Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Arizona Focused Program Integrity Review

Final Report

July 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Arizona to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2012.

Background: State Medicaid Program Overview

The CMS review team conducted the onsite portion of the focused program integrity review of the Arizona state Medicaid agency by meeting with representatives at the offices of the Arizona Health Care Cost Containment System (AHCCCS). Arizona is a Medicaid expansion state with over 1.8 million Medicaid beneficiaries. Arizona's American Indian population comprises its ten percent fee-for-service (FFS) Medicaid program, while the remaining 90 percent, or approximately 1.6 million of the beneficiaries, are mandated to participate in the managed care delivery system and must enroll with an MCO. The total Medicaid expenditures for state fiscal year (SFY) 2016 totaled approximately $11.3 billion. The state's Federal Medical Assistance Percentage is 68.92 percent.

The AHCCCS operates under a Section 1115 Medicaid demonstration waiver. The AHCCCS currently contracts with 17 MCOs across six lines of business, including two contracts with state agencies, the Division of Economic Security-Division of Developmental Disabilities (DES-DDD), for the provision of services to children in foster care and services to members with developmental disabilities. In addition, AHCCCS manages the FFS American Indian Health Plan which serves American Indians who chose to not receive their services through an MCO.

Methodology of the Review

In advance of the onsite visit, CMS requested that Arizona and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of February 28, 2017, the CMS review team visited the AHCCCS Office of the Inspector General (AHCCCS-OIG) and the Division of Health Care Management (DHCM). They conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their personnel responsible for implementing the corporate compliance program. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 1.6 million beneficiaries, or 90 percent of the state's Medicaid population, were enrolled in 17 MCOs during FFY 2016. The state spent approximately $7.4 billion, or 70 percent of the state's total Medicaid expenditures, on managed care contracts in FFY 2016. All Arizona providers are enrolled with the state centrally in order to participate in the Medicaid managed care program. Once a provider enrolls with the state, they may contract with an MCO and go through the MCO credentialing process in order to participate in the Arizona Medicaid managed care program.

The AHCCCS-OIG has the authority to oversee all program integrity activities including conducting preliminary and full investigations relating to fraud, waste, and abuse in the Medicaid managed care program. One of the primary functions of the AHCCCS-OIG is to analyze and investigate billing patterns from claims data for fraud, waste, and abuse activity in the Medicaid managed care program. The state's contract only requires the MCOs to report alleged or suspicious Medicaid provider cases which have been substantiated through MCO preliminary investigations.

When an MCO refers a case to the state, the AHCCCS-OIG assumes complete authority and ownership of the case referral. This means the MCOs are contractually required to follow only the state's instruction regarding any further actions related to the referred case. In accordance to the contract, the MCOs completely rely on the AHCCCS-OIG to handle all fraud, waste, or abuse matters, once the case is referred. This process makes the state less dependent upon the MCOs' compliance personnel to control fraudulent activity and allows the state to maintain full control of all full investigations, overpayment recoveries, referrals to the Medicaid Fraud Control Unit (MFCU), and payment suspensions. The state also controls all provider terminations and all notifications to the U.S. Department of Health and Human Services' Office of the Inspector General (HHS-OIG) resulting from any adverse action to limit a provider's participation in the Medicaid program. The AHCCCS's program integrity oversight structure is unique; unlike most program integrity models in other states, the Arizona MCOs do not participate in the program integrity process beyond the preliminary investigation and case referral process, without approval from the state. They are also contractually restricted from collecting any overpayments or recoupments directly.

The DHCM assists the AHCCCS-OIG in accomplishing the program integrity objectives of the AHCCCS-OIG. The DHCM is structured under three primary units which are: operations,

clinical (to include quality of care issues) and finance/data analysis, and research. These units are responsible for evaluating the quality of care provided to eligible beneficiaries, while providing oversight and continuous monitoring of the program integrity contract requirements for all Arizona managed care health plans.

