BerryDunn

Findings and Recommendation Report (FARR) for *Arizona Health Care Cost Containment System*

Submitted to:
Arizona Health Care Cost Containment Systems
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1.0 Executive Summary

In April 2023, BerryDunn and the Arizona Health Care Cost Containment System (AHCCCS) entered into an agreement via Task Order YH23-015 for BerryDunn to provide Forensic Accounting and Auditing Services. As part of this agreement, AHCCCS requested a review of claims for behavioral health services provided to American Indian (AI) and Alaska Native (AN) members, among other populations. As part of the review and assessment, BerryDunn was asked to provide findings and recommendations based on the review of claims data, member eligibility and enrollment, and payment activity post reimbursement to providers.

BerryDunn's claims and provider post-payment review started with our health analytics data experts conducting a trend analysis on the claims and provider files that we requested and received from AHCCCS. The trend analysis identified anomalies and suspicious provider billing activity that required further review from our program integrity experts. BerryDunn's program integrity experts reviewed the claims and payment activity in greater detail and produced the following results:

- Thirteen potential Fraud, Waste, and Abuse (FWA) memos delivered to the Office of the Inspector General (OIG) for further review and investigation
- Between January 2019 and August 2023, $218,456,784.48 in claims were paid to fifteen of the provider entities from our potential FWA findings
- Twenty-six unique findings of suspicious provider billing activity that fell into these general areas of concern:
    - Policy or regulation violations
    - Claim volume significantly exceeding averages
    - Billing activity not physically possible
    - Billing activity not following best or typical practices
    - Abrupt change in billing behavior and service offerings after a new AHCCCS policy was implemented
- Twenty recommendations that generally fell into the following areas:
    - Reports that help monitor billing activity and alert AHCCCS when established thresholds are surpassed
    - Policy changes
    - Periodic quality reviews
    - Additional or modified claim edits
    - Confirmation of AHCCCS policy, process, or system changes already made.

Our member enrollment review started with our eligibility and fraud examiners coordinating with the AHCCCS Member Enrollment Team to conduct a series of on-site and virtual sessions. The

review was focused on members who were associated with providers of concern and had switched from a managed care plan to American Indian Health Program (AIHP) at least once in the last five years. The team looked at data and information in the following AHCCCS systems:

- Member enrollment history (MMIS) contact information, such as phone numbers, email address, and physical address (MMIS)
- Verification of Social Security number and citizenship (SOLQI)
- Race, ethnicity, and American Indian and Alaska Native Status and tribe (HEA Plus and MMIS)
- Call recordings for the switch to the AIHP and recordings for the switch to an Managed Care Organization (MCO) plan, if switching back from the AIHP (Genesys)
- A list of calls identified as potentially suspicious that were reported by Enrollment Contact Center staff through the shared reporting spreadsheet

The time-intensive nature of the enrollment reviews resulted in the team reviewing 17% (84 / 485) of our sampling list. Because of the time commitment of each review, the team continuously updated the population of members prioritized for review based on new information obtained during our review and attempted to identify different potentially fraudulent schemes.

The member enrollment review resulted in the following:

- Two potential FWA memos delivered to OIG for further review and investigation
- Eight unique findings in the following categories:
    - Missing demographic data needed for AIHP enrollment
    - Suspicious call activity related to the member enrollment
    - Suspicious plan switching between the managed care plans and AIHP
    - Potential vulnerabilities in existing member enrollment policy
    - Inconsistent application of existing member enrollment policy
- Six member data patterns and trends for further review
    - Members with short AIHP enrollment periods
    - Members with increased claims volumes from a provider of concern after switching to AIHP
    - Members with high-frequency caller phone numbers tied to their enrollment
    - Members enrolled in AIHP shortly after being released from incarceration
    - Members with phone numbers associated with a plan change that do not match phone numbers in the case
    - Members requesting plan changes from anonymous phone numbers

- Five recommendations
    - Periodic reviews of AIHP-enrolled members particularly those without AI/AN noted in the MMIS
    - Evaluation of training programs for Member Services staff and creation of training materials on proper plan change policies and processes
    - Monthly spot audits of Member Services representative calls to ensure policies are being followed
    - Periodic reviews of forms submitted for enrollment to ensure licensed entities are submitting the request
    - Creation of criteria and instructions for contact center agents and members to report potential FWA

In addition to the items identified and recommended above, BerryDunn recommends the following broad initiatives for AHCCCS to further identify and prevent FWA:

- Conduct a deeper review of the same populations, providers, claims, and services from the original task order. This option would expand on the recommendations from the 17 FWA memos and help AHCCCS execute some of the additional reviews the BerryDunn team recommended in each memo.
- Conduct a broader program integrity review of the AHCCCS program. This option would expand the review activities from the original task order to all or more AHCCCS member populations, providers, and services (not just behavioral health services for AI/AN).
- Conduct a comprehensive organizational assessment of AHCCCS. This option would involve a review of the entire organization with the goal of identifying initiatives and actions to be taken to move AHCCCS toward a high-performing organization with a program integrity mindset.

Thank you for the opportunity to provide our findings and recommendations to AHCCCS.

2.0 Sources of Information

2.1 Findings and Recommendations Review Documentation

Table 2.1 below includes a summary of the documentation and data that the BerryDunn team used to complete its independent review and analysis.

Table 2.1: Findings and Recommendations Review Documentation

Document/Data Type	Description	Source
Claims Data	A subset of claims involving providers of concern from January 1, 2019 – July 31, 2023, and additional providers discovered while conducting the review.	AHCCCS provided BerryDunn with access to the network so the team could analyze the following tables: • The table CAF_TRIBAL_SERVICES contained all AI/AN professional detail and facility header claims information. • For provider analysis, we were provided two tables: Provider Enrollment CAF_TRIBAL_PR_DEM and Provider Demographic CAF_TRIBAL_PR_ADDRESS. Both tables were used for provider analysis to identify additional potential providers of concern.
Member Enrollment Data	A subset of member eligibility and enrollment involving providers of concern from January 1, 2019 – July 31, 2023, and additional providers discovered while conducting the in-person and virtual phone call reviews. Includes circumstances surrounding provider interaction with and solicitation of members for services.	AHCCCS provided BerryDunn with access to the network so the team could analyze the following tables • Member Enrollment CAF_TRIBAL_ENROLLMENT • Member Demographic CAF_TRIBAL_MBR_COHORT Both tables were used to identify members who switched plans.
AHCCCS Organizational Charts	Staff rosters, including roles and responsibilities for each unit, with name of employees filling each position	AHCCCS SharePoint
Diagrams	Medicaid enterprise systems diagrams	AHCCCS SharePoint

Document/Data Type	Description	Source
Medicaid Information Technology Architecture (MITA) State Self-Assessment	Most recent self-assessment	AHCCCS SharePoint
State Plan and Amendments	Arizona State Plan for the Medicaid Program and any State Plan amendments	AHCCCS SharePoint
Vendor Assessment	Completed by an external vendor (NTT Data) for the State	AHCCCS SharePoint

3.0 Project Information

3.1 Project Goals

The primary goal of this task order was to complete auditing, analysis, compliance review, and assessment services, focused primarily on behavioral health care services provided to AI/AN members, in order to establish situational awareness and strategic planning. Additional goals for this work included providing recommendations to AHCCCS on the following:

- Potential process improvements
- Fraud detection and deterrence improvements
- Staffing and training recommendations

Please note, though this report certainly contains information that allows for some establishment of situational awareness, the work specifically focused on formally establishing awareness is currently on hold (as of the time of the submission of this report), to allow time for proper redaction to occur.

