Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Arizona Comprehensive Program Integrity Review

Amended Final Report

January 2013

Reviewers:
Debra Tubbs, Review Team Leader
Theodore Jackson
Gretchen Kane
Elizabeth Lindner
Bonnie Harris, Review Manager

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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 MIG also conducted a telephone interview with the Arizona Medicaid Fraud Control Unit (MFCU).

This review focused on the program integrity activities within AHCCCS' Office of Inspector General (OIG). The AHCCCS OIG is responsible for program integrity activities within the Arizona Medicaid program. This report describes one noteworthy practice, four effective practices, and six regulatory compliance issues in the State's program integrity operations.

The CMS is concerned that the review identified one repeat and one partial repeat finding from its 2009 review of Arizona. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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 Medicaid program. On June 1, 2011, the program served 1,338,686 beneficiaries, 89.2 percent of whom were enrolled in 15 managed care entities (MCEs).

At the time of the review, AHCCCS had 53,803 enrolled providers. Although most of these are affiliated with MCEs, 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. Medicaid net expenditures in Arizona for the State fiscal year (SFY) ending June 30, 2011 totaled $9,740,180,904. This figure includes $8,327,854,673 in payments to MCEs.

Medicaid Program Integrity Division

In Arizona, the AHCCCS OIG is the organizational component dedicated to fraud and abuse activities. At the time of the review, the AHCCCS OIG had 63 full-time equivalent positions allocated to Medicaid program integrity functions with 1 vacancy. The table below presents the

total number of preliminary and full investigations and overpayment amounts identified and recouped by the AHCCCS OIG and MCEs in the last four SFYs.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Recouped
2008	227	21	$4,217,774	$3,767,022
2009	122	13	$2,652,596***	$5,267,022
2010	231	27	$8,244,787***	$4,184,065
2011	284	39	$4,758,675	$2,536,141

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** According to the State, the lower number in 2009 was due to the expansion of the AHCCCS OIG and the large increase for 2010 includes the identified overpayments of $4.5 million in an open case.

Methodology of the Review

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

During the week of May 22, 2012, the MIG review team visited the AHCCCS OIG office. The team conducted interviews with numerous AHCCCS OIG officials. To determine whether MCEs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the managed care contracts. The team conducted in-depth interviews with representatives from five MCEs and met separately with State staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Arizona's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of AHCCCS OIG, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Arizona's Children's Health Insurance Program operates as a stand-alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, AHCCCS OIG 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 provided.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Centralized provider registration

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

The presence of a centralized screening and registration system gives the State the capacity to perform automatic monthly exclusion and debarment checks of all providers. In addition, enhancements to the system allows for the entry of an unlimited number of agents and managing employees. However, as discussed later in the report, the PRU reported it was not currently entering agents and managing employees at enrollment, but plans to do so in the future.

Effective Practices

As part of the comprehensive review process, CMS invites each State to self-report practices that it believes are effective and demonstrate a commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Arizona reported its statutory authority, a fraud prevention unit, use of a contractor database, and a Compliance Officer Network Group as effective practices.

AHCCCS OIG statutory authority

The AHCCCS OIG continues to use its State statutory authorities to enhance its ability to monitor, prevent, detect, and improve its effectiveness in taking actions against fraud and abuse in the Medicaid program. Some of the items listed were noted in the 2009 MIG review report, while the first item addresses a new effort in the fight against fraud. These provisions include:

- a new authority for collecting investigative costs from providers that enables the State to collect the cost incurred during an investigation, audit, or inquiry. The AHCCCS OIG collected a total of $452,850 in SFYs 2009-2011;
- 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 AHCCCS OIG 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.

AHCCCS OIG Fraud Prevention Unit
In January 2009, realignment within AHCCCS resulted in the transfer of the Fraud Prevention Unit to the AHCCCS OIG. The Fraud Prevention Unit processes referrals sent by a sister agency, the Department of Economic Security, to confirm the eligibility of an applicant in a hospital setting when applying for Medicaid benefits. Within three days of the receipt of a referral, the Fraud Prevention Unit confirms the eligibility status. In calendar year 2011, the Fraud Prevention Unit conducted 7,776 investigations with a reported estimated cost avoidance savings of $23,159,651, which is based on the cost to AHCCCS OIG via medical category, capitation rate, or estimated fee-for-service (FFS) and length of certification period, if the ineligible case had been approved.

Use of contractor database in developing cases
In the 2009 MIG review, it was noted that AHCCCS OIG was able to use a large contractor database, which combined 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 OIG uses as background information in its investigations. The AHCCCS OIG's contract permits it to conduct unlimited searches for a basic monthly charge.