The CMS review team analyzed the AHCCCS-OIG's oversight of the program integrity operations for Mercy Care Plan, Health Choice Arizona (Health Choice), and DES-DDD. At the time of the onsite review, the AHCCS-OIG had a total of 87 full time equivalent positions (FTEs) dedicated to program integrity responsibilities including managed care program integrity oversight.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

Mercy Care Plan is a not-for-profit health plan providing acute care services to AHCCCS Medicaid beneficiaries. Mercy Care Plan partners with multiple hospitals through Dignity Health and the Carondelet Health Network. The plan's parent hospitals include: St. Joseph's, Phoenix Children's, Barrow Neurological Institute, Chandler Regional, Mercy Gilbert, St. Joseph's, St. Mary's, and Holy Cross. In addition, Mercy Care Plan, along with Maricopa Integrated Health System, manages the Regional Behavioral Health Authority (RBHA) with AHCCCS for Maricopa County. Mercy Care plan operates in all 15 counties in Arizona. The plan contracts with Aetna to perform program integrity activities, along with various administrative tasks and deliverables. The Aetna special investigations unit is headquartered in Connecticut.

Health Choice provides acute care services for Arizona Medicaid beneficiaries. Health Choice is a subsidiary of its parent company, IASIS Healthcare, and is located in Phoenix, Arizona. Health Choice serves eight counties in Arizona. The Health Choice brand also consists of other lines of business spanning Arizona, Florida, and Utah. Health Choice's compliance division is responsible for the oversight of program integrity activities and contractual compliance with the AHCCCS's contract. The MCO's program integrity activities, in conjunction with the state, may consist of: post pay audits, potential overpayments, prepay reviews, data mining, provider education, or provider terminations. Health Choice also contracts with virtual vendors to perform and monitor fraud, waste, and abuse.

The DES-DDD is a not-for-profit sister agency of AHCCCS and is contracted by the state to provide services for individuals with developmental disabilities, which includes acute care, behavioral health, and long-term care services. The DES-DDD has a program integrity corporate compliance unit which processes all suspected fraud, waste, and/or abuse referrals. Provider oversight and performance is monitored by both the Quality Assurance unit and the Contracts unit, while the complaints received by the MCO are addressed through the Consumer Resolution System in the Office of Family Resources.
Enrollment information for each MCO as of February 2017 is summarized below:

Table 1.

	Mercy Care	Health Choice	DES-DDD
Beneficiary enrollment total	396,979	250,206	37,991
Provider enrollment total	6,710	32,467	2,334
Year originally contracted	1985	1990	1970
Size and composition of compliance office	6.0 FTEs	5.0 FTEs	5.0 FTEs
National/local plan	Local	Local	Local

Total Medicaid expenditure information for each MCO as of February 2017 is summarized below:

Table 2.

MCOs	FFY 2014	FFY 2015	FFY 2016
Mercy Care	$1.3 billion	$1.5 billion	$1.6 billion
Health Choice	$518.0 million	$607.0 million	$725.0 million
DES-DDD	$1.0 billion	$1.1 billion	$1.2 billion

State Oversight of MCO Program Integrity Activities

The office responsible for governing fraud, waste, and abuse in the Arizona Medicaid managed care program is the AHCCCS-OIG. The AHCCCS-OIG is responsible for performing oversight of the MCO corporate compliance programs, and addressing complaints concerning suspected or alleged managed care provider fraud, waste, and abuse. The AHCCCS-OIG coordinates this effort, in conjunction with the DCHM. The AHCCCS-OIG is responsible for investigating Medicaid fraud, waste, and abuse; the DCHM is responsible for coordination and oversight of the MCO contract requirements. Both organizational divisions are located within AHCCCS, who frequently communicates and coordinates the managed care contract requirements, and the overall program integrity activities of the MCOs. This is accomplished in conjunction with other key divisions such as the Division of Budget and Finance and the Office of Administrative Legal Services.

Also, the state has extensive written policies and procedures that provide detail regarding how each area will conduct oversight of the MCOs, including which unit within the state Medicaid agency is responsible for each specific activity. These policies and procedures are outlined in the *AHCCCS Medical Policy Manual* (AMPM) as well as the *AHCCCS Contractor Operations Manual* (ACOM). In addition, these policies and procedures are the resources used to provide guidance to the MCOs regarding the prevention, detection, and reporting of fraud, waste, and abuse activities to AHCCCS-OIG.

The AHCCCS has developed and implemented performance metrics to monitor the compliance of the MCOs in meeting all of the contractual requirements related to the delivery of health care and services to its members. The state focused on the "Triple Aim" goals developed by the Institute for Health Improvement (IHI) and adopted by the CMS. The IHI defines the "Triple Aim" goals as "a framework for optimizing health system performance."