3.2 Project Scope

Per the YH23-0154 Forensic Accounting and Auditing award letter, BerryDunn was responsible for performing the following activities as directed by AHCCCS:

5.1 Claims analysis and case investigation for dates of service on and after January 1, 2019, specific to provider registration, provider qualifications, prior authorization processes and procedures, medical necessity, verification of services rendered, utilization, transportation, and AHCCCS coverage for behavioral and physical health services;

5.2 Auditing of member eligibility and enrollment including circumstances surrounding provider interaction with, and solicitation of, members for services;

5.3 Forensic auditing of claims processes and procedures and potential program integrity risks;

5.4 Process recommendations for agency-wide collaboration and coordination of fraud, waste, and abuse investigative information;

5.5 Recommended process improvements to address issues identified within the scope of work, including, but not limited to, staffing levels, staff training, and software and information systems;

5.6 Auditing of payment activity post reimbursement to providers;

5.7 Develop recommendations to support coordination of member care and transition of services; and

5.8 Develop recommendations for the improved and timely detection and deterrence of fraud waste and abuse, including training and resources needed.

BerryDunn divided this report into two core sections: Section 4.0: Claims and Provider Post-Payment Review and Section 5.0: Member Enrollment Review. Table 3.2 below includes a summary of the sections of the FARR that address each of the scope items detailed above.

Table 3.2: Findings and Recommendations Review Documentation

Scope Number	Scope Description	FARR Section
5.1	Claims analysis and case investigation for dates of service on and after January 1, 2019, specific to provider registration, provider qualifications, prior authorization processes and procedures, medical necessity, verification of services rendered, utilization, transportation, and AHCCCS coverage for behavioral and physical health services;	Section 4
5.2	Auditing of member eligibility and enrollment including circumstances surrounding provider interaction with, and solicitation of, members for services;	Section 5
5.3	Forensic auditing of claims processes and procedures and potential program integrity risks;	Section 4
5.4	Process recommendations for agency-wide collaboration and coordination of fraud, waste, and abuse investigative information;	Sections 4 and 5
5.5	Recommended process improvements to address issues identified within the scope of work, including, but not limited to, staffing levels, staff training, and software and information systems;	Sections 4 and 5
5.6	Auditing of payment activity post reimbursement to providers;	Section 4
5.7	Develop recommendations to support coordination of member care and transition of services; and	Section 5
5.8	Develop recommendations for the improved and timely detection and deterrence of fraud waste and abuse, including training and resources needed.	Sections 4 and 5

4.0 Claims and Provider Post-Payment Review

4.1 Methodology

At the onset of the engagement, AHCCCS shared concerns surrounding the identification of atypical billing trends for behavioral health providers specifically within the AI/AN population. AHCCCS also provided an initial list of providers of concern that had already been identified by AHCCCS as potentially having fraudulent billing practices. BerryDunn's team used the situational information shared, as well as the initial list of providers of concern, to identify potential patterns in the data.

To perform a detailed claims analysis, AHCCCS provided BerryDunn with access to their network to review data tables that contained claims information, member information, and provider information for the AIHP population. To begin our review, our data analytics team aggregated the data to find trends, oddities, outliers, and/or data spikes of potential concern. To identify these trends, our team completed a wide variety of analyses, including, but not limited to, the following:

- Statistical analysis of claim payment information by CPT/HCPC code unit quantity in order to apply statistical analysis to codes, units, and payment information to flag outliers that could indicate additional potential providers of concern
- Identification of billing service codes of particular concern (billing service codes H0038 and H2016)
- Application of basic scenarios in order to identify outliers and patterns in the data, which allowed our team to establish a baseline of trends to look for
- Overall trend analysis for payments per month per time period to establish what should be considered "normal," as well as establish gaps, irregularities, and mass billing in comparison to more normal billing patterns
- Establishment of statistically significant parameters to be able to make connections between the identified providers of concern with other providers in the data set
- Completing duplicate claims identification and analysis in order to identify a subset of members who had duplicate services billed on the same day by different providers
- Identification of per diem codes (codes that should only be occurring once a day) in order to analyze the data to identify billing that occurred more frequently
- Completing statistical identification of billing that is out of trend (abnormally high dollar amount and/or high frequency of claims submission)
- Identification of a potential patient list that was being used fraudulently by many providers
- Analysis of the provider enrollment data to identify newly enrolled providers who enrolled and immediately began out-of-norm billing patterns

4.2 Assumptions

BerryDunn considers assumptions as premises about the business, policy, technical, and/or project environment that for the sake of the project are taken as fact. Assumptions for the claims and provider post-payment analysis recommendations include the following:

- AHCCCS periodically reviews claims reports to help ensure the edits/stopgaps implemented are working as designed and preventing inaccurate payments.
- Each servicing provider provides services for 10 hours or less with the exception of an inpatient/24-hour facility or during on-call hours.
- Providers should not bill in excess of their capacity limits.
- Providers licensed to serve adults should not bill services for minors.
- Individual servicing providers should be listed on claims submissions where required.
- Edit L237 covers all service codes for overlapping services of same style of services from paying for service codes in addition to H0038 and H2016.

4.3 Limitations

Our methodology was designed to identify potential trends, patterns, and potential FWA and assess the processes in place surrounding claims and provider post-payment analysis. However, there were limitations to our methodology that impacted the period, type, and amount of data reviewed. Limitations for the claims and provider post-payment analysis recommendations include the following:

1. To provide baseline reporting criteria, BerryDunn excluded the known providers who were previously identified as a concern or referred for additional review from claims analysis. The billing averages BerryDunn provided could contain fraudulent billing that may skew the averages.

4.4 BerryDunn FWA Memoranda

Please note, all identification of potential FWA was documented in FWA Memoranda, which include details specifying BerryDunn's findings of concern. All memos were delivered through the appropriate channels and were sent directly via secure email to the OIG. The findings and observations documented below can be found in FWA Memoranda 002 – 007, FWA Memoranda 009 – 014, and FWA Memoranda 016. Table 4.4, on the following page, contains a summary of the potential FWA memoranda sent to the OIG based on the findings from the claims and provider post-payment analysis and the disposition as of September 29, 2023. To maintain confidentiality, we removed the names of the providers aligned to each memorandum.

