ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SINGLE AUDIT REPORTING PACKAGE

Year Ended June 30, 2022

ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM

SINGLE AUDIT REPORTING PACKAGE

Year Ended June 30, 2022

CONTENTS

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities, the general fund, and the aggregate remaining fund information of ***Arizona Health Care Cost Containment System*** **(AHCCCS)** as of and for the year ended June 30, 2022 and the related notes to the financial statements, which collectively comprise AHCCCS' basic financial statements and have issued our report thereon dated September 6, 2023.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered ***AHCCCS'*** internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control. Accordingly, we do not express an opinion on the effectiveness of ***AHCCCS'*** internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We identified deficiencies in internal control, described in the accompanying schedule of findings and questions costs as items 2022-001 and 2022-002 that we consider to be material weaknesses.

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Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether ***AHCCCS'*** financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed an instance of noncompliance or other matter that is required to be reported under *Government Auditing Standards* and which is described in the accompanying schedule of findings and questioned costs as item 2022-001.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

September 6, 2023

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM; REPORT ON INTERNAL CONTROL OVER COMPLIANCE; AND REPORT ON SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS REQUIRED BY THE UNIFORM GUIDANCE

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

Report on Compliance for Each Major Federal Program

We have audited ***Arizona Health Care Cost Containment System's (AHCCCS)*** compliance with the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget ("OMB") Compliance Supplement that could have a direct and material effect on ***AHCCCS'*** major federal programs for the year ended June 30, 2022. ***AHCCCS'*** major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Our audit of ***AHCCCS'*** major federal program was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2022. The State of Arizona's major federal programs were determined by the Office of the Auditor General applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal program or any other major federal programs of the State of Arizona.

In our opinion, ***AHCCCS*** complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2022.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States (Government Auditing Standards); and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of ***AHCCCS*** and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for the major federal program. Our audit does not provide a legal determination of ***AHCCCS'*** compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to ***AHCCCS'*** federal programs.

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Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on ***AHCCCS'*** compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, Government Auditing Standards, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about ***AHCCCS'*** compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, Government Auditing Standards, and the Uniform Guidance, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding ***AHCCCS'*** compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of ***AHCCCS'*** internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Other Matters

The results of our auditing procedures disclosed instances of noncompliance which are required to be reported in accordance with the Uniform Guidance and which are described in the accompanying schedule of findings and questioned costs as items 2022-003 and 2022-004. Our opinion on the major federal program is not modified with respect to these matters.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the noncompliance findings identified in our noncompliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we did identify a deficiency in internal control over compliance that we consider to be a material weakness and a deficiency in internal control over compliance that we consider to be a significant deficiency.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. We consider the deficiency in internal control over compliance described in the accompanying schedule of findings and questioned costs as item 2022-003 to be a material weakness.

A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiency in internal control over compliance described in the accompanying schedule of findings and questioned costs as item 2022-004 to be a significant deficiency.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the internal control over compliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

We have audited the financial statements of ***AHCCCS*** as of and for the year ended June 30, 2022, and have issued our report thereon dated September 6, 2023 which contained an unmodified opinion on those financial statements. Our audit was performed for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by the Uniform Guidance and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

Mayer Hoffman McCann P.C.

October 31, 2023

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2022
(amounts expressed in thousands)