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Arizona's MCO contract states that the MCO is required to identify and report all cases of credible allegations of fraud to the state. No other action is required unless authorized by the state. All full investigations, the tracking of those investigations, actions such as payment suspensions or recovery of overpayments, and referrals to the MFCU are performed by the AHCCCS-OIG, as outlined in the AMPM and the ACOM.

The AHCCCS-OIG's organizational structure is separated into several units which include: provider enrollment, provider audits, member audits, data analytics, forensic accounting, and performance improvement and audits. This structure allows the state Medicaid agency to effectively address the program integrity components established. The state has located these units conducting program integrity activities together in an effort to include all areas involved in the delivery of Medicaid health care services. These units interact on a daily basis regarding program integrity initiatives and investigations. The structure also allows for the linking of member and provider issues, running data analytics, coordinating provider audits, forensic accounting investigations, and working with provider enrollment. In addition, this structure provides AHCCCS centralized interaction with the state legislature, provider associations, government agencies, and other stakeholders. Maintaining such a presence within the state Medicaid program is vital to ensure appropriate managed care oversight and this particular Arizona program integrity model allows for streamlined processes that offer efficiencies that would otherwise not be possible

The contract language covering the reporting requirements states that if an MCO discovers or is made aware of an incident of alleged fraud, waste, or abuse, the contractor must immediately report the incident to AHCCCS-OIG within ten business days by completing and submitting the reporting form available on the AHCCCS-OIG's webpage. All pertinent documentation that would assist AHCCCS in its investigation should be attached to the form. If an MCO, administrative services subcontractor, or provider identifies an incident which warrants self-disclosure, the incident must be reported within ten business days to AHCCCS-OIG by completing and submitting the provider self-disclosure form available on the AHCCCS-OIG webpage. When a case of alleged fraud, waste, or abuse has been referred to AHCCCS-OIG, the MCO must not take action to recoup or otherwise offset any suspected overpayments.

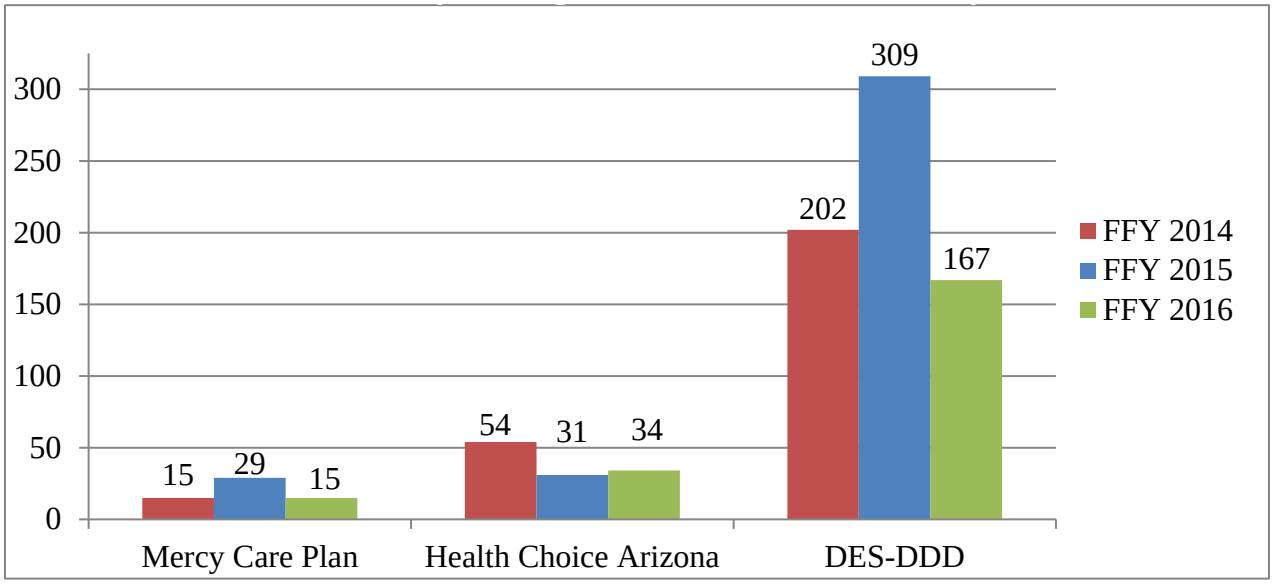
In the event AHCCCS-OIG feels it would be beneficial to seek additional and/or clarifying details regarding a referral from the MCO, the AHCCCS-OIG may first choose to request preliminary review work from the contractor to expand the allegation and to obtain additional documentation that will support an investigation by AHCCCS-OIG. When the investigation concludes, the AHCCCS-OIG will notify the contractor in a manner that safeguards the integrity and confidentiality of the investigation. If the MCO receives anything of value which might be construed as repayment of any amount expended due to fraud, waste, or abuse, the contractor

