

A REPORT  
TO THE  
ARIZONA LEGISLATURE

Performance Audit Division

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Performance Audit

# Arizona Health Care Cost Containment System

—Medicaid Fraud and  
Abuse Prevention, Detection,  
Investigation, and Recovery Processes

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September • 2012  
REPORT NO. 12-06



**Debra K. Davenport**  
Auditor General

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**Dot Reinhard**, Manager and Contact Person

**Sebrina Beckstrom**, Team Leader

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**Mike Devine**

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**DEBRA K. DAVENPORT, CPA**  
AUDITOR GENERAL

**STATE OF ARIZONA**  
OFFICE OF THE  
**AUDITOR GENERAL**

**MELANIE M. CHESNEY**  
DEPUTY AUDITOR GENERAL

September 24, 2012

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Tom Betlach, Director  
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, *A Performance Audit of the Arizona Health Care Cost Containment System (AHCCCS)—Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes*. This report is in response to an October 26, 2010, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, AHCCCS agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on September 25, 2012.

Sincerely,

Debbie Davenport  
Auditor General

## REPORT HIGHLIGHTS PERFORMANCE AUDIT

### Our Conclusion

The Arizona Health Care Cost Containment System (AHCCCS) has processes in place to detect Medicaid fraud and abuse but should continue to enhance its training and data analysis. AHCCCS also needs to enhance its processes for investigating potential fraud and abuse cases in a timely manner. Finally, AHCCCS needs to make several changes in its processes for recovering Medicaid payments made in cases of fraud or abuse to ensure maximum benefit to the State.



2012

## AHCCCS has processes to prevent and detect Medicaid fraud and abuse but can enhance training and data analysis

**AHCCCS has established required provider registration activities**—To help prevent Medicaid fraud and abuse, AHCCCS' Office of Inspector General (OIG) registers all of AHCCCS' medical providers, such as doctors and home healthcare agencies. The OIG also conducts unannounced site visits at certain providers' offices.

**AHCCCS conducts pre-approval investigations to ensure its members are eligible to receive benefits**—The OIG conducts investigations of applicants for benefits when referred by the Department of Economic Security's eligibility workers, who conduct the majority of Medicaid eligibility determinations. In 2012, 35 percent of the 5,334 applicants investigated were determined ineligible.

**AHCCCS should regularly update its training and continue to enhance its data analysis capabilities**—The OIG makes Medicaid fraud and abuse training available to contracted health plans, which oversee the provision of healthcare services to AHCCCS members, and

providers on AHCCCS' Web site. The OIG also developed mandatory fraud training for eligibility caseworkers. However, it does not regularly update its training to reflect emerging fraud and abuse trends identified by OIG investigators.

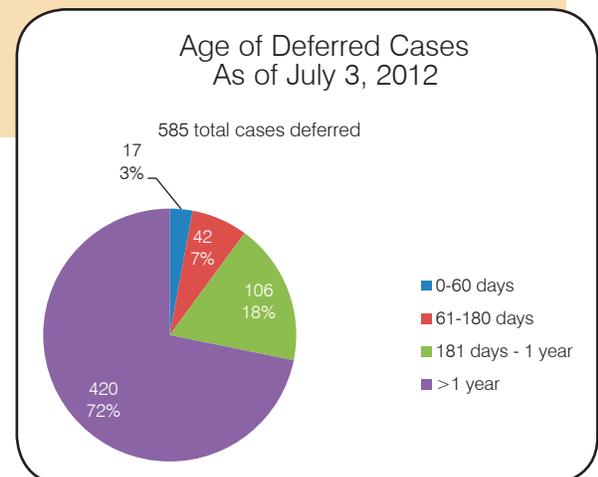
AHCCCS uses a contractor to analyze claims data, looking for known fraud patterns. In addition, since June 2012, AHCCCS has had a data-sharing partnership with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, that allows the OIG to identify improper billing and utilization patterns by comparing Medicare and Medicaid claims. AHCCCS also entered into a contract with three companies for data-analytics-consulting services, as required by 2011 legislation.

