AHCCCS
Arizona Health Care Cost Containment System

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

Janice K. Brewer, Governor
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September 30, 2014

Cynthia Nanes
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Dear Ms. Nanes:

Enclosed is Arizona State Plan Amendment (SPA) #14-011, effective July 1, 2014, which updates the State Plan to reflect changes to Third-Party Liability.

If you have any questions about the enclosed SPA, please contact Christopher Vinyard at (602) 417-4034.

Sincerely,

Monica Coury
Assistant Director
Office of Intergovernmental Relations

Cc: Cheryl Young
Barry Levin
Tyler Sadwith

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 14-011	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

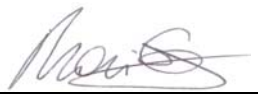
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 C.F.R. 433.138(d)(1); (d)(4)(i); (d)(4)(ii); (d)(4)(ii); (e); (g)(2)(i); (g)(3)(i)(iii); (g)(4)(i)(ii)(iii); 42 C.F.R. 433.139(b)(3)(ii)(A); (f)(2)	Annual net gain of $100,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.22-A; pages 1-5 Attachment 4.22-A Supplement Attachment 4.22-B; pages 1-2	Same

10. SUBJECT OF AMENDMENT:

Updates the State Plan to reflect changes to Third Party Liability

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
	Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Monica Coury	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: 9-30-14	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Arizona

THIRD PARTY LIABILITY

4.22(b)(1):

Frequency of data exchanges required by 42 CFR 433.138 (d) (1), State Wage Information Collection Agency (SWICA), and SSA Wage and Earnings Files.

The Arizona Health Care Cost Containment System (AHCCCS) conducts data exchanges as required by federal law.

The State Wage ~~and SSA Wage Earnings~~ Information is provided ~~to AHCCCS~~ by the Arizona Department of ~~Economic Security' (DES)~~Administration's Office of Employment and Population Statistics (EPS), which is the ~~State's designated Income and Eligibility Verification System (IEVS) agency~~State Wage Information Collection Agency. ~~DES performs all matches against tapes which are provided by AHCCCS on a monthly basis.~~ The eligibility systems (AZTECS and HEAplus) of the Arizona Department of Economic Security and AHCCCS matches with the State Wage file during the application and renewal process. It also searches for a match every six months for families that report no income during their application or renewal.~~The State Wage and SSA Wage Earnings data requests, received from AHCCCS, are merged with those of DES and submitted on a monthly basis to the appropriate agency. DES forwards the "full file" response to AHCCCS for processing.~~ AHCCCS and DES collect SSA income and Medicare information from the SVES and SOLQI processes provided by SSA. DES collects SSA income information from the BENDEX file provided by SSA.

Frequency of data exchange required by 42 CFR 433.138(d)(3), IV-A Agency.

The DES refers TPL information to AHCCCS on a daily basis.

Frequency of data exchange required by 42 CFR 433.138(d)(4)(i), State Workers Compensation or Industrial Accident Commission.

AHCCCS conducts quarterly data exchanges with the Industrial Commission of Arizona (ICA) to match Medicaid recipients with records of those with employment related injuries or illnesses. ~~Previously, AHCCCS was unable to accomplish a data match with the Industrial Commission for Worker's Compensation information and HCFA had deemed this requirement as having been met in a letter dated July 12, 1994. However, due to a data system change at the Industrial Commission, AHCCCS was able to complete its first data match for Workers' Compensation information in March 1998. The data has been referred to the AHCCCS TPL Contractor to begin a cost avoidance and recovery investigation. AHCCCS will conduct a data match on Workers' Compensation information on a quarterly basis.~~

Frequency of data exchange required by 42 CFR 433.138(d)(4)(ii), State Motor Vehicle· accident report files.

