Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Arizona Focused Program Integrity Desk Review:

Medicaid Managed Care Oversight

May 2023

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity desk review to assess Arizona's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FYs) 2019 – 2021. This focused program integrity desk review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused program integrity desk review, CMS reviewed information and documents provided by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also evaluated certain program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations that were identified during the focused desk review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **no** findings that create risk to the Arizona Medicaid program related to managed care program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **one** observation related to Arizona's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observation identified during this review includes the following:

MCO Investigations of Fraud, Waste, and Abuse

> **Observation #1:** CMS encourages Arizona to assist the MCOs with increasing proactive measures to actively refer suspected fraud to the state and facilitate additional informational sessions and technical assistance to help improve the number of credible allegations of fraud referrals by MCOs.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Arizona Managed Care Program and the Focused Program Integrity Desk Review

The Arizona Health Care Cost Containment System (AHCCCS) is the single State Medicaid Agency (SMA) responsible for the administration of the Arizona Medicaid program, referred to as AHCCCS. Within AHCCCS, the Office of Inspector General (OIG) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, which covers FYs 2019-2021, Arizona contracted with seven MCOs to provide health services to the Medicaid population. As part of this review three of these MCOs were selected for review: Health Choice Arizona, Mercy Care, and Arizona Complete Health. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In May 2022, CMS conducted a focused program integrity desk review of Arizona's managed care program. This focused desk review assessed the state's compliance with CMS regulatory

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by the three selected MCOs. During this review, CMS identified no recommendations and one observation. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established regulations at §§ 438.66 and 438.602 that require SMAs to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO Special Investigations Units (SIU), the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. **Results of the Review**

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring regulations at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

In Arizona, these oversight and monitoring requirements are implemented by the AHCCCS OIG. The mission of the AHCCCS OIG is to prevent, detect, and recover improper payments due to fraud, waste, and abuse. The AHCCCS OIG has been designated as a criminal justice agency and is authorized by the Federal Bureau of Investigation (FBI) and the Arizona Department of Public Safety to access criminal justice information relevant to official investigations. The AHCCCS OIG works in partnership with other AHCCCS divisions; the Attorney General's office; other federal, state, and local law enforcement agencies; program contractors; and the MCOs to prevent, detect, and recover improper payments due to fraud, waste, and abuse.

Arizona's Medicaid program operates under an integrated managed care model through a Section 1115 Medicaid Demonstration Waiver. Per the contracts with the MCOs, the AHCCCS OIG has the sole authority to handle and dispose of any matter involving fraud, waste, and/or abuse. If a MCO discovers or is made aware that an incident of alleged fraud, waste, and/or abuse has occurred, the MCO must report the incident to the AHCCCS OIG (as specified in the contract) by completing and submitting the "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program" form located on the AHCCCS OIG webpage. All pertinent documentation that could assist the AHCCCS OIG in the investigation is required to be attached to the form. Once a case has been referred, the MCO takes no action to recoup, offset, or act in any manner inconsistent with the AHCCCS OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, and/or impose a civil monetary penalty. The AHCCCS contract with the MCOs does not give authority to the MCOs to refer suspected network provider fraud, waste, or abuse directly to the MFCU. The MCOs can refer only to the AHCCCS OIG.

In accordance with AHCCCS OIG policy ACOM 103 – Fraud, Waste, and Abuse, and § 455.17, the process for identifying fraud, waste, and or abuse includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and other matters necessary to comply with the authority or obligations vested in AHCCCS OIG under federal or state law, rules and regulations, or agency policies.

The AHCCCS OIG is comprised of various organizational units that are responsible for investigating member fraud, conducting provider investigations of external referrals and internally detected cases using data mining activities, ensuring compliance with governing laws and regulations, and conducting performance improvement projects and independent provider audits. The Forensic Accounting Unit (FAU) conducts complex financial health care fraud and health care corporate investigations and provides financial assistance, training, and efficiency in the furtherance of those investigations. The Program Integrity Team (PIT) performs data mining, conducts a variety of ad-hoc data samples and data audits on a post-payment basis, and conducts

periodic utilization reviews of target providers to identify trends and determine potential fraudulent billing practices.

