

## PROGRAM INTEGRITY

### **What is Medicaid Program Integrity?**

The Centers for Medicare and Medicaid policy define 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.”

### **How does AHCCCS support program integrity efforts?**

The AHCCCS Program has established a multifaceted approach towards Program Integrity. The Agency develops an annual Program Integrity Plan to determine the focus for the upcoming year. The current PI Plan can be found at

<http://www.azahcccs.gov/reporting/PoliciesPlans/ProgramIntegrityPlan.aspx>.

The AHCCCS Program Integrity efforts are spearheaded by the Office of the Inspector General in coordination with resources deployed by contracted health plans and the Arizona Department of Economic Security (ADES).

In addition, AHCCCS contracts with numerous data and analytic vendors to ensure the best oversight of the program. Examples include

1. *EDI Watch* provides a data analytic tool that analyzes over 100 million claims to look for billing irregularities.
2. *HMS* provides regular data matches with commercial insurance carriers to determine third party coverage that can be used for coordination of benefits.
3. *Work Number* provides real time salary data for employers that account for over one-third of the employees in the state.
4. *Lexus/Nexus* provides access to a rich data base of information.
5. Government databases like Social Security, ADES Base Wage data and the Arizona Criminal Justice Information System are all vital in providing Program Integrity information.

### **What authority does the AHCCCS Office of the Inspector General have?**

The AHCCCS Office of Inspector General employs a staff of 55 individuals responsible for investigating provider and member fraud. The Inspector General has full subpoena power and the authority to administer oaths. Once a program integrity case has been confirmed, the Office of the Inspector General is empowered to impose civil monetary penalties in an amount up to \$2,000 for each item or service claimed, together with an additional penalty not to exceed twice the amount claimed. The Office also has the authority to exclude a provider from participation in the AHCCCS system. Finally, the Office of the Inspector General works closely with the Attorney General’s Office and the County Attorney’s Office in the prosecution of cases involving member and provider fraud.

### **What are the main components of the AHCCCS Program Integrity Plan?**

The Program Integrity Plan is focused on four main components:

**Fraud Detection and Prevention**

Fraud is "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." The OIG is responsible for investigating both provider and member fraud issues.

**Coordination of Benefits**

With the exception of KidsCare, it is permissible for an AHCCCS Medicaid member to have private commercial coverage in addition to being on AHCCCS. However, under federal law, AHCCCS in all but a few instances is the "payor of last resort," meaning that if an AHCCCS member has other insurance coverage, that insurer must pay for the medical expenses incurred. Through the AHCCCS prepayment coordination of benefits process, almost \$1.4 billion in health care expenses are covered by other carriers, including Medicare.

**Post Payment Third Party Liability**

AHCCCS and the contracted health plans both retain resources to pursue post payment recoveries associated with events like accidents that involve future settlements or payments, portions of which can be used to offset the costs previously covered by AHCCCS.

**Proper Claims Editing Capability**

AHCCCS and the contracted health plans have edits built into their billing systems that actually prevent reimbursement of uncovered services or erroneous claims. For example, the system has an edit to prevent a health plan from paying for a birth to a male member. System checks also identify issues like upcoding, where a provider uses a higher paying billing code inappropriately. These types of claim reviews are the most common concerns with respect to maintaining program integrity.

**Program Integrity Results (Fiscal Year 2010)**

Total OIG Member Fraud Cases Investigated	892
Total OIG Provider Fraud Cases Investigated	291
Total Convictions	15
Total OIG Fraud Avoidance and Recoveries	\$34.7 million
Total Prepayment Coordination of Benefits	\$1,376.4 million
Total Post Payment Third Party Liability Recoveries	\$21 million
Health Plan Claims Edits	\$301 million

**How does the public report fraud or abuse in the AHCCCS system?**

Providers and individuals may make a report either through the AHCCCS website at <http://www.azahcccs.gov/fraud/reporting/reporting.aspx> or by calling IT IS NOT OK(1-888-487-6686) or (602) 417-4045.