Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Arizona Comprehensive Program Integrity Review

Final Report

February 2010

Reviewers:
Todd Chandler, Review Team Leader
Randy Anderson
Annette Ellis
Mark Rogers

TABLE OF CONTENTS

Introduction 1

The Review 1
- Objectives of the Review 1
- Overview of Arizona's Medicaid Program 1
- Program Integrity Section 2
- Methodology of the Review 2
- Scope and Limitations of the Review 3

Results of the Review 3
- Effective Practices 3
- Regulatory Compliance Issues 4
- Vulnerabilities 6

Conclusion 8

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Arizona Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Arizona Health Care Cost Containment System (AHCCCS). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Office of Program Integrity (OPI), which is primarily responsible for Medicaid program integrity oversight. This report describes five effective practices, four regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Arizona improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Arizona's Medicaid Program

The AHCCCS administers the Arizona Medicaid Program. As of the State fiscal year (SFY) ending June 30, 2008, the program served 1,030,355 recipients, with Medicaid expenditures totaling $7,403,277,083. The Federal medical assistance percentage for Arizona during Federal fiscal year 2008 was 66.20 percent. At the time of the review, AHCCCS had 10,317 enrolled providers. Although most of these are affiliated with managed care organizations (MCOs), the State requires all Medicaid providers to be enrolled centrally by the AHCCCS Provider Registration Unit (PRU).

Arizona Medicaid operates largely on a managed care basis under the waiver authority of Section 1115 of the Social Security Act. The State currently utilizes three different models of managed care: acute care, long term care, and behavioral health. The AHCCCS contracts with 19 different managed care entities. Two of the entities are run by sister State agencies to AHCCCS. The Department of Economic Services/Division of Developmental Disabilities runs an MCO under contract with AHCCCS, while the Department of Human Services/Department of Behavioral Health Services operates a prepaid inpatient health plan (PIHP) as opposed to a full-service MCO. As of November 18, 2008, 874,450 recipients, or more than 85 percent of all Arizona Medicaid recipients, were enrolled in managed care in either an MCO or PIHP. Approximately 85 percent of Arizona's Medicaid expenditures were for recipients with managed care coverage.

Program Integrity Section

The organizational component dedicated to fraud and abuse detection activities is the OPI. At the time of the review, OPI had approximately 23 staff dedicated to identifying provider fraud, abuse, and inappropriate payments. Organizationally, OPI is located under the AHCCCS deputy director and has full discretion in implementing program integrity initiatives. The OPI director and most of the staff have law enforcement backgrounds. All AHCCCS programs are required to report suspected provider and recipient fraud and abuse to OPI.

The OPI is tasked with investigating both provider and recipient fraud and abuse. Besides developing cases of suspected provider fraud for the MFCU, OPI conducts random audits based on information collected from investigations and coordinates as needed with Federal, State and local law enforcement. In addition, OPI has initiated reviews of contractors, such as MCOs, when other investigations suggest there may be overpayments.

The table below presents the total number of audits, investigations, and overpayment amounts identified and collected for the last three SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations Performed	Number of Audits Performed	Amount of Overpayments Identified	Amounts Recouped
2006	132	21	$ 4,033,888	$ 1,259,840
2007	190	24	$ 8,839,414	$ 5,553,002
2008	215	24	$ 6,769,942	$ 2,466,602

All recoveries of identified overpayments in managed care programs are collected by OPI, which distributes the recovered funds to the Federal government, the State and the MCOs.

Methodology of the Review

In advance of an onsite visit, the review team requested that Arizona complete a comprehensive review guide and supply documentation to support its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of November 17, 2008, the MIG review team visited the offices of AHCCCS and the MFCU. The team conducted interviews with numerous AHCCCS officials, as well as with the MFCU Director. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's MCO contracts. The team conducted in-depth interviews with representatives from seven MCOs and one of the two sister State agencies that functions as an MCO, and met separately with AHCCCS staff to discuss managed care oversight and monitoring efforts. The team also conducted sampling of provider enrollment applications, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of OPI. Arizona operates a stand alone Children's Health Insurance Program (CHIP) under the authority of a separate Section 1115 waiver and Title XXI of the Social Security Act. As such, CHIP was excluded from this review. Unless otherwise noted, AHCCCS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that AHCCCS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These include a number of statutory provisions that assist significantly in combating fraud and abuse. They also include the State's designation as a Criminal Justice Agency and the effective use of a large contractor database during fraud and abuse investigations.