In addition, the AHCCCS OIG contracts, either directly or indirectly, with other entities to conduct program integrity activities. These entities include Qlarant, Gainwell, and LexisNexis. The AHCCCS OIG has also entered into a data sharing agreement with the Healthcare Fraud Prevention Partnership (HFPP) to share healthcare data to be used to mutually promote cooperation and coordination as well as enhance capabilities for the detection and prevention of fraud, waste, and abuse across the healthcare industry.

The AHCCCS implemented the Arizona Medicare/Medicaid Data Matching Project, also known as the Arizona Medi-Medi Project, to assess the value of comparative analysis of Medicare and Medicaid claims data with the intent of furthering the detection, pursuit, prosecution, and elimination of aberrant practices. The AHCCCS OIG has coordinated with Qlarant, the CMS Unified Program Integrity Contractor (UPIC) for the western jurisdiction. Qlarant shares information and intelligence with AHCCCS's OIG to jointly pursue investigations common to both the Medicare and Medicaid programs. The AHCCCS OIG meets regularly, telephonically and in person, with the staff of Qlarant to review meeting minutes, share data analyses, update Medi-Medi cases and investigation status, and discuss other issues related to program integrity. An activity spreadsheet maintained by Qlarant is automatically processed by AHCCCS OIG to ensure all referrals are reviewed and cases created, where applicable.

The AHCCCS contracts with Gainwell to conduct Recovery Audit Contractor (RAC) oversight, which includes working with the AHCCCS OIG and AHCCCS Third Party Liability (TPL) Unit to identify and recoup improper payments.

The AHCCCS OIG also contracts with LexisNexis for the use of the data analytics product, Intelligent Investigator. The current three years of claims, encounters, and supporting data are deployed on the LexisNexis servers quarterly. The dashboard displays data that highlights significant areas of concern and potentially fraudulent cases. The system also identifies billing spikes (provider, member, and code usage) and the top 12 providers of concern based on a predictive modeling analysis.

In addition, the AHCCCS has implemented the Credit Balance Audit Program that reaches out to providers to review their accounting practices around credit balances on Medicaid payments. Primarily these reviews are instituted to identify overpayments and administer recoveries on behalf of AHCCCS and any applicable acute or long-term care MCO that is similarly contracted. These reviews are conducted either on site at the provider's physical location, or as a desk or self-audit.

We determined that the AHCCCS OIG has a robust and effective oversight program that is in compliance with CMS regulations at §§ 438.66 and 438.602. CMS did not identify any findings or observations related to these requirements.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The AHCCCS provides Section 1115 Medicaid Demonstration Waiver health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid state plan groups as well as Demonstration expansion groups. The MCO general contract for Arizona is developed by AHCCCS pursuant to A.R.S. §36-2903 et seq. and §36-2932 et seq. The AHCCCS currently holds 15 managed care contracts with seven MCOs and two state agencies, across five lines of business (AHCCCS Complete Care (ACC); Long Term Care – Developmental Disabilities; Long Term Care -Elderly and/or Physically Disabled; Regional Behavioral Health Authority; and services to children in foster care). The AHCCCS does not delegate program integrity duties to the MCOs; however, Section D: Program Requirements of the MCO contract requires the establishment and implementation of procedures that include provision for the prompt referral of any potential fraud, waste, and abuse to AHCCCS OIG. The MCOs are contractually required to employ sufficient staff and utilize appropriate resources to achieve contractual compliance, including a Corporate Compliance Officer, a Contract Compliance Officer, and a Quality Management (QM) Manager, all of which are to be located in Arizona. The QM Manager must have experience in quality management and clinical investigations.

