Transportation's Motor Vehicle Division (MVD) and the Industrial Commission of Arizona.

# AHCCCS should implement additional procedures and data-sharing agreements for recovering monies from other insurers

## AHCCCS should implement two additional post-payment recovery procedures

To help ensure that AHCCCS is the payor of last resort, federal regulation and state laws also require that AHCCCS identify and recover monies from other liable parties after members' healthcare expenses have been paid. AHCCCS requires its contracted health plans to conduct post-payment recovery activities for its managed care members and contracts with HMS to conduct post-payment recovery activities primarily for its fee-for-service members (see Introduction, pages 8 through 10, for a more complete explanation of the processes). AHCCCS has established oversight processes to ensure that both its contracted health plans and HMS perform these activities. Auditors' reviews of AHCCCS' oversight activities show they are sufficient for health plans, but for HMS, need improvement in one area. In addition, AHCCCS sometimes accepts less money from a liable third party than the settlement amount recommended by HMS, and should document its reasons for doing so.

**Liable third party**—A person or entity that is liable to pay all or part of the healthcare expenses incurred by an AHCCCS member. For example, liable third parties include health insurance companies or Medicare.

**Post-payment recovery**—A process where AHCCCS and its contracted health plans collect monies from liable third parties to cover AHCCCS members' healthcare costs that have already been paid by AHCCCS and its contracted health plans.

Source: Auditor General staff analysis of AHCCCS contract information.

**Oversight of contracted health plans appears adequate**—To ensure that contracted health plans are performing required post-payment recovery activities, AHCCCS has established an oversight process. As part of its oversight, AHCCCS conducts a triennial review of each contracted health plan. This review considers a total of six items related to post-payment recovery. For example, AHCCCS determines whether its health plans reported settlement information to AHCCCS within 10 business days from the settlement date, as required. If AHCCCS determines that a health plan has not met contractual requirements, the health plan is required to develop a corrective action plan. If upon followup by AHCCCS the health plan does

not appear to be making attempts to correct deficiencies, other penalties can be applied, such as monetary sanctions or termination of the contract. Auditors examined the summaries of findings from all 11 AHCCCS' health plan contractor reviews conducted in 2010 and selected the 3 contractors that had the highest number of partial compliance or noncompliance findings for the post-payment recovery contract requirements to determine if these contractors had submitted corrective action plans. Auditors found that these contractors had established corrective action plans, approved by AHCCCS, to address all noncompliant areas.

AHCCCS should improve its oversight of HMS and implement an additional post-payment recovery procedure—AHCCCS has implemented oversight processes designed to ensure that HMS properly manages third-party liability cases, accurately determines settlement amounts, and appropriately recovers payments from liable third parties. For example, in cases where an AHCCCS member is involved in an accident, such as an automobile accident, this money may come in the form of settlements that both AHCCCS and the liable third party have agreed to. When a liable third party or his/her representative offers a settlement amount, HMS prepares a case settlement document for AHCCCS' review and approval that includes information about the AHCCCS member's accident or injury, healthcare expenses paid by AHCCCS, the settlement offer, and the applied formulas mandated by court rulings and law.<sup>1</sup> AHCCCS reviews the settlement document, verifies HMS' calculated value of the healthcare costs paid, and approves the settlement amount. Auditors reviewed a random sample of 42 settlement cases from the month of April 2011 and found that HMS valued all claims appropriately; if there was a settlement amount calculated, the amount was correct; and a lien to recover the settlement amount was filed in a timely manner. Auditors also determined that HMS has established processes to ensure timely settlement of cases. For example, HMS caseworkers are required to check the status of cases every 90 days, and AHCCCS produces and sends to HMS exception reports on cases where the status has not been updated as required.

