AHCCCS
Arizona Health Care Cost Containment System

Katie Hobbs, Governor
Carmen Heredia, Cabinet Executive Officer
and Executive Deputy Director

February 12, 2024

The Honorable Katie Hobbs
Governor of Arizona
1700 W. Washington St.
Phoenix, Arizona 85007

Dear Governor Hobbs:

Pursuant to A.R.S. 36-2923, please find the enclosed AHCCCS Report on Insurance Carrier Compliance. Please do not hesitate to contact me if I can answer any questions or provide additional information.

Sincerely,

Carmen Heredia
Cabinet Executive Officer
and Executive Deputy Director

cc: The Honorable Adrian Fontes, Secretary of State
The Honorable Warren Peterson, President, Arizona Senate
The Honorable Ben Toma, Speaker, Arizona House of Representatives
Holly Henley, Director, Arizona State Library, Archives & Public Records

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Report to the Arizona Legislature Regarding Insurance Carrier Compliance with A.R.S. § 36-2923: Data Match and Claims Payment for Third Party Liability

December 2023

Insurance Carrier Compliance with A.R.S § 36-2923

Introduction

The Arizona Health Care Cost Containment System (AHCCCS) is pleased to submit the following report pursuant to A.R.S. § 36-2923.B. A.R.S. § 36-2923 requires any party that by statute, contract or agreement is responsible for paying for items or services provided to an Arizona Medicaid-eligible person to comply with the claims data match and billing requirements outlined therein. This report provides: 1) a summary of State Fiscal Year 2023 total AHCCCS claims cost avoided; 2) a review of carrier compliance in terms of data matching; and 3) a review of carrier compliance in terms of claims processing and post-payment recoveries.

SFY 2023 AHCCCS Claims Pre-Payment Cost Avoided

During SFY 2023, AHCCCS and its health care contractors cost avoided with other commercial insurance carriers and/or with Medicare provider medical claims for members of over $2.3 billion. This amount is comprised of:

- $359.8 million of provider claims that were partially the responsibility of a commercial carrier and Medicaid;
- $1,293.1 million of provider claims that were partially the responsibility of the Medicare Program; and,
- $672.4[1] million of provider claims with no financial obligation to the health care contractors as the entire claim was the responsibility of Medicare or a commercial carrier.

[1] The $672.4 million of provider claims for SFY 2023 represents unaudited data reported by the AHCCCS Contractors.

As depicted in the table below, the amount of provider claims that have been cost avoided has exceeded a billion dollars in each of the past five years. In addition to these values captured in AHCCCS encounters, AHCCCS plans reported in SFY 2023 an additional $672.4 million in estimated claims costs that were offset completely by third-party payers and no encounter was submitted.

	State Fiscal Year (in Millions)				
	2023	2022	2021	2020	2019
Provider claims that were partially the responsibility of a commercial carrier and Medicaid	$359.8	$233.7	$211.9	$164.0	$133.1
Provider claims that were partially the responsibility of the Medicare Program	$1,293.1	$1,096.1	$1,139.3	$921.7	966.7
Total	**$1,652.9**	**$1,329.8**	**$1,351.2**	**$1,085.7**	**$1,099.8**

Data Matching

A.R.S. § 36-2923 Requirement

A. A health care insurer shall:

1. Provide all enrollment information necessary to determine the time period in which a person who is defined as an eligible person pursuant to A.R.S. § 36-2901, paragraph 6, subdivision (a) or that person's spouse or dependents may be or may have been covered by the health care insurer and the nature of that coverage…

Overview of the Data Matching Process

AHCCCS maintains a database of insurance coverage information with changes disseminated daily to its health care contractors. Health Management Systems, Inc. (HMS), through a competitively bid contract, is responsible for the verification and identification of health insurers that may be liable for paying all or part of the expenditures for medical assistance provided to AHCCCS eligible persons.

Daily HMS verifies new or updated health insurance information provided by AHCCCS, its health care contractors, and the member eligibility determination entities by matching demographic information against its national database of insurance information submitted by carriers who have entered into data sharing agreements with HMS. Additionally, HMS matches the entire AHCCCS population against the same database monthly to identify health insurance coverage that otherwise is unknown to AHCCCS. The HMS database is comprised of eligibility information from over 1,000 plans nationally and over a billion segments of insurance coverage. HMS provides AHCCCS daily updates to the insurance coverage database. AHCCCS then provides this data on a daily basis to the health care contractors. The contractors use this data as part of the claims payment process. Before a provider is paid, the claims system will check against the coverage database. If a member has other commercial insurance or Medicare, the system will deny the claim unless an appropriate Explanation of Benefits (EOB) form is included. Since Medicaid is the payer of last resort that payment will reflect only those items not covered by the other policy. By identifying other responsible parties and cost avoiding those claims that are their responsibility, AHCCCS only pays claims, or portions of claims, where the state is truly the payer of last resort.

Health insurers meet the claims data match compliance requirement of A.R.S. § 36-2923 by entering into data matching agreements with HMS and either submitting eligibility data to HMS or executing the data match themselves. Health insurers who do not execute a data matching agreement with HMS are considered to be non-compliant with A.R.S. § 36-2923. When an eligibility source identifies a member with coverage through a carrier with which HMS does not have a Data Use/Data Sharing Agreement (DUA), HMS contacts the carrier to verify the coverage and then begins working with the carrier to enter into a DUA to share confidential and protected information.

