AHCCCS PROGRAM INTEGRITY PLAN
2016

INTRODUCTION

Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid Agency, uses federal, state, and county funds to provide health care coverage to the State's low income groups, acute, and long-term care Medicaid population. AHCCCS was established as a mandatory managed care program that makes prospective capitation payments to contracted health plans responsible for the delivery of care. In 2016, AHCCCS is expected to spend approximately $11.23 billion providing health care coverage to over 1.8 million Arizonans through a network of over 61,000 providers.

The Centers for Medicare and Medicaid (CMS) policy defines Medicaid Program Integrity as the "…planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse." In keeping with the comprehensive nature of this definition, AHCCCS believes that Program Integrity is an important component of all operational departments. Program Integrity is also an important piece of the overall agency Strategic Plan.

ENVIRONMENTAL SCAN or SITUATIONAL ASSESSMENT

AHCCCS continues to evaluate and implement Program Integrity strategies to address the growing number of Arizonans receiving Medicaid.

AHCCCS continues to focus on the integration of physical and behavioral health. In 2015, through collaboration with the Arizona Department of Health Services, members with Serious Mental Illness in the greater part of Arizona were transitioned to a single plan to integrate both physical and mental health services. This process occurred in Maricopa County in 2014, allowing this year's integration of services to be available statewide. In addition, over 85,000 Dual Eligible AHCCCS members began receiving physical health, general mental health, and substance abuse services from their single acute health plan.

AHCCCS continues to expand on processes related to Payment Modernization. AHCCCS and our contracted plans are spending considerable time and effort on strategies to move away from a traditional fee-for-service arrangement to better aligned reimbursement systems. AHCCCS continues to increase requirements on our contracted plans in terms of value based payment structures. These requirements will continue to escalate in the future.

Additionally, AHCCCS continues to be involved in efforts nationally by Medicaid Directors to engage CMS on establishing more collaborative, focused, and efficient program integrity efforts. Given the changing landscape of the entire healthcare system and the challenges associated with implementation of new mandates, the AHCCCS Administration is developing the 7th Annual Program Integrity Plan. The plan summarizes previous accomplishments and identifies new strategies to ensure the best possible use of limited resources.

Given the current fiscal environment at both the state and federal level, and the size of the AHCCCS program, Program Integrity efforts are critical if maximum dollars are to remain available to serve individuals in need.

PROGRAM INTEGRITY MISSION

Throughout the Agency, promote economy, efficiency, accountability, and integrity in the management and delivery of services in order to ensure that AHCCCS is an effective steward of limited resources.

CY 2015 KEY ACCOMPLISHMENTS

- AHCCCS realized over $1 billion in avoided and recovered costs as a result of coordination of benefits, third party recoveries, and Office of the Inspector General (OIG) activities.
- AHCCCS supported the investigations of 27 successful prosecutions of either members or providers.

- AHCCCS receives data from Motor Vehicle Division (MVD) and Industrial Commission to assist with third party liability identification.
- AHCCCS receives County inmate data for more than 80% of the state to assist with eligibility compliance.
- AHCCCS established a non-emergency medical transportation (NEMT) task force to develop more robust strategies and change policies to strengthen provider oversight. The screening process including site visits and routine checks through the PECOS database has started and will continue throughout the 2016 calendar year.
- Civil Monetary Penalties were issued in CY 2015 amounting to $5,860,517.25 in sanctions.
- 5 provider suspensions were issued during FY 2015 as a result of the determination of credible allegations of fraud.

AHCCCS Recovery, Savings and Cost Avoidance

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	% Change SFY14-SFY15
Coordination of Benefits						
Total Commercial COB	$113,001,472	$112,038,407	$121,716,277	$ 125,064,195	$140,400,878	+12%
Total Medicare COB *	$815,066,365	$836,709,557	$922,490,575	$ 1,055,239,043	$991,531,425	-6%
Total COB Cost Avoidance	**$928,067,837**	**$948,747,964**	**$1,044,206,851**	**$ 1,180,303,238**	**$1,131,932,303**	**-4%**
Third Party Liability						
Total Recoveries **	$9,924,206	$11,118,940	$11,692,628	$ 11,905,088	$8,843,418	-26%
Total Distributions	$8,310,570	$9,232,308	$9,427,596	$ 9,976,724	$7,348,805	-26%
Net Recoveries from TPL	**$1,613,636**	**$1,886,632**	**$2,265,032**	**$1,928,364**	**$1,494,613**	**-22%**
Office of Inspector General (OIG)						
Provider Fraud Unit Recoveries and Savings***	$6,007,659	$11,094,794	$19,200,500	$24,033,483	$11,934,312	-50%
Member Fraud Unit Recoveries and Savings****	$24,493,145	$29,967,560	$31,712,316	$34,217,415	$26,210,174	-23%
Total OIG Recoveries	**$30,500,804**	**$41,062,354**	**$50,912,816**	**$58,250,898**	**$38,144,487**	**-35%**
Incarceration No Pay+						
Incarceration Total Capitation Cost Avoided					**$26,006,071**	N/A
FFS Audit Savings+						
Total FFS Audit Savings					**$2,366,468.14**	N/A
RECOVERY/COST AVOIDANCE TOTAL	**$960,182,277**	**$991,696,950**	**$1,097,384,699**	**$1,240,482,500**	**$1,199,943,942**	**-3%**