Federal Grantor/Pass Through Agency/Program or Cluster Title	Federal Assistance Listing Number	Contract Number	Passed through to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services				
Centers for Medicare and Medicaid Services				
Medical Assistance Program (Title XIX)	93.778	11-W-00275/09	$ -	$ 15,416,559
COVID-19 Medical Assistance Program (Title XIX)	93.778	11-W-00275/09	-	1,229,012
Total Medical Assistance Program (Title XIX), part of the Medicaid Cluster			-	16,645,571
Centers for Medicare and Medicaid Services				
Children's Health Insurance Program (Title XXI)	93.767	21-W-00064/09	-	311,292
COVID-19 Children's Health Insurance Program (Title XXI)	93.767	21-W-00064/09	-	17,304
Total Children's Health Insurance Program (Title XXI)			-	328,596
Substance Abuse and Mental Health Services Administration				
COVID-19 - Emergency Grants to address Mental and Substance Use Disorders During COVID-19	93.665	H79FG000250	2,330	2,726
Substance Abuse and Mental Health Services Administration				
Block Grants for Community Mental Health Services	93.958	B09SM085982	17,735	18,595
COVID-19 Block Grants for Community Mental Health Services (MHBG)	93.958	B09SM085982	-	112
Total Block Grants for Community Mental Health Services (MHBG)			17,735	18,707
Substance Abuse and Mental Health Services Administration				
Block Grants for Prevention and Treatment of Substance Abuse	93.959	B08TI084630	33,871	42,169
COVID-19 Block Grants for Prevention and Treatment of Substance Abuse (SABG)	93.959	B08TI084630	-	935
Total Block Grants for Prevention and Treatment of Substance Abuse (SABG)			33,871	43,104
Substance Abuse and Mental Health Services Administration Projects of Regional and National Significance (93.243)				
Arizona Pilot Program for Treatment for Pregnant and Postpartum Women	93.243	H79TI083173	417	725
Substance Abuse and Mental Health Services Administration				
Projects for Assistance in Transition from Homelessness (PATH)	93.150	X06SM085811	1,188	1,348
Substance Abuse and Mental Health Services Administration				
Opioid STR (State Targeted Response)	93.788	H79TI080250	(10)	(10)
State Opioid Response (SOR)	93.788	H79TI081709, H79TI083320	22,519	38,028
Subtotal 93.788			22,509	38,018
Centers for Disease Control and Prevention				
COVID-19 Community Health Workers For Public Health Response and Resilient	93.495	NU58DP006992	-	139
Substance Abuse and Mental Health Services Administration				
Mental Health Disaster Assistance and Emergency Mental Health	93.982	H07SM083746	1,827	1,852
Total US. Department of Health and Human Services			79,877	17,080,786
U.S. Department of Treasury				
Passed through the Office of the Arizona Governor				
COVID-19 Coronavirus Relief Fund	21.019	ISA-AHCCCS-CRS-111921-02	-	908
TOTAL EXPENDITURES OF FEDERAL AWARDS			$ 79,877	$ 17,081,694

See Independent Auditors' Report
See Notes to Schedule of Expenditures of Federal Awards

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2022

(1) Basis of presentation

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the federal grant activity of the ***Arizona Health Care Cost Containment System*** ("***AHCCCS")*** under programs of the federal government for the year ended June 30, 2022. The information in the Schedule is presented in accordance with the requirements of *Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of ***AHCCCS,*** it is not intended to and does not present the financial position, changes in net position or cash flows of ***AHCCCS.***

Additionally, our audit of ***AHCCCS'*** major federal program was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2022. The State of Arizona's major federal programs were determined by the Office of the Auditor General by applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal programs or any other major federal programs of the State of Arizona.

(2) Summary of significant accounting policies

Expenditures reported on the Schedule of Expenditures of Federal Awards are reported on the accrual basis of accounting. Such expenditures are recognized following either the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Negative amounts shown on the Schedule represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years. ***AHCCCS*** has elected not to use the ten percent de minimis indirect cost rate allowed under the Uniform Guidance for certain programs.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2022

Section I – Summary of Auditors' Results

Financial Statements

1.	Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Unmodified
2.	Internal control over financial reporting:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	None reported
3.	Noncompliance material to financial statements noted?	No

Federal Awards

1.	Internal control over major federal programs:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	Yes
2.	Type of Auditor's report issued on compliance for major federal program:	Unmodified
3.	Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No
4.	Identification of major federal programs:	