OPI statutory authority

The OPI makes use of a series of statutory provisions which greatly enhance its ability to prevent, detect, and take effective action against provider fraud and abuse in the Medicaid program. These provisions include:

- a balanced billing statute which authorizes the State to assess heavy civil penalties and/or reduce future payments to providers who attempt to collect amounts from individuals that exceed the value of claims billed or approved reimbursement rates,
- subpoena power and the authority to compel examinations under oath granted to the OPI Director or any designee in fraud and abuse investigations,
- authority to levy civil penalties and simultaneously exclude providers found to have engaged in fraud and abuse,
- the creation of a legal duty to report suspected fraud and abuse and the provision of immunity for persons who report in good faith, as long as they were not a perpetrator of the actual fraud, and
- development of legislation creating a controlled substances monitoring program that provides for a computerized central database tracking system to track the prescribing, dispensing and consumption of Schedule II, III and IV controlled substances dispensed by medical practitioners or pharmacies with valid licenses or permits.

OPI designation as a Criminal Justice Agency

On February 6, 2002, the Federal Bureau of Investigation designated the AHCCCS Office of Investigations a Criminal Justice Agency. This designation has expanded OPI's

access to major sources of criminal justice information, including the National Crime Information Center database and the Arizona Criminal Justice Information System. Additionally, AHCCCS is able to receive and share restricted criminal justice information with other Federal, State, and local agencies.

Use of contractor database in developing cases
The AHCCCS is able to use a large contractor database, which combines personal data from multiple public and private databases, in developing fraud and abuse cases. The contractor maintains more than 17 billion records on individuals and businesses which AHCCCS uses as background information in its investigations. The AHCCCS' contract permits it to conduct unlimited searches for a basic monthly charge.

Additionally, the MIG review team identified two practices that are particularly noteworthy. The CMS recognizes the State's efforts to bring all program integrity stakeholders together in periodic meetings and AHCCCS' centralized provider registration policy.

Compliance Officer Network Group
The OPI sponsors a semi-annual Compliance Officer Network Group meeting that includes all MCO Compliance Officers, all OPI staff, various divisions of AHCCCS, the Attorney General's Office, and CMS Regional Office staff. The Director of OPI and the two Deputy Directors are the main presenters. Other personnel or experts may be brought in to provide training on special topics. The meeting provides all stakeholders with updates and training on fraud and abuse issues, an introduction to new OPI staff, and opportunities to network among agencies.

The State reports that as a result of these meetings the number of referrals from MCOs has increased, and MCOs have communicated more among themselves on program integrity issues. The meetings have fostered greater partnership between OPI and the MCOs in their efforts to detect and prevent fraud and abuse, and have led to a greater MCO willingness to report and share information about suspected provider fraud.

Centralized provider registration
The AHCCCS requires that all providers, including MCO providers, be enrolled with its PRU. By requiring that all MCO providers be certified directly with AHCCCS, the State is able to maintain centralized control over the screening and registration process and better ensure the integrity of its programs.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations related to recipient verification of services and required disclosure and notification activities.

The AHCCCS does not verify with recipients whether services billed by providers were received.

The regulation at 42 CFR § 455.20 requires that State Medicaid agencies have a method for verifying with recipients whether services billed by providers were received. Arizona does not issue Explanations of Medical Benefits (EOMBs) or use any other method to verify with recipients whether services billed were actually rendered. Arizona does not contractually require its Medicaid MCOs to verify whether managed care enrollees received services through the issuance of EOMBs or other methods.

***Recommendation*:** Develop and implement a procedure for verifying with recipients whether billed services were received.

The AHCCCS provider enrollment process does not capture complete ownership, control, and relationship information.

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership and control information required under this section.

All managed care and fee-for-service (FFS) providers must be Medicaid certified by the PRU in Arizona. While the State's provider registration application solicits ownership and control disclosures from providers, its applications do not capture all of the required relationship information. The provider application asks only for the relationship of the entity's owners but does not ask about relationships with the owners of subcontractors. Therefore, the inter-relationships of entities, related organizations, and subcontractors cannot be easily established, and AHCCCS cannot determine when someone with an ownership or control interest in the provider also has such an interest in a subcontractor that may be excluded.

***Recommendation*:** Modify provider enrollment applications to capture the full range of required ownership, control, and relationship information.

The AHCCCS PRU does not collect required criminal conviction information from all providers.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The PRU staff does not distribute the State's Ownership and Control and Criminal Offenses Form to individual providers or practitioner groups in FFS Medicaid or managed care. It does not, therefore, capture required criminal conviction disclosures from two classes of providers and cannot forward such information to HHS-OIG. Additionally, the PRU does not notify HHS-OIG of any criminal conviction disclosures received concerning providers, persons with an ownership or control interest, or managing employees of the provider that it may receive from institutional providers. This finding was also cited during a previous CMS review of Arizona in March 2004.

Recommendation**:** Develop and implement procedures to collect health care-related criminal conviction information from individual practitioners and group practices and to report relevant disclosures submitted by all providers to HHS-OIG as required.