During the 2012 review, the State reported that it had collected the cost of doing investigations or case-associated Civil Monetary Penalties (CMPs) for 48 cases identified in the first three quarters of SFY 2011 for which CMPs of $1,440,182 were identified and $1,203,930 were collected. Additionally, the State reported that in the last three quarters of SFY 2011 and the first two quarters of SFY 2012 there were 16 investigations opened for improper billings using the contractor's database. Recoupment for the 16 investigations totaled $1,015,861.

Compliance Officer Network Group
In the 2009 MIG review, it was noted that the Office of Program Integrity, since renamed the AHCCCS OIG, sponsors a semi-annual Compliance Officer Network Group meeting that includes all MCE compliance officers, AHCCCS OIG staff, various divisions of AHCCCS, the Attorney General's Office, and CMS Regional Office staff. The AHCCCS OIG director and two deputy directors are the main presenters. Other personnel or experts may be brought in to provide training on special topics. The meetings provide all stakeholders with updates and training on fraud and abuse issues, introductions to new AHCCCS OIG staff, and opportunities to network among agencies.

The meetings have fostered greater partnership between AHCCCS OIG and the MCEs in

their efforts to detect and prevent fraud and abuse, and have led to a greater MCE willingness to report and share information about suspected provider fraud. During the 2012 review, the AHCCCS OIG reported no change to this process.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required ownership and control, business transactions, and criminal conviction disclosures, searches for excluded and debarred individuals and entities, reporting of adverse actions, and notices of exclusion.

The State does not capture all required ownership and control disclosures from disclosing entities.

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

During the 2012 review, Arizona's PRU continues to enroll all Medicaid FFS and managed care network providers using the common provider application, disclosure of ownership form, and agreement for all applicants. However, the "Disclosure of Ownership/Control and Criminal Offenses Statements" form does not solicit all the required enhanced addresses for corporate entities. Specifically, it does not solicit the P.O. Box address. Further, the form does not solicit the name, address, DOB and SSN of any managing employee of the disclosing entity. However, the State did make the necessary changes to the disclosure form during the onsite review.

The AHCCCS contracting staff collects MCE ownership and control information during the Request for Proposal (RFP) process. The "Financial Disclosure Statement" of the RFP does not solicit the required enhanced addresses for corporate entities, which must include as applicable primary business address, every business location and P.O. Box address. Further, it does not solicit the DOB and SSN of any individual (or tax identification number in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more interest. Finally, the disclosure section in the RFP does not solicit the name, address, DOB and SSN of any managing employee of the disclosing entity.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not adequately address business transaction disclosure requirements in its managed care contracts.
The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The AHCCCS contracting staff collects a list of significant business transactions between the MCE and any wholly owned provider or supplier during the five-year period ending on the contractor's most recent fiscal year during the RFP process. However, there is no language in the MCE contracts or in the State's policies and procedures that references the requirement at 42 CFR 455.105 to submit the information requested at 455.105(b)(1) and (b)(2) within 35 days of the date on a request by the Secretary or the Medicaid agency.

Recommendation: Revise the MCE contracts to require disclosure upon request of the information identified in 42 CFR 455.105(b).

The State does not collect criminal conviction disclosures from providers or contractors.
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 HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Arizona's enrollment/disclosure form and the "Financial Disclosure Statement" of the managed care RFP ask for the identification of any individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XXI. However, the State does not ask for the required information for convictions of criminal offenses in the Title XX program since the inception of the program in accordance with the regulation. It was determined that citing Title XXI on the disclosure form was a typographical error, so the State corrected the form during the onsite.

Recommendation: Develop and implement policies and procedures for the appropriate collection of disclosures from providers and MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers and MCEs,

who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System[1] (EPLS) no less frequently than monthly.

During the 2012 review, Arizona collects information about the provider and persons with an ownership or control interest in the provider, agents, subcontractors, and managing employees during the enrollment process for both FFS and managed care network providers. The names of persons with ownership and control interest and providers are checked against the LEIE and the EPLS upon enrollment and monthly automatically thereafter in the Medicaid Management Information System (MMIS).

At the time of the review, Arizona did not enter the names of agents, subcontractors, and managing employees into the MMIS. Therefore, agents, subcontractors, and managing employees were only subject to manual LEIE checks at enrollment, not annually. Arizona does not conduct manual EPLS exclusion checks.

In the 2009 MIG review, the team found that Arizona did not conduct exclusion and debarment checks on MCE owner, officer, directors, and managing employees as part of the contracting process.

Arizona's contracting staff collects MCE ownership and control information during the RFP process. However, the State does not check the LEIE or EPLS to see if the individuals listed have been excluded from participation or debarred. Since MCEs are not enrolled or registered by the PRU and not given a registration number, they are not subject to automated monthly exclusion searches. This leaves the State vulnerable to having excluded individuals in key MCE positions.