The Division of Health Care Management (DHCM) is responsible for overall monitoring of the MCOs. The DHCM is structured under two primary units, the Clinical/Operations and Data/Finance. The DHCM has the primary responsibility for monitoring contract compliance of the MCOs; however, other areas within AHCCCS also receive deliverables and have additional monitoring responsibilities of MCO compliance, including the: Office of General Counsel, Division of Business and Finance, TPL Unit, and AHCCCS OIG. The DHCM monitors overall MCO performance based on various deliverables that are received throughout the contract cycle, ad hoc reports, and focused and operational reviews. Operational reviews are performed on all MCOs a minimum of one time during each three-year contract period and are used to assess each MCO's compliance with AHCCCS' contract standards. At the conclusion of the audit, a corrective action report is generated and distributed to the MCO. In the event the MCO is not performing in accordance with contract requirements, the state may take a number of actions, including notice of concern, corrective action plan, notice to cure, and sanctions. In addition to compliance actions taken, AHCCCS also offers technical assistance to its MCOs to further educate, if necessary, and help prevent noncompliance from reoccurring.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

The AHCCCS contracts provide criteria for how the MCOs will conduct their Corporate Compliance Programs. The MCO is contractually required to have a Corporate Compliance Program that is designed to guard against fraud, waste, and abuse and is supported by other administrative procedures including a Corporate Compliance Plan. The MCO's written Corporate Compliance Plan is required to adhere to the contract and the AHCCCS Contractors Operations Manual (ACOM) Policy 103 and be submitted to AHCCCS OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The MCOs are also required to submit a program integrity audit/review program as part of the compliance plan designed to identify fraud, waste, and/or abuse. The program integrity audit/review program must ensure the MCO tracks inadequate billing practices and identifies emerging trends to provide technical assistance to contracted providers and avoid future occurrences of problematic billing. The MCOs are also required to submit to AHCCCS OIG an external audit plan/schedule and audit report of all individual provider audits.

The MCO is required to appoint a Corporate Compliance Officer, in accordance with Section D, Paragraph 15, Staffing Requirements of the MCO contract. In addition, the MCO must ensure adequate training addressing fraud, waste, and/or abuse prevention, recognition, and reporting, and encourage employees, members, and any subcontractors to report fraud, waste, and/or abuse without fear of retaliation.

Section D, Paragraph 58, Corporate Compliance, of Arizona's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. In

addition, a review of the MCOs' compliance plans and programs found that each of the three MCO's compliance plans contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Arizona, this requirement is met through the contract as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The MCO is required to perform periodic surveys of its membership, as specified in ACOM Policy 424, to verify that members have received services that have been paid for by the MCO and identify potential service/claim fraud. The MCO must perform, at a minimum, quarterly audits to determine member receipt of paid services.

The verification sample is selected from a universe of paid claims with dates of service from the reporting quarter and not more than 45 days from the date of payment. The sampling is proportionally selected from the entire range of services available under the contract and must include at least 100 randomly selected claims. Individual survey results indicating that paid services may not have been received are referred to the MCO's fraud and abuse department for review and then referred to the AHCCCS OIG. In addition, MCOs are required to submit a Quarterly Verification of Services Audit Report that includes the total number of surveys given, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS OIG for further review. The results and an analysis of the results of any MCO initiated surveys are submitted 15 days after the end of the quarter that follows the reporting quarter.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

A review of the state's policy found that MCOs are contractually required as a condition of receiving payments to establish written policies, and to ensure adequate training and ongoing education, for all of its employees, members, and any subcontractors and/or agents of the MCO regarding the following: detailed information about the Federal False Claims Act, the administrative remedies for false claims and statements, any state laws relating to civil or

criminal liability or penalties for false claims and statements, and whistleblower protections under such laws. The AHCCCS oversees these requirements through the process of operational reviews as well as MCO deliverables.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

The AHCCCS requires all providers to register with the state. Once the registration is approved, providers may then seek a contract/credentialing from each individual MCO. As a result, any time a provider has payments suspended in whole or in part by the AHCCCS, the payment suspension applies to any MCO network in which they are contracted/credentialed to participate. A payment suspension is initiated when the AHCCCS OIG determines that an allegation of fraud is credible and the matter is referred to the MFCU or other law enforcement agency for investigation. If the MFCU accepts a fraud referral from the AHCCCS OIG but does not want the OIG to suspend payments because it may alert a provider to a pending investigation, this would be considered a good cause exception not to suspend, and this request must be in writing from the MFCU.

