AHCCCS

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

Janice K. Brewer, Governor
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May 26, 2009

The Honorable Russell Pearce, Chairman
Senate Appropriations Committee
Arizona State Senate
1700 W. Washington
Phoenix, Arizona 85007

Dear Senator Pearce:

I wanted to write and express the agency's concerns about a number of technical issues in the series of budget bills that were recently approved by the Senate Appropriations Committee. I certainly understand and appreciate the tremendous challenge facing the legislature and the State of Arizona and that difficult policy decisions will have to be made. The intent of this letter is not to debate any policy issues included within the budget documents but to raise technical concerns associated with the proposal.

ARRA County Distribution

Senate Bill 1145, Section 1 returns 61.4% of the increased Federal Matching funds associated with the America Reinvestment and Recovery Act (ARRA). Based on our calculations and to remain compliant with the federal maintenance of effort requirements, AHCCCS calculates the amount that should be returned at 62.2%.

Primacy Requirements

Senate Bill 1145, Section 3 establishes a new Primacy requirement. Section B states that "beginning October 1, 2009, public monies may not be expended on any claim or premium in the absence of a third party certification that a comprehensive, electronic test of primacy has first been executed." There are a number of problems associated with this specific provision, as well as the entire section.

- We are not aware of any system that is in existence in the United States or anywhere else that meets the mandates established by this section. If there is any such system currently operational, I would welcome the opportunity to learn more.
- The establishment of this system would require administrative resources. As you may be aware, AHCCCS currently has 231 fewer filled positions as compared to September 2007. A series of administrative reductions have been implemented. There are no funds in the agency to develop this system, let alone within a 90-day period.
- Given the lack of a proven system and the requirements in this legislation on not only Medicaid health plans but also commercial insurers and others, a significant portion of the State's health care related economic activity will come to a grinding halt on September 30, 2009.
- Because AHCCCS is a managed care model, the specific language cited above raises the question whether AHCCCS could even pay out capitation, which currently is pre-paid on a monthly basis. This would significantly alter the managed care payment process.

Repeal of Existing Third Party Liability Statute

Senate Bill 1145, Section 13 repeals Section 36-2923, which details the current Third Party Liability requirements for AHCCCS and commercial carriers. This language was added by the legislature just a couple of years ago in response to a federal mandate under the Deficit Reduction Act of 2005. The federal law requires that states have this specific language in state statute or risk all federal financial participation. I have included a memo developed by my legal counsel for additional information.

Provider Rate Reduction

Senate Bill 1145, Section 28 states "Any rate reductions made pursuant to subsection A and B in combination shall not exceed five percent." This is not consistent with what the budgetary expectations are for the AHCCCS program. The FY 2010 budget assumes two things:

1. Capitation rates will remain flat; and
2. $50 million in General Fund ($200 million Total Fund) savings will be realized from a 5% provider rate reduction.

As was detailed in the March 9, 2009 letter from AHCCCS to the Joint Legislative Budget Committee, the capitation rates for Contract Year Ending 2010 will have to recognize increased utilization in order to remain actuarially sound. Therefore, in order to accomplish a 0% growth in capitation rates, provider rate reductions of up to 5% would need to be implemented. Because the language in section 28 limits the provider rate reduction to 5%, it is not possible to realize both the 0% capitation rate growth and 5% provider rate reduction assumptions. The projected savings of $50 million to the General Fund will not be possible.

Program Funding

Senate Bill 1188, Section 9 provides funding for the AHCCCS program. As detailed in an AHCCCS memo distributed on May 5, 2009, the AHCCCS program has been growing at an annual rate of almost 11% over the past 12 months. To put this in perspective, if we take the current population and assume no growth – not one new member to join AHCCCS – the funding in this budget is short by $30 million. Given the state of the economy, it is safe to assume the program will continue to grow, only increasing the FY 2010 projected shortfall.

$200 Million Fraud Reduction

The JLBC summary sheets detail a $50 million fraud reduction line item. In order to save the General Fund $50 million, it means the agency would have to find $200 million worth of fraud, which is the Total Fund amount. To date, we have not seen a proposal or any new technology that can guarantee $200 million in fraud reduction.

Program integrity is a critical function and a top priority for the agency. I am proud to note that even with the sizeable reductions we have had to implement, AHCCCS has actually been able to restructure and increase the resources under the program integrity umbrella. However, we are always open to new ideas and given the interest expressed by individual vendors and others, AHCCCS recently issued a Request for Information (RFI).

Through this RFI process, vendors can submit proposals on how the agency might improve program integrity. I am happy to provide updates on potential projects or new technology discovered through the RFI process. However, until and unless some more concrete proposals can be established, $200 million in total fund Medicaid savings simply will not be realized.