Table 4.4: Potential FWA Memoranda Submitted to OIG for Review

Memorandum Name	Submission Date	OIG Disposition
002_Potential FWA	7/21/2023	Linked to OIG Case 2023-0666
003_Potential FWA	7/25/2023	Linked to OIG Case 2023-1236
004_Potential FWA	7/25/2023	Linked to OIG Case 2023-2719
005_Potential FWA	7/25/2023	Linked to OIG Case 2023-1051
006_Potential FWA	7/25/2023	Linked to OIG Case 2023-3174
007_Potential FWA	7/26/2023	Linked to OIG Case 2023-1114
009_Potential FWA	8/18/2023	Linked to OIG Case 2023-2891
010_Potential FWA	8/25/2023	Linked to OIG Case 2022-2897
011_Potential FWA	8/28/2023	Linked to OIG Case 2023-3538
012_Potential FWA	8/31/2023	Linked to OIG Case 2023-1681
013_Potential FWA	8/31/2023	Linked to OIG Case 2023-1475
014_Potential FWA	9/13/2023	Linked to OIG Case 2023-1690
016_Potential FWA	9/15/2023	Linked to OIG Case 2023-0984

4.5 Findings

BerryDunn identified trends through the review that the team assessed to be significant to the circumstances surrounding claims processing. BerryDunn's team cannot verify with certainty that reported instances are FWA; however, the team believes these trends warrant further investigation by OIG for FWA.

Please see Table 4.5, on the following page, for a complete list of BerryDunn's findings during our analysis and review (specifically related to claims and provider post-payment review). We have attempted to categorize the findings, but it is possible that many findings could potentially belong to multiple categories.

Table 4.5: Claims and Provider Post-Payment Review Findings

ID	Category	Finding Description	Additional Information (If Applicable)
F01	Provider Licensing and Enrollment	Prior to 2019, the provider enrollment process was a manual, paper-based process. After 2019, the complete enrollment file is now contained within the Arizona Provider Enrollment Portal (APEP) system; however, this system is not capable of producing a report of a provider's record. The lack of easy-to-generate report(s) limits AHCCCS' ability to determine key performance metrics for provider enrollment, including the status of the enrollment application and/or the ability for AHCCCS to assess the application's alignment with regulation and policies. This makes it more difficult to conduct enrollment reviews and audits as part of an OIG investigation.	N/A
F02	Provider Licensing and Enrollment	BerryDunn identified a case where a provider licensed as Behavioral Health (BH) Residential Facility – Adult billed and received payments for services provided to minor-aged children. Services for minor-aged children should not be able to be billed under Behavioral Health (BH) Residential Facility – Adult.	• Member aged nine who turned ten in residential treatment for 325 days on dates of service August 26, 2020 – July 16, 2021, for F902, attention-deficit hyperactivity disorder, combined type • Member aged eight in residential treatment for 325 days on dates of service August 26, 2020 – July 16, 2021, for F902, attention-deficit hyperactivity disorder, combined type
F03	Provider Licensing and Enrollment	BerryDunn identified a provider that billed and received payment for services using the Type 2 organization National Provider Identifier (NPI) listed as both the servicing and billing provider for all claims rather than a Type 1 individual NPI for the servicing provider. The federal government requires providers who administer "medical and other health services" to obtain an NPI number. This could be an	N/A

ID	Category	Finding Description	Additional Information (If Applicable)
		indicator that other providers of service within the organization may not be enrolled with AHCCCS.	
F04	Payments	BerryDunn identified payment patterns where an inordinately high number of claims were paid for in what would be considered a small period (e.g., less than a year) in comparison to established normal trends.	• Payments totaling $51,839,119.08 for eight months of service • Payments totaling $12,752,521.22 for three months of service
F05	Payments	BerryDunn identified payment patterns where the same behavioral health services paid to different providers on the same date of service for the same member.	• Provider billed six units of H0004 for member for date of service April 27, 2023, on May 19, 2023. • Provider billed another three units of H0004 for same member/date of service on May 19, 2023. • A separate provider billed two units of H0004 for same member/date of service on May 4, 2023.
F06	Payments	BerryDunn identified payments for services on dates of service occurring prior to issuance of an NPI. The federal government requires providers who administer “medical and other health services” to obtain an NPI number.	• Provider’s enrollment was retroactively dated for January 16, 2023. • Provider billed for services on January 16, 2023, and NPI was issued January 18, 2023.
F07	Billing	BerryDunn identified provider(s) circumventing the service limit edit by rebilling services with lessor units and receiving payment for services previously denied for exceeding service limit.	• Provider submitted a claim with 60 units of H0004 on May 1, 2023, which was denied. Provider resubmitted claim on May 11, 2023, for eight units. • Provider submitted a claim with 80 units of T1016 on May 1, 2023, which was denied.

ID	Category	Finding Description	Additional Information (If Applicable)
			Provider resubmitted claim on May 11, 2023, for eight units.
F08	Billing	BerryDunn identified a provider who billed and received payments for repeating peer services, training, or education for members with no case management or counseling for the member. It is reasonable to assume a member would need case management or counseling to also be receiving peer services, training, or education.	• Provider provided case management/counseling to 3 members compared to the 507 members receiving peer services, training, or education.
F09	Billing	BerryDunn identified a case where a provider billed and received payments for behavioral health services provided to children under 10 for diagnosis code F10.20 - alcohol dependence, uncomplicated, to include infants and toddlers.	• Age 0 – Dates of service November 28, 2022 – January 20, 2023 • H0031 – Mental health assessment, by non-physician • T1016 – Case management, each 15 minutes • Age 1 – Dates of service November 28, 2022 – January 20, 2023 • H0031 – Mental health assessment, by non-physician • T1016 – Case management, each 15 minutes
F10	Billing	BerryDunn identified a provider billing multiple members with exact same service codes, billed units, dates of service, and diagnosis code.	• Provider billed 80 units of T1016 for 308 members with alcohol dependance for dates of service March 6, 2023 – March 10, 2023.
F11	Billing	BerryDunn identified a provider who billed and, in some cases, received payment for services provided to incarcerated members.	• Provider received payment in the amount of $2,971.11 for one incarcerated member for dates of service January 18, 2023 – January 20, 2023.

