**AHCCCS PROGRAM INTEGRITY PLAN**
**SFY 2014**

## 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 State Fiscal Year (SFY) 2014, AHCCCS is expected to spend approximately $9.5 billion providing health care coverage to over 1.3 million Arizonans through a network of over 59,000 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 http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf.

## ENVIRONMENTAL SCAN or SITUATIONAL ASSESSMENT

AHCCCS has followed the Governor's lead in preparing the state for implementation around the various components of the Affordable Care Act. On June 17, 2013, the Governor's Medicaid Restoration Plan was signed into law. As a result, coverage will be restored to thousands of childless adults who are eligible for AHCCCS under the voter mandated Proposition 204 and will also include coverage for adults from 100-133% of the federal poverty level, beginning January 1, 2014. After having to make significant contractions 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 including covering more lives.

On November 28, 2012, Governor Brewer informed the Obama administration that Arizona will not pursue the creation of a state-based Health Exchange. Arizona will participate in a Federally Facilitated Marketplace (FFM), as outlined in the guidelines of the Patient Protection and Affordable Care Act. The Agency has completed planning and design for an IT infrastructure to support ACA related changes to Medicaid and Medicaid restoration and is moving forward with development of the Heath-e-Arizona Plus system and an interface to the Federally Facilitated Marketplace. An evaluation and implementation of Program Integrity strategies to address these health care system changes is a priority for AHCCCS.

Additionally, AHCCCS continues to be 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 the changing landscape of the entire healthcare system and the challenges associated with implementation of new mandates, the AHCCCS Administration is developing the 5th 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 be used 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

## FY 2013 KEY ACCOMPLISHMENTS

- AHCCCS realized over $1 billion in avoided and recovered costs as a result of coordination of benefits, third party recoveries, and OIG activities.
- AHCCCS supported the investigations of 22 successful prosecutions of either members or providers.
- AHCCCS Director helps lead the National Association of Medicaid Directors (NAMD) Executive Workgroup, which works with CMS to develop more effective and collaborative Program Integrity strategies between states and CMS.
- AHCCCS receives data from Motor Vehicle Division (MVD) and Industrial Commission to assist with third party liability identification.
- AHCCCS was one of the first states to receive access to the Medicare Fraud Investigation Database (FID) to leverage Medicare resources in Medicaid Program Integrity efforts.
- AHCCCS awarded a new contract for a Coordination of Benefits/Recovery Audit Contractor (RAC)/Third Party Liability (COB-TPL) contractor.
- 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.
- 10 civil monetary penalties were issued in SFY 2013 amounting to $ 2,574,082.08 in sanctions.
- 7 provider suspensions were issued as a result of credible allegations of fraud.

### AHCCCS Recovery, Savings and Cost Avoidance

| | SFY 2011 | SFY 2012 | SFY 2013 | % Change SFY12-SFY13 |
|---|---|---|---|---|
| **Coordination of Benefits** | | | | |
| Total Commercial COB | $113,001,472 | $112,038,407 | $121,716,277 | 8% |
| Total Medicare COB * | $815,066,365 | $836,709,557 | $922,490,575 | 10% |
| **Total COB Cost Avoidance** | **$928,067,837** | **$948,747,964** | **$1,044,206,851** | **10%** |
| **Third Party Liability** | | | | |
| Total Recoveries ** | $9,924,206 | $11,118,940 | $11,692,628 | 5% |
| Total Distributions | $8,310,570 | $9,232,308 | $9,427,596 | 2% |
| **Net Recoveries from TPL** | **$1,613,636** | **$1,886,632** | **$2,265,032** | **20%** |
| **Office of Inspector General (OIG)** | | | | |
| Provider Fraud Unit Recoveries and Savings*** | $6,007,659 | $11,094,794 | $4,571,551 | -58% |
| Member Fraud Unit Recoveries and Savings**** | $24,493,145 | $29,967,560 | $32,941,497 | 10% |
| **Total OIG Recoveries** | **$30,500,804** | **$41,062,354** | **$37,513,048** | **-9%** |
| | | | | |
| **RECOVERY/COST AVOIDANCE TOTAL** | **$960,182,277** | **$991,696,950** | **$1,083,984,931** | **9%** |

* 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 & 2013 report of Provider Fraud Unit results (includes global settlements)
**** From June 2012 & 2013 report of Member Fraud Unit results (includes Social Security leads)

## FY 2014 PROGRAM INTEGRITY STRATEGIES

### 1. Leverage contractor expertise to maximize capabilities

a. Continue pilot with Contractor to analyze provider fraud and determine if we continue or expand the pilot

b. Release a data analytics RFI, get information back and meet with potential vendors resulting, in the development of a data analytics RFP

### 2. Continue opportunities to improve Provider Compliance

a. Expand provider registration verification including:

   i. Enhanced certification requirements for non-emergency transportation providers
   ii. Conducting site visits for all new non-emergency transportation providers and reenrolling providers beginning February 1, 2014
   iii. Continuing implementation of re-registration of individual group homes
   iv. Establishing higher standards for Fiscal Intermediaries/Fiscal Agents

b. Collaborate with Medicare to evaluate all existing providers including, potentially taking advantage of the CMS PECOS database

c. Track leads from Truven data to determine if pursuing a RFP is prudent

d. Work with HMS to establish viable managed care organization (MCO) Recovery Audit Contractor (RAC) and fee-for-service (FFS) RAC

e. Develop and implement audit methodology for Primary Care rate increases and Meaningful Use payments

f. Implement NEMT task force recommendations including increased oversight, audits, investigations and increase provider training efforts

g. Work with CMS and NAMD to streamline provider registration and verification requirements

### 3. Continue opportunities to improve Member Compliance

a. Evaluate necessary Program Integrity strategies for the Federally Facilitated Marketplace, Health E Arizona Plus and Medicaid interface

b. Continue Pilot Project to reduce the back log in member cases by half in FY 2014

c. Create a new member QC process to replace PERM and MEQC and focus on new eligibility requirements

### 4. Continue emphasis on Program Integrity training

a. Update website training

b. Continue DES training

**5. Compliance with Reporting Requirements**

a. Implement outstanding OAG 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 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 refining reconciliation of federal recovery-reporting records with those of the AHCCCS OIG.

**6. Participate in federal partnerships**

a. Measure outcomes associated with FID process

b. AHCCCS Director will continue to serve on NAMD Executive Workgroup and work with CMS on several Program Integrity issues including new audit contractor requirements

**7. Continue to expand use of technology and data analytics**

a. Leverage access to Medicare Fee-for-Service (A, B and D) data for Program Integrity purposes

b. Fully participate in global settlements including value of all encounters