

AHCCCS PROGRAM INTEGRITY PLAN SFY 2015

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) 2015, AHCCCS is expected to spend approximately \$11.5 billion providing health care coverage to over 1.5 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](#).

ENVIRONMENTAL SCAN or SITUATIONAL ASSESSMENT

As a result of implementing Medicaid Restoration in 2014, there are currently 340,000 more individuals covered by the AHCCCS program than in 2013. AHCCCS continues to evaluate and implement Program Integrity strategies to address the growing number of Arizonans receiving Medicaid.

AHCCCS continues to focus on the integration of physical and behavioral health. In 2014, through collaboration with the Arizona Department of Health Services, approximately 17,000 members with Serious Mental Illness were transitioned on April 1, 2014 to Mercy Maricopa Integrated Care plan (MMIC) in Maricopa County.

In addition 60,000 or 45% of our duals are aligned through the use of Dual Special Needs Plans. This is the highest percentage nationally and is an important opportunity for the member to be served by the same organization for both Medicare and Medicaid.

AHCCCS continues to expand on processes related to Payment Modernization. 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. We have implemented a new payment system on October 1, 2014. 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 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 6th 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 2014 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 27 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 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. The screening process including site visits and routine checks to the PECOS database has started and will continue throughout the 2015 calendar year.
- 12 civil monetary penalties were issued in SFY 2014.
- 13 provider suspensions were issued during FY 2014 as a result of the determination of credible allegations of fraud which is a relatively new tool available to State Medicaid programs.

AHCCCS Recovery, Savings and Cost Avoidance

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	% Change SFY13-SFY14
Coordination of Benefits					
Total Commercial COB	\$113,001,472	\$112,038,407	\$121,716,277	\$ 125,064,195	+9%
Total Medicare COB *	\$815,066,365	\$836,709,557	\$922,490,575	\$ 1,055,239,043	+8%
Total COB Cost Avoidance	\$928,067,837	\$948,747,964	\$1,044,206,851	\$ 1,180,303,238	+8%
Third Party Liability					
Total Recoveries **	\$9,924,206	\$11,118,940	\$11,692,628	\$ 11,905,088	+9%
Total Distributions	\$8,310,570	\$9,232,308	\$9,427,596	\$ 9,976,724	+9%
Net Recoveries from TPL	\$1,613,636	\$1,886,632	\$2,265,032	\$1,928,364	-8%
Office of Inspector General (OIG)					
Provider Fraud Unit Recoveries and Savings***	\$6,007,659	\$11,094,794	\$19,200,500	\$24,033,483	+7%
Member Fraud Unit Recoveries and Savings****	\$24,493,145	\$29,967,560	\$31,712,316	\$34,217,415	+9%
Total OIG Recoveries	\$30,500,804	\$41,062,354	\$50,912,816	\$58,250,898	+8%
RECOVERY/COST AVOIDANCE TOTAL	\$960,182,277	\$991,696,950	\$1,097,384,699	\$1,240,482,500	+8%

* 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)

**** Report of Member Fraud Unit results (includes Social Security leads)

FY 2015 PROGRAM INTEGRITY STRATEGIES

1. Leverage resources to enhance detection, prevention and investigations

a. Data Analytics Initiative

- I. Develop, and release a Request for Proposal (RFP) and award a contract for new data analytics.
- II. Develop and implement the data analytics process “data driven cases” with the initial focus on 3 major PI audit projects.
- III. OIG restructured and set forth a new process incorporating coding, trends and algorithms to detect outliers with potential improper billing issues.
- IV. OIG will be monitoring trends, suspicious billing practices, and communicating the findings that potentially can be addressed by the contractors avoiding future occurrences of fraud.

2. Pursue New Initiatives in the Office of Inspector General

a. Improve Case Management

- I. Enhance communication with the contractors to increase quantity and quality of referrals from Plans.
- II. Streamline and improve the monetary recoupment process, the Civil Monetary Penalties (CMP), and the Settlement process including participation from the AHCCCS' Legal Counsel.

b. Strengthen the collaboration with the Arizona Attorney General's Office to increase the quality of cases for prosecution.

c. Incorporate a new system to measure case development, recoupment, and collections to ensure a continuous monitoring investigative performance, recoupment and savings. Develop AHCCCS'OIG Medicaid Fraud Task Force (MFTF) to Include partner agencies such as DES-OI and DBHS; and State, Local, and Federal Law Enforcement Agencies; such as FBI, HHS-OIG and VA OIG

- I. Identify and allocate additional resources. Include Attorney General Office's designated OIG attorney
- II. Include AHCCCS' Legal Counsel participation
- III. Oversight and management of law enforcement cases for member-provider fraud
- IV. Designate law enforcement supervisor (Provider) and law enforcement investigator for member side

d. Set forth processes to increase efficiency and effectiveness of OIG initiatives and programs.

- I. Develop and implement the SharePoint site for OIG (case management system, e-sign).
- II. Automate reports – create ability to use electronic signatures -
- III. Redesign the Report of Investigation (ROI) template to rid duplicative material (provider fraud; member fraud) – Member implemented and provider almost ready
- IV. Automate the CMPs, Letter of Recoupment, and Settlements

e. Pursue global settlements individually as a state.

f. Have Hospital Presumptive Eligibility program integrity strategies in place for 2015 implementation.

3. Continue opportunities to improve Provider Compliance

- a. Expand provider registration verification including:
 - I. Exploring the possibility to incorporate the certification requirements applicable to Non-Emergency Medical Transportation (NEMT) to all provider types that are allowed to provide NEMT as an additional category of service.
 - II. Design a Web portal for interactive online re-enrollment process, and all the required forms for provider registration by June 30, 2015
 - III. Conducting site visits for all new NEMT providers and reenrolling providers
 - IV. Implementing a pilot for staff to use an automated site visit system by Jan. 2015
 - V. Eliminating independent direct care workers provider type 28 by January 2015
 - VI. Require that provider type 77 Behavioral Health Outpatient Clinical are in compliance with all NEMT requirements for re-enrollment in 2015 if NEMT is one of their categories of services.
- b. Collaboration with CMS Medicare
- c. Increase the use of the CMS PECOS database for new and re-enrolling high risk provider types such as: Durable Medical Equipment, NEMTs, and Home Health Agencies. Continue working with HMS regarding the Recovery Audit Contractor (RAC) outcomes =
- d. Develop and implement audit methodology for Primary Care rate increases and Meaningful Use payments

4. Continue opportunities to improve Member Compliance

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

5. Continue emphasis on Program Integrity training

- a. Update website training

6. Participate in federal partnerships

- a. Measure outcomes associated with Fraud Investigations Database for Medicare (FID) process
- b. AHCCCS Director will continue to serve on NAMD Executive Workgroup and work with CMS on several Program Integrity issues including proposed new rules around program integrity 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 by March 2015