Assistance Listing Number	Name of Federal Program or Cluster
93.778	Medical Assistance Program (Title XIX), part of the Medicaid Cluster

5.	Dollar threshold used to distinguish between type A and type B programs (State of Arizona level):	$46,426,127
6.	Auditee qualified as a low-risk auditee?	The State of Arizona does not qualify as a low-risk auditee

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2022

Section II – Financial Statement Findings

Item: 2022-001

Subject: Timeliness in Reporting and Adequacy of Staffing

Criteria or Specific Requirement: AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2022, AHCCCS' financial reporting and federal award information was due to ADOA by November 10, 2022.

Condition: For the year ended June 30, 2022, AHCCCS encountered significant delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2022, AHCCCS' financial reporting and federal award information was due to ADOA by November 10, 2022, but was not provided until September 7, 2023.

Cause: The significant delays in AHCCCS' close and financial reporting process were caused by a lack of resources as a result of reduced staffing from retirements and employee turnover within AHCCCS' Division of Budget and Finance. Additionally, the lack of resources was exacerbated as a result of the COVID-19 pandemic and the myriad of federal and state responses that continue to impact the Medicaid program. This has increased the volume and complexity of accounting activity within AHCCCS resulting in increased workloads for existing personnel with AHCCCS' Division of Budget and Finance.

Effect: The State was not able to meet its financial reporting and audit requirements and deadlines. This also impacted decision-makers' ability to rely on financial information that is not provided in a timely manner. Additionally, the delay in the federal award reporting resulted in the State's delay in issuing its single audit reporting package which was due March 31, 2023 and could result in actions being taken by federal grantors on various federal awards. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Not a repeat finding

Recommendation: We recommend that AHCCCS review the overall size of the finance and accounting department within the Division of Budget and Finance and consider adding additional resources such that the compliment of finance and accounting professionals is sufficient to timely close the books and completed year-end and quarterly reporting timely. We also recommend that given the growth of the program and as a result of turnover, that management assess the skills, knowledge and experience of the accounting department to ensure that resources are sufficient to facilitate timely financial reporting.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2022

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2022-002

Subject: Data Breach

Criteria or Specific Requirement: AHCCCS is required to implement policies and procedures and security measures over IT systems to adequately protect data and to prevent the breach of sensitive data.

Condition: On May 11, 2023, AHCCCS became aware of a breach of personal information affecting 2,632 out of over 2.4 million individuals in Arizona who are enrolled Medicaid members.

Cause: Due to a programming error with the Health-e-Arizona Plus (HEAPlus, the AHCCCS eligibility system) the system toolbar allowed some household accounts in the HEAPlus system to be viewable to individuals not included in their household.

Effect: As a result of the breach, 2,632 individuals in Arizona who are enrolled Medicaid members were impacted as some household accounts in the HEAPlus system were viewable to individuals not included in their household. The viewable details included first and last name, address and the last 4 digits of social security numbers. At the point of discovery, AHCCCS disabled the HEAPlus system toolbar that allowed members to view this information. On July 3, 2023, AHCCCS began to notify, in writing, those members whose personal information was compromised and offered free credit reports and credit report monitoring. AHCCCS also notified the U.S. Department of Health and Human Services (HHS)/Office of Civil Rights (OCR) of the breach. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Not a repeat finding

Recommendation: We recommend that AHCCCS review their existing IT policies and procedures and develop a process to ensure procedures are being consistently followed. We also recommend AHCCCS monitor employee' adherence to the IT policies and procedures on a periodic basis to ensure they are consistently followed and inform employees of updates to the policies and procedures throughout the year. Lastly, we recommend that all programming changes be run through a configuration management testing phase prior to implementation/go-live.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2022

Section III – Federal Award Findings

Item: 2022-003

Assistance Listing Number: 93.778

Programs: Medical Assistance Program (Medicaid; Title XIX)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Pass-Through Grantor Identifying Number: 11-W-00275/09