ID	Category	Finding Description	Additional Information (If Applicable)
F12	Billing	BerryDunn identified a case where a provider billed and received payments for members exceeding license capacity limits.	• Provider has a license capacity limit of eight and billed for nine members on the same dates of service: ○ June 5, 2021 – June 16, 2021 ○ October 1, 2021 – October 15, 2021 ○ October 16, 2021 – October 27, 2021 ○ February 7, 2022 – February 18, 2022 ○ February 19, 2022 – March 4, 2022 ○ March 5, 2022 – March 18, 2022 ○ March 19, 2022 – March 23, 2022
F13	Billing	BerryDunn identified a case where a provider billed and received payments for more than one assessment or evaluation for members within the same month. Typically, more than one of the same assessments is not provided in the same week.	• Provider billed and received payment for service code H0031 - mental health assessment, by non-physician, for three distinct members on multiple dates of service: ○ May 12, 2023, and May 16, 2023, for diagnosis code F3132 - bipolar disorder ○ September 16, 2021, and September 21, 2021, for diagnosis code F1020 - alcohol dependence, uncomplicated ○ June 5, 2023, and June 12, 2023, for diagnosis code F1520 - other stimulant dependence, uncomplicated
F14	Billing	BerryDunn identified a case where a provider held months of billing for behavioral services until last date of service. Typically, an outpatient clinic would bill at the time of service versus waiting up to 90 days to bill.	• Provider submitted claim on February 22, 2023, for member date of service range December 1, 2022 – February 22, 2023.

ID	Category	Finding Description	Additional Information (If Applicable)
			• Provider submitted claim on January 31, 2023, for member date of service range December 1, 2022 – January 31, 2023.
F15	Billing	BerryDunn identified a provider who billed and received payments for the organization using a single servicing provider for all claims versus each servicing provider in the organization billing for the services they provided.	N/A
F16	Billing	BerryDunn identified a servicing provider who billed and received payments on a single date of service for units that exceeded a 24-hour period.	• Provider billed a total of 2,514 units (37,710 minutes) on date of service March 8, 2023, for 247 distinct members. There are 1,440 minutes (96 units) in 24 hours.
F17	Billing	BerryDunn identified a provider who billed and received payments for service code H0004 - Behavioral Health Counseling and Therapy, per 15 minutes, in excess of four hours (16 units). Typically, individual/group counseling sessions are less than two hours.	N/A
F18	Billing	BerryDunn identified a provider who billed and received payments for services on weekends and holidays (outside listed business hours) for six months that did not indicate service codes for crisis intervention/stabilization. Typically, if outpatient service providers provide services after hours or on holidays, they would be due to crisis intervention/stabilization.	• Provider billed H0004 - Counseling and T1016 - Case Management on New Year's Day, Easter, and Fourth of July. • Provider billed daily from January 1, 2023 – July 17, 2023, despite provider website stating Monday through Friday business hours.
F19	Billing	BerryDunn identified a case where a provider billed service code H0018 - Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem, and did not bill any other professional services.	N/A
F20	Billing	BerryDunn identified a case where the provider billed service code 99205 - office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate	N/A

ID	Category	Finding Description	Additional Information (If Applicable)
		history or examination and high level of medical decision-making, for all new patient visits. Typically, there is a mixture in the level of service provided to a new patient and a consistency of high level of care for all new patients is abnormal.	
F21	Billing	BerryDunn identified a provider who billed and received payment for non-covered service code T1020 – Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facilities for Mental Retardation (ICF/MR) or Institution for Mental Diseases (IMD), part of the individualized plan of treatment.	N/A
F22	Billing	BerryDunn identified a case where a provider billed and received payment for 9 – 12 hours of service for each distinct member. It is unusual for a provider to provide the exact same services and units for multiple members.	• Provider billed an average of 9 –12 hours of H0038 - Self-help/peer services, per 15 minutes, H2014 - Skills training and development, per 15 minutes, and H2027 - Psychoeducational service, per 15 minutes for each distinct member daily during their time of service.
F23	Billing	BerryDunn identified a provider who billed more than one unit for service code H2016 – Comprehensive community support services, per diem. Per diem services are limited to one unit. The claims for more than one unit were denied.	
F24	Billing	BerryDunn identified a scenario where a provider ceased daily billing for members when AHCCCS implemented the behavioral health billing thresholds. This scenario was an abrupt change in billing behavior and service offerings after a new AHCCCS policy was implemented.	• Provider only billed dates of service May 1, 2023, for one member and May 24, 2023, for two members after behavioral health billing thresholds changed.
F25	Billing	BerryDunn identified a case where a provider began billing services not previously billed after AHCCCS implemented service limits on behavioral health services.	• Provider billed eight units of H2025 - ongoing support to maintain employment, per 15 minutes, for 63 distinct members on dates of service May 30, 2023, June 1,

ID	Category	Finding Description	Additional Information (If Applicable)
			2023, and June 2, 2023, for a total payment of $14,258.64. • Provider billed H2016 - Comprehensive community support services, per diem, for 59 distinct members on dates of service July 1, 2023 – August 4, 2023, for a total payment of $74,722.56.
F26	Billing	BerryDunn identified a case where a provider billed and received payment for service code H0015 - Alcohol and/or drug services; intensive outpatient, 6 days a week and stopped providing services to members when AHCCCS proposed the FFS rate change effective May 1, 2023. This scenario was an abrupt change in billing behavior and service offerings after a new AHCCCS policy was implemented.	N/A

4.6 Recommendations

Based on the findings presented in Section 4.5 above, BerryDunn has developed a list of recommendations for AHCCCS to consider implementing. Though these recommendations vary, the focus of our review and correlating recommendations was specifically on the claims and providers post-payment review concentrating on the AI/AN population.

To summarize, BerryDunn recommends considering the implementation of edits and regular reviews of recommended reports and/or medical records to help identify/prevent issues more promptly. This will also likely allow any claims processed that are not compliant with AHCCCS policy to be reversed. The Payment Error Rate Measurement (PERM) cycle review looks for claims to be reversed/corrected within 60 days of the paid date to avoid being cited as a PERM error. Existing and new staff will need training on the desired use of reporting and guidance on claim reviews and resolution in a timely manner to help prevent PERM errors and help identify potentially fraudulent activity.

Please see Table 4.6 on the following page, for a complete list of the BerryDunn recommendations, specifically related to claims and provider post-payment review, resulting from the findings identified during our analysis. We have attempted to categorize the recommendations, but it is possible that many recommendations could potentially belong to multiple areas.

