AHCCCS PROGRAM INTEGRITY PLAN
SFY 2013

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 acute and long-term care Medicaid population, low income groups, and small businesses. 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 State Fiscal Year (SFY) 2013, AHCCCS is expected to spend approximately $8.4 billion providing health care coverage to over 1.2 million Arizonans through a network of over 50,000 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

Given the current fiscal environment and the size of the AHCCCS program, Program Integrity efforts are critical if maximum dollars are to be used to serve individuals in need. After having to make significant changes to the AHCCCS program during the Great Recession, the State of Arizona faces significant health care policy issues that must be addressed over the next several months. In addition, AHCCCS has been involved in efforts nationally by Medicaid Directors to engage the Center for Medicare and Medicaid Services (CMS) on establishing more collaborative, focused and efficient program integrity efforts. Given these ongoing challenges, the AHCCCS Administration is developing the 4th Annual Program Integrity Plan. The plan summarizes previous accomplishments and identifies new strategies to ensure the best possible use of limited resources.

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.

FY 2012 KEY ACCOMPLISHMENTS

- AHCCCS realized over $960 million in avoided and recovered costs as a result of coordination of benefits, third party recoveries, and OIG activities.
- AHCCCS supported the investigations of 25 successful prosecutions of either members or providers. This is the largest overall number in the history of the AHCCCS program.
- AHCCCS hired a new Inspector General.
- AHCCCS worked with the National Association of Medicaid Directors (NAMD) on their national program integrity efforts and on their white paper, Tackling Fraud, Waste, and Abuse in the Medicare and Medicaid Programs at http://medicaiddirectors.org/node/360.
- AHCCCS conducted a compliance review of all contracted health plans' program integrity efforts. The review, which demonstrated that contractors are in compliance, also identified opportunities for technical assistance that will support continued improvement.
- AHCCCS implemented Motor Vehicle Division (MVD) photo verification as part of the eligibility verification process for providers, generating over one million images per month.

- AHCCCS initiated the evaluation of Medicaid Incentive Payments available to providers for Electronic Health Records (EHR).

- AHCCCS implemented the Affordable Care Act (ACA) provider registration requirements related to verification, site visits, and provider suspension.

- AHCCCS, based on an audit by the Office of the Auditor General, was found to have only a 1.11% error rate when determining eligibility.

- AHCCCS completed a three-year Fee-For-Service (FFS) Recovery Audit Contract (RAC) review (including reinsurance). Based on $3.2 billion in claims paid, recovery findings totaled $2,200.

- AHCCCS initiated a Medi-Medi pilot program designed to compare and analyze claims data generated under Medicare and Medicaid programs for the purpose of uncovering fraud and abuse that may be missed when programs are examined separately.

AHCCCS Recovery and Cost Avoidance

	SFY 2010	SFY 2011	SFY 2012	% Change SFY11-SFY12
Coordination of Benefits				
Total Commercial COB	$94,692,775	$113,001,472	$112,038,407	-1%
Total Medicare COB *	$781,161,382	$815,066,365	$836,709,557	3%
Total COB Cost Avoidance	**$875,854,157**	**$928,067,837**	**$948,747,964**	**2%**
Third Party Liability				
Total Recoveries **	$8,066,128	$9,924,206	$11,118,940	12%
Total Distributions	$6,644,163	$8,310,570	$9,232,308	11%
Net Recoveries from TPL	**$1,421,965**	**$1,613,636**	**$1,886,632**	**17%**
Office of Inspector General (OIG)				
Provider Fraud Recoveries	$7,469,772	$6,007,658	***$10,043,708	67%
Member Cost Avoidance	$22,963,994	$24,493,145	****$30,720,228	25%
Total OIG Recoveries	**$30,433,766**	**$30,500,803**	**$40,763,936**	**34%**
RECOVERY/COST AVOIDANCE TOTAL	**$907,709,888**	**$960,182,276**	**$979,906,748**	**2%**

* 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
*** From June 2012 report of Provider Fraud Unit results (includes global settlements)
**** From June 2012 report of Member Fraud Unit results (includes Social Security leads)

FY 2013 PROGRAM INTEGRITY STRATEGIES

1. Leverage contractor expertise to maximize capabilities

a. Release RFI for RAC

b. Issue RFP for COB/TPL/RAC with new vendor in place by 10/01/2013

c. Release RFI for Biometrics and Card Swipe technology

d. Participate in Medi-Medi pilot program

e. Explore contract with outside experts for Pharmacy evaluation

2. Continue opportunities to improve Provider Compliance

a. Continue provider registration verification

b. Collaborate with Medicare to evaluate all existing providers

c. Conduct demonstration with two vendors to compare vendor data/solutions with CMS data

3. **Continue opportunities to improve Member Compliance**

a. Establish agreement with Maricopa and two other counties

b. Develop letter for health plans to send to members not cooperating with third party coverage

4. Continue emphasis on Program Integrity training

a. Update website training

b. Continue DES training

5. Implement Audit Recommendations

a. Implement PERM Audit Recommendations

b. Implement OAG and CMS Audit Recommendations

i. Develop and implement a formal plan to regularly update Medicaid fraud and abuse prevention and detection training and other guidance, and continue to identify opportunities for enhancement of fraud detection through data analyses.

ii. Strengthen processes for investigating fraud and abuse cases in a timely manner by improving case screening, refining prioritization practices, establishing specific case close-out procedures, and completing development of a new case management system. Formalize respective policies.

iii. Improve processes for recovering maximum payments made in cases of fraud or abuse by documenting specific considerations used to arrive at settlement decisions, refining reconciliation of federal recovery-reporting records with those of the AHCCCS OIG, establishing a formal collection program supported by a written policy, and refining cash-handling practices.

6. Participate in federal partnerships

a. Obtain access to Medicare Fraud Investigations Database

b. Participate in federal-state collaboration with CMS

7. Continue to expand use of technology and data analytics

a. Obtain access to Motor Vehicle Division (MVD) crash data for use in TPL

b. Work through Industrial Commission for Workers' Compensation data