In addition, AHCCCS monitors open, pending, and closed third-party liability cases to ensure post-payment recovery checks were received in the appropriate amount. AHCCCS receives and reviews monthly reports from HMS that describe the status of all post-payment recovery cases opened, pending, and closed in the previous month. Because HMS is paid based on a percentage of the monies recovered, it has an incentive to identify and collect the maximum amount of post-payment recoveries it can. Further, AHCCCS reviews cases listed on the HMS monthly report to ensure HMS is consistently identifying new cases and that payments are received regularly on open cases. In addition, AHCCCS performs a monthly reconciliation comparing the post-payment recovery monies it receives to HMS' monthly reports to ensure that HMS is properly reporting all cases with collections. AHCCCS reviews the information prior to approving payment to HMS.

<sup>1</sup> The amount of monies recovered in cases where a member sues a third party and is awarded monies are limited by two court rulings: (1) *Arkansas Department of Human Services v. Ahlborn*, applicable to Medicaid cases nation-wide, and (2) *Southwest Fiduciary, Inc. v. AHCCCS*, applicable only to Arizona Medicaid cases.

AHCCCS monitors all third-party liability cases to ensure post-payment recovery checks were received in the appropriate amount.

Based on the examination of the 42 settlement cases, auditors determined that the liable third-party collections HMS delivered to AHCCCS for deposit were accurate when compared to HMS' recorded receipts. Auditors also reviewed AHCCCS' reconciliation of post-payment recovery receipts to HMS' reports for the month ending April 2011 and determined that the process was reasonable.

However, auditors' review of the 42 settlement cases revealed two additional procedures AHCCCS should implement to enhance its post-payment recovery activities. Specifically, AHCCCS should:

- **Review a sample of cases that are paid in full**—As indicated above, AHCCCS reviews and approves HMS' work on cases where there is a settlement and AHCCCS will receive less than the amount it paid for a member's healthcare services. However, AHCCCS does not review those cases where HMS recovers from a liable third party the full amount AHCCCS paid. To ensure HMS has included all of the appropriate healthcare services costs that AHCCCS paid in the full amount to be recovered, AHCCCS should also review a sample of cases paid in full.
- **Document decisions to accept less than HMS' recommended settlement amount**—According to AHCCCS, for some cases there are specific reasons it may accept less than the amount HMS recommended; for example, if the legal costs to pursue the recommended settlement amount would outweigh the additional monies it might receive. When this occurs, AHCCCS should document its decision to settle for less and forward this information to HMS to ensure all AHCCCS decisions related to the case are included in the case file.

## AHCCCS should continue efforts to establish user agreements with state agencies

To ensure it meets federal requirements to identify liable third parties, AHCCCS should develop data-sharing agreements with other state agencies. Specifically, AHCCCS is federally required to obtain data on motor vehicle accidents and thus should establish a data-sharing agreement with the Arizona Department of Transportation's Motor Vehicle Division (MVD). In addition, AHCCCS is required to obtain data on work-related injuries and illnesses, and therefore, should continue its efforts to establish a data-sharing agreement with the Industrial Commission of Arizona.

**AHCCCS should establish data-sharing agreement with MVD**—To help identify liable third parties, AHCCCS should establish an agreement with the MVD to obtain motor vehicle accident data. Federal code 42 CFR §433.138 requires AHCCCS to obtain information from motor vehicle accident files for the purpose of identifying liable third parties for Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists. Establishing

Federal code requires AHCCCS to obtain motor vehicle accident information to help identify liable third parties.

a data-sharing agreement with the MVD to obtain accident data would provide another source of information to AHCCCS to identify members involved in motor vehicle accidents, determine if there is another liable party, and work to recover healthcare costs from those determined to be liable. Federal code allows states to obtain from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), a waiver for this requirement if they can show that they have made reasonable attempts to obtain the data. AHCCCS obtained a CMS waiver in 1990 for this requirement because of computer system incompatibility issues with the MVD. However, according to MVD staff who have been working with AHCCCS on another project, the MVD updated its computer systems in 2011, and these changes allow for data-sharing. Therefore, AHCCCS should establish a data-sharing agreement with the MVD for motor vehicle accident report data.