Table 4.6: Claims and Provider Post-Payment Review Recommendations

ID	Category	Recommendation Description
R01	Claims Edits/ Service Limits	On May 3, 2023, AHCCCS implemented claim editing to help prevent providers from receiving payment for overlapping services for the same style of services for service codes H0038 and H2016. • AHCCCS has since requested additional service codes to be added to edit L237. Although AHCCCS already implemented these claim edits within the system, BerryDunn recommends monthly reviews of these edits to ensure they are appropriately preventing claims from processing incorrectly. Additionally, AHCCCS could develop a report that looks for overlapping services of same style, member, and date(s) of service to ensure multiple providers are not incorrectly billing for the same/similar services, member, and date(s) of service. Appropriate policy updates should be documented, including standard operating procedures, for how to handle the new claim edits, potential future reporting, and the process addressing impacts of these edits. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R02	Claims Edits/ Service Limits	On May 3, 2023, AHCCCS implemented behavioral health service limits on Fee-For-Service claims received on and after May 3, 2023. Providers billing more than the service limit will be required to submit documentation to support the services billed on the service date. Although AHCCCS already implemented these service limits within the system, BerryDunn recommends monthly reviews of these edits to ensure they are appropriately preventing claims from processing incorrectly. Additionally, AHCCCS could develop a report that looks for paid claims more than service limits to help ensure the provider submitted proper documentation to support units billed. Appropriate policy updates should be documented, including standard operating procedures, for how to handle this new service limit, potential future reporting, and the process for requesting provider documentation. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R03	Claims Edits/ Service Limits	On May 3, 2023, AHCCCS implemented reporting to flag claims to pend for review prior to paying for minor-aged children. Although AHCCCS already implemented these reporting flags within the system, BerryDunn recommends monthly reviews of the paid claims to help ensure the claims are processed correctly. Additionally, AHCCCS could develop a report that looks for paid claims with behavioral health services for minor-aged children to ensure the servicing provider is licensed to serve minor-aged children.

ID	Category	Recommendation Description
		Appropriate policy updates should be documented, including standard operating procedures, for how to handle these new reporting flags, potential future reporting, and the process for reviewing any pends for review. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R04	Claims Edits/ Service Limits	BerryDunn recommends implementing edits to help prevent unauthorized payment of services for incarcerated members, including policy updates, future reporting to address this change, and training (if necessary) for staff who will address any potential impacts of the edit and handle communications with the provider community. BerryDunn realizes that some services are supposed to be covered for incarcerated people (e.g., inpatient stays).
R05	Claims Edits/ Service Limits	BerryDunn recommending implementing edits to deny claims for providers licensed to serve adults and billing services for minor-aged children, including policy updates, future reporting to address this change, and training (if necessary) for staff who will address any potential impacts of the edit and handle communications with the provider community.
R06	Claims Edits/ Service Limits	BerryDunn recommends implementing edits to help prevent payment of claims that are missing Type 1 individual NPI for mental health servicing provider, including policy updates, future reporting to address this change, and training (if necessary) for staff who will address any potential impacts of the edit and handle communications with the provider community.
R07	Claims Edits/ Service Limits	BerryDunn recommends completing a comprehensive review of edits to ensure that sufficient edits are in place to align with provider types; based on changes over the last year, this may require additional updates. For any misalignment identified, BerryDunn recommends implementing edits to deny claims on the front end, if the claim is not an approved service for the provider type, including policy updates, future reporting to address this change, and training (if necessary) for staff who will address any potential impacts of the edit and handle communications with the provider community.
R08	Reviews	BerryDunn recommends completing a medical documentation review of claims submitted by potential providers of concern and any providers who have suspicious activity to verify the following: Service was provided to the members by an AHCCCS-enrolled provider, as well as the level of service provided to a new/existing patient
R09	Reviews	• BerryDunn recommends evaluating the provider enrollment files for all behavioral health providers servicing the AI/AN population in order to confirm enrollment validity and scope of license. Additionally, BerryDunn recommends considering a secondary review of all providers actively providing services for the AI/AN population.

ID	Category	Recommendation Description
R10	Reviews	BerryDunn recommends conducting periodic reviews to help ensure claims are paying correctly based on AHCCCS policy and edits to ensure applicable edits are working as designed.
R11	Reviews	BerryDunn recommends conducting weekly reviews to help ensure steps are not missed or skipped during the provider enrollment process. The review would identify actions such as backdating applications and primary source verification to validate the process aligns with procedures identified in the AHCCCS Provider Enrollment Manual. Once the team determines that weekly provider reviews no longer yield new issues, the team can move the reviews to monthly or potentially even quarterly. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address necessary reviews.
R12	Reporting	BerryDunn recommends developing a report that would help identify behavioral health providers with high-volume billing activity where monthly reporting threshold averages were calculated per month per provider type per non-provider of concern indicator. In addition, the Provider Services and Claims teams could conduct monthly reviews of provider claims submissions to help ensure cases of overutilization are identified and questioned, prior to releasing payment, to determine the reason for overutilization (e.g., billing at the entity level versus the individual provider). This can help reduce issues of posting excessive hours in a short period or end of month billing for the total or multiple months. Recommendations for potential monthly reporting by provider type are provided below: • A3 – Community Service Agency: >$40,000 • A4 – Lic Indep Substance Abuse Couns (LISAC): >$50,000 • A6 – Rural Substance Abuse Transitional Agcy: >$45,000 • BC – Board Certified Behavior Analyst: >$55,000 • 19 – Registered Nurse Practitioner: >$25,000 • 31 – DO-Physician Osteopath: >$25,000 • IC – Integrated Clinics: >$500,000 • 77 – BH Outpatient Clinic: >$600,000 • 85 – Licensed Clinical Social Worker (LCSW): >$25,000 • 86 – Licensed Marriage and Family Therapist (LMFT): >$15,000 • 87 – Licensed Professional Counselor (LPC): >$30,000

ID	Category	Recommendation Description
		*Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.

R13	Reporting	BerryDunn recommends developing a report that would help identify when any behavioral health provider rebills denied claims with a lesser number of units.
		• Criteria for the report should include identifying denied claims then comparing to paid claims for
		  ○ same member,
		  ○ rendering provider,
		  ○ beginning date of service, and
		  ○ HCPC/CPT code,
		• where the unit quantity of the paid claim is less than the unit quantity of the denied claim.
		*Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.

R14	Reporting	BerryDunn recommends developing a report that would help identify claims for members with same service codes, billed units, and dates of service. • Based on the results of same service, units, and dates of service from the report, recommend completing a medical documentation review of claims submitted by provider to verify if the service was provided to the member and that the servicing provider is an AHCCCS-enrolled provider. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R15	Reporting	BerryDunn recommends developing a report that would help identify servicing providers billing for services that exceed 10 hours/40 units in a day. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R16	Reporting	BerryDunn recommends developing a report that would monitor when providers are billing more than their capacity. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.

ID	Category	Recommendation Description
R17	Reporting	BerryDunn recommends developing a report that would help identify claims paid with a Type 2 organization NPI listed as the servicing provider and utilize the report to request medical records to determine that the servicing provider is an AHCCCS-enrolled provider. *Potential Staffing Need: Please note, this recommendation would have an impact on staffing levels, and appropriately trained staff would need to be available to address any concerns identified by a report like this.
R18	Staffing and Training	Once decisions are made around additional reporting and edits that will be implemented, BerryDunn recommends completing an in-depth review of staffing levels for claims processing and audits. Many of the findings provided in Section 4.5 of our report illustrated a need for a build of edits based on monthly reporting thresholds. AHCCCS would need additional staff who can devote time to reviewing pended claims and dispositioning.
R19	Staffing and Training	There is a need for a deeper evaluation of the training programs created to onboard and support claims representatives. The team determined areas for policy and procedure improvement that might require remedial training of current staff.
R20	Policies	BerryDunn recommends considering the updating of policies related to requests for retroactive provider effective dates to note that retroactive enrollment date should not be prior to issuance of an NPI.

