AHCCCS Coordination of Benefits and Third Party Liability

Definitions

Coordination of Benefits/Cost Avoidance (COB) – a method of avoiding payment of claims when other insurance resources are available to the member.

Third Party Liability (TPL) – the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise liable to pay all or part of the medical expenses incurred by an AHCCCS member.

Statutory Requirements

- AHCCCS is by Federal law the "payor of last resort" in most instances. Payor of last resort means that AHCCCS only pays claims after all other forms of payment have been exhausted. According to 42 CFR 433.138, 42 CFR 433.139 and the Deficit Reduction Act of 2005, AHCCCS is required to take measures to identify third party payors who are responsible for paying for services provided through AHCCCS and its program contractors.
- Federal Deficit Reduction Act (DRA) of 2005 created clear parameters for the exchange of commercial health plan information with Medicaid. The DRA mandated that states enact similar language.
- Legislature enacted conformity language in 2007. A.R.S. 36-2923, which was enacted during the 2007 legislative session, requires that private health insurers provide AHCCCS with the enrollment and claims data necessary to ensure that it is "the payor of last resort."

Implementation

- AHCCCS has traditionally contracted with a vendor to provide TPL and COB services. In the past year, AHCCCS competitively rebid these services. Health Management Systems (HMS) won the contract and was awarded a one-year contract with four potential one-year renewals.
- HMS is reimbursed based on a percentage of recoveries. Funds must be recovered for the company to be compensated.
- HMS offers a variety of Services under the contract to AHCCCS.