AHCCCS should continue efforts to establish new agreement with the Industrial Commission—To help identify liable third parties, AHCCCS should continue its efforts to establish an agreement with the Industrial Commission to obtain data on work-related injuries and illnesses. According to A.R.S. §23-921, the Industrial Commission is responsible for administering all of Arizona’s workers’ compensation claims. Federal code 42 CFR §433.138, requires AHCCCS to obtain information on work-related injuries or illnesses for the purposes of identifying liable third parties. In 1999, AHCCCS established a data-sharing agreement with the Industrial Commission. However, according to an AHCCCS document, the data exchange was unsuccessful due to computer system incompatibilities. In November 2006, AHCCCS met with the Industrial Commission, and in May 2011, AHCCCS again contacted the Industrial Commission to inquire about establishing a data-sharing agreement. However, as of September 25, 2011, the Industrial Commission indicated it did not have the staff or financial resources to participate in a data exchange with AHCCCS. Although AHCCCS has been unable to successfully implement the agreement with the Industrial Commission to obtain work-related injury or illness data, to ensure AHCCCS meets this federal requirement, AHCCCS should continue to work with the Industrial Commission to establish an agreement. If AHCCCS is unsuccessful, it should apply for a waiver for this requirement from CMS, as required by federal regulation.

## Recommendations:

- 2.1 AHCCCS should review a sample of cases in which the liable third party pays in full to ensure HMS has included all of the appropriate healthcare services costs and properly valued these cases.
- 2.2 AHCCCS should document the reasons it will sometimes accept less than the amount HMS recommended and forward this information to HMS to include in the case file.

Federal code requires AHCCCS to obtain work-related injury or illness information to identify liable third parties.

- 2.3 AHCCCS should establish an agreement with the MVD to obtain motor vehicle accident data so that AHCCCS can use the data to identify potential liable third parties.
- 2.4 AHCCCS should continue working with the Industrial Commission to obtain information about AHCCCS members who have work-related injuries or illnesses, and if unsuccessful, it should request a waiver for this requirement from CMS.



## APPENDIX A

# Methodology

This appendix provides information on the methods auditors used to meet the audit objectives.

This performance audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Auditor General and staff express appreciation to the Arizona Healthcare Cost Containment System (AHCCCS) Director and his staff for their cooperation and assistance throughout the audit.

Auditors used the following specific methods to meet the audit's objectives:

- To determine whether AHCCCS is meeting state and federal requirements for coordinating healthcare benefits and post-payment recoveries, auditors reviewed the Code of Federal Regulations, Arizona Revised Statutes, the Arizona Administrative Code, AHCCCS' State Plan, and the federal Public Assistance Reporting Information System (PARIS) manual. Auditors also interviewed AHCCCS administrators and staff, and reviewed AHCCCS' procedures for coordinating benefits with Medicare, the Arizona Department of Transportation, Motor Vehicle Division, and the Industrial Commission of Arizona. In addition, auditors interviewed the PARIS project director and obtained federal Veterans Affairs data exchange information to understand the potential benefits of the PARIS data for determining liable third parties; examined the AHCCCS acute care and ALTCS contracts and the Health Management Systems, Inc. (HMS) contract; and reviewed the summaries of all the findings from AHCCCS' 2010 health plan compliance reviews.
- Auditors' work on internal controls focused on reviewing AHCCCS' processes and written policies and procedures to assess compliance with federal and state coordination of benefits requirements. Auditors also interviewed HMS personnel to obtain background information and document its liable third-party identification and post-payment recovery processes, including internal controls over check handling.
- To evaluate HMS' controls over insurance carrier compliance and to establish the propriety of the AHCCCS-submitted insurance carrier compliance report, auditors selected 31 of the 308 insurance carriers identified in AHCCCS' January 2011 Insurance Carrier Compliance report. Auditors then examined HMS' efforts to establish data-sharing agreements with these 31 insurance carriers, including initial outreach letters and noncompliant letters sent to insurers with no established data-sharing agreements.
- To determine if HMS properly valued and managed third-party liability cases, auditors reviewed a random sample of 42 of the 1,080 post-payment recoveries reported to AHCCCS by HMS for the month of April 2011. The number of items selected in the sample was stratified by the proportion of monies recovered by case type.
- Auditors also evaluated AHCCCS' cost-avoidance figures to determine whether the amounts reported to the Legislature appeared reasonable.