5.0 Member Enrollment Review

BerryDunn was tasked with reviewing AHCCCS member enrollment into the AIHP to review the circumstances under which members were enrolling into the AIHP, including whether members were being solicited by providers to switch to the AIHP or were impacted by other potentially fraudulent schemes.

5.1 Methodology

BerryDunn coordinated with the Member Enrollment Team at AHCCCS to conduct our review. The BerryDunn enrollment review team performed an on-site review at AHCCCS from August 2 –5, 2023. The team conducted information-gathering meetings with Enrollment Contact Center staff to understand the processes in place during the period under review and performed a walkthrough of systems utilized by enrollment staff in the day-to-day management of AHCCCS member enrollment.

The BerryDunn team worked directly with AHCCCS enrollment staff to review data in a variety of systems necessary for our review. The following systems were used: MMIS, SOLQI, HEA Plus, and Genesys Cloud Call Center system, which maintains the call center recordings.

BerryDunn reviewed enrollments into the AIHP based on a total sample of 485 members. The first sample created was 247 members who switched from a managed care plan to AIHP at least once within the past five years and had claims billed to a provider of concern. The second sample of 228 members was similarly generated and based on an updated list of providers of concern. We additionally reviewed 10 members who had a sharp increase in claims after switching to the AIHP regardless of affiliation to providers of concern.

The BerryDunn team performed the analysis by reviewing the following data and information in AHCCCS systems:

- Member enrollment history (MMIS) contact information, such as phone numbers, email address, and physical address (MMIS)
- Verification of Social Security number and citizenship (SOLQI)
- Race, ethnicity, and American Indian and Alaska Native Status and tribe (HEA Plus and MMIS)
- Call recordings for the switch to the AIHP and recordings for the switch to an MCO plan, if switching back from the AIHP (Genesys)
- A list of calls identified as potentially suspicious that were reported by Enrollment Contact Center staff through the shared reporting spreadsheet

The team conducted two rounds of enrollment review on the following dates and reviewed the following number of AHCCCS members' enrollments:

- On-site at AHCCCS from August 2 – August 5, 2023
    - Thirty-seven members from our sampling list
- Virtually with AHCCCS on August 24, 25, 31, and September 13, 2023

- Forty-seven members from our sampling lists

The team reviewed 84 (17%) of 485 members contained in our sampling lists. We also reviewed members discovered during call review in varying levels of detail to understand the impacts of members who were not captured by our sampling methodology. These members were all either part of the same call as a sample member or associated with a high-frequency phone number we identified, and therefore, part of the same underlying scheme.

The time-intensive nature of the enrollment reviews resulted in the team reviewing 17% (84 / 485) of our sampling list. Because of the time commitment of each review, the team continuously updated the population of members prioritized for review based on new information obtained during our review and attempted to identify different potentially fraudulent schemes. We performed data analysis and prioritized the following member enrollment data patterns within our lists of 485 members for review:

- Members with only one period of enrollment in the AIHP, and for less than 30 days
- Members with only one period of enrollment in the AIHP, and for a period of 30 – 60 days
- Members with only one period of enrollment in the AIHP, and for a period of 60 – 90 days
- Members with a history of enrollment in an MCO who switched into the AIHP, and a large increase in the dollar value of claims accompanied the switch to the AIHP
- Members with a history of enrollment in an MCO, accompanied by one period of enrollment in the AIHP for less than five days, and then a switch to a different MCO
- Members with a sharp increase in claims after switching to the AIHP

The review of member enrollment resulted in Memoranda 008 and 017 to the AHCCCS OIG. Throughout the review, BerryDunn's team documented review results and obtained supporting documentation from AHCCCS Enrollment Contact Center staff when potential FWA was identified. The following documents were obtained by BerryDunn to inform memoranda and reporting to AHCCCS OIG:

- Call recordings related to switching the plan to AIHP, and if applicable, the subsequent call recording to switch the member to an MCO
- Screenshot of the Genesys call data for the call recording obtained
- Screenshot of the MMIS call notes for the interaction with an AHCCCS Enrollment contact center agent
- Screenshot of the call history over the course of months for applicable phone numbers

5.2 Limitations

The BerryDunn member enrollment review team noted the following scope limitations of the review:

1. The Genesys call system does not contain call recordings prior to January 2022, which is when the system was implemented. Prior to Genesys, calls were recorded in a Cisco system, and these calls were not readily available at the time of our review. The member enrollment data provided to BerryDunn started in 2018; however, because Genesys call data was unavailable, the team focused the review on the period where call recordings were available.
2. The MMIS contains race and ethnicity data; however, this data does not contain a historical record of race and ethnicity changes. Therefore, the team could not identify whether a member was AI/AN at the time of the change to AIHP with certainty.
3. In some cases when an AHCCCS employee transferred out of the enrollment contact center, the call recording selected for the member review could not be found.
4. The review provides findings based on circumstantial evidence that requires the use of professional judgment and inference by the review team. AHCCCS OIG and its law enforcement partners would need to further review specifically identified members and evidence to assess and verify whether a violation of policy or law occurred.
5. The review does not constitute an audit nor a fraud investigation, and there are limitations to the conclusions that can be drawn for the following reasons:
    a. The sample size of members reviewed is not large enough to extrapolate results to the entire AIHP-enrolled population.
    b. The review was conducted through documentary evidence (enrollment history, MMIS data points, and call recordings); however, we did not conduct procedures that enabled us to confirm with certainty the identity of acting parties (members, providers, or other actors).
6. The main objective of BerryDunn's review was to review the circumstances surrounding AIHP enrollment to identify trends, patterns, and schemes that could have enabled FWA within AHCCCS programs, specifically, the AIHP. Secondarily, we did attempt to identify individuals or entities that were committing FWA; however, that was not the main objective. When BerryDunn's team obtained evidence that indicated potential FWA, we did specifically identify the members and/or other actors.
7. The team at AHCCCS that provided information for the member enrollment review could only speak primarily to items related to requests for plan changes. Observations related to member care and transition of services were limited because of the AHCCCS enrollment team's role of effectuating plan changes between MCOs and the AIHP. The support of members related to care and transition of services would be served by other units within AHCCCS.

5.3 Findings

BerryDunn identified trends through the review that the team assessed to be significant to the circumstances surrounding member enrollment into the AIHP. BerryDunn cannot verify with certainty that reported instances are FWA; however, below is a summary of the findings.