shall forward that recovery to AHCCCS-OIG within 30 days of its receipt. The contractor must also report any credentialing denials to AHCCCS.

The MCOs submit monthly reports of fraud, waste, and abuse activity to the AHCCCS-OIG, which are then sent to the program integrity team for review. The contract does not include language that requires the MCO to report suspected provider fraud, waste, and abuse to the Arizona MFCU.

Table 3 lists the number of referrals that Mercy Care Plan, Health Choice, and DES-DDD made to the state in the last three FFYs. Overall, with the exception of DES-DDD, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has not changed over time.

Table 3.



The DES-DDD has the highest volume of fraud, waste, and abuse referrals, although they have the lowest volume of providers and beneficiaries from the MCOs reviewed. During the onsite review, it was determined that a substantial amount of managed care program integrity case referrals originated from the AHCCCS-OIG. The CMS review team discovered that AHCCCS-OIG internally developed 175, 297, and 166 fraud referrals respectively, during the past three FFYs. The AHCCCS-OIG has also taken action to increase provider self-referrals and communication with regulators through participation on certified fraud examiner (CFE) conference panels. Presenters on these CFE panels include AHCCCS-OIG, the Arizona MFCU, and the U.S. Department of Justice's Office of the Attorney General. This conference was instituted approximately three years ago to raise awareness regarding the method for providers to correctly pay back Medicaid overpayments. The provider self-referral conferences have generated additional program integrity case referrals to the AHCCCS-OIG. In the first year of the conference, 37 provider self-referrals were generated. In FFY 2015, provider self-referrals increased to 109. In FFY 2016, the provider self-referrals continued to increase to 163.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs.

As required by 42 CFR 438.608, the state does review the managed care entity's (MCE's) compliance plan and communicates approval/disapproval with the MCEs. The AHCCCS-OIG oversees each MCO's corporate compliance program required for participation in the Arizona Medicaid program. The DHCM operational review team conducts operational review audits of the MCOs. The AHCCCS-OIG also participates on the team and assists in conducting those audits of the corporate compliance standards. The standards identified are as follows: corporate compliance plan; internal control system; audits; recoveries; trainings and ongoing education; investigations, data, results, and methodology; disclosures and screening; and suspected fraud, waste, and abuse reporting.

The purpose of the operational review audit is to assess each contractor's compliance with AHCCCS's contract standards. The operational audit reviews are to be conducted a minimum of one time during each three-year contract period; however, the CMS review team was informed that these audits typically occur annually. At the conclusion of the audit, a corrective action report is generated and distributed to the MCO. The state also has an additional assessment tool where the AHCCCS-OIG identifies certain program integrity elements as critical for the purpose of improving their current program integrity structure model. In addition, the CMS review team and AHCCCS discussed proactively improving its program integrity program by continuing to refine its managed care compliance standards and initial assessment tools, in preparation of the new managed care federal regulatory requirements.

The review of the compliance plan revealed no issues. All of the MCOs provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The state does collect and review all encounter data from the MCOs and maintains the ability to run program integrity related analysis of that data. The AHCCCS-OIG performs data analysis of the managed care encounters and will initiate its own investigations from the results of the analysis performed. The AHCCCS-OIG encounter data is analyzed by the five data analysts who form the program integrity team located within the AHCCCS-OIG.

The AHCCCS-OIG may contact the MCO and request additional information, or have the MCO conduct further research and provide additional information, if required. The bulk of the managed care investigative cases are developed internally through the use of the encounter data, along with data analytic software that enables the AHCCCS-OIG to quickly validate the issue being investigated; determine the exposure to a known fraud, waste, and abuse scheme; identify aberrant billing issues; and generate quality investigation leads.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. This is not applicable in Arizona, since the state is responsible for collecting any identified overpayment amounts associated with an investigation. Since the overpayment recoveries process is completely controlled by the state, it essentially resembles the state's FFS delivery system.