* Excludes identified reporting errors; SFY 2011 includes 2 previously excluded MCOs
** Includes estate, trust, and casualty recoveries for fee-for-service and joint case reinsurance payments
*** Report of Provider Fraud Unit results (includes global settlements & Savings)
**** Report of Member Fraud Unit results (includes Social Security leads)
\+ Added to this report in FY2015

2016 PROGRAM INTEGRITY STRATEGIES

1. Automation

a. Provider Automation
   i. Developing an on-Line Provider Registration process
   ii. Creating an on-Line Provider ability to update their file information

b. Collection's Portal
   i. Set forth ACH payment options for Providers and Members related to approved settlement agreements

c. DHS Licenses
   i. Automation of licensing data interface directly with AHCCCS data for provider verification

d. Case Tracking Platform
   I. OIG is deploying resources to develop a document repository system to store critical case information and develop more useful metrics

2. Data Analytics and Trends

a. OIG has been working closely with AdvanceMed (CMS contractor) in developing a system that integrates Medicare and Medicaid data to provide case information and investigation development.

b. OIG will continue to pursue Program Integrity Audits to follow-up on several that have been completed to date including, Status B Codes, New Patient Billing, Duplicate E&M and Bilateral coding.

c. OIG will continue to partner with other stakeholders to develop reports from the new eligibility HEAplus to ensure member compliance.

3. **Partnerships**

a. Improve collaboration with contractors under Corporate Compliance
   I. Continue regular meetings to share information with Managed Care Organizations regarding their corporate compliance plan that includes all the program integrity activities.

b. OIG will continue operating a task force with some of our most experienced investigators to increase our footprint among law enforcement agencies.

c. OIG has broadened its resources by entering into a Memorandum of Understanding with the Social Security Administration, which allows the OIG to identify and investigate referrals pertaining to eligibility fraud.

d. OIG will work to ensure appropriate compliance with the new Hospital Presumptive Eligibility program mandated by CMS.

e. OIG will continue to participate at the National Advocacy Center providing diverse trainings to other states as well as ensuring participation from our work force.

f. OIG will continue to actively partner with other states to strengthen resources and knowledge.

g. OIG will partner with the Department of Public Safety (DPS) to run background checks on high risk providers as required by CMS.

h. Participate in the Technical Advisory Group and the National Association of Medicaid Directors meetings.

4. Non-Emergency Medical Transportation (NEMT) Task Force

a. Expand provider registration verification including:
   I. OIG will regularly monitor FFS utilization of NEMT services for various provider types.
   II. OIG will continue to maintain current information on the website as it relates to NEMT providers with active tribal business licenses.

b. AHCCCS will publish a Request for Information to tribal representatives to gather information about the infrastructure available among tribes to administer an NEMT Broker model.

c. OIG will continue to pursue permission from CMS to leverage the federal database PECOS for provider information.

5. Program Integrity Operations

a. Continue emphasis on Program Integrity training
   i OIG will continue to provide training and actively participating in task force meetings, other agencies' fraud related meetings and training.
   ii OIG will continue to provide internal training for New Employees as well as educating contractors and senior leadership on program integrity initiatives.
   iii Provider Subject Matter Experts to provide training at the Department of Justice.

b. Continue expanding effective use of the Civil Monetary Penalties to enforce program compliance.

c. Ensure the diligent use of the Credible Allegation of Fraud suspension process.

d. DFSM will continue to pursue and complete audits of payments made to providers.

6. Best Practices

a. Continue to enhance and improve the subject matter topics for the Compliance Officer Networking Group (CONG).

b. Creating an automated referral process to allow the OIG to track, monitor, and facilitate appropriate and necessary case development.

c. Participate in the Global Settlement process.