Arizona does not report to the HHS-OIG adverse actions taken on provider applications.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. During onsite interviews, PRU staff stated that when they do not enroll a provider or subsequently terminate a provider for program integrity reasons, they do not notify HHS-OIG.

Recommendation**:** Develop and implement procedures to notify HHS-OIG when actions are taken to limit a provider's ability to participate in the Medicaid program.

Vulnerabilities

The review team identified five areas of vulnerability in Arizona's program integrity practices. These include several practices which hinder the State in identifying excluded providers, owners and managing employees and the failure to check licenses from out-of-state providers.

Not conducting exclusion checks on individual providers and practitioner groups in the initial enrollment process, and exclusion and debarment checks on MCO owners, officers, directors and managing employees as part of the contracting process.
The AHCCCS Information Technology (IT) staff receives an electronic transmission of the Medicare Exclusion Database (MED) from CMS on a monthly basis. The IT staff transmits this data to the PRU using an RF640 form. However, during a walkthrough of the enrollment process, the MIG team noted that individual providers and practitioner groups are not checked against the RF640 (MED) during initial enrollment, while institutional providers were checked. An excluded provider would only be detected during a subsequent automated monthly check of the AHCCCS provider network against the RF640. The PRU staff depends upon the monthly check to catch excluded providers that may be in the system. If there is a match during the automated check, the provider will be terminated from the system. Because the process contains a lag time before new providers are checked, the State is left open to temporarily allowing certain types of excluded providers into the Medicaid program.

Additionally, individual providers and practitioner groups do not receive the Disclosure of Ownership and Control and Criminal Conviction form during the application process. This

leaves AHCCCS unable to check for exclusions on individuals with ownership or control interests in individual provider or practitioner groups.

The AHCCCS contracting staff collects MCO ownership, control and criminal conviction information during the Request for Proposals (RFP) process but does not check to see if the individuals listed have been excluded from participation by HHS-OIG and does not check the Excluded Parties List System, maintained by the U.S. General Services Administration, for debarments. Since MCOs are not enrolled or registered by the PRU and not given a registration number, they are not subject to AHCCCS' automated monthly exclusion searches. This leaves AHCCCS vulnerable to having excluded individuals in key MCO positions indefinitely.

Recommendations**:** Develop and implement procedures to conduct exclusion checks on individual providers and practitioner groups during the registration/enrollment process. Add the Disclosure of Ownership and Control and Criminal Offenses Form to the registration packet for individual and group practitioners. Develop and implement a process to check MCO disclosure information for excluded or debarred individuals during the RFP process and periodically thereafter.

Not capturing managing employee information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The AHCCCS provider enrollment forms do not solicit information on managing employees other than directors or managing employees with health care-related criminal convictions. However, other persons in managing employee positions could be excluded individuals. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendation**:** Modify AHCCCS provider enrollment forms to require the disclosure of managing employee information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not capturing information on owners, officers, directors, and managing employees in the Medicaid Management Information System (MMIS).
Arizona's MMIS does not have data fields that capture information on owners, officers, directors, and managing employees who may be reported as part of the provider and MCO disclosure process. Therefore, such individuals cannot be checked for possible exclusions on an ongoing basis. There is no evidence that AHCCCS has an alternate way of performing these checks.

***Recommendation*:** Develop and implement procedures to capture information on owners, officers, directors, and managing employees in the MMIS or in an alternate manner that would permit ongoing exclusion checks to be performed.

Not checking licenses of out-of-state providers.
Individual out-of-state providers who seek to enroll for a one-time billing are not required to send in a copy of their license to AHCCCS. This leaves the program vulnerable to doing business with providers who may have severe restrictions on their licenses.

***Recommendation*:** Develop and implement a procedure to verify the licenses of out-of-state providers on a consistent basis.

Not requiring a street address from owners and board members affiliated with providers enrolling in Arizona's Medicaid program.
During MIG's review of a sample of provider applications, the review team found in the case of one provider that the address given for two owners and eight board members was the same Post Office (P.O.) Box listed as the correspondence address for the entity. The listing of a P.O. Box instead of a street address can hinder the efforts of provider enrollment staff to identify specific individuals during an exclusion search.

***Recommendation*:** Require that providers, owners and board members provide street addresses during enrollment to facilitate State exclusion checks.

CONCLUSION

The State of Arizona applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- a number of statutory provisions that enhance the State's ability to combat fraud and abuse,
- enhanced access to criminal justice system information through OPI's designation as a Criminal Justice Agency,
- access to a large contractor database in developing cases,
- sponsorship of semi-annual program integrity compliance meetings which bring all stakeholders together for networking, training, and valuable policy discussions, and
- the requirement that all providers, including managed care providers, be enrolled and certified by the State's Provider Registration Unit.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS encourages Arizona to examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require the State to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Arizona will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Arizona has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Arizona on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.