

## **AHCCCS PROGRAM INTEGRITY PLAN 2017**

### **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 2017, AHCCCS is expected to spend approximately \$12.2 billion providing health care coverage to over 1.9 million Arizonans through a network of over 66,000 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.

### **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 expand on processes related to a value-based focus versus volume. 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 8<sup>th</sup> 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 2016 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 62 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 90% of the state to assist with eligibility compliance.
- Civil Monetary Penalties were issued in CY 2016 amounting to \$6,178,204.59 in sanctions.

### AHCCCS Recovery, Savings and Cost Avoidance

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	% Change SFY15-SFY16
<b>Coordination of Benefits</b>							
Total Commercial COB	\$113,001,472	\$112,038,407	\$121,716,277	\$ 125,064,195	\$140,400,878	\$139,477,139	-1%
Total Medicare COB *	\$815,066,365	\$836,709,557	\$922,490,575	\$ 1,055,239,043	\$991,531,425	\$1,092,768,200	10%
<b>Total COB Cost Avoidance</b>	<b>\$928,067,837</b>	<b>\$948,747,964</b>	<b>\$1,044,206,851</b>	<b>\$ 1,180,303,238</b>	<b>\$1,131,932,303</b>	<b>\$1,232,245,339</b>	<b>9%</b>
<b>Third Party Liability</b>							
Total Recoveries **	\$9,924,206	\$11,118,940	\$11,692,628	\$ 11,905,088	\$8,843,418	\$8,962,935	1%
Total Distributions	\$8,310,570	\$9,232,308	\$9,427,596	\$ 9,976,724	\$7,348,805	\$7,673,665	4%
<b>Net Recoveries from TPL</b>	<b>\$1,613,636</b>	<b>\$1,886,632</b>	<b>\$2,265,032</b>	<b>\$1,928,364</b>	<b>\$1,494,613</b>	<b>\$1,289,270</b>	<b>-14%</b>
<b>Office of Inspector General (OIG)</b>							
Provider Fraud Unit Recoveries and Savings***	\$6,007,659	\$11,094,794	\$19,200,500	\$24,033,483	\$11,934,312	\$20,164,328	69%
Member Fraud Unit Recoveries and Savings****	\$24,493,145	\$29,967,560	\$31,712,316	\$34,217,415	\$26,210,174	\$20,630,360	-21%
<b>Total OIG Recoveries</b>	<b>\$30,500,804</b>	<b>\$41,062,354</b>	<b>\$50,912,816</b>	<b>\$58,250,898</b>	<b>\$38,144,487</b>	<b>\$40,794,688</b>	<b>7%</b>
<b>Incarceration No Pay+</b>							
<b>Incarceration Total Capitation Cost Avoided</b>					<b>\$26,006,071</b>	<b>\$27,923,926</b>	<b>7%</b>
<b>FFS Audit Savings+</b>							
<b>Total FFS Audit Savings</b>					<b>\$2,366,468</b>	<b>\$439,483</b>	<b>-81%</b>
<b>RECOVERY/COST AVOIDANCE TOTAL</b>							
	<b>\$960,182,277</b>	<b>\$991,696,950</b>	<b>\$1,097,384,699</b>	<b>\$1,240,482,500</b>	<b>\$1,199,943,942</b>	<b>\$1,302,692,708</b>	<b>8%</b>

- \* 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

## 2017 PROGRAM INTEGRITY STRATEGIES

### 1. Automation

- a. Provider Automation
  - i. Linking the on-Line Provider Registration process with AHCCCS Databases (PMMIS)
  - ii. Creating an on-Line Provider ability to update their file information (phase II)
- b. Collection's Portal
  - i. Work with ISD and DBF to finalize ACH payment option. Once implemented, define percentage goal for payments made through ACH.
- c. Licenses
  - i. Continuation of the automation of licensing data to interface directly with AHCCCS data for provider verification.
- d. SMART Case Management System
  - i. OIG is deploying resources to develop a document repository system to store critical case information and develop more useful metrics;
  - ii. Working with ISD to develop the case management database for OIG
- e. SharePoint
  - i. OIG will automate each of its sections; to include the referral process.
  - ii. Develop a resource library for all OIG staff
  - iii. Provider Compliance complete by 3/2017

### 2. Data Analytics and Trends

- a. OIG, working closely with the new CMS UPIC contractor integrating Medicare and Medicaid data, will continue to track joint cases and recoupments as initiated from case information and investigations.
- b. OIG will initiate three Program Integrity Audits
- c. Working with DHCM, the OIG will identify and present cases that meet the criteria for the Compliance Committee with the goal of improving front-end processing to avoid repeatable errors.
- d. OIG will continue to identify potential vulnerabilities in the member compliance process of HEAplus, to ensure only eligible members receive the necessary services as well as quantify the extent to which HEAplus has improved the determination process to prevent approving ineligible applicants.
  - i. OIG will work with DMS and the Project Director to quantify the cost avoidance of HEAplus automation to identify potential Fraud Waste and Abuse.
- e. OIG will work with the Chief Medical Officer and her staff to develop cases and identify intelligence gaps related to opioid and pharmaceutical fraud, waste, and abuse.
  - i. This ad-hoc working group will ensure the appropriate, confidential referrals are provided to the Quality of Care team
  - ii. OIG will work with external pharmaceutical and prescription fraud investigators to assist in the limited access by members to pharmaceuticals.