The Health Care Fraud and Abuse (HCFA) Section of the Office of the Arizona Attorney General advises the AHCCCS administration in writing not less than every 90 days as to the status of an investigation and makes all reasonable efforts to promptly pursue the evaluation, investigation, and expeditious prosecution or other resolution of such matters. Any request by the HCFA to the AHCCCS to delay notification to the provider of a payment suspension must be made promptly in writing. The suspension of payments will generally not continue if it has been in effect for 18 months and there has been a resolution of the investigation or when the case is closed or dropped because of insufficient evidence to support the allegations. An evaluation of the continuance to suspend payments must be conducted every 180 days to determine whether there is good cause not to continue the suspension. If no law enforcement agency accepts the referral, the AHCCCS OIG must immediately release the payment suspension.

Arizona Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The AHCCCS communicates all payment suspensions to the MCOs through both DHCM and the AHCCCS OIG. The MCO contract requires the MCOs to suspend payments once the AHCCCS has determined a credible allegation of fraud exists. A credible allegation of fraud may originate from a variety of sources[2] and must be verified by the AHCCCS OIG as having specific indicators of reliability. The MCO contract requires MCOs to have in place internal controls, including policies and procedures to implement a suspension, termination, or exclusion of a provider from the MCO's network of providers. All three MCOs included in the

[2] A credible allegation of fraud may be an allegation from any source, including but not limited to: fraud hotline complaints; claims data mining; patterns identified through provider audits, civil false claims cases, and law enforcement investigation referrals.

review had suspension policies in place.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

Arizona adequately addressed the requirements at §§ 438.608(a)(2) and (d). Per the MCO contract Section D: Program Requirements, once a case of alleged fraud, waste, or abuse has been referred to the AHCCCS OIG, the MCO must take no action to audit, investigate, recoup, or otherwise offset any suspected overpayments or act in any manner inconsistent with AHCCCS OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, and/or impose a civil monetary penalty. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the MCO.

The only overpayments the MCOs are allowed to recoup are monies received from the collection of third-party liability overpayments. The MCOs are required to follow ACOM Policy 434, which includes information on how to report overpayments and adjust encounter submissions for third-party liability overpayments. According to the AHCCCS Contractor Operations Manual, Chapter 400 – Operations, the MCO must offset future payments if it has established probable existence of a third-party liability at the time the claim is filed. However, there are limited circumstances when offsetting future payments is prohibited, and the MCO shall apply post-payment recovery processes. If AHCCCS determines that the MCO is not actively engaged in offsetting future payments to avoid post-payment recoveries, the MCO will be subject to sanctions. All MCOs are contractually required to disclose and refund third-party overpayments within the later of 60 days after the date the overpayment is identified or the date the next applicable cost report is due. The MCOs report a summary of their third-party recoveries of overpayments quarterly in the Cost Avoidance Savings Recovery Report.

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

Arizona has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from AHCCCS as required by § 455.21(c)(3)(iv). Additionally, the state meets with the MFCU every 90 days to discuss case referrals. All MCO referrals for potential fraud are sent to AHCCCS, which investigates the referral and makes a determination about whether to send the case to the MFCU. The HCFA serves as the MFCU in Arizona. The unit consists of attorneys, investigators, an auditor, a nurse investigator, paralegal, and support staff. The HCFA is authorized to carry out the responsibilities of investigation and criminal prosecution of health care fraud involving Medicaid funded providers, fraud in the administration of the AHCCCS agency, abuse/neglect of patients, and misappropriation of patient funds in AHCCCS funded health care facilities. The MCOs are not contractually required to have SIUs or program integrity units. The AHCCCS OIG is responsible for addressing complaints and performing oversight of the MCO to ensure all suspected referrals are made and contracted program integrity requirements are performed of suspected provider fraud, waste, and abuse investigations related to the Medicaid program.