Award Year: July 1, 2021 – June 30, 2022

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud (CAF) cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. As of August 23, 2023, a total of 317 providers have been suspended from Medicaid payments (since the start of Federal Fiscal Year 2020). AHCCCS' contracted providers as of June 30, 2022 totaled 120,566. These provider payment suspensions are known as Credible Allegations of Fraud (CAF) suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Questioned Costs: Unknown

Context: Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud (CAF) has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Upon the conclusion of an investigation, AHCCCS may terminate a provider and/or lift their suspension at that time. At the point a referral is made, and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment. The investigation is on-going and AHCCCS is not currently able to estimate a total overpayment or amount of improper payments made to the providers. Therefore, we are unable to estimate any questioned costs related to the fraud allegations.

Effect: As of August 23, 2023, a total of 317 providers have been suspended from Medicaid payments (since the start of Federal Fiscal Year 2020). These provider payment suspensions are known as Credible Allegations of Fraud (CAF) suspensions.

Once a credible allegation of fraud determination is made, AHCCCS is required to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS. AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation (FBI), the U.S. Department of Health and Human Services (HHS), the U.S. Attorney's Office, the Internal Revenue Service (IRS), and local and tribal

law enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law. At present, the investigation is on-going and AHCCCS is not currently able to estimate a total overpayment or amount of improper payments made to the providers.

This is deemed to be a material weakness in internal control of compliance.

Cause: AHCCCS did not have sufficient controls in place to safeguard against unnecessary utilization of care and services and to prevent fraud. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post-payment review of behavioral health claims. While AHCCCS' claims processing system uses the CMS required claim edit protocols to look for improperly billed claims as noted in the National Correct Coding Initiative (NCCI) and such edit protocols are updated regularly per CMS requirements, AHCCCS did not have sufficient additional claim edits that were necessary for behavioral health claims. For example, AHCCCS did not have sufficient edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS did not have sufficient controls in which claims were reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Identification as a Repeat Finding: Not a repeat finding

Recommendation: We recommend that AHCCCS review and enhance existing policies and procedures and related controls to ensure sufficient processes and controls are in place to safeguard against unnecessary utilization of care and services and to prevent fraud. We also recommend that AHCCCS institute an ongoing and appropriate pre- and post- payment review of behavioral health claims. Likewise, AHCCCS should increase their level of scrutiny over certain behavioral health provider types,

We further recommend that AHCCCS examine the existing Medicaid payment system and implement system-wide improvements. These improvements should include the establishment of additional reporting to flag concerning claims for pre-payment review, setting of billing thresholds and establishing prepayment review for various behavioral health claim types. We also recommend that AHCCCS establish sufficient controls in which claims are reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Views of Responsible Officials: Management of AHCCCS concurs in part with the finding. See Corrective Action Plan.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2022

Item:	2022-004
Assistance Listing Number:	93.778
Programs:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Pass-Through Grantor Identifying Number:	11-W-00275/09
Award Year:	July 1, 2021 – June 30, 2022
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud (CAF) cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).
Condition:	AHCCCS did not identify and perform a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis.
Questioned Costs:	Unknown
Context:	In a population of 2,957 member and provider cases with identified credible allegations of provider and member fraud assigned during fiscal year 2022, we conducted a non-statistical sample of 40 member and 40 provider investigations to ascertain if AHCCCS performed a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis. In our sample of 40 member and 40 provider investigations, we noted 3 of 40 member investigations and 4 of 40 provider investigations for which there was a significant delay, more than one year, from the date the case referral was received and the date the case was assigned for investigation.
Effect:	Untimely fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases. This is deemed to be a significant deficiency in internal control of compliance.
Cause:	Management has reported to us that insufficient investigative staff impacted AHCCCS' ability to investigate potential fraud or abuse incidents in a timely

manner. Additionally, AHCCCS has not established clear timeframes in which referrals received are assigned for investigation.