### Recommendation:

AHCCCS should develop and implement a plan to regularly update its fraud training for eligibility caseworkers and continue to identify data analysis capabilities for fraud detection.

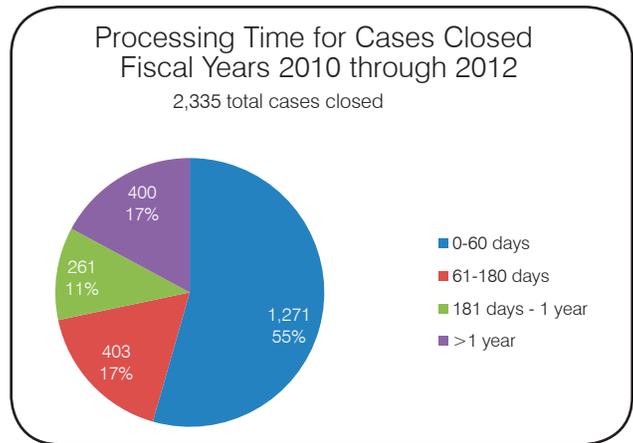
## AHCCCS should enhance fraud and abuse investigation processes

**Many fraud and abuse referrals not investigated in a timely manner**—The OIG, which conducts investigations into suspected member and provider fraud and abuse cases, does not consistently do so in a timely manner. First, it places many cases that it cannot immediately investigate in deferred status, and many deferred cases are not opened for 1 year or more.



Second, although the OIG resolves many of the cases it opens for investigation in a timely manner, we found that about 28 percent of investigations resolved in fiscal years 2010 through 2012 took 6 months to more than 1 year to resolve. The OIG explained that the lack of experienced staff helped account for the delays in conducting investigations.

**Additional efforts needed to ensure highest priority cases are worked first and investigations progress as quickly as possible**—The OIG does not have written guidelines for prioritizing fraud and abuse cases. *Standards for Law Enforcement Agencies* recommend a prioritization system that focuses on cases that have the best chance of being successfully resolved. Accordingly, cases not likely to result in cost savings or recovery should be closed out. In addition to establishing written priority screening guidelines, the OIG should also strengthen its 60-day supervisory case review policy to include a requirement to discuss whether cases should be continued or closed and document the decisions made during case reviews.



**Recommendation:**

AHCCCS should enhance its processes for investigating fraud and abuse cases to ensure timely and effective resolutions.

**AHCCCS should improve its recovery processes**

**Settlement decisions should be clearly documented**—When fraud or abuse is substantiated, AHCCCS is responsible for recovering the amounts established in settlement agreements. Recovery amounts are established by a court when an AHCCCS member or provider has been convicted of a criminal offense or by the OIG through civil settlement agreements. AHCCCS does not consistently document the mitigating and aggravating factors it considers in reaching settlement decisions. As a result, it is not clear whether AHCCCS always seeks the maximum amount allowed by statutes and rules.

**AHCCCS needs to ensure federal recovery reporting is accurate**—After a recovery amount is established, AHCCCS must report the amount to the federal government, which reduces future federal contributions by the federal share of the amount reported. We identified 4 reporting errors out of 25 cases sampled that resulted in an erroneous reduction of the federal contribution by approximately \$12,800. AHCCCS lacked adequate procedures to prevent and detect such errors.

**Limited collection procedures place recoveries at risk**—Many settlements are paid over a period of time, and the OIG is responsible for collecting the payments. We found that the OIG has not established a formal collection policy or program, increasing the difficulty in collecting the more than \$2 million in recovery amounts that are over 90 days past due as of April 2012. AHCCCS should establish a formal collection program for delinquent accounts that includes monthly aging and followup, state tax and lottery intercepts, and referral to the Attorney General’s debt collection program.

**Recommendation:**

AHCCCS should document the specific considerations used to arrive at civil settlement amounts, ensure that recovery amounts are accurately reported to the federal government, and establish a formal collections program.