AHCCCS conducts quarterly data matches with the Arizona Department of Transportation (ADOT) to identify Medicaid recipients with motor vehicle accident reports. ~~The requirement that AHCCCS conduct a data match with MVD was deemed as having been met in a letter from HCFA, dated January 30, 1990.~~

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~~AHCCCS does not conduct a data match with the State Motor Vehicle Department (MVD) at this time. Previously, in attempting to conduct a data match, it was determined that MVD does not require the Social Security Number (SSN) to be included in the MVD record, and the SSN is necessary for matching to AHCCCS records. Additionally, a complete data match has not been feasible because the information collected by the MVD that AHCCCS needs to identify potential cases has been stored in separate data banks (computer systems).~~

~~For several years, the MVD has been working on a plan for implementing a new computer system which will merge all MVD data into one system. Although the MVD does not require the inclusion of an applicant's SSN, it can be and often is provided by the applicant and included in the applicant's record. Therefore, there is a possibility of matches to the MVD record, if and when, the three data banks are merged. Should a merged MVD computer system become reality, AHCCCS and its TPL Contractor will meet with the MVD representatives to discuss the feasibility and time frame for conducting future data matches.~~

Frequency of the diagnosis and trauma code edits 800-999 (excluding 994.6) per 42 CFR 433.138(e).

Diagnosis and trauma code edits are conducted monthly. AHCCCS contracts with a TPL Contractor to perform the required diagnosis and trauma code edits matches and recovery.

The TPL Contractor is provided, via the secure FTP server, a monthly extract of fee-for-service (FFS) paid claims that include the claim specific diagnosis codes. The TPL Contractor conducts diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6, for all fee-for-service claims, and returns a file of matched members not previously identified in a trauma code data match. Each Member identified in the data match is sent a questionnaire, and they are asked to respond within 10 days.

~~AHCCCS produces a monthly tape of paid claims showing diagnosis and trauma codes of 800-999 (excluding 994.6) and submits data to the TPL Contractor for processing.~~

4.22(b)(2):

Methods used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(l)(i), SWICA, SSA Wage and Earnings Files, and IV-A Agency.

AHCCCS and the DES Division of Benefits and Medical Eligibility (DBME) workers identify ~~and verify the employer group information, including the TPL information, by contacting the employer through IEVS leads based on~~ potential TPL based on information obtained from the SWICA and SSA Wage and Earnings files. ~~The DBME eligibility interviewer (EI) obtains verification whenever TPL resources are indicated. Third~~ The TPL ~~Party Liability~~ information is inputted into the Arizona Technical Eligibility Computer System (AZTECS), ACE, or HEAplus eligibility systems~~DBME computer system~~. AZTECS is the DES eligibility system for various public assistance programs; AHCCCS Customer Eligibility (ACE) is the eligibility system used by AHCCCS for ALTCS enrollment; Health-e-Arizona Plus (HEAplus) is the state's new eligibility system designed to comply with the Affordable Care Act. Medical eligibility is currently being transitioned to HEAplus. Eventually, the state plans to use HEAplus to determine eligibility for all of the state's public assistance programs. This information is transmitted ~~nightly~~ daily to the AHCCCS Prepaid Medical Management Information System (PMMIS). Once entered into the ~~AHCCCS Prepaid Medical Management Information System (PMMIS)~~PMMIS, the information is sent to the AHCCCS TPL Contractor for verification. Once verified the information is communicated to the AHCCCS Managed Care Contractors~~health plans~~ via the enrollment roster which provides the insurance carrier ~~name~~information.

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The DES Division of Child Support Enforcement (DCSE), which is the State IV-D Agency, plays a major role in medical support enforcement. DCSE is responsible for transmitting relevant health insurance information to AHCCCS when medical support is secured. Information is verified through the absent parent's employer ~~via the CS-157 after using the locate service~~ and is then entered into the Arizona Tracking and Location Automated System (ATLAS). DCSE transmits a ~~monthly tape~~daily file to AHCCCS which contains all TPL adds, changes and deletes.

Method for meeting the follow-up requirements contained in 42 CFR 433.138(g)(2)(i), Health insurance information and Workers' Compensation data exchanges.

Health Insurance Data Exchanges:

Identifying Members with other medical coverage information begins with the initial eligibility process and continues throughout the Member's Medicaid eligibility. Commercial insurance coverage information is maintained in the Pre-paid Medical Management Information System (PMMIS). AHCCCS utilizes its TPL Contractor to perform insurance verifications and data matches. New insurance referrals and updates to existing commercial insurance coverage information are batched daily and placed on the secure FTP server. The TPL Contractor picks-up the file and verifies the changes. When the verifications are completed the TPL Contractor returns the coverage information to the secure FTP server. In addition to verifying new segment information received from AHCCCS, the TPL Contractor monthly matches the entire Medicaid membership with their national database of commercial insurance policy information and verifies the coverage of potential matches and returns the verified information to the secure FTP server. Upon receipt of the verified coverage information, AHCCCS updates PMMIS and, if appropriate, transmits verified coverage information to the appropriate health plan (MCO) using the secure FTP server.