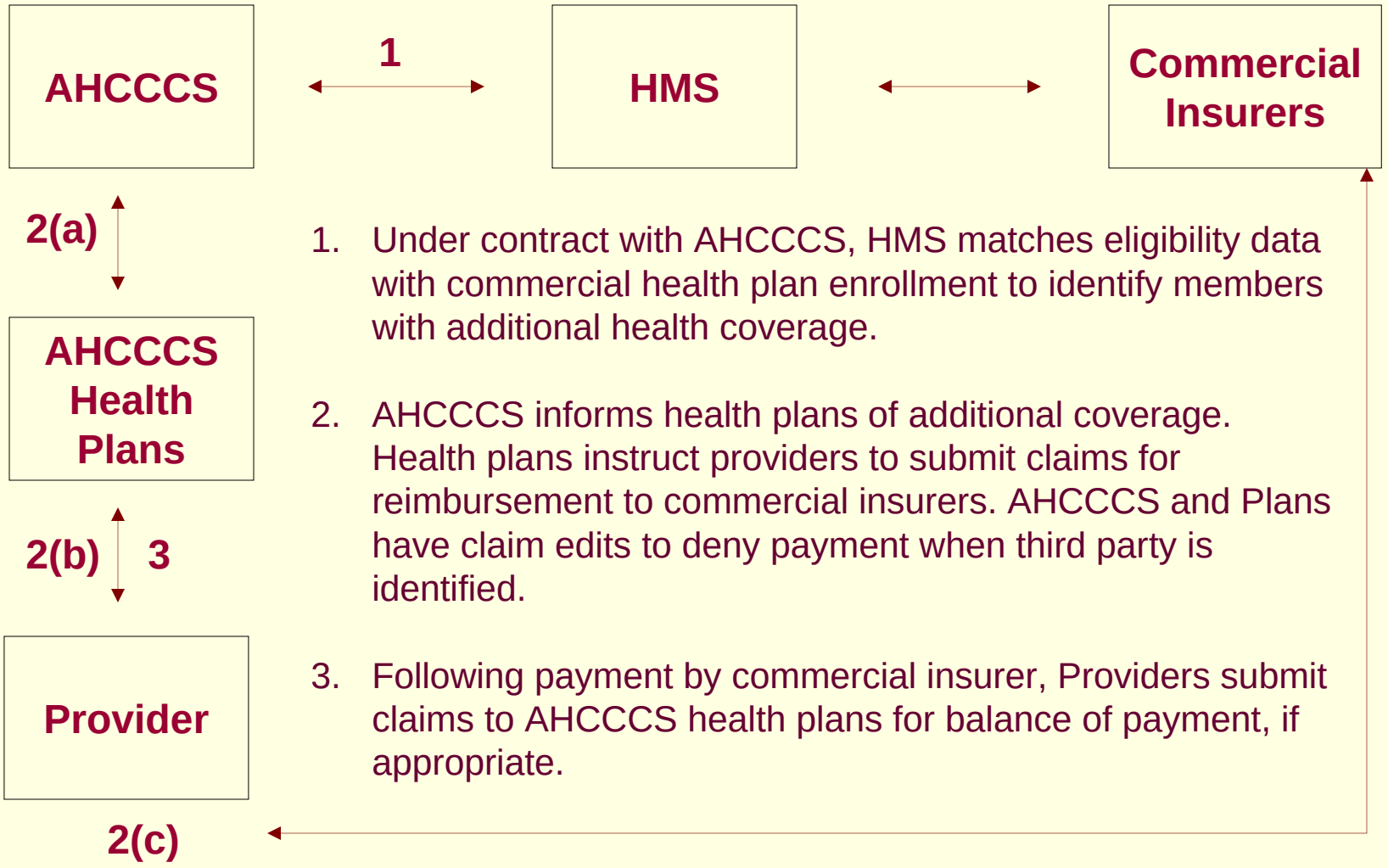
Coordination of Benefits

- One of the primary services under the HMS contract is to regularly update the AHCCCS eligibility data base by matching members with commercial insurance carriers. (See Flow Chart for Process)
- HMS currently has data sharing agreements and performs data matches with 28 of the top 30 insurance companies in this state, covering over 99% of the lives covered by those top 30 carriers. Utilizing these regularly updated data matches, AHCCCS and its contractors can identify an individual who has other health insurance coverage prior to paying a claim.
- On average 35,000-40,000 members have other commercial coverage identified on the AHCCCS database.
- In addition, approximately 100,000 members have Medicare. The COB process for these individuals works in a different manner.
- As detailed in the flow chart, this information is used in managing provider payment at the front end BEFORE the claim is paid. Both AHCCCS and the contracted health plans have appropriate edits in the claims system to ensure that claims are properly coordinated when other insurance is identified.
- Contracted health plans clearly have a financial incentive to fully ensure that claims are appropriately coordinated.
- During the past year, $57 million in Total Fund costs were avoided through the coordination of benefits.
- These savings ARE already incorporated into the capitation rates that are paid to contracted health plans.

Third Party Liability

- HMS also serves as the AHCCCS fee-for-service program vendor for ensuring all efforts are taken to pursue TPL.
- These efforts include functions such as casualty and estate recovery.
- Typically this area involves AHCCCS making the original payment for medical services and then pursuing other legal avenues to seek reimbursement from liable parties.
- During the past 12 months, $8.5 million in Total Funds were recovered. The federal funds portion is returned to the federal government and the state match amount is used to offset state match requirements.
- The contracted health plans also have TPL contractors that provide similar services. Again, the plans have a fiscal incentive to maximize TPL.

AHCCCS Third Party Liability Process



1. Under contract with AHCCCS, HMS matches eligibility data with commercial health plan enrollment to identify members with additional health coverage.

2. AHCCCS informs health plans of additional coverage. Health plans instruct providers to submit claims for reimbursement to commercial insurers. AHCCCS and Plans have claim edits to deny payment when third party is identified.

3. Following payment by commercial insurer, Providers submit claims to AHCCCS health plans for balance of payment, if appropriate.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
OFFICE OF PROGRAM INTEGRITY

The following provides an overview of the AHCCCS Office of Program Integrity and its efforts to combat fraud in our state Medicaid program:

1. SUBPOENA POWER & AUTHORITY TO ADMINISTER OATHS (A.R.S. § 36-2918).
As part of an investigation of fraud or abuse, this statute authorizes the issuance of a subpoena to any person to compel the attendance of a witness and the production of any record to support an investigation or audit.

2. CIVIL MONETARY PENALTY AUTHORITY (A.R.S. § 36-2918).
The statute assesses a civil penalty for any false or fraudulent claim of up to $2,000.00 for each item or service claimed and an additional penalty of an amount not to exceed twice the amount **claimed.** This statute also authorizes AHCCCS to exclude an individual that has violated this provision from participation in the system.

3. DESIGNATION AS A CRIMINAL JUSTICE AGENCY.
On February 6, 2002, the AHCCCS Office of Program Integrity was designated a Criminal Justice Agency. This designation authorizes us to access Arizona motor vehicle records, the National Crime Information Center (NCIC) data base, as well as the Arizona Criminal Justice Information System.