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# INTRODUCTION

## Scope and Objectives

The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System (AHCCCS) pursuant to an October 26, 2010, resolution of the Joint Legislative Audit Committee. This audit is the third in a series of audits conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and examines AHCCCS' Medicaid fraud and abuse prevention, detection, investigation, and recovery processes.

The first audit found that AHCCCS has processes in place that help it comply with state and federal requirements for coordinating the payment of healthcare benefits with other responsible parties. The second audit found that AHCCCS and the Department of Economic Security (DES) appropriately determined Medicaid eligibility for almost all applicants, and although 5.92 percent of the eligibility determinations are at risk for processing errors such as not correctly calculating or verifying income, just 1.11 percent are at risk for being incorrect eligibility determinations. A fourth report will address the statutory sunset factors.

# Medicaid applicants must be approved through an eligibility determination process

## Majority of AHCCCS program operates under managed care model

AHCCCS was established to administer Arizona's Medicaid program, which provides healthcare for certain low-income individuals and families living in Arizona. Medicaid is a federal healthcare program for low-income individuals and families that is jointly funded by the federal and state governments. AHCCCS was implemented in October 1982 as the nation's first state-wide Medicaid program designed to provide medical services to eligible persons primarily through a managed care system. Under a managed care system, AHCCCS contracts with entities, known as health plans, which coordinate and pay for the medical services AHCCCS members receive from registered AHCCCS healthcare providers, such as physicians and hospitals. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive monthly capitation payments (see textbox).

**Capitation payment**—A fixed monthly amount paid in advance to AHCCCS' contracted health plans for each enrolled member. At least annually, based on information such as the historical use and cost of medical services provided and inflation data, capitation payment amounts are determined using mathematical and statistical methods. Monthly capitation amounts paid to AHCCCS' contracted health plans can vary by individual based on factors such as age, gender, geographical service area, and program (see examples below):

Examples of average <i>Acute Care</i> monthly capitation rates <sup>1</sup>					Average <i>Arizona Long Term Care System</i> monthly capitation rate <sup>1</sup>
Age <1 Male/Female	Age 1-13 Male/Female	Age 14-44 Female	Age 14-44 Male	Age 45+ Male/Female	
\$460	\$97	\$222	\$138	\$347	\$3,000

<sup>1</sup> See page 2 for explanation of Acute Care and Arizona Long Term Care System programs.

Source: Auditor General staff analysis of AHCCCS information contained in its contracts, actuarial certifications, and Acute Care and Arizona Long Term Care System rates effective October 1, 2011.

Approximately 90 percent of AHCCCS' members are enrolled with its contracted health plans in managed care. For the remaining members, known as fee-for-service members, AHCCCS reimburses registered healthcare providers directly.<sup>1</sup> According to the Kaiser Family Foundation, as of October 2010, 47 states and the District of Columbia used managed care programs to some degree, but only 9 states, including Arizona, had 80 percent or more of their members enrolled in comprehensive managed care programs.<sup>2,3</sup>

AHCCCS members receive a full range of medical services under the following three primary programs:

- **Acute Care**—As shown in Table 1 (see page 3), the majority of AHCCCS' members are enrolled in its Acute Care program. This Medicaid program provides a wide range of healthcare services, such as inpatient and outpatient hospital services, physician services, immunizations, and laboratory and x-ray services to children, pregnant women, and other low-income adults.
- **Arizona Long Term Care System (ALTCS)**—A small percentage of members receive services under ALTCS. The ALTCS program provides acute care, behavioral health, long-term care, and case management services to individuals who are elderly, physically disabled, or developmentally disabled and meet the criteria for institutionalization.
- **KidsCare**—Children under age 19 may receive medical services under KidsCare, the name given to Arizona's federal Children's Health Insurance Program. Children may qualify for KidsCare if their family's income exceeds the limit allowed for Medicaid, but is still below the federally established amount for this program. Children enrolled in KidsCare receive the same medical services available under Arizona's Acute Care program. New enrollment in the KidsCare Program has been frozen since January 1, 2010, due to lack of funding, and AHCCCS has established a waiting list of applicants. However, effective May 1, 2012 through January 1, 2014, AHCCCS will be receiving monies from three hospitals that will allow AHCCCS to provide coverage for 21,700 children in what is being called KidsCare II.<sup>4</sup> This state-wide program will offer the same benefits, but has a lower income eligibility threshold than the KidsCare program.