Monthly, the TPL Contractor matches AHCCCS FFS paid claims with the contractor's national medical insurance coverage database and if a Member match is found the responsible insurance carrier is billed for paid claims that may have been overlooked by the State's internal TPL activities. All recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

Workers' Compensation Data Exchanges:
AHCCCS conducts a quarterly data match with the ICA. The TPL Contractor conducts the data match of AHCCCS Members with individuals who have filed a claim with the ICA. Quarterly, the ICA places a file containing all of the Workers Compensation claims opened within the last 24 months on the AHCCCS secure FTP server. The TPL Contractor picks up the file, matches the data with AHCCCS Membership, and then uses the file of the matched FFS members in either the diagnosis and trauma code edit recovery process (see diagnosis and trauma code edits below) or for a more specialized recovery effort. Again if appropriate, workers compensation information is transmitted to the appropriate health plan (MCO) using the AHCCCS secure server, to be used in their recovery effort. Workers compensation recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.
~~The DES and ALTCS eligibility workers request and document all medical coverage information on the application. DES sends a nightly eligibility tape to AHCCCS.~~

~~The valid information is entered and maintained in the appropriate PMMIS/TPL computer file. All updates to the member's TPL file occur within seven working days after receipt of the information. The AHCCCS Member File Integrity Section (MFIS) maintains the actual copies of the referrals received from the various agencies and the on-line updates document. The daily referrals are batched and filed by date of update, for future reference. If there is a need to verify to a particular TPL referral, PMMIS is checked for the original date of update and then compared with the original referral.~~

~~Once the tape is received and matched against PMMIS, any new information is transmitted to the health plan via its enrollment roster, which is a "yes" or "no" TPL indicator and includes the insurance carrier's name.~~

~~AHCCCS completed its first data match with the Industrial Commission of Arizona for Worker's Compensation information in March 1998. The AHCCCS TPL Contractor is analyzing the information for cost avoidance and recovery action.~~

4.22(b)(3):

Method used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(3)(i)(iii), State motor vehicle accident report file data exchanges.

AHCCCS conducts a quarterly data match with the ADOT. AHCCCS provides ADOT a file containing the AHCCCS ID number, SSN and other required information for members who are over the age of 14 years during that last 24 months.

ADOT conducts the matching process and returns a file that contains the AHCCCS ID number and any matched "crash" data. Since ADOT only has the ability to match the AHCCCS members with licensed drivers, AHCCCS expands the ADOT returned file to include AHCCCS Members who are part of the Member's household, or otherwise associated with the ADOT matched member in the AHCCCS eligibility system, before sending it to the TPL contractor for follow-up. Upon receipt of the file, the TPL Contractor eliminates previously reported casualty cases and uses the FFS matches as a referral to the Trauma Edit Code Edit process (see diagnosis and trauma code edits below), or sends them to the appropriate health plan (MCO) using the AHCCCS secure FTP server, to be used in their recovery effort. Recoveries from the ADOT data matches are reported in the year of the AHCCCS paid claim using appropriate reporting categories.~~AHCCCS does not conduct a data match with the state Motor Vehicle Department (MVD) at this time. Previously, in attempting to conduct a data match, it was determined that MVD does not require the Social Security Number (SSN) to be included in the MVD record, and the SSN is necessary for matching to AHCCCS records. Additionally, a complete data match has not been feasible because the information collected by the MVD that AHCCCS needs to identify potential cases has been stored in separate data banks (computer systems).~~

~~For several years, the MVD has been working on a plan for implementing a new computer system which will merge all MVD data into one system. Although the MVD does not require the inclusion of an applicant's SSN, it can be and often is provided by the applicant and included in the applicant's record. Therefore, there is a possibility of matches to the MVD record, if and when, the data banks are merged. Should a merged MVD computer system become reality, AHCCCS and its TPL Contractor will meet with the MVD representatives to discuss the feasibility and time frame for conducting future data matches.~~

4.22(b)(4):

Method used for following up on paid claims contained in 42 CFR 433.138(g)(4)(i)(ii)(iii), diagnosis and trauma code edits.