Arizona's contract with the MCEs does not ask specifically for managing employee information. It does require an annual submission of the name, SSN, and DOB of the following staff members: Administrator/Chief Executive Officer/Chief Operating Officer, Medical Director/Chief Medical Officer, and Chief Financial Officer. The PRU is checking these names manually against the LEIE once a year. Since the onsite review, Arizona has amended the MCEs contract to comply with the regulation.

Recommendations: Develop policies and procedures for appropriate collection and maintenance

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[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

The State does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Finding)
The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

In the 2009 review, the team found that Arizona did not notify HHS-OIG when it denied enrollment to a provider or subsequently terminated a provider for program integrity reasons. During the 2012 review, Arizona is still not notifying HHS-OIG when they deny enrollment to a provider or terminate a provider for program integrity reasons in both FFS and managed care programs. During the interview process, the State confirmed that there was no policy or procedure in place to report to HHS-OIG nor were they reporting all adverse actions taken on providers' participation in the Medicaid program to HHS-OIG.

In addition, Arizona's AHCCCS Medical Policy Manual Chapter 900, Policy 950 on credentialing and recredentialing and managed care contract requirements does not provide clear guidance on directing the MCEs to report all adverse actions related to fraud, abuse, or integrity taken on provider participation during the credentialing process. Current policies and procedures only require the MCEs to report to the State any known serious issues and/or quality deficiencies for a provider. If the issue/quality deficiency results in a provider's suspension or termination from the contractor's network, it must be reported. If an adverse action is taken with a provider due to a quality of care concern, the contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit. Without being notified of any adverse actions taken by the MCEs, the State cannot report appropriate adverse actions to HHS-OIG.

Recommendations: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program. Require contracted MCEs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG.

The State does not provide notice of exclusion consistent with the regulation.
Under the regulation at 42 CFR 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in 1001.2005 and 1001.2006.

When Arizona initiates a Medicaid provider termination[2], the State provides notice to the provider. However, the State does not have a mechanism for informing beneficiaries, the public or, when applicable, the licensing medical board of the action.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion consistent with 42 CFR 1002.212.

[2] For reporting purposes, CMS refers to State actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions."

Conclusion

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

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

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. The CMS is particularly concerned over the two uncorrected repeat findings. The CMS expects the State to correct them as soon as possible.

To that end, we will require Arizona to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter.

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 will take more than 90 calendar days from the date of the letter. If Arizona has already taken action to correct compliance deficiencies, 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.

Official Response from Arizona
February 2013

Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

February 4, 2013

Director Angela Brice-Smith
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 21244-1850

RE: Medicaid Integrity Program Arizona Comprehensive Program Integrity Review report dated January 7, 2013

Dear Ms. Brice-Smith:

Thank you for the opportunity to review the amended Medicaid Integrity Program Arizona Comprehensive Program Integrity Review report. We appreciate the efforts of the review team as we continue to improve the efficiency and effectiveness of our program integrity processes.

Program Integrity is an essential component of all AHCCCS operations and has been area of concentrated focus for the agency. AHCCCS has directed significant attention to the development of programs and processes that support program integrity efforts.

One of my first actions as Director of AHCCCS was the creation of the Office of Inspector General (OIG) which consolidated functions under the office and elevated the reporting of the Inspector General (IG) to the Director. In addition, the agency has made a significant commitment to program integrity through the allocation of resources, assuring a common direction and focus for OIG functions. While the agency has experienced a staffing decrease of 30% during the Great Recession, the OIG staff has actually increased from 22 positions in July 2007 to 68 positions today, an increase of 46 positions. Many of the positions were transferred in as Provider Enrollment was moved under AHCCCS OIG. The additional resources have assisted AHCCCS in implementing many of the required changes by the enactment of the Patient Protection & Affordable Care Act which is related to all of your findings. AHCCCS was also able to recruit a new IG who is an experienced professional with Department of Justice, CMS, and Medicare experience. In addition, AHCCCS established an Executive-led team that developed a comprehensive Program Integrity Plan that is published on the web annually, implemented program integrity e-learning tools for staff, providers, MCOs, and the public, and initiated vendor contracts for analyses of program integrity data.

Along with these internal efforts, we continually strive for enhancement and innovation in our program integrity efforts, and we welcome additional productive suggestions for improvement. In addition to the examination by this review team, we have been subject to a stream of audits by various federal agencies, and we are pleased that these audits confirm that the AHCCCS OIG is among the “best practice” national leaders in Medicaid fraud, waste and abuse. For example, we have been cited by federal agencies as a best

practice leader in our date of death matching process (HHS OIG), our program integrity collaborations with our health plan compliance officers (CMS), and our civil settlement process (CMP) which were also some of five the noteworthy effective practices identified by your team.