4. LEXIS NEXIS CHOICEPOINT.
This database combines personal data from multiple public and private databases. The firm maintains more than 17 billion records of individuals and businesses that we use as lead information in our investigations. AHCCCS has a contract for unlimited searches for a basic monthly charge.

5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM (A.R.S § 36-2602; A.R.S. § 36-2903).
These statutes provide for a computerized central database tracking system to track the prescribing, dispensing and consumption of schedule II, III and IV controlled substances that are dispensed by a medical practitioner or by a pharmacy that holds a valid license or permit. They also provide for the computerized central database tracking system task force; AHCCCS is a member of the task force.

6. OTHER DATA BASES.
AHCCCS uses other data sources to assist in its efforts to combat fraud and abuse. These include:

- Experian credit reporting services;
- Base wage inquiry via the State unemployment division of the Arizona Department of Economic Security (DES);
- County Assessor records; and
- Various public web sites.

7. STAFFING.
There are 34 Investigators (including management) and 4 administrative assistants assigned to Phoenix, Tucson and Flagstaff. The investigators conduct audits and investigations pertaining to allegations of provider fraud, member fraud and internal misconduct.

8. COOPERATION WITH ATTORNEY GENERAL'S OFFICE AND COUNTY ATTORNEY'S OFFICE.
The Medicaid Fraud Control Unit (MFCU) is a federally mandated unit within the Arizona Attorney General's Office that is charged with prosecuting AHCCCS provider fraud cases. The Office of Program Integrity works closely with the MFCU, as well as the County Attorney's Office in coordinating the prosecution of all cases involving provider fraud.

9. CONTRACTED HEALTH PLANS.
Health plans are required by contract to have a compliance program. The Compliance Officer must report to a senior corporate officer with the authority to make independent fraud referrals to AHCCCS. As part of the scheduled Operational Financial Review of each health plan, the Office of Program Integrity reviews the corporate compliance program to ensure the independence and operational effectiveness of the program. The Office of Program Integrity sponsors a compliance officer network group meeting three times per year. All compliance officers from each contracted health plan are invited to attend to share ideas, identify problem areas and learn about emerging trends.

10. CASELOAD, RECOVERIES AND PROGRAM SAVINGS.
For State Fiscal Year 2009, the Office of Program Integrity's total recoveries and savings were **$26,246,747**.

Provider Fraud Unit	**Member Fraud Unit**	**Fraud Prevention Unit**
Cases assigned: 131	Cases assigned: 215	Cases assigned: 8,370
Recoveries: $3,929,249	Recoveries: $166,978	
Program Savings: $1,451,487	Program Savings: $1,144,507	Program Savings: $19,466,807

10. MEMBER FRAUD AND FALSIFICATION OF INFORMATION.
The Office of Program Integrity investigates allegations pertaining to AHCCCS members who may have falsified information submitted to DES or AHCCCS to obtain medical benefits. When the investigation substantiates allegations of criminal misconduct, the case is presented to the county attorney with jurisdiction.

11. AUDIT OF THE AHCCCS FRAUD PROGRAM.
A recent CMS Audit found: "[I]t is evident by the outcomes of investigations (convictions, recoupments, exclusions, etc.) by both the state and the MFCU that Arizona has invested a lot in its efforts to identify fraud and abuse."

12. THE FRAUD HOTLINE
The Office of Program Integrity maintains fraud reporting hot lines: 888-487-6686 (602-417-4193) and 602-417-4045. Fraud may also be reported via the web site: www.azahcccs.gov, click on Reporting Fraud and Abuse.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Region IX
Division of Medicaid & Childrens Heatlh Operations
90 7th Street, Suite 5-300(5W)
San Francisco, CA 94103-6707

DATE: May 28, 2008

TO: Medicaid State Director's
Region IX

FROM: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

SUBJECT: Audit of Selected States' Medicaid Payments for Services Claimed to Have Been Provided to Deceased Beneficiaries (A-05-05-00030)

In September 2006, the HHS Office of the Inspector General (OIG) completed an audit of Medicaid payments for services claimed to have been provided to deceased beneficiaries in ten States. See the OIG report, "Audit of Selected States' Medicaid Payments for Services Claimed to have been Provided to Deceased Beneficiaries" at (http://oig.hhs.gov/oas/reports/region5/50500030.pdf).