AHCCCS' contracts with a TPL Contractor to perform the required diagnosis and trauma code edits for AHCCCS. The TPL Contractor conducts diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6, for all fee-for-service claims. The Centers for Medicare & Medicaid Services (CMS) developed a list of codes shown to be unproductive and offered a blanket waiver to all states. AHCCCS adopted the recommendation and edited all of the ICD-9 codes listed. The following lists of codes are currently being edited from the Trauma Code Edit Report: 900 - 919.5, 921.3, 930, 931 - 939.9, 942.22, 944.20, 945, 946.2, E950 - E958.8, 958.3, 960 - 979.9, 980 980.9, 981, 986, 989.5, 990 - 995.89, 996 - 998.9 and 999.8.

AHCCCS provides the TPL Contractor, via the AHCCCS secure FTP server, a monthly extract of the AHCCCS paid claims which include the claim specific diagnosis codes. The TPL Contractor matches an extract of those claims, that contain specific trauma codes, with the database of AHCCCS Members, and returns a file of matched members not previously identified in a trauma code data match. Each Member identified in the current data match is sent a questionnaire, and are asked to respond within 10 days. If the questionnaire is returned indicating an incorrect address, a letter is sent to the eligibility office where the member was determined eligible requesting the address be verified with the office records and that any difference be referred to the TPL Contractor for correction of their information. The TPL Contractor will then mail a new questionnaire using the corrected address information.

The TPL Contractor will review the response to the questionnaire and determine if a casualty case should be opened. If a case is opened a medical lien is filed against the member for possible third party recovery and the TPL Contractor actively pursues recovery from the liable source. All recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

If after 30 days the completed questionnaire is not returned by the member, a letter is sent asking the member to contact the TPL Contractor. If a response to the letter is not received within 30 days, the TPL Contractor will attempt to contact the member by telephone, if a telephone number is available. If the member cannot be contacted by telephone, another letter is sent to the member stating that AHCCCS is requesting that the member contact the TPL Contractor. If after 30 days there is no response to this letter there are no additional attempts to contact the member unless the member is later identified through either the ADOT or ICA data matched (see above.) If the member is identified in either of these data matches a new round of questionnaires begins using the information identified in the ADOT 'crash data" or from the ICA workers compensation file.~~AHCCCS contracts with a TPL Contractor to perform all of its TPL recovery activities and required TPL data matches.~~

~~AHCCCS conducts diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6, for all fee-for-service claims. HCFA developed a list of codes shown to be unproductive and offered a blanket waiver to all states. AHCCCS adopted HCFA's recommendation and edited all of the ICD-9 codes listed. The following list of codes are currently being edited from the Trauma Code Edit Report: 900- 919.5, 921.3, 930, 931 - 939.9, 942.22, 944.20, 945, 946.2, E950- E958.8, 958.3, 960- 979.9, 980 980.9, 981, 986, 989.5, 990 - 995.89, 996- 998.9 and 999.8.~~

~~A medical lien is filed against the member for possible third party recovery if the claims have a referral date that is less than 60 days prior to the date the tape is received. However, due to statutory provisions which require the filing of liens within 60 days from the date of notification of injury, a lien is not filed where the date of notification is more than 60 days~~

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~~from the date the referral is received. In these cases, AHCCCS uses its subrogation rights or assignment of rights to pursue recovery.~~

~~A referral for subrogation is issued on claims where the date of notification is between 60 and 120 days from the date of referral and the total claim amount is $250.00 or more. Claims with a date of notification which is more than 120 days from the date of referral are not processed by the TPL Contractor, thereby avoiding duplication of cases which are received from other referral sources, i.e., contracted health plans, providers, attorneys, etc. The TPL Contractor mails a questionnaire to the member at the time the case is opened. The determination of third party liability is identified from the response to the questionnaire returned by the member and/or a responsible third party in those instances where a lien is filed or subrogation rights are used. Members are asked to respond within 10 days of receipt of the questionnaire. If the questionnaire is returned indicating an incorrect address, a letter is sent to the eligibility office where the member was determined eligible requesting the address be verified with the office records and that any difference be referred to the TPL Contractor for correction of their information. The TPL Contractor will then remain the questionnaire using the corrected address information.~~