CMS did not identify any findings or observations related to these requirements.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. The quarterly meetings consist of agendas the MCOs put together to present regarding compliance with fraud, waste, and abuse requirements, as well as other program integrity initiatives. In addition to quarterly meetings held by the AHCCCS OIG, the Deputy Inspector General of the Provider Compliance Unit in AHCCCS OIG holds Compliance Officer Networking Groups (CONG) meetings with the MCO compliance officers. These meetings, both ad hoc and scheduled, routinely consist of direct feedback on referral submissions and attachments, questions regarding specific AHCCCS policy, coordination discussion for requirements of items relative to both fraud, waste, and abuse, and quality of care concerns the MCOs must report and respond to. **MCO**

Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Arizona has established such a process in accordance with §§ 455.13-17 and 438.608(a)(7). The AHCCCS OIG maintains the authority for investigation referrals to the MFCU and/or other law enforcement entities and the determination of whether or not fraud, waste, and abuse has occurred. Arizona does require MCOs to conduct program integrity audits, prepayment and post-payment reviews; however, all suspected fraud, waste, and abuse issues are to be immediately referred to AHCCCS OIG for further investigation. The AHCCCS OIG will notify the MCO when an investigation concludes. If it is determined by AHCCCS OIG to not be a fraud, waste, or abuse case, the MCO must adhere to the applicable AHCCCS policy manuals for disposition.

The MCO promptly notifies AHCCCS when it receives information about changes in a member's circumstances that may affect the member's eligibility, including changes in the member's residence or the death of a member. The MCO must also report to AHCCCS any credentialing denials including, but not limited to, those that are the result of licensure issues, quality of care concerns, excluded providers, and due to alleged fraud, waste, or abuse. The AHCCCS OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation.

The MCOs agree to permit and cooperate with any onsite review when contracting with AHCCCS. A review by the AHCCCS OIG may be conducted without notice and for the purpose of ensuring program compliance.

MCO Oversight of Network Providers

CMS verified that each Arizona MCO had an established process for making referrals to the state, consistent with CMS requirements and the state's contract requirements. The AHCCCS OIG has sole authority for investigating referrals of potential fraud, waste, and abuse. The AHCCCS OIG maintains the authority for oversight, investigation, referrals to MFCU and/or other law enforcement entities and the determination of whether or not fraud, waste, and/or abuse has occurred regarding all Medicaid programs, services, and monies. The AHCCCS provides guidance to the MCOs to work with providers to advance the integrity of the Medicaid program. The MCOs are required to have in place internal controls, policies, and procedures to prevent, detect, and report fraud, waste, and/or abuse activities to AHCCCS OIG.

- **Health Choice Arizona:** The Health Choice Arizona SIU team operates as part of the Health Choice Compliance Department and processes fraud, waste, and abuse referrals. The SIU designee takes the following general steps: enters all referrals in

the fraud, waste, and abuse tracking log; creates a file for each referral, which includes the actual referral, a note form, and any related research items; coordinates a review to determine the appropriate category; facilitates the review with the SIU manager and investigators, as needed, as well as the designated Compliance Officer and Chief Compliance Officer, if needed, for the final decision on recommended disposition; and if a referral is determined to be suspected fraud, wase, and abuse, Health Choice Arizona immediately (not later than 10 calendar days) refers the case to the SMA. Once a case has been referred to AHCCCS, Health Choice Arizona will not recoup from the provider. The AHCCCS OIG will notify the MCO when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation. If it is determined by AHCCCS OIG that the matter does not represent a fraud, waste, and/or abuse case, AHCCCS OIG will return the matter to the MCO for disposition in accordance with applicable laws and/or contracts.

- **Mercy Care:** Mercy Care does not make a distinction between preliminary and full investigations because AHCCCS does not allow the MCOs to investigate fraud, waste, and abuse. Mercy Care completes the preliminary investigation after receiving a complaint to determine whether or not fraud, waste, and/or abuse exists. The fraud, waste, and abuse investigator fills out the fraud, waste, and abuse intake form with specifics from the complaint including the provider involved, and any other specifics noted in the complaint including the complainant's contact information and dates of service involved. If fraud, waste, or abuse is suspected, the review is stopped and referred to AHCCCS OIG within 10 days of discovery. If a direct referral is not deemed necessary, Mercy Care requests permission from AHCCCS OIG for review to ensure there are no conflicts with any open AHCCCS OIG cases. If a direct referral is not deemed necessary, the case is added to the fraud, waste, and abuse/compliance bi-weekly team meeting agenda for review and tracking. If referral to AHCCCS OIG and prepayment review are not deemed necessary, the provider may be flagged for either follow-up in subsequent program integrity reviews or through a follow-up fraud, waste, and abuse investigation.