To explain this further, even if the RFI process demonstrates any concrete proposals that might yield greater fraud reductions, the agency would have to issue a Request for Proposals. Assuming everything goes perfectly, it would take at least one quarter to go through that process and put a new vendor in place. That means the new vendor would have to discover $1 million in fraud every single day between October 1, 2009 and June 30, 2010.

We appreciate your commitment to resolving the State's budget deficit and your consideration of the issues raised in this letter. Again, our intent is to provide you with the information you need in order to make informed policy decisions. If you have any questions on any of these matters, certainly feel free to contact me at (602) 417-7411.

Sincerely,

Anthony D. Rodgers
Director

cc: The Honorable John Kavanagh, Chairman, House Appropriations Committee
Richard Stavneak, Director, Joint Legislative Budget Committee
Eileen Klein, Office of Strategic Planning and Budgeting
Senator Paula Aboud

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DATE: May 20, 2009

TO: Tom Betlach, Deputy Director

FROM: Matt Devlin, General Counsel

SUBJECT: Federal Medicaid Requirements for Third Party Identification and Payment and the Proposed Repeal of A.R.S. § 36-2923

You have asked for my legal opinion regarding the repeal of A.R.S. § 36-2923 as proposed in the amendment to Senate Bill 1145. In brief, the Arizona Medicaid program will be at risk of losing all federal financial participation for the Medicaid portion of the AHCCCS program if the bill, as amended, becomes law.

As a condition of the receipt of federal financial participation in State expenditures for Medicaid, the State must have in place a "State Plan" approved by the federal government that meets the requirements of the Medicaid Act. 42 U.S.C. § 1396b. Among other requirements, every acceptable State Plan must provide the assurance that the State is in compliance with 42 U.S.C. § 1396a(a)(25) which requires, in part, that the State have in effect laws that require commercial group health plans, as a condition of doing business in the State, to:

1. Provide the State Medicaid Agency, upon request, with information regarding dates of coverage and the scope of coverage for Title XIX eligible persons, their spouses and their dependents; and
2. Accept claims submitted by the State, if the claim has been submitted within three years of the date of service.

The full text of the relevant requirement is appended to the end of this memo[i]. The State of Arizona complies with this requirement through A.R.S. § 36-2923.

However, section 13 of the amendment to the Senate bill proposes the repeal of A.R.S. § 36-2923. While section 3 of the amendment proposes adding A.R.S. § 12-3021, neither that section nor any of the other proposed amendments meets the requirements of the Medicaid Act. Specifically, the federal provision that requires disclosure of coverage must apply to:

> "health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USCS § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service…"

While subsection (E) of A.R.S. § 36-2923 meets this requirement, the amendment does not. Furthermore, federal law requires that the State enact a law that prohibits those insurers from denying a claim as untimely if the claim is presented to the insurer by the State within three years of the date of service. While subsection (A)(4) of A.R.S. § 36-2923 meets this requirement, the amendment does not.

Section 13 of the amendment would also cause AHCCCS to be out of compliance with a separate provision of the same section of the Medicaid Act that prohibit the State from denying payment for certain services despite the existence of other insurance. Specifically, section 13 proposes to add A.R.S. § 12-3021 which, at subsection (B), requires: "Beginning October 1, 2009, public monies may not be expended on any claim or premium in the absence of a third-party certification that a comprehensive, electronic test of primacy has first been executed." However, the Medicaid Act requires the State to make payment for certain services without regard to the existence of third party liability, including prenatal and preventative pediatric services or when third party liability is based on the insurance of a non-custodial parent involved in a child support enforcement effort by the State (although the State may pursue reimbursement after the fact)[ii]. Since the proposed language of A.R.S. § 12-3021 prohibits the expenditure of any state funds prior to establishing the existing of other insurance, it conflicts with federal requirements.

Whenever the State fails to execute its Medicaid program in accordance with federal requirements and the requirements of its approved State Plan, the federal government can deny federal financial participation for the program in whole or in part. 42 C.F.R. § 430.35. If the legislative changes included in section 13 of the amendment to Senate Bill 1145 are enacted as proposed, the State is at risk of losing federal financial participation for the AHCCCS program.

ENDNOTES

[i] Specifically, section 6035(b) of the federal Deficit Reduction Act added the following State Plan requirements to section 1902(a)(25) of the Medicaid Act:

> (I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USCS § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--
>
> (i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1902(e)(13)(D) [42 USCS § 1396a(e)(13)(D)]) for, or are provided, medical assistance under the State plan under this title [42 USCS §§ 1396 et seq.] (and, at State option, child health assistance under title XXI [42 USCS §§ 1397aa et seq.]), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;
>
> (ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
>
> (iii) respond to any inquiry by the State regarding a claim for payment for any health care item or

service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

[ii] 42 U.S.C. § 1396a(a)(25) includes the following provisions:

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B) [42 USCS § 1396d(a)(4)(B)]) covered under the State plan, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act [42 USCS §§ 651 et seq.], the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);