Policy 103 in Chapter 100 of the ACOM states that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste, and abuse. In Arizona, the MCO assigns to AHCCCS the right to recoup any amounts overpaid to a provider as a result of fraud, waste, or abuse. If the MCO receives anything of value which may be construed as a repayment of any amount expended due to fraud, waste, or abuse, the MCO must forward the recovery to the AHCCCS-OIG within 30 days of its receipt.

The tables below show the respective amounts reported by AHCCCS for the past three FFYs. Since Mercy Care Plan, Health Choice, and DES-DDD are only responsible for referring cases resulting from preliminary investigations and are not allowed to seek recoveries, the following tables represent the overpayment figures reported by AHCCCS that were associated to each MCO.

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	15	10	$9,787	$9,787
2015	29	23	$6,732	$2,700
2016	15	11	$0	$0

*Conducted by the MCO.

The state reported overpayment amounts only for FFY 2014 and FFY 2015. No overpayment amounts were identified for FFY 2016 for cases referred by Mercy Care Plan.

Table 4-B.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	54	52	$0	$0
2015	31	18	$0	$0
2016	34	17	$0	$0

*Conducted by the MCO.

The state reported no overpayments identified or recovered pertaining to the cases they investigated that were referred by Health Choice.

Table 4-C.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	202	142	$106,318	$72,767
2015	309	279	$2.4 million	$220,083
2016	167	167	$103,681	$72,294

*Conducted by the MCO.

The state reported full investigations, overpayments identified, and overpayments recovered resulting from the preliminary investigations referred by DES-DDD.

During onsite interviews, the AHCCCS-OIG stated that some of these amounts are actively being pursued, and are currently either in-process or backlogged; this is particularly true for cases reported in FFY 2015. The AHCCCS-OIG has a total backlog of over 700 cases. After discussion regarding the state's handling of these cases, the CMS review team determined that the backlog poses no program integrity concerns at this time. The state mentioned that cases of low priority are maintained in the tracking system, should another referral be made which could related to those low priority cases. The AHCCCS-OIG designates cases currently being worked as active; cases that have not been assigned to investigator as deferred; or cases that are with prosecution or another law enforcement agency as suspended.

The DES-DDD mentioned that the MCO's compliance unit currently does not have regularly scheduled meetings with the AHCCCS-OIG. The DES-DDD did discuss its future plans to conduct meetings on a quarterly basis, at minimum. Also during onsite interviews, the CMS review team received conflicting information regarding the number of cases referred by the MCOs. Not all of the MCOs were referring cases with related overpayments and some of the reporting in the volume of cases referred contained minor inconsistencies, the CMS review team discussed with the AHCCCS-OIG the benefits of establish regular meetings with the MCOs throughout the year. These meetings would allow for all parties involved in the program

integrity case referral process to discuss case referrals and contract program integrity requirements, as the DES-DDD recommends. Such meetings may also present an opportunity to improve the quality of the case referrals by analyzing and discussing how to improve the quality of the case referrals.

Payment Suspensions

In Arizona, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is not any contract language mirroring the payment suspension regulation at 42 CFR 455.23. Since the MCOs are not involved in the fraud, waste, and abuse process once a preliminary investigation referral is made to the AHCCCS-OIG, there is only general contract language requiring the MCOs to suspend payments when instructed by AHCCCS. The AHCCS maintains the authority to implement a payment suspension and the MCOs are contracted to process the action as instructed. The MCOs will not implement a payment suspension action without being directed by the AHCCCS-OIG.

When a payment suspension is implemented by AHCCCS-OIG as a result of an investigation, AHCCCS-OIG sends a letter to the provider and immediately notifies the AHCCCS's quality management administrator. Upon receipt of the official provider suspension letter, the quality management administrator notifies the MCO of the suspension within 24 hours. If the situation warrants, AHCCCS may also issue a pre-notice of an impending suspension or termination to allow the MCO to work with the provider to regarding the compliance issue(s). The AHCCCS stated that they strive to communicate provider suspension information to the MCOs as quickly as possible, so that the MCOs may take immediate action.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "AHCCCS is the only Medicaid authority in the State of Arizona to terminate a provider from the State Medicaid program. Therefore, the MCOs are not allowed to terminate a provider from the Medicaid program."