  Mercy Care trains for fraud, waste, and abuse at the point of hire and annually thereafter. Additionally, Mercy Care requires providers to train their staff on fraud, waste, and abuse, and provides related training materials on their website. These training materials include information regarding the False Claims Act, Anti-Kickback Statute, and the Stark Law.

- **Arizona Complete Health:** Arizona Complete Health, a subsidiary of Centene Corporation, has a SIU that conducts preliminary reviews when it receives information that causes concern about potential fraud, waste, and abuse. All preliminary reviews receive a case number, are tracked in the SIU tracking system, and are completed within 30 working days (unless otherwise specified by federal/state regulations or contract terms). Once a preliminary review has been completed, the SIU staff prepare a preliminary report detailing findings and providing recommendations. The MCO reports to the state immediately but not later than 10 days as per ACOM Policy 103. Arizona Complete Health does not conduct an

investigation of the allegations of fraud, waste, and abuse involving the AHCCCS program. Notification to AHCCCS OIG shall be in accordance with ACOM Policy 103, and as specified in Attachment F3 of the contract. In accordance with the contract, Arizona Complete Health does not perform any program integrity activities at the local level. Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse meet CMS requirements and state contract requirements. In accordance with A.R.S. §§36-2918.01 and ACOM Policy 103, the MCO and its subcontractors and providers are required to immediately notify the AHCCCS OIG regarding any suspected fraud or abuse in accordance with 42 CFR §455.17, and as outlined in the contract sections outlining Program Requirements, Corporate Compliance. The AHCCCS OIG does require and allow MCOs to conduct program integrity audits, and pre-pay/post-pay reviews; however, all suspected fraud, waste, and abuse items are to be immediately referred to the AHCCCS OIG.

Figure 1 below describes the number of investigations referred to Arizona by each MCO. As illustrated, the number of Medicaid provider referrals from Health Choice Arizona and Arizona Complete Health seems low compared to the size of the MCOs.

Figure 1. Number of Investigations Referred to Arizona by each MCO

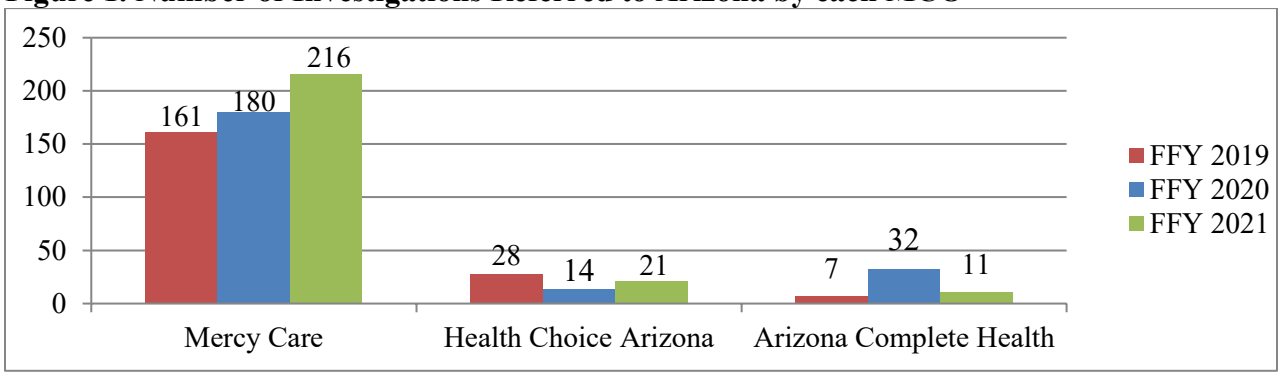

Table1, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be included in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table: Mercy Care's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	N/A*	N/A*	N/A*	N/A*
2020	N/A*	N/A*	N/A*	N/A*
2021	N/A*	N/A*	N/A*	N/A*

Table: Health Choice Arizona's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	N/A*	N/A*	N/A*	N/A*
2020	N/A*	N/A*	N/A*	N/A*
2021	N/A*	N/A*	N/A*	N/A*