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<sup>1</sup> AHCCCS reimburses providers on a fee-for-service basis for (1) individuals receiving services under the Federal Emergency Services program, or (2) Native American members who choose to receive services through a tribal fee-for-service contractor.

<sup>2</sup> Comprehensive managed care is defined as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) Federally Qualified Center services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment services; (7) family planning services; (8) physicians' services; and (9) home health services.

<sup>3</sup> Kaiser Family Foundation. (2010). *Medicaid enrollment in comprehensive managed care as a share of total Medicaid enrollment, October 2010*. Retrieved January 31, 2012, from [www.statehealthfacts.org](http://www.statehealthfacts.org)

<sup>4</sup> Laws 2011, Ch. 234, §2, allows AHCCCS, subject to U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), approval, to authorize any political subdivision to provide monies necessary to qualify for federal matching monies to provide healthcare coverage to persons who would have been eligible pursuant to A.R.S. §36-2901.01.

Table 1: AHCCCS Enrollment by Program  
At July 1, 2009, 2010, 2011, and 2012  
(Unaudited)

Program	2009	2010	2011	2012
Acute Care	1,174,598	1,272,118	1,300,674	1,212,693
Arizona Long Term Care System	48,673	50,241	51,314	52,498
KidsCare	51,838	30,445	17,649	15,330
Total	<u>1,275,109</u>	<u>1,352,804</u>	<u>1,369,637</u>	<u>1,280,521</u>

Source: Auditor General staff analysis of the AHCCCS July 1, 2009, 2010, 2011, and 2012, *Population Highlights* reports.

AHCCCS receives federal monies along with state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program. As shown in Table 2 (see page 4), during fiscal year 2012, AHCCCS estimates that its revenues will total more than \$8.4 billion, with approximately \$5.66 billion coming from the federal government, approximately \$2.16 billion from the State, about \$341 million from the counties, and \$275 million from other sources. AHCCCS' estimated expenditures for fiscal year 2012 total nearly \$8.4 billion, with about \$6.4 billion, or 76 percent, going toward capitation payments. AHCCCS' estimated revenues and expenditures for fiscal year 2012 are each approximately \$1.2 billion less than fiscal years 2010 and 2011 because some changes were made to Arizona's Medicaid program during the 2011 legislative session. For example, enrollment in Arizona's Medicaid program for some individuals, such as childless adults, is no longer being accepted.<sup>1</sup> In addition, the federal matching rate returned to its typical level in fiscal year 2012. Specifically, the American Recovery and Reinvestment Act of 2009 and additional federal legislation increased the federal matching rate from approximately 66 percent to between 71 and 76 percent from October 1, 2008 through June 30, 2011. This change and the changes to the Arizona Medicaid program resulted in the fiscal year 2012 estimated federal government revenues being approximately \$1.4 billion lower. However, the State's estimated revenue did not show a similar decrease, in part due to the reduction in the federal matching rate that required the State to contribute more of each dollar spent.

AHCCCS receives federal, state, county, and other monies, such as tobacco taxes, to operate Arizona's Medicaid program.

<sup>1</sup> In December 2011, the Arizona Court of Appeals upheld the State's decision to stop new enrollment for childless adults, indicating that it was a political decision that was not subject to judicial resolution. In February 2012, the Arizona Supreme Court refused to review the Appeals Court's decision.