The reporting policies do allow the MCOs to deny a provider's participation at credentialing or re-credentialing; when this occurs, the MCO will notify the state of their denial to credential the provider. Any provider found to be on any of the exclusion or sanction lists may be disenrolled and the identity of the provider must be disclosed to AHCCCS-OIG immediately, in accordance with Policy 103 found in the ACOM. Policy 103 directs the contractor to report any contract denials to AHCCCS, as mandated both contractually and in policies and procedures; this includes, but is not limited to licensure issue; quality of care concerns; excluded providers; and/or alleged fraud, waste, or abuse.

During onsite interviews and CAP follow up discussions, the state was unable to provide details regarding how they address reported MCO denials specifically related to fraud, waste, and abuse, or quality of care issues. In addition, the MCOs' responses regarding their handling of denials were inconsistent with the contractual structure, which governs the Arizona Medicaid managed care program. Currently, no uniform policy exists regarding how the state should handle the

participation of providers with adverse actions instituted at the MCO level and outside of the credentialing/re-credentialing process.

In Arizona, the MCOs do not report termination information, since that responsibility maintained by the state. However, the state does not submit terminated providers to CMS for uploading on the CMS secure web-based portal. The state informed the CMS review team that it is currently working to establish guidelines to adhere to this process and to determine which providers terminated in the past ten years fall under the for cause policy.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs*		Total #of Providers Terminated for Cause in Last 3 Completed FFYs	
All MCOs Combined	2014 2015 2016	9,935 10,067 6,109	2014 2015 2016	22 36 24

*Arizona Medicaid providers must first contract with AHCCCS, prior to enrolling with an MCO. The figures represent the volume of providers terminated or disenrolled by AHCCCS, regardless of the MCO in which the provider is enrolled.

Overall, the number of providers terminated for cause by both of the plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason.

Most of the MCOs rely on the state to notify them of actions taken at the state level against providers, prior to taking any action at the plan level. The state mentioned that Arizona MCOs do not report termination information, since they do not terminate providers. However, Mercy Care Plan and Health Choice mentioned they may take adverse actions, and they do terminate Medicaid providers prior to notifying the state. If these plans were to terminate providers, the MCOs would notify the state typically within one day, in order for the providers to be terminated centrally by the state from the AHCCCS system.

During onsite interviews with the MCOs, the CMS review team determined that the MCOs often misunderstood the review team's reference regarding fraud, waste, or abuse, or quality of care terminations. In addition, the MCOs also misinterpreted the credentialing and re-credentialing policies and procedures; the MCOs interpreted these policies as the same as the fraud, waste, and abuse policies and procedures related to MCO provider terminations. However, the DES-DDD's response differed from the other MCOs' responses; the DES-DDD mentioned that they would not terminate a Medicaid provider without the AHCCCS-OIG's direction first.

Based upon Arizona's Medicaid policies and procedures, AHCCCS is the only state Medicaid authority that may terminate a provider from either the state Medicaid program and/or within the managed care Medicaid program. This misinterpretation issue does not pose a program integrity operational risk for the state, since AHCCCS is the only authority that may terminate providers

from the Medicaid program; however, the state should review the differing responses related by the MCOs to the CMS review team and determine if training or education is required.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The state demonstrated compliance with all regulatory requirements regarding all database checks. The state corrected all prior review deficiencies and correctly enter the names of agents, subcontractors, and managing employees into the Medicaid Management Information System. Therefore, agents, subcontractors, and managing employees are now subject to automatic LEIE and EPLS checks at enrollment, reenrollment, and monthly thereafter. The state's contracting staff collects all required MCE ownership and control information during the request for proposal process, and checks the LEIE or EPLS to determine if the individuals listed have been excluded from participation or debarred.

Recommendations for Improvement

Recommendations should be specific to areas identified during the onsite review as a finding, vulnerability, or risk.