Table: Arizona Complete Health's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	N/A*	N/A*	N/A*	N/A*
2020	N/A*	N/A*	N/A*	N/A*
2021	N/A*	N/A*	N/A*	N/A*

* The MCOs in the state of Arizona are not required to track overpayment recoveries, as the state is the sole proprietor to the recovery process (with the exception of third-party liability overpayments). Any overpayment identified or collected belongs exclusively to the state. In the MCO contract, Section D, Program Requirements – Reporting Alleged Fraud, Waste, or Abuse of the AHCCCS Program, it states, "In the event that AHCCCS/OIG, either through a criminal restitution order, civil monetary penalty or assessment, a global civil settlement or judgement, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity/individual, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. The Contractor hereby assigns to AHCCCS each, every, any and all of its rights to recover overpayments due to fraud, waste or abuse including any and all monetary recoveries in connection with, related to, or otherwise arising out of the overpayment(s)."

Observation #1: CMS encourages Arizona to assist the MCOs with increasing proactive measures to actively refer suspected fraud to the state and facilitate additional informational sessions and technical assistance to help improve the number of credible allegations of fraud referrals by MCOs.

D. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further specifies that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Arizona MCO general contract and responses from each of the MCOs, CMS determined that Arizona was in compliance with § 438.242. Specifically, the contract language requires the MCO to submit an external replacement file (via an AHCCCS-approved

vendor using a prescribed AHCCCS file format) to directly update impacted encounters. This external replacement file is required to be submitted within 120 days from completion of the recovery project. To submit an external replacement file, the MCO contacts the AHCCCS Encounter Unit at the completion of the recovery project for a list of approved AHCCCS vendors, as well as the acceptable external replacement file format, to coordinate submission of these files. The MCOs are contractually required to have an Encounter Manager who ensures AHCCCS encounter reporting requirements are met. The Data Management and Oversight Unit has administrative oversight of encounter submissions.

The AHCCCS conducts annual encounter validation studies of the MCO encounter submissions. In addition, encounters pass through approximately 500 edits/audits, including federal coding standards (i.e., National Correct Coding Initiative Medically Unlikely Edits, AHCCCS policy edits). All encounters must be submitted within 240 days of the end date of service, date of discharge, or eligibility posting, whichever is latest. Data mining occurs both on ad hoc and standard basis and occurs across multiple units within AHCCCS including, but not limited to:

- The Data Management Oversight Unit within DHCM produces a variety of statistics to ensure encounter completeness, throughput tracking based upon dates of service and dates of submission, encounter MCO submission/validation studies, etc.
- The Actuarial Unit within DHCM performs a variety of ad hoc analyses utilizing encounter data when engaged in the annual capitation rate settings process, and when reviewing costs impacts for MCO outside the annual process. These ad hoc analyses include looking at encounter data by month, form type, line of business, and MCO to see if there are any gaps and how total costs compare to financials.

The AHCCCS OIG uses multiple types of algorithms to analyze claims and encounter data. The types of algorithms include: aberrant global surgery billing; assistant surgeon not approved; compromised procedure codes; drug seekers and pill mills; excess lab services; fictitious medical practices; full/partial duplicate billing; high office visits with limited prescriptions; outliers; and unbundling/upcoding.

Encounters are utilized by AHCCCs' in-house actuaries as part of the capitation rate setting process. The actuaries review costs reported on encounters to financial statement costs. This activity validates the completeness of the encounter data, and vice versa. Several other activities are performed to ensure encounter data completeness and its appropriateness to set capitation rates. The medical loss ratio (MLR) is used in the capitation rate setting process to project the MCOs future MLR given the projected changes in the capitation rates. The AHCCCS's Finance Unit reviews the medical loss and solvency ratio data reported in the MCO's financial statements on a quarterly basis with multiple units in the agency. The actuaries validate the completeness of the financial statements with encounter data and utilize both the MLR and the solvency data when setting and reviewing capitation rates. Encounters subject to overpayment recoveries as required in the contract for all MCOs must be reprocessed appropriately either as a total void or a replacement of the encounter with updates to what was paid.