~~If, after 30 days, the completed questionnaire is not returned by the member, a letter is sent asking the member to contact the TPL Contractor. If a response to the letter is not received within 30 days, the TPL Contractor will attempt to contact the member by telephone, if a telephone number is available. If the member cannot be contacted by telephone, another letter is sent to the member stating that AHCCCS is requesting that the member contact the TPL Contractor. If, after 30 days, there is no response to this letter, the case is filed and periodically reviewed. Additional attempts to contact the member are made at each review. If no contact occurs within two years, the file is closed and archived.~~

~~If the questionnaire or other referral source identifies Third Party Liability information, multiple efforts are made by the TPL Contractor to recover funds from the potentially liable source. All health insurance information obtained is immediately referred to the AHCCCS MFIS Unit for entering into the PMMIS Recipient Subsystem within seven working days of receipt. All~~

~~casualty insurance information is entered into the TPL Contractor's case management system to track.~~

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: ARIZONA

State: _____

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)

Pursuant to the Deficit Reduction Act of 2005, Arizona adopted A.R.S. § 36-2923, with an effective date after June 30, 2009, that requires third parties to provide the State with coverage, eligibility and claims data that is outlined in 25 USC § l902(a)(25)(I). ~~The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, ofl902(a)(25)(I) of the Social Security Act.~~

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THIRD PARTY LIABILITY

4.22(d)(l):
Method used in determining the provider's compliance with the billing requirements as specified in 42 CFR 433.139(b)(3)(ii)(A).

Providers are not required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

AHCCCS pays and chases all claims, regardless of submission time frames, for services furnished to AHCCCS members on whose behalf medical support enforcement is being carried out by the State IV-D agency.

4.22(d)(2):
Method used in determining cost effectiveness as specified in 42 CFR ~~143~~433.139(f)(2).

AHCCCS considers the cost effectiveness principle in determining what the estimated net recovery amount to be pursued based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors will be considered:

- Settlement as may be affected by insurance coverage or other factors relating to the liable party;
- Factual and legal issues of liability as may exist between the client and liable party;
- Problems of proof faced in obtaining the award or settlement; and
- The estimated attorney's fee and costs required for AHCCCS to pursue the claim.

After considering the above factors, AHCCCS may pursue a lesser recovery amount to the extent that it determines it to be cost effective to do so.~~A cost analysis was conducted to determine the cost of initiating and pursuing recoveries.~~

~~The threshold was determined by first identifying the amount of work time each employee spends on the various activities for a typical case, to initiate and pursue recovery. Next, the salary for each employee was identified to calculate the employee cost for pursuing the recovery. The administrative cost for the filing of liens, and legal fees were also included in the calculation to determine this threshold. On July 30, 1991, the threshold of $250.00 was implemented on all cases generated from the Trauma Code Edit Report and was implemented on all cases originating from referral sources on August 30, 1991. The $250.00 cost threshold continues to be used.~~

~~*Commercial Insurance:* AHCCCS' TPL Contractor, on behalf of AHCCCS, conducts commercial insurance data matches with numerous insurance companies. A cost analysis of commercial insurance billings was conducted by AHCCCS' TPL Contractor which determined an effective cost threshold of$50.00 per claim/$10.00 co-pay per member. The TPL Contractor's analysis was based, in part, on such factors as: systems operation costs (preparation, tracking, posting, and updating of claims); staffing costs (systems and support); and paper costs (reports, forms and mailing).~~

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4.22(d)(3):

Method used for determining billing accumulation as specified in 42 CFR 433.139(f)(3).

Specific member claims must generally total $250.00, or more, in order for a case to be considered for potential recovery. Claims expenses are accumulated beginning with the date of injury to, whichever occurs first, the last date of treatment or the case is settled. ~~The TPL Contractor conducts diagnosis and trauma code edits for codes 800 through 999,with the exception of code 994.6 and those codes specified in 4.22 (b)(4), for all fee-for-service claims. AHCCCS generates a monthly extract tape of paid claims identifying diagnosis and trauma codes. Claims for a specific member must total $250.00 or more in order for a case to be considered for potential recovery.~~

~~Claims are not accumulated on members from one report to another via the Trauma Code Edit report. When a case is opened either via the Trauma Code Edit report or through another referral source, the expenses are accumulated beginning with the date of injury to,~~

~~whichever occurs first, the last date of treatment or the case is settled, and listed in chronological order by individual provider. This accumulation is released to the interested third party via a Medical Payments Chronology Letter. This Chronology Letter reflects the total AHCCCS paid and liable medical claims and AHCCCS contractor's claims which relate to the member's injuries.~~