Overview of the Arizona Health Insurer Identification Process

Working collaboratively with AHCCCS, HMS maintains a comprehensive list of carriers compiled from multiple sources:

- The AHCCCS Master Carrier List: health insurers who have been identified by AHCCCS as currently or previously carrying policies on AHCCCS members;

- Department of Insurance Licensed Carriers: A comprehensive list of licensed insurance carriers doing business in the State of Arizona and regulated by the Department of Insurance; and,
- Health insurers that are known to HMS to provide health insurance coverage.

HMS cross references identified carriers against those currently covered by an existing DUA. If the health insurer is covered by an existing DUA and is currently data matching with AHCCCS then the Carrier is deemed compliant. If the carrier does not have an active DUA in place, HMS contacts the carrier via mail to the corporate address, notifying it of the statutory requirement to share eligibility data with the AHCCCS program. Carriers are given a reasonable amount of time to respond and either provide a reason why A.R.S. § 36-2923 is not applicable to them or to establish a DUA and begin data sharing. HMS assigns insurance carriers that are not covered by an existing DUA to one of two tiers:

- Tier I Carriers – insurance companies that have a verified insurance policy for one or more AHCCCS members within the past 36 months; and,
- Tier II Carriers – all other insurance carriers. These carriers may be registered with the Arizona Department of Insurance or identified from all other sources, but are not included in the Tier I list.

Health Insurer Compliance with the Data Sharing Requirement of A.R.S. § 36-2923

HMS continuously reviews the insurance carriers to determine who should be sharing their membership information with AHCCCS and sends letters and makes telephone calls to the carriers that do not have an existing DUA to bring them into compliance with the claims data matching requirement. There were only three noncompliant carriers covering 253 members in SFY 2023.

As discussed later in this report, if for some reason AHCCCS and the health care contractors were not able to cost avoid with the commercial coverage pre-payment, health insurers are required to honor claims that are submitted by this state within a three-year period beginning on the date on which the item or service was furnished. The table on the following page reflects verified insurance policies that were in effect on June 30, 2023, or were terminated within the past three years that can be utilized for cost avoidance or post-payment recovery. This table demonstrates that virtually all of Tier I Carriers, whose policies were active within the last 3 years, have entered into a DUA (see Appendix A and Appendix B).

Verified Insurance Policies as of June 30, 2023	Carriers		Active Policies within 3 years	
	Number	%	Number	%
Compliant	177	98.3%	837,658	99.97%
Noncompliant	3	1.7%	253	0.03%
Declined a DUA	*2*	*1.1%*	*1*	*0.00%*
Unresponsive	*1*	*0.6%*	*252*	*0.03%*
Totals	**180**	**100%**	**837,911**	**100%**

AHCCCS doesn't have authority to enforce compliance with A.R.S. § 36-2923 with out-of-state carriers; however, HMS will continue to follow up with the remaining two noncompliant Tier I Carriers in an effort to bring them in compliance with the data sharing requirements of A.R.S. § 36-2923.

Claims Processing

A.R.S. § 36-2923 Requirement

A. A health care insurer shall: (continued)

2. Accept the state's right of recovery from a third party payor pursuant to section 36-2903 and the assignment to this state of any right of an individual or other entity to payment from the third party payor for an item or service for which payment has been made pursuant to this chapter…

3. Respond to any inquiry made by the director regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service. This paragraph applies to a claim in which the administration determines there is a reasonable belief that the individual was insured by the health care insurer on the date of service referenced by the claim.

4. Not deny a claim submitted by this state solely on the basis of the date of the submission of the claim, the type or format of the claim form or the failure to present proper documentation at the point of sale that is the basis of the claim if the following conditions have been met:

(a) The claim is submitted by this state in the three-year period beginning on the date on which the item or service was furnished.

(b) An action by this state to enforce its rights with respect to the claim is commenced within six years after the state submitted the claim. The health care insurer may deny the claim submitted by the state if the health care insurer has already paid the claim in accordance with the benefit plan under which the member was covered by the health care insurer on the date of service.

Overview of Post-Payment Claims Recoveries

While the main focus is to ensure the data is available to coordinate the benefit at the front-end pre-payment, there are limited exceptions where the program pursues post-payment recoveries. The post-payment recovery process matches paid claims against the verified insurance policies with termination dates within the past 3 years. When insurance coverage is identified for a member that spans the time period the item or medical service was provided, HMS generates a bill for those items or services to the commercial carrier. The post-payment recovery process ensures that AHCCCS recovers its payments from a responsible party that was unknown at the time the claim was adjudicated. The fee-for-service post-payment process is conducted monthly and resulted in approximately $5.8 million in recoveries during SFY 2023. AHCCCS also made another $15.6 million in post-payment recoveries from commercial carriers in SFY 2023 where our health plan contractors didn't make an eligible recovery from a commercial insurance policy within two years of the date of service. In these cases, HMS made the recoveries for AHCCCS since AHCCCS contractually has the right of recovery after 24 months from the date of service, but before the three-year recovery period elapses.

Methodology Used to Determine if the Health Insurer is Compliant

A carrier is considered to be compliant with A.R.S. § 36-2923 when the carrier adequately responds to a claim for payment as outlined by the statute. Any carrier not responding to a claim for payment or not adhering to the time periods allowed are considered non-compliant.

Based on retroactive billing efforts conducted by HMS during SFY 2023, TRICARE is the only insurance company identified that does not adhere to the State's claims payment requirement. TRICARE is the health care program serving active-duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. Federal TRICARE statutes have primacy over A.R.S. § 36-2923 and TRICARE is not required to honor claims that are filed after one year from the date of service.