Notes and limitations regarding findings: BerryDunn refers to members in our findings; however, we cannot with certainty know whether the individual calling the enrollment contact center was the member or an individual impersonating a member. We attempted to distinguish between the two based on call characteristics. Additionally, BerryDunn's findings and observations cannot with certainty implicate fraudulent activity.

We note that the following policies likely enabled the potentially improper AIHP plan enrollment:

- AHCCCS policy permitted members to switch to the AIHP even if their AHCCCS file did not have any record of the member being AI/AN. AHCCCS policy allowed the member to verbally assert they were AI/AN and the enrollment contact center agent would read a disclaimer, and if the member accepted the disclaimer, the plan change would be made.
- AHCCCS enrollment contact center agents were not allowed to deny plan change requests based on call characteristics, such as a member being coached in the background, or other suspicious behavior that would indicate the caller was impersonating a member.
- AHCCCS policy did not permit an enrollment contact center agent to question any perceived gender discrepancy, which might have made it easier for anyone to impersonate a member.

The following findings and observations were identified during the BerryDunn review of members from the sampling list and were reported in more specificity with supporting documentation in Memoranda 008 and 017:

1. We identified that 57 of 74 members we sampled did not have any data indicators of AI/AN status at the time of the AIHP enrollment request.
2. We identified phone numbers with a high frequency of calls to the enrollment contact center that were potentially impersonating AHCCCS members to switch the members into the AIHP. In these calls, we identified suspicious patterns that indicated impersonation may be occurring. We also noted that the high-frequency phone numbers did not match any phone numbers on file for the member.
3. We identified members who had their plan switched to the AIHP and then subsequently called the enrollment contact center and stated they did not make or authorize the previous plan change to the AIHP. These members would switch their plan back to the MCO. In some of these instances the members who called to switch the plan back to an MCO noted that the plan was changed to AIHP for multiple members of their household and was not an authorized plan change.
4. We identified members who had their plan switched to the AIHP and then subsequently called the enrollment contact center and stated they changed the plan to the AIHP to obtain housing, and that switching to the AIHP was a condition imposed by a sober living or other similar type of facility.

5. We identified members who switched their enrollment to the AIHP as a means to change MCO plans. AHCCCS policy allows AI/AN members to change plans at any time without the open enrollment period restrictions that apply to non-AI/AN members.
6. We reviewed call recordings from calls to switch a member's enrollment to the AIHP, where the caller was being coached regarding what to say to the AHCCCS agent to complete the plan change.
7. We identified members who called to switch to the AIHP and appeared to be from a facility. Upon completing the plan switch the caller would ask if the agent can help someone else change their plan to the AIHP. It often appeared there was someone in the background coaching the caller to request the change to AIHP and how to answer agent questions regarding AI/AN status.
8. We identified the inconsistent application of member enrollment policies by contact center agents, such as:
    a. In one sampled case, an agent recommended an AI/AN member who was seeking to change MCO plans outside of the open enrollment period to switch to AIHP and then call back the subsequent day to change to the desired plan. This member was permitted to change to the AIHP; however, in this case the AIHP was used to circumvent AHCCCS member enrollment policy.
    b. Inconsistent application of the policy to read the disclaimer to non-AI/AN members prior to enrollment in the AIHP.

5.4 Recommendations for Potential Further Analysis

BerryDunn reviewed 84 members from our sampling list of 485 members. Our prioritized review identified certain member enrollment, claims, and phone number data patterns that AHCCCS should consider using for further analysis. We recommend the following trends and patterns for further review:

1. Members with one AIHP enrollment for a period of 30 days or less had a higher likelihood of being victims of an unauthorized plan change or coerced into a plan change by a residential facility.
2. Members with a sudden increase in claims from a known provider of concern after switching to the AIHP were often noted as potential FWA in the samples we reviewed.
3. Members whose plan was changed to AIHP through a call originating from an identified high-frequency caller phone number were often noted as potential FWA in the samples we reviewed.
4. Members who were incarcerated and switched to AIHP shortly after being released may have been convinced or coerced to switch to AIHP as a condition of staying in a residential facility.
5. Members who had their plan changed to AIHP by a call where the phone number in Genesys does not match any phone numbers on file for the member in the MMIS were

often reported as potential FWA in the samples we reviewed. Additionally, we note that calls that are shown as anonymous by the Genesys caller ID were likely to be calls from a facility.

6. Export call data from the Genesys system to identify anonymous phone numbers used to change member plans. Also, analyze the frequency of the same phone numbers being recorded in the Genesys system enrollment queue to identify high-frequency calls from the same phone number utilized to change member plans.

5.5 Recommendations for Improvement

BerryDunn understands that AHCCCS has made changes to the policy surrounding enrollment into the AIHP, including no longer accepting calls as a method for updating plan enrollment. As of July 21, 2023, AHCCCS only permits enrollment into the AIHP by a form completed by an AHCCCS-registered Indian Health Service facility, tribally owned and/or operated 638 facilities, and Urban Indian Health Organizations. The activities reviewed related to member enrollment were from the period prior to the policy change. We identified areas for consideration by AHCCCS that could help reduce risk related to member enrollment.

The following recommendations are provided to AHCCCS for consideration to potentially improve controls over the AIHP enrollment process and the operation of the enrollment contact center:

1. Perform a periodic review of AIHP-enrolled members and flag members for review when their race is not noted as AI/AN in the MMIS. We understand that often there are multiple races in applications in HEA Plus; however, limiting AIHP enrollment based on the race noted in the MMIS may provide additional control over the member enrollment.
2. There is a need for a deeper evaluation of the training programs created to onboard and support member representatives.
    a. Conduct remedial education with all Member Services employees on proper plan change policies and processes.
    b. Conduct general training with Member Services employees to help ensure consistency in the identification and reporting of questionable plan change requests.
3. Conduct monthly spot-audits of Member Services representative calls to help ensure policies and procedures are followed and not violated.
4. Conduct periodic reviews of forms submitted to change members' enrollment to AIHP to help ensure only licensed and permitted facilities are submitting the request.
5. Create consistent criteria and definitions for contact center agents to report potential FWA and create a standardized notation method for noting the reasons the call was reported for potential FWA. Additionally, create clear and consistent instructions for agents to provide to members for potential FWA reporting.

6.0 Conclusion and Next Steps

As AHCCCS moves forward, it faces many important decisions regarding how to stay vigilant in its pursuit to mitigate FWA. Sharing early investigative findings, trends, and suggestions on identifying FWA against the AI/AN community can help employees be more focused on the "flags" as they process and review transactions. Continued collaboration between the OIG, Attorney General (AG), and AHCCCS leaders with opportunities for outreach to the AI/AN community and leaders to stop "bad actors" from taking advantage of this vulnerable population is also recommended.