The AHCCCS uses encounter data to set fee-for-service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and determine

compliance with performance standards. Encounter data must be provided to AHCCCS in a manner that identifies the physician who delivered services to patients, per Section 1903(m)(2)(A)(XI) of the Social Security Act.

The MCO is required to monitor and resolve pended encounters and encounters denied by AHCCCS. The MCO is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the MCO. The MCO must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Encounters are not adjusted by the MCOs when recoveries occur as a result of AHCCCS' efforts. The AHCCCS will instead flag all encounters that are impacted by retroactive commercial insurance recoveries and store the information in a database. Utilizing data from the replacement file submitted by the MCO, and the database used to store AHCCCS' recoveries, AHCCCS adjusts prior and current payment reconciliations and reinsurance payments when appropriate.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Arizona was in compliance with § 438.602(e). Specifically, the AHCCCS DHCM conducts operational reviews at least once every three years. In the event additional monitoring is required, focused reviews are completed on a more frequent basis. While the operational reviews are managed by the Operations Unit in the DHCM, there are many other divisions and units involved with the review including the AHCCCS OIG, which reviews the area of corporate compliance.

CMS did not identify any findings or observations related to these requirements.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Arizona has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, when a referral is received from an MCO, AHCCCS OIG ensures fee-for-service claims and all MCO encounters are reviewed as part of the trending and data analysis. On a monthly basis, AHCCCS produces encounter reconciliation files containing the prior 30 months of approved, voided, plan-denied, pended, and AHCCCS-denied encounters received and processed by AHCCCS. These files are utilized to compare the encounter financial data reported with plan claims data and submitted encounters to processed claims to validate completeness of encounter submissions.

III. Conclusion

CMS supports Arizona's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused desk review identified no recommendations that require the state's attention, and one observation for improvement.

While Arizona is not required to develop a corrective action plan for the observation noted in this report, CMS encourages the state to take this observation into account when evaluating its program integrity operations going forward.

CMS looks forward to continuing to work with Arizona to build strong and effective program integrity oversight of the state's Medicaid managed care program.

IV. Appendices

Appendix A: Status of Prior Review

Arizona's last CMS program integrity review was in February 2017, and the report for that review was issued in July 2017. The report contained 4 recommendations. On September 6, 2017, the CMS review team conducted a thorough review of the corrective actions taken by Arizona to address all recommendations reported in calendar year 2017. The findings from the 2017 Arizona focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Arizona MCOs

Arizona MCO Data	Arizona Complete Health	Health Choice Arizona	Mercy Care
Beneficiary enrollment total	246,788	219,073	403,749
Provider enrollment total (ACC – AHCCCS Complete Care; RBHA – Regional Behavioral Health Authorities; ALTCS – Arizona Long Term Care System)**	ACC and RBHA 26,072;	ACC 22,003; RBHA 22,011	ACC 23,718; RBHA 16,748; ALTCS 24,270
Year originally contracted	2015	1990	1985
Size and composition of SIU	2 Senior Directors; 2 Directors; 6 Managers; 3 Clinical Investigators; 3 SIU Investigators. There is 1 SIU FTE fully dedicated to Arizona.	3 Investigators-Investigator Level III (Supervisor)-Clinical Investigator-Investigator Level I (Coding Specialist)	7 staff comprised of 1 manager who is a Certified Professional Coder, Certified Professional Medical Auditor, and Certified Fraud Examiner; 2 Senior Lead FWA Investigators; 3 auditors who are all certified coders; and 1 auditor who is a Certified Medicator Auditor
National/local plan	Local	Local	Local

** - Provider may participate in more than one AHCCCS program.

Table C-2. Medicaid Expenditure Data for Arizona MCOs

MCOs	FY 2019	FY 2020	FY 2021
Arizona Complete Health	$1,275,497,035	$1,343,576,364	$1,848,204,748
Health Choice	$1,088,942,967	$954,841,923	1,422,519,199
Mercy Care	$3,211,267,348	$3,525,557,210	$4,022,921,818
Total MCO Expenditures	$5,575,707,350	$5,823,975,497	$7,293,645,765

Appendix D:

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)