Auditors received cost-avoidance data from AHCCCS' medical management information system for healthcare services provided to managed care and fee-for-service members during the month of April 2011. Auditors then totaled the amount of services cost avoided and compared this information to the data compiled and reported by AHCCCS to the Legislature. Based on this work, auditors determined that AHCCCS' process for reporting cost avoidance figures appeared reasonable. Auditors also reviewed the management information system's automated filters that prevent incorrect or incomplete claims from processing through the information system, and guidance published by AHCCCS to inform the contracted health plans of the proper procedures for submitting claims. Auditors did not examine whether AHCCCS or its contracted health plans were ensuring that Medicare and other insurers were paying the appropriate amount because this process was outside the scope of the audit.

- The information used to develop the report's Introduction section was obtained from AHCCCS documents published on its Web site, such as contracts, AHCCCS' fiscal year 2010 and 2011 audited financial statements, and information from AHCCCS administrators and staff, including internal reports. In addition, information on other states was obtained from the Kaiser Family Foundation Web site, and from HMS.

# AGENCY RESPONSE

**Janice K. Brewer, Governor**  
**Thomas J. Betlach, Director**

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*Our first care is your health care*  
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

April 2, 2012

Debra K. Davenport, CPA  
Auditor General  
Office of the Auditor General  
2910 North 44th Street, Suite 410  
Phoenix, AZ 85018

RE: Coordination of Benefits Performance Audit, Draft Report dated March 26, 2012

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the Arizona Health Care Containment System (AHCCCS), Coordination of Benefits Performance Audit. We appreciate the professionalism and efforts of the audit team and believe that the implementation of the findings will further enhance the efficiency and effectiveness of the AHCCCS Coordination of Benefits programs that during fiscal year 2011 cost avoided claims in excess of \$1.2 billion with a \$1.8 million administrative cost to the AHCCCS Administration.

Below are our responses to each recommendation in the report in the order they are listed.

**Recommendations: Page 18**

Recommendation # 1.1:

AHCCCS should develop and implement written procedures for monitoring HMS' efforts to identify members with other insurance. The procedures should include a description of AHCCCS' monitoring process and methods for documenting the results of its oversight and any corrective actions taken.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. AHCCCS does monitor HMS' efforts to identify members with other health insurance; however, it is not formalized in a written policy. AHCCCS will enhance the monitoring process and formalize it in writing to better document HMS monitoring.

Recommendation # 1.2:

AHCCCS should reactivate plans to develop and implement a process to analyze the PARIS Veterans Affairs data and establish procedures to analyze the federal match file. In developing its procedures, AHCCCS could make use of materials available on the PARIS Web site, including manuals and best practices from other states.

Ms. Debra K. Davenport, CPA

April 2, 2012

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Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. In addition to the data problems identified in the PARIS Veterans Affairs files, and the delays in the file format changes by PARIS, the data base AHCCCS currently uses to support working the interstate match is not adequate for analyzing the VA or other federal data. A System Service Request (SSR) has been submitted to develop a web based system that is more robust and flexible, to allow us to perform an analysis of the data and to develop appropriate procedures for ongoing use of the data.

Recommendation # 1.3:

AHCCCS should develop and implement a method to calculate and track costs avoided from using the PARIS data matches to report on the benefits achieved.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. The requested web based system to support all PARIS functions will be designed to include the ability to track costs avoided.

### **Recommendations: Pages 22 and 23**

Recommendation # 2.1:

AHCCCS should review a sample of cases in which the liable third party pays in full to ensure HMS has included all of the appropriate healthcare services costs and properly valued these cases.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented.