BACKGROUND

The OIG's audit sought to (1) consolidate the results of the 10 State audits of unrecovered overpayments for medical services claimed to have been provided to deceased Medicaid beneficiaries and (2) determine why the States did not identify and recover the overpayments.

In 8 of the 10 States audited, providers received an estimated total of $27.3 million ($15.1 million Federal share) in Medicaid overpayments, which the States never recovered for services claimed to have been provided after a beneficiaries' death. All 10 States had procedures and some form of prepayment screening to identify and recover Medicaid overpayments. However, prepayment screening by some States did not successfully identify the overpayments for deceased beneficiaries because the States did not use all available death information and because their payment systems had data entry, matching, and processing problems. Furthermore, although 9 of the 10 States had some form of postpayment screening, the screening did not identify all overpayments for services associated with deceased beneficiaries.

1. States Did Not Use All Available Death Information

States did not use all available sources of death information, such as SSA's death file and the States' vital statistics and health department death files, to identify payments for services claimed to have been provided after a beneficiaries' deaths. Thus, these States

ORIG: File
RC: TR

lacked important information when considering whether to make initial payments or whether the payments were for services after beneficiaries' deaths that should be recovered.

2. Payment Systems Had Data Entry, Matching, and Processing Problems

Data entry, matching, and processing problems in State Medicaid payment systems resulted in unidentified and unrecovered payments made on behalf of deceased beneficiaries. These problems included inaccurate and incomplete information entered into the Medicaid Management Information System, delayed posting of deaths to the Medicaid Management Information System, limited prepayment and postpayment screening procedures, and unexplained system errors. Further, the recording of incorrect Social Security numbers in the Medicaid record during enrollment sometimes hampered data matching.

ARIZONA EXAMPLE

The OIG identified Arizona's approach to addressing the problem as particularly noteworthy. We are attaching a summary of the steps they take to ensure such erroneous payments are not made.

We would like the Medicaid agencies to work with the other relevant agencies in their State to eliminate payments for services claimed to have been provided to deceased beneficiaries and strengthen their existing post-payment review processes to recover such payments made.

If you have any questions regarding enhancements to a State's MMIS to enhance this process, feel free to contact Jenny Chen at 415-744-3689.

Jackie Glaze

Jackie Glaze

Arizona Health Care Cost Containment System (AHCCCS)
Processing the date of death of members

AHCCCS is the Medicaid agency in Arizona. Arizona is a managed care environment and most members are enrolled in health plans (with the exception of Native American members selecting Indian Health Services, and members eligible for emergency services only). Those plans are paid a monthly capitation for prospective enrollment. The eligibility for Medicaid is determined by several agencies and is transmitted to AHCCCS and updated in a central computer database. When a member dies, the notification of the death to AHCCCS comes from a variety of sources.

Arizona is a 1634b state in which the SSI cash beneficiaries are automatically Medicaid eligible. The Social Security Administration (SSA) transmits that eligibility to AHCCCS on daily files. When SSA is made aware of a beneficiary's death, SSA sends the termination of the eligibility on the daily file to AHCCCS with the term reason of death. This immediately terminates the eligibility as of the date of death and the capitation is recouped from the health plan starting with the day after the death.

The Arizona Department of Economic Security (DES) determines eligibility for the TANF (family) related eligibilities. They transmit that eligibility on daily files. When they are aware of a recipient's death, they terminate the eligibility for the end of the month and AHCCCS updates the termination with the term reason of death.

AHCCCS internally determines eligibility for Long Term Care, SSI related non-cash eligibility, Medicare Cost Sharing and KidsCare (SCHIP). When it becomes known that a member has died and verification is obtained with the actual date of death, the eligibility is terminated and the capitation is recouped after the date of death.

AHCCCS also receives a monthly file from the Arizona Office of Vital Records of all deaths recorded in the state in the prior month. AHCCCS matches that file against the member database and terminates or updates the date of death on all matched members. Any terminations or adjustments to the date of death result in the recoupment of the capitation effective the day after the date of death.

Arizona also receives death notifications from CMS for Medicare beneficiaries. The monthly CMS Electronic Data Base file, the monthly Part D response file, and the monthly Medicare premium buy-in files all can contain information that a member is deceased. These are resolved automatically and/or through discrepancy reports. When buy-in is involved, an immediate termination of the buy-in is made and a recoupment is completed of any premiums that were paid after the month of death. Any other eligibility is also processed and recoupments are made.