**Table 2: Schedule of Revenues, Expenditures, and Changes in Fund Balance<sup>1</sup>**  
**Fiscal Years 2010 through 2012**  
(In Thousands)  
(Unaudited)

	<b>2010</b> <b>(Actual)</b>	<b>2011</b> <b>(Actual)</b>	<b>2012<sup>2</sup></b> <b>(Estimate)</b>
<b>Revenues:</b>			
Federal government <sup>3</sup>	\$ 7,229,797	\$ 7,077,440	\$ 5,663,201
State government <sup>3</sup>	1,720,054	2,012,179	2,163,412
County government <sup>3</sup>	247,043	277,663	341,131
Other <sup>4</sup>	302,363	272,449	275,024
Total revenue	<u>9,499,257</u>	<u>9,639,731</u>	<u>8,442,768</u>
<b>Expenditures and transfers:</b>			
<b>Capitated payments—</b>			
Acute care	4,181,191	4,163,405	3,150,673
Long-term care	1,940,629	1,957,650	1,959,774
KidsCare	91,795	55,095	36,068
Mental health and Children's Rehabilitation Services <sup>5</sup>	1,413,917	1,422,241	1,234,025
<b>Fee-for-service—</b>			
Acute care	847,605	874,121	759,836
Long-term care	119,705	127,138	134,366
Other <sup>6</sup>	685,871	805,577	898,318
Administrative	177,092	163,936	180,616
Total expenditures	<u>9,457,805</u>	<u>9,569,163</u>	<u>8,353,676</u>
Transfers to the State General Fund	2,699	1,268	1,244
Net transfers to other state agencies <sup>7</sup>	39,213	38,184	41,928
Total expenditures and transfers	<u>9,499,717</u>	<u>9,608,615</u>	<u>8,396,848</u>
Net change in fund balance	(460)	31,116	45,920
Fund balance, beginning of year	685	225	31,341
Fund balance, end of year	<u>\$ 225</u>	<u>\$ 31,341</u>	<u>\$ 77,261</u>

<sup>1</sup> The table includes all AHCCCS financial activity except the Healthcare Group. The Healthcare Group provides medical coverage primarily to small, uninsured businesses and is managed as a self-supporting operation.

<sup>2</sup> The estimates for fiscal year 2012 revenues and expenditures are significantly less than fiscal years 2010 and 2011 because multiple changes were made to the Medicaid program and the State's contribution during the 2011 legislative session that affected fiscal year 2012. See page 3 for additional information.

<sup>3</sup> Consists of all monies that originally came from the federal, state, or county governments, including monies passed through other entities, such as other state agencies.

<sup>4</sup> Amounts primarily consist of monies that were authorized for use on AHCCCS expenditures by the Legislature or voters, such as tobacco litigation monies, gaming revenues, and tobacco tax monies administered by AHCCCS. For example, Proposition 204 (November 2000) authorized the use of tobacco settlement monies to increase the number of people eligible for coverage in AHCCCS. Similarly, Proposition 202 (November 2002) provides a portion of gaming revenues to be used for a trauma and emergency services program.

<sup>5</sup> Amounts consist of capitated mental health and Children's Rehabilitation Services expenditures that were passed through to the Arizona Department of Health Services. Beginning in fiscal year 2012, the Children's Rehabilitation Services appropriation was moved to AHCCCS; therefore, AHCCCS no longer passes through these monies to the Department and instead makes payments directly to the providers.

<sup>6</sup> Amounts consist of various other expenditures that were not paid as capitated payments or fee-for-service. For example, reinsurance, a stop-loss program for partial reimbursement after a deductible is met, is included in this category.

<sup>7</sup> Amounts primarily consist of monies transferred to the Arizona Departments of Health Services and Economic Security for monies appropriated by the Legislature to these agencies. Specifically, the Legislature appropriated over \$35 million each year in fiscal years 2010 through 2012 to the Department of Health Services for behavioral health services from the tobacco tax monies AHCCCS administers. Similarly, approximately \$3 million each year was appropriated to the Department of Economic Security in fiscal years 2010 through 2012 from county contributions for administration costs for Proposition 204 (November 2000) implementation.