In addition to the items identified and recommended in the Claims and Member sections, BerryDunn recommends considering the following options:

- **Option 1:** Conduct a deeper review of the same populations, providers, claims, and services from the original task order. This option would expand on the recommendations from the 17 FWA memos and help AHCCCS execute some of the additional reviews the BerryDunn team recommended in each memo.
- **Option 2:** Conduct a broader program integrity review of the AHCCCS program. This option would expand the review activities from the original task order to all or more AHCCCS member populations, providers, and services (not just behavioral health services for AI/AN).
- **Option 3:** Conduct a comprehensive organizational assessment of AHCCCS. This option would involve a review of the entire organization with the goal of identifying initiatives and actions to be taken to move AHCCCS toward a high-performing organization with a program integrity mindset. The assessment would include a review of the following organizational areas:
    - Communication mechanisms
    - Environment (physical)
    - Information technology
    - Leadership
    - Organization and team structure
    - Policies, process, procedures
    - Team expectations
    - Training

Appendix A: Glossary of Acronyms

Table A includes a glossary of acronyms used in the Findings and Recommendations report.

Table A: Glossary of Acronyms

Acronym	Definition
ACJIS	Arizona Criminal Justice Information System
AG	Attorney General
AHCCCS	Arizona Health Care Cost Containment System
AI	American Indian
AIHP	American Indian Health Program
AN	Alaska Native
APEP	AHCCCS Provider Enrollment Portal
BH	Behavioral Health
CNSI	Client Network Services, Inc.
DMPS	AHCCCS Division of Member and Provider Services
FARR	Findings and Recommendations Review
FWA	Fraud, Waste, and Abuse
HEAplus	Health-e-Arizona Plus – AHCCCS' Medicaid Eligibility and Enrollment System
ICF/MR	Intermediate Care Facilities for Mental Retardation
IMD	Institution for Mental Diseases
LCSW	Licensed Clinical Social Worker
LISAC	LIC Independent Substance Abuse Counselor
LPC	Licensed Professional Counselor
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of the Inspector General
PERM	Payment Error Rate Measurement
RFP	Request for Proposal

Acronym	Definition
SAM	System for Award Management
SOLQI	State On-Line Query Internet
SOW	Scope of Work
SSA	Social Security Administration

Appendix B: Findings and Recommendations Review Participants

Table B includes a list of invested parties who participated in fact-finding meetings and communications.

Table B: Findings and Recommendations Review Participants

Name	Organization and Role
Kristen Challacombe	AHCCCS – Deputy Director for Business Operations
Patricia Dennis	AHCCCS – Assistant Director – Division of Member and Provider Services
Carmen Heredia	AHCCCS – Chief Cabinet Officer/Executive Deputy Director Medicaid and CHIP Program
Daniel Lippert	AHCCCS – Chief Information Officer
Claudia Rodriguez	AHCCCS – Administrator – Office of Communication, Advocacy, Resolution and Enrollment
Kasey Rogg	AHCCCS – Chief Legal Officer/General Counsel
Jeffrey Tegen	AHCCCS – Assistant Director – Division of Business and Finance
Vanessa Templeman	AHCCCS – Inspector General

Appendix C: Summary of Member Analysis Findings

Table C contains a summary list of the findings and observations mentioned in the Member analysis section. The following findings and observations were identified during the BerryDunn review of members from our sampling list and were reported in more specificity with supporting documentation in memoranda 008 and 017.

Table C: Member Findings Summary

Item	Finding
1	We identified that 57 of 74 members we sampled did not have any data indicators of AI/AN status at the time of the AIHP enrollment request that would permit the member access to the AIHP.
2	We identified phone numbers with a high frequency of calls to the enrollment contact center that were potentially impersonating AHCCCS members to switch the members into the AIHP. In these calls we identified suspicious patterns that indicated impersonation may be occurring. We also noted that the high frequency phone numbers did not match any phone numbers on file for the member.
3	We identified members who had their plan switched to the AIHP, and then subsequently called the enrollment contact center and stated they did not make or authorize the previous plan change to the AIHP. These members would switch their plan back to the MCO. In some of these instances the members that called to switch the plan back to an MCO noted that the plan was changed to AIHP for multiple members of their household and was not an authorized plan change.
4	We identified members who had their plan switched to the AIHP and then subsequently called the enrollment contact center and stated they changed the plan to the AIHP to obtain housing, and that switching to the AIHP was a condition imposed by a sober living or other similar type of facility.
5	We identified members who switched their enrollment to the AIHP as a means to change MCO plans. AHCCCS policy allows AI/AN members to change plans at any time without the open enrollment period restrictions that apply to non-AI/AN members.
6	We reviewed call recordings from calls to switch a member's enrollment to the AIHP, where the caller was being coached regarding what to say to the AHCCCS agent to complete the plan change.
7	We identified members who called to switch to the AIHP and appeared to be from a facility. Upon completing the plan switch the caller would ask if the agent can help someone else change their plan to the AIHP. It often appeared there was someone in the background coaching the caller to request the change to AIHP and how to answer agent questions regarding AI/AN status.
8	We identified the inconsistent application of member enrollment policies by contact center agents, such as: a. In one sampled case, an agent recommended an AI/AN member who was seeking to change MCO plans outside of the open enrollment period to switch to AIHP and then call back the subsequent day to change to the desired plan. This member was permitted to change to the AIHP, however,

Item	Finding
	in this case the AIHP was used to circumvent AHCCCS member enrollment policy. b. Inconsistent application of the policy to read the disclaimer to non-AI/AN members prior to the enrollment in the AIHP.

Appendix D: Summary of Member Analysis Recommendations

Table D contains a summary of the recommendations to potentially improve controls over the AIHP enrollment process, and the operation of the enrollment contact center.

Table D: Member Recommendation Summary

Item	Recommendation
1	Perform a periodic review of AIHP enrolled members and flag members for review when their race is not noted as AI/AN in the MMIS. We understand that often there are multiple races in applications in HEA Plus, however, limiting AIHP enrollment based on the race noted in the MMIS may provide additional control over the member enrollment.
2	There is a need for a deeper evaluation of the training programs created to onboard and support Member representatives. • Conduct remedial education with all Member Services employees on proper plan change policies and processes. • Conduct general training with Member Services employees to ensure consistency in the identification and reporting of questionable plan change requests.
3	Conduct monthly spot-audits of member services representative calls to help ensure policies and procedures are followed and not violated.
4	Conduct periodic reviews of forms submitted to change member's enrollment to AIHP to ensure only licensed and permitted facilities are submitting the request.
5	Create consistent criteria and definitions for contact center agents to report potential FWA and create a standardized notation method for noting the reasons the call was reported for potential FWA. Additionally, create clear and consistent instructions for agents to provide to members for potential FWA reporting.