Recommendation # 2.2:

AHCCCS should document the reasons it will sometimes accept less than the amount HMS recommended and forward this information to HMS to include in the case file.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. The HMS recommended settlement amounts are based on formulaic approaches to the apportionment of settlement proceeds that are required by federal and state statute, rules and case law. In most cases, the HMS valuation is accepted by AHCCCS, as the recommendation results in a fair and equitable distribution of the available recovery. However, from time-to-time AHCCCS will accept less than HMS' recommendation when the difference in a member's settlement offer is small enough that it is not cost effective to pursue the difference through the administrative and judicial appeals process; or if AHCCCS determines the formulaic apportionment of damages does not meet all of the conditions required by A.R.S. § 36-2915(H) when settling a claim.

Ms. Debra K. Davenport, CPA

April 2, 2012

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AHCCCS agrees that it is important to document the reason for accepting less than the HMS recommended amount and is working with HMS to update the settlement case file to better document the decision made.

Recommendation # 2.3:

AHCCCS should establish an agreement with the MVD to obtain motor vehicle accident data so that AHCCCS can use the data to identify potential liable third parties.

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. While AHCCCS believes that it has alternative procedures in place to identify members who have sustained injuries as the result of a motor vehicle accident, it recently implemented a data sharing process with MVD to obtain driver license pictures of members for provider point-of-service eligibility verification purposes. Shortly after completion of that project, it began discussions with MVD to enter into a data sharing agreement to obtain motor vehicle accident data to further enhance its post-payment cost recovery efforts.

Recommendation # 2.4:

AHCCCS should continue working with the Industrial Commission to obtain information about AHCCCS members who have work-related injuries or illnesses, and if unsuccessful, it should request a waiver for this requirement from CMS

Response: The Finding of the Auditor General is agreed to, and the audit recommendation will be implemented. AHCCCS is in contact with the Industrial Commission of Arizona regarding renewing efforts to enter into a successful data sharing agreement. If these efforts are not successful it will seek a waiver from CMS.

Again, I would like to thank the Auditor General and staff for their time and effort in evaluating the AHCCCS Coordination of Benefits programs. We appreciate the professional approach of the audit team as well as their cooperative attitude with AHCCCS staff.

Sincerely,

Thomas J. Betlach  
Director

cc: Dorothy Reinhard, Auditor General  
Deborah Corcoran, Auditor General

## Performance Audit Division reports issued within the last 24 months

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<b>10-04</b>	Department of Agriculture— Food Safety and Quality Assurance Inspection Programs	<b>11-06</b>	Arizona Department of Veterans' Services—Veteran Home
<b>10-05</b>	Arizona Department of Housing	<b>11-07</b>	Department of Corrections— Oversight of Security Operations
<b>10-06</b>	Board of Chiropractic Examiners	<b>11-08</b>	Department of Corrections— Sunset Factors
<b>10-07</b>	Arizona Department of Agriculture—Sunset Factors	<b>11-09</b>	Arizona Department of Veterans' Services—Veterans' Donations and Military Family Relief Funds
<b>10-08</b>	Department of Corrections— Prison Population Growth	<b>11-10</b>	Arizona Department of Veterans' Services and Arizona Veterans' Service Advisory Commission— Sunset Factors
<b>10-L1</b>	Office of Pest Management— Regulation	<b>11-11</b>	Arizona Board of Regents— Tuition Setting for Arizona Universities
<b>10-09</b>	Arizona Sports and Tourism Authority	<b>11-12</b>	Arizona Board of Regents— Sunset Factors
<b>11-01</b>	Department of Public Safety— Followup on Specific Recommendations from Previous Audits and Sunset Factors	<b>11-13</b>	Department of Fire, Building and Life Safety
<b>11-02</b>	Arizona State Board of Nursing	<b>11-14</b>	Arizona Game and Fish Commission Heritage Fund
<b>11-03</b>	Arizona Department of Veterans' Services—Fiduciary Program		
<b>11-04</b>	Arizona Medical Board		
<b>11-05</b>	Pinal County Transportation Excise Tax		

## Future Performance Audit Division reports

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Arizona Health Care Cost Containment System—Medicaid Eligibility Determination