Identification as a Repeat Finding: Not a repeat finding

Recommendation: We recommend that AHCCCS conduct a workload/cost analysis to evaluate whether its funding and staffing levels are sufficient to timely investigate member and provider fraud or abuse incidents. We also recommend that AHCCCS establish a policy which includes clear timeframes in which referrals received are assigned for investigation and closely monitor compliance with the policy.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Section IV – Prior Year Findings and Questioned Costs Relating to Federal Awards

None

CORRECTIVE ACTION PLAN

Item:	2022-001
Subject:	Timeliness in Reporting and Adequacy of Staffing
Criteria or Specific Requirement:	AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2022, AHCCCS' financial reporting and federal award information was due to ADOA by November 10, 2022.
Condition:	For the year ended June 30, 2022, AHCCCS encountered significant delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2022, AHCCCS' financial reporting and federal award information was due to ADOA by November 10, 2022, but was not provided until September 7, 2023.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Budget and Finance
Phone Number:	(602) 417-4705
Anticipated Completion Date:	June 30, 2025

Views of Responsible Officials and Corrective Actions:	AHCCCS will be implementing the following measures to increase timeliness of the audit completion, however, it should be noted that many of the complexities and federal initiatives related to COVID and ARPA that have contributed to the delay, will be continuing through the FY23-FY25 audits.
	• Staffing
	  ○ AHCCCS's current finance staff work tirelessly and are great assets to the agency. However, AHCCCS will review the current size and requisite skills, knowledge, and expertise of the existing accounting department to ensure adequate resources are in place to timely complete the year end close and financial reporting process as well as to ensure the accuracy and timeliness of other quarterly financial reporting.
	  ○ To that end, AHCCCS has created and filled a new Deputy Assistant Director of Business Finance to provide a higher level of oversight of the audit process and is currently recruiting for a new Audit Manager position who be directly responsible for the accounting positions who complete the audit.

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- Provide comprehensive cross training to other team members who are already helping with the current FY 2023 audit.

- Pre-Audit Preparation
  - On a quarterly basis, prepare a draft of the financial statements with no accruals based only on AFIS data. The purpose is to ensure all transactions have the appropriate chart of accounts elements and are mapped correctly to the respective accounting lines.
  - On a quarterly basis, prepare a draft Schedule of Expenditures of Federal Awards to identify at an earlier stage of the audit any additional major programs that will be audited besides Medicaid and CHIP.
- Overall Efficiencies
  - Increased collaboration with external auditing firm to develop comprehensive workplan for meeting deadlines and ensuring that external resources are available to meet targeted deadlines.
  - Increased inter-agency collaboration to ensure resources from outside the Division of Business and Finance understand and are committed to targeted deadlines.
  - Over the next few years, redesign and automate other internal processes agency-wide to increase efficiency and provide the audit team members additional time to address the financial statements.

Item:	2022-002
Subject:	Data Breach
Criteria or Specific Requirement:	AHCCCS is required to implement policies and procedures and security measures over IT systems to adequately protect data and to prevent the breach of sensitive data.
Condition:	On May 11, 2023, AHCCCS became aware of a breach of personal information affecting 2,632 out of over 2.4 million individuals in Arizona who are enrolled Medicaid members.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Budget and Finance
Phone Number:	(602) 417-4705
Anticipated Completion Date:	January 1, 2025

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Views of Responsible Officials and Corrective Actions:

AHCCCS has disabled the toolbar feature that allowed members to see the inappropriate information. Additionally, AHCCCS will create workarounds in HEAPlus and PMMIS to ensure no further information is erroneously disclosed. Plans for system changes to address this issue are being drafted and implementation will occur once it is decided what the final solution should look like.

All system programming changes now go through a complete systems development life cycle that includes requirements development, programming, unit testing, system regression testing, and user acceptance testing. This process will provide the best possible method for avoiding these types of breaches in the future.