As your cover letter indicates and as described below, AHCCCS rectified four of the six findings at the time of the audit. This was accomplished by making minor changes to existing documents to ensure we capture all of the required information under the newly enacted laws. In addition, subsequent to the CMS review AHCCCS has addressed the sixth finding; *The State does not provide notice of exclusion consistent with the regulation,* by creating a webpage on the OIG website to ensure that all parties are notified of a state initiated exclusion. However, we have not proposed a corrective action for the fifth finding; *The State does not report all adverse actions taken on provider participation to the HHS-OIG*. We believe the standard has been inaccurately applied due to a misinterpretation of the regulation by CMS. A more detailed explanation regarding our rationale is detailed below.

Finding #1:
The State does not capture all required ownership and control disclosures from disclosing entities.

Recommendation:
Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

Response:
AHCCCS modified all Contracts; Section D; Corporate Compliance paragraph to require the capture of the required ownership and control disclosures from the MCEs to capture all disclosures required under the regulation.

Finding #2:
The State does not adequately address business transaction disclosure requirements in its managed care contracts.

Recommendation:
Revise the MCE contracts to require disclosure upon request of the information identified in 42 CFR 455.105(b).

Response:
AHCCCS revised the MCE contracts to require disclosure upon request of the information identified in 42 CFR 455.105(b).

Finding #3:
The State does not collect criminal conviction disclosures from providers or contractors

Recommendation:
Develop and implement policies and procedures for the appropriate collection of disclosures from providers and MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers and MCEs, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs.

Response:
AHCCCS was collecting disclosures from providers and MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers and MCEs, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Our disclosure document had a typographical error that was reconciled during the onsite review; Title XXI was changed to Title XX. AHCCCS has modified ACOM Policies (103, Fraud & Abuse) and all contracts to meet the requirement. As mentioned in the findings, AHCCCS corrected the form during the onsite and resolved the issue.

Finding #4:
The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)

Recommendation:
Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Response:
Prior to the review, AHCCCS created an automated system that screens all providers, any person with an ownership or control interest, or who is an agent or managing employee of the provider. This occurs through the screening of the LEIE and the EPLS exclusion databases upon enrollment, reenrollment, and at least monthly thereafter. AHCCCS contracts have had requirements in Section E, Contract Clauses & in Section D, Program Requirements requiring MCEs to check for suspensions and debarments. This automated system now captures all of the required information under the regulations to ensure that the State does not pay Federal funds to excluded persons or entities.

Response:
Finding #5:
The State does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Finding)

Recommendation:
Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program. Require contracted MCEs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG.

Response:
The AHCCCS Administration respectfully disagrees with Finding #5. AHCCCS believes that it does report all adverse actions taken on provider participation to the HHS-OIG. Pursuant to 42 C.F.R. §1002.3(b)(3), when a final adverse action is taken against a provider, the AHCCCS OIG Provider Registration Unit promptly reports this adverse action to HHS-OIG. A "final adverse action" is defined in the AHCCCS Medical Policy Manual (AMPM), Chapter 900, Policy 950 as:

a. Civil judgments in Federal or State court related to the delivery of a health care item or service.

b. Federal or State criminal convictions related to the delivery of a health care item or service

c. Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:

i. Formal or official actions, such as revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,
ii. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
iii. Any other negative action or finding by such Federal or State agency that is publicly available information.
iv. Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(H), respectively) and
v. Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

The AHCCCS Administration, pursuant to Policy 950 of the AMPM also requires its contracted health plans to report these final adverse actions if taken at the health plan level. However, AHCCCS contracted health plans are not required by Policy nor by federal law to report a denial of credentialing if that denial is not related to licensure issues, fraud, waste or abuse. For example, a provider that is denied credentialing by a health plan for "adequate network" reasons has not been denied inclusion in the Medicaid program for licensure issues, fraud, waste or abuse reasons. As such, this example would not result in a report to HHS-OIG. In fact, if such a report we require in this type of scenario, it would have a

chilling effect on providers nation-wide, and would result in serious negative financial and reputational consequences to providers.

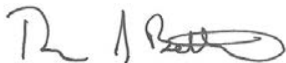
The AHCCCS Administration continually strives to improve its program integrity provisions and outcomes. While we disagree with HHS-OIG's finding #5, and believe AHCCCS and our contracted health plans are in compliance with 42 C.F.R. §1002.3(b)(3), we are in the process of amending the AMPM Policy 950 to further clarify the contracted health plans' obligations under this regulation and policy. In addition, we are developing a desk-level procedure for the AHCCCS Provider Registration Unit to follow when reporting a final adverse action to HHSOIG.

Finding #6:
The State does not provide notice of exclusion consistent with the regulation

Recommendation:
Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion consistent with 42 CFR 1002.212.

Response:
AHCCCS OIG developed and will be implementing a webpage to ensure that all parties identified by the regulation are notified of a State-initiated exclusion consistent with 42 CFR 1002.212.

Sincerely,



Thomas J. Betlach
Director