- Continue refining the state's managed care compliance standards and initial assessment tools, in preparation of the new managed care federal regulatory requirements.
- Establish regularly scheduled meetings between the state and the MCOs to discuss the volume of and quality of cases referred, and program integrity contract requirements. These meetings should focus on MCOs with low volumes of overpayments identified and collected, to determine if referrals are meeting the state's quality standards. If required, provide training to improve the quality of MCO referrals. In addition, continue working with the MCOs to develop specific program integrity training to improve the volume of case referrals from the MCOs, such as joint training with MCOs focusing on including medical necessity in the case review process.
- The state should adhere to the guidelines established for reporting for cause provider terminations occurring since January 1, 2011, to the CMS secure web-based portal (TIBCO MFT). The AHCCCS-OIG should email the completed CMS Medicaid termination notification template, along with the termination letter, to CMS.
- The state should evaluate the MCOs regarding consistency and conformance when taking any adverse action outside of the credentialing and re-credentialing process which limits a provider's participation in the Medicaid program. The state should determine if there is a full understanding of this process by all managed care plans and provide further guidance, if warranted.

Section 2: Status of Corrective Action Plan

Arizona's last CMS program integrity review was in May 2012, and the report for this review was issued in January 2013. The report contained six findings and no vulnerabilities. During the onsite review in February 2017, the CMS review team conducted a thorough review of the corrective actions taken by Arizona to address all issues reported in calendar year 2013. The findings of this review are described below.

Findings -

1. ***The state does not capture all required ownership and control disclosures from disclosing entities.***

   Status at time of the review: Corrected

   - The state corrected this as of October 1, 2014, when revisions were made to the contract language which now requires the MCOs to comply with all elements contained in 42 CFR 455.104.
   - The state modified the corporate compliance paragraph in Section D for all contracts to capture the required ownership and control disclosures from the MCOs, per the regulation.
   - The state's contract procedures also identify who will be responsible for collecting this information and at what point in the contract procurement process this will occur. In addition, the state addressed the necessary revisions on the financial disclosure statement mentioned in the 2012 program integrity review report.

2. ***The state does not adequately address business transaction disclosure requirements in its managed care contracts.***

   Status at time of the review: Corrected

   The state corrected and cleared this item prior to the onsite review with the Medicaid Integrity Group's state liaison. The state's managed care contracts were revised to adequately address the business transaction disclosure requirements contained in 42 CFR 455.105.

3. ***The state does not collect criminal conviction disclosures from providers or contractors.***

   Status at time of the review: Corrected

   The state made the necessary revisions to the contract language requiring the MCOs to collect criminal conviction disclosures, in compliance with 42 CFR 455.106.

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

Status at time of the review: Corrected

The state corrected this finding as of October 1, 2014, when revisions were made to the contract language which now require the MCOs to comply with all elements contained in 42 CFR 455.436.

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

Status at time of the review: Corrected

- The state corrected this finding and requires the MCOs to report denials at credentialing and re-credentialing within one business day. The MCO has to display the reasons or participation denials pursuant to AMPM Policy 950.
- The CAP, however, still does not provide details regarding how the state will address denials that are related to issues of fraud, waste, and abuse, or quality of care. Arizona is unique in that the MCOs do not have a role in terminating Medicaid providers for fraud, waste or abuse or quality of care concerns. That responsibility is maintained by the state Medicaid agency in Arizona.

6. The state does not provide notice of exclusion consistent with the regulation.

Status at time of the review: Corrected

The state supplied the CMS review team with both a notice of exclusion consistent with the regulation and a copy of the ACOM 440 (Managed Care Expiration or Termination of Contract). The ACOM 440 provides direction regarding notifying contractors who have been terminated. The state also submitted its procedures whereby state staff from the Medical Quality Assurance division assist beneficiaries in transitioning to another provider.

Technical Assistance Resources

Technical Resources should be specific to areas identified during the onsite review as a finding, vulnerability, or risk. Choose any of the following. This list is not all inclusive.
To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Arizona to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which may help address the risk areas identified in this report. Courses that may be helpful to Arizona are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html.
- CMS provides a fraud prevention toolkit located on CMS.gov that includes:
    - The 4Rs (Record, Review, Report, and Remember) brochure
    - Fact sheets on preventing and detecting fraud
    - Frequently Asked Questions
    - The CMS.gov website also contains information regarding the Center for Program Integrity and fraud prevention efforts in Original Medicare (FFS), Part C and Part D, and Medicaid. For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.
    - For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Arizona to build an effective and strengthened program integrity function.