Item: 2022-003

Assistance Listing Number: 93.778

Programs: Medical Assistance Program (Medicaid; Title XIX)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Pass-Through Grantor Identifying Number 11-W-00275/09

Award Year: July 1, 2021 – June 30, 2022

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria:

AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud (CAF) cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

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AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition:

The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. As of August 23, 2023, a total of 317 providers have been suspended from Medicaid payments (since the start of Federal Fiscal Year 2020). AHCCCS' contracted provides as of June 30, 2022 totaled 120,566. These provider payment suspensions are known as Credible Allegations of Fraud (CAF) suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Name of Contact Person: Jeff Tegen, Assistant Director, AHCCCS Division of Budget and Finance

Phone Number: (602) 417-4705

Anticipated Completion Date: December 31, 2024

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Views of Responsible Officials and Corrective Actions:

In response to this item, AHCCCS has made holistic, system-wide improvements to the Medicaid payment system, including:

1. Required behavioral health providers to submit additional assessment, treatment plan, and medical records documentation with their claims,
2. Required Fee-For-Service providers billing more than 2 units of hourly codes or 4 units of 15-minutes codes on a single date of service, to provide additional documentation,
3. Added new reporting to flag concerning claims for review before payment, including, but not limited to, claims for services that could not be rendered as billed, claims for substance use treatment for minors age 12 and under, claims for services by different providers that should not be provided on the same day, and overlapping services of the same style,
4. Set billing thresholds and imposed prepayment review for various scenarios including multiple providers billing the same client on the same day for similar services, excessive number of hours per day, and the age of patients,
5. All codes intended for per diem services have been limited in the system and providers must bill each day separately rather than in date ranges, so per diem codes cannot be billed more than once a day on any given date of service,
6. Researched and confirmed that the National Correct Coding Initiative (NCCI) Medicaid coding methodologies, which allow for states to reduce improper payments, are in place and functioning correctly,
7. Set a specific rate for billing code H0015 for drug and alcohol treatment services, a change from the previous rate that paid a percentage of the billed amount,
8. Hired a forensic auditor to review all claims since 2019,
9. Implemented emergency rules to enhance and expand AHCCCS authority to exclude providers affiliated with bad actors,
10. Elevated three behavioral health provider types to the high-risk category for all new registrants, requiring fingerprints, on-site visits, background checks, and additional disclosures,
11. Implemented federal authority to impose a moratorium on new provider registrations for all Behavioral Health Outpatient Clinics, Integrated Clinics, Non-Emergency Transportation providers, Behavioral Health Residential Facilities, and Community Service Agencies,
12. Ended approval of retroactive provider registrations without good cause documentation,
13. Eliminated the ability for providers to bill on behalf of others,
14. Eliminated the ability for a member to switch enrollment from a managed care health plan to the American Indian Health Program (AIHP) over the phone,
15. Added a data request process for law enforcement agencies to assist with missing persons cases, and

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16. Revised the Provider Participation Agreement (PPA) to explicitly require that if a provider stops providing services to AHCCCS members during an ongoing investigation, they must help the member transition to a new provider for care. Similarly, they are required to provide to AHCCCS a member census and, upon request, any other information needed to assist in care coordination. If they do not comply, AHCCCS has the right to file an injunction to require the provider to comply with the PPA.

AHCCCS plans to implement additional measures to further strengthen the agency's ability to detect and prevent potentially fraudulent activity. A partial list includes:

- Requiring visual attestation of individual billers,
- Requiring third-party billers to disclose terms of compensation, and
- Determine methodology for AIHP enrollment criteria.

Item:	2022-004
Assistance Listing Number:	93.778
Programs:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Pass-Through Grantor Identifying Number	11-W-00275/09
Award Year:	July 1, 2021 – June 30, 2022
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud (CAF) cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).
Condition:	AHCCCS did not identify and perform a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis.