Source: Auditor General staff analysis of the AHCCCS fiscal years 2010 and 2011 financial statements audited by an independent certified public accounting firm and AHCCCS-prepared fiscal year 2012 estimates dated January 24, 2012, that are primarily composed of fiscal year 2012 appropriations.

## Federal regulations and state laws establish Medicaid fraud and abuse requirements

Medicaid fraud and abuse (see textbox), and the authority and requirements for handling suspected Medicaid fraud and abuse cases, are established in both federal regulations and state laws. Specifically, federal regulation requires that state Medicaid agencies, such as AHCCCS, have methods for identifying, investigating, and referring suspected Medicaid fraud cases to law enforcement officials.<sup>1</sup> Similarly, state laws establish several requirements related to Medicaid fraud and abuse. These laws, among other things, stipulate that (1) all federal Medicaid fraud and abuse laws apply to all persons, contractors, and providers participating in Arizona's Medicaid program; (2) Arizona Medicaid contractors and providers must report to AHCCCS suspected fraud or abuse cases; (3) AHCCCS has the authority to compel by subpoena attendance of a witness or records to support a Medicaid fraud and abuse investigation; and (4) AHCCCS can impose and collect civil penalties and assessments.<sup>2</sup>

**Fraud**—An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

**Abuse**—Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Source: 42 CFR §455.2

## AHCCCS has various processes to combat Medicaid fraud and abuse

As the State's Medicaid agency, AHCCCS is required to have processes in place for handling potential Medicaid fraud and abuse cases within its program. AHCCCS' Medicaid fraud and abuse program includes prevention, detection, investigation, and recovery activities. To help ensure AHCCCS' processes meet federal requirements, the federal government conducts audits of AHCCCS' fraud efforts every 3 years.

**AHCCCS performs various Medicaid fraud and abuse prevention and detection activities**—To help combat Medicaid fraud and abuse, AHCCCS has implemented a wide range of specific prevention and detection activities, many of them in specific response to federal or state requirements. Finding 1 (pages 11 through 19) discusses these activities in more detail and makes recommendations for improving two areas related to fraud prevention and detection. Examples of AHCCCS' prevention and detection activities include:

- Requiring all providers, such as doctors and home healthcare agencies, to register with AHCCCS before they are allowed to provide services to AHCCCS members. This process helps ensure only licensed providers that are not

<sup>1</sup> 42 CFR §455.13

<sup>2</sup> A.R.S. §§36-2905.04, 36-2918, and 36-2918.01

already excluded from providing Medicaid services per the U.S. Department of Health and Human Services' List of Excluded Individuals and Entities are approved for Medicaid registration.

- Using a photo identification program that allows providers to quickly confirm a member's identity. This program incorporates pictures from Arizona driver's licenses and state-issued identification cards into AHCCCS' online verification tool.
- Providing periodic training to staff that perform eligibility determinations. This training, which was developed by AHCCCS' Office of Inspector General (OIG), defines Medicaid fraud, explains areas to look for that are potential indicators of applicant fraud, and explains reporting requirements.
- Requiring its contracted health plans, which coordinate and pay for AHCCCS members' services, to establish their own fraud and abuse compliance program to prevent and detect suspected Medicaid fraud and abuse, and report suspected Medicaid fraud and abuse to AHCCCS.
- Systematically reviewing claims data for patterns of fraud or abuse. For example, AHCCCS uses claims data to identify patterns that suggest potential fraud or abuse, including such things as overbilling for services or billing for services not provided. Monthly, it also conducts matches of death records from the Arizona Department of Health Services against its member database to ensure its AHCCCS member roster does not include individuals who have died.

### AHCCCS investigates suspected cases of Medicaid fraud and abuse—Once AHCCCS receives a referral about suspected Medicaid fraud or

abuse, its staff conduct an investigation to obtain the evidence needed to determine whether fraud or abuse has occurred. As shown in Table 3, the majority of referrals about suspected Medicaid fraud and abuse come from AHCCCS staff, but AHCCCS receives referrals from various other sources. These sources make their referrals through various methods, including AHCCCS' referral hotline (1-888-ITS-NOT-OK) and by mail.

Finding 2 (pages 21 through 29) discusses AHCCCS' fraud and abuse investigation processes in more detail and makes recommendations for improving the timeliness of its investigations and the accuracy of its case management system. In general, AHCCCS' investigative activities include interviewing individuals; and reviewing records,

**Table 3:** Fraud Referral Sources for Cases Closed Fiscal Years 2010 through 2012 (Unaudited)

	2010	2011	2012
AHCCCS	387	660	78
Contractors/providers	131	135	113
DES	90	88	55
Public	105	70	92
Other <sup>1</sup>	163	220	228
<b>Total</b>	<b>876</b>	<b>1,173</b>	<b>566</b>

<sup>1</sup> Other includes a variety of sources including anonymous, law enforcement, and other state agencies.

Source: Auditor General staff analysis of referral information obtained from the OIG's case management system for cases closed during fiscal years 2010 through 2012.

including bank, criminal history, and medical records. Once AHCCCS' investigation is complete, AHCCCS refers cases involving suspected fraud and abuse to either a county attorney's office or the Arizona Attorney General's Office. The Arizona Attorney General and county attorneys have concurrent authority to prosecute Medicaid fraud cases.<sup>1</sup> Member cases are generally referred to a county attorney because the Arizona Attorney General's Office focuses on provider fraud cases. Specifically, as allowed by federal regulation, the Arizona Attorney General has established a specific unit, called a Medicaid Fraud Control Unit (MFCU), to investigate and prosecute provider fraud cases (see textbox).<sup>2</sup> AHCCCS has established a Memorandum of Understanding with the Attorney General's MFCU, which calls for AHCCCS to conduct a preliminary investigation of suspected fraud to determine whether there is a sufficient basis to refer the case to the MFCU for a full investigation and prosecution.

Sometimes AHCCCS' investigations are resolved through civil settlements instead of being referred for prosecution. For example, an AHCCCS provider may discover an error in billing during an audit and self-report the information to AHCCCS, or, according to AHCCCS, the costs of AHCCCS' establishing willful intent to commit fraud outweigh the costs of handling the case through a civil settlement. In these types of cases, AHCCCS has the authority to impose civil penalties and assessments.

AHCCCS works to recover monies from criminal restitution agreements and civil settlements—Once a member or provider suspected of Medicaid fraud or abuse has been convicted of a criminal offense or has signed a civil settlement agreement, AHCCCS is responsible for collecting the amounts owed. Finding 3 (pages 31 through 40) discusses AHCCCS' recovery, reporting, and collection efforts in more detail and makes recommendations in several areas.

Because the federal government shares in the cost of the Medicaid program, AHCCCS is required to report the recovery amounts established in criminal restitution and civil settlement agreements to the federal government. The federal government's contribution to Arizona's Medicaid program is then reduced proportionately in a future period by the recovery amounts reported. For example, if Arizona reported recovery agreement amounts totaling \$1,000 and the federal government contributed 66 percent of the monies for Arizona's program, then in a future period, the federal government's contribution to Arizona's program would be

### Medicaid Fraud Control Units

- Present in 49 states and the District of Columbia.<sup>1</sup>
- Staff size ranges from 4 in Wyoming, 17 in Arizona, and 282 in New York.
- Annually certified by the U.S. Department of Health and Human Services, Office of Inspector General, to ensure that these units meet federal requirements such as having state-wide authority to prosecute Medicaid fraud cases.
- Federal government covers 90 percent of the costs of an MFCU during the first 3 years of the unit's operation on a reimbursement basis and 75 percent in subsequent years.

<sup>1</sup> North Dakota does not have an MFCU.

Source: Auditor General staff analysis of information obtained from the U.S. Department of Health and Human Services, Office of Inspector General's Web site.

<sup>1</sup> A.R.S. §§13-2310, 13-2311, and 13-3713(G)

<sup>2</sup> 42 CFR part 1007

reduced by \$660.<sup>1</sup> Although AHCCCS must reimburse the federal government its share, according to AHCCCS, it does not have to reimburse its contracted health plans from the recoveries it collects because its health plans have already received a capitation payment to cover the member’s healthcare services or pay the provider.

According to unaudited AHCCCS information, recovery amounts established in criminal restitution or civil settlement agreements, for both members and providers,

between fiscal years 2010 and 2012 totaled between approximately \$3.8 million and \$6.6 million (see Table 4).<sup>2</sup> Because each state’s program for combating Medicaid fraud and abuse can vary, and given the different size and scope of each state’s Medicaid program, it is hard to provide comparable recovery data. However, according to the Web site for the U.S. Department of Health and Human Services, Office of Inspector General, in federal fiscal year 2011, Arizona’s MFCU, which investigates and prosecutes provider fraud, reported \$3.3 million in recoveries, while recoveries for other states’ MFCUs ranged from \$1.2 million in Delaware to \$388 million in California.<sup>3,4</sup>

**Table 4: Recovery Amounts for Criminal Restitution and Civil Settlement Agreements Established in Fiscal Years 2010 through 2012<sup>1</sup> (Unaudited)**

Fiscal Year	Agreement Amounts
2010	\$3,785,656
2011	\$4,721,445
2012	\$6,600,400

<sup>1</sup> These amounts include recovery agreements established by federal agencies, such as the U.S. Department of Health and Human Services, Office of the Inspector General, for cases that affect multiple jurisdictions, as well as investigative costs assessed in agreements.

Source: Auditor General staff analysis of information obtained from AHCCCS OIG’s case management system, for cases closed during fiscal years 2010 through 2012.

In addition to recovery amounts established in criminal restitution or civil settlement agreements, according to AHCCCS, the OIG estimates cost savings that result when the OIG prevents a member from receiving or continuing to receive benefits inappropriately or prevents a provider from inappropriately billing for services. According to the OIG, these activities resulted in an estimated \$21.4 million in member and provider cost savings in fiscal year 2012.

AHCCCS’ processes for combating Medicaid fraud and abuse are reviewed every 3 years—Although the states are primarily responsible for combating fraud and abuse in the Medicaid program, the CMS provides technical

<sup>1</sup> The amount the federal government contributes to Arizona’s Medicaid program varies (see page 3 for more information), and future contributions are reduced based on the matching rate that was in place when the fraud or abuse occurred.

<sup>2</sup> These amounts include recovery amounts established by federal agencies, such as CMS, for cases that affect multiple jurisdictions.

<sup>3</sup> According to the Web site for the U.S. Department of Health and Human Services, Office of Inspector General, the information on recoveries is self-reported and reflects the amount a defendant is required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections. Further, it states that statistical information for each MFCU should be interpreted in light of the state-specific organization and authorities governing the MFCU.

<sup>4</sup> According to Arizona’s MFCU, its recovery figures represent not only cases referred to it by AHCCCS’ OIG, which in turn are reported in AHCCCS OIG’s recovery figures, but also cases referred to it by other entities.

assistance, guidance, and oversight in these efforts. For example, the CMS provides guidance for strengthening provider enrollment in state Medicaid programs, best practices for interacting with MFCUs, and various training courses through its Medicaid Integrity Institute.<sup>1</sup> In addition, the CMS conducts program integrity audits in each state once every 3 years to assess the effectiveness of a state's program, including its compliance with federal law and regulatory requirements (See Finding 1, pages 11 through 19, for more information on AHCCCS' most recent review).

## Staffing and expenditures

Although AHCCCS sees combating fraud and abuse in its \$8 billion Medicaid program as an agency-wide effort, its OIG handles many of its key duties for managing fraud cases. According to the AHCCCS Director, one of his first actions as Director in 2009 was creating the OIG. This involved consolidating fraud investigative staff from AHCCCS' Office of Program Integrity with other AHCCCS units such as the Provider Registration Unit and Fraud Prevention Unit, as well as requesting additional positions. The OIG is managed by an Inspector General