- iii. Conduct data analytics, review referrals, refer to CSPMP, and conduct provider audits to enhance case development
- iv. Identify and track high risk providers, work with appropriate external partners, and refer to MFCU all criminal cases.
- v. Work collaboratively with the Pharmacy Board for intelligence data sharing.

### **3. Partnerships**

- a. Continue collaboration with contractors under Corporate Compliance
  - I. Through the Corporate Compliance Officers Networking Group, develop timely topics for interactive meetings about data collected by the Managed Care Organizations in support of their program integrity activities.
  - II. OIG will have at least two meetings a year with individual Corporate Compliance Officers to discuss specifics related to their compliance plan
- b. Track case development, progress, monetary recoupments, and program savings related to the task force efforts with our state and federal partners to continue to increase our footprint among law enforcement agencies.
- c. OIG Task Force on-going efforts:
  - a. In concert with the Social Security Administration, Office of the Inspector General, the OIG will continue to investigate joint cases based on referrals pertaining to eligibility fraud; and the OIG will track cases and savings related to this effort.
  - b. In concert with the Attorney General's Office, Tucson, the OIG will continue to investigate joint cases based on eligibility issues related to subjects of border crimes.
- d. OIG will begin to conduct Hospital Presumptive Eligibility audits on facilities approved to participate in the program.
- e. OIG will work with CMS, as a member of the Technical Advisory Group (TAG), to develop innovative courses at the National Advocacy Center (NAC); and the OIG will continue to participate as a faculty member to ensure training is provided by Subject Matter Experts.
- f. OIG will continue to actively partner with other states to strengthen resources and knowledge.
- g. In support of CMS's Fingerprint Compliance Background Check program, the OIG will work closely with the Department of Public Safety (DPS) to establish timely completion of fingerprint and background checks of high risk providers.
- h. Participate in the Technical Advisory Group, the National Association of Medicaid Program Integrity Directors meetings, and the National Association of Medicaid Directors meetings.

### **4. Provider Enrollment and Revalidation**

- a. Track and monitor provider registration revalidation process

- b. OIG will continue to maintain current information on the website as it relates to Non-Emergency Medical Providers, FCBC, and update monthly the tracking of tribal business licenses.
- c. Working with CMS, OIG will continue to leverage the federal database PECOS for provider registration to determine providers disallowed in the Medicare system, and therefore, not able to be Medicaid providers.

## **5. Program Integrity Operations**

- a. Continue emphasis on Program Integrity program recoveries, training, and interactions with other federal, state, or local law enforcement entities.
  - i. OIG will continue to provide training, both internal and external, to enhance program integrity capabilities.
  - ii. OIG will work joint cases and actively participate in task force meetings, and other agencies' fraud related meetings; to include Medi-Medi investigations.
  - iii. OIG will continue to work closely with MCO's Senior Leadership and Corporate Compliance Officers regarding the development of new program integrity initiatives.
  - iv. OIG will continue to provide Subject Matter Experts to provide training at the NAC.
- b. OIG will track and monitor the Civil Monetary Penalties to enforce program compliance.
- c. OIG will ensure the due diligent use of the Credible Allegation of Fraud suspension process; or exclusion, whichever is most appropriate and in the best interest of AHCCCS.
- d. OIG will monitor and track the recovery of Non-Title XIX (NTXIX) funds as identified within OIG cases.
- e. Pursue collections; and write-offs in collaboration with the AGO's Bankruptcy and Collection Section.
- f. Performance Improvement and Audit section will conduct DRAs, HPEs, ORs, and provider audits as necessary and appropriate.
- g. EHR Post-Payment Review team will conduct audits as set forth by CMS.
- h. Comply with Managed Care Regulations §438.608(a), §438.608(c) and §438.608(d) by July 2017

## **6. Best Practices**

- a. Continue to introduce new topics and initiatives; Continue to leverage cross program Subject Matter Experts; seek to enhance and improve the subject matter topics for the Compliance Officer Networking Group (CONG).
  - i. Highlight best practices of providers, MCOs, and relevant organizations dedicating to ending FWA through education, training bulletins, and sharing of analyzed data sets.
- b. Finalize the automation of the referral process to allow the OIG to track, monitor, and facilitate appropriate and necessary case development.

c. Participate in the Global Settlement process.