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Name of Contact Person: Jeff Tegen, Assistant Director, AHCCCS Division of Budget and Finance

Phone Number: (602) 417-4705

Anticipated Completion Date: December 31, 2023

Views of Responsible Officials and Corrective Actions:

In early 2023, AHCCCS completed a staffing analysis which determined additional needed staffing as follows: 1 manager, 3 supervisors, 17 staff investigator positions; permanent funding for 10 time limited investigator positions. In addition, to address workload and costs structurally, AHCCCS is pursuing potential opportunities to partner with contracted Managed Care Organizations (MCO) by referring certain provider and member fraud incidents to MCO contractors for investigation. If such a process is implemented, it is anticipated that referral of investigations to MCO contractors may significantly impact the level of necessary OIG funding and staffing. Such a process may require managed care contract amendments and may also require approval from CMS. As AHCCCS implements the new referral processes, the agency will monitor workload and costs to evaluate whether funding and staffing levels are sufficient and will work with the Legislature to revise appropriations if needed.

AHCCCS implemented a triage process to preliminarily investigate all **provider** fraud or abuse cases. Cases are preliminarily investigated when they are screened within 90 days of receipt, assigned a priority level, and referred to the Attorney General's office, or other law enforcement agency, if the cases are identified for criminal investigation.

To screen a case and assign a priority level of a referral of a potential fraud or abuse incident, an OIG supervisor assigns the matter a priority level. Priority One is "MEDIA, DEATH, NEGLECT, IMMEDIATE JEOPARDY/CONCERN, GOVERNOR OR DIRECTOR REFERRAL, CATS (CONSTITUENT AFFAIRS), ASSAULT, PRIORITY LAW ENFORCEMENT, EVIDENCE PRESERVATION". Priority Two is "ALL OTHER LAW ENFORCEMENT CASES". Priority Three is "ALL OTHER CASES". The supervisor enters the priority level for the matter into the OIG SMART database and assigns the matter to an investigator. The SMART database has been programmed to incorporate the prioritization process and OIG staff were trained and the SMART database process was implemented by the end of March 2023.

Upon assignment, investigators review a case for possible referral to the Attorney General's office, or other law enforcement agency, within 24 hours and thereafter if further investigation warrants. Additionally, to ensure that priority level one cases are preliminarily investigated and referred within 90 days to the Attorney General's office, or other law enforcement agency, (if applicable), each investigator tracks the progress of the investigation using a spreadsheet which is reviewed with their supervisor on a rotating periodic basis. All 2023 Provider cases have been implemented with these procedures.

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The triage and assignment process to preliminarily investigate **member** fraud or abuse cases was already in existence. Member personnel have a handbook outlining process, procedure, and workflow for their various priorities and allegations. Priority One is "Residency, member death, Joint, Information Only, ALTCS, Voluntary Withdrawal, or Identity Card Issues". Priority Two is "TPL or Fast Track". Priority Three is "High Dollar". Priority Four is "Low Dollar or Short Benefit Time". Priority Five is "Child Custody or Other Cases".

Only specific Member Case Priorities and Allegations have preliminary investigation timelines. Priority One cases with an allegation of Residency, ID Card Issues or Member Death are expected to have preliminary investigations completed within 10 days of assignment to an investigator. Priority Two cases with TPL allegations are expected to have preliminary investigations completed within 60 days of assignment to an investigator. Priority Two cases with Fast Track allegations are expected to have preliminary investigations completed within 30 days of assignment to an investigator. All other Priorities and allegation cases have completed investigative timeframes that vary from 120 days to 2 years as defined in the Member Handbook.

AHCCCS has updated its Member handbook to provide clear process expectations, including the standard rotating review of each investigator's case load with their supervisor to ensure preliminary investigations deadlines are completed, updated entries to the case management system occur, and subsequent allegations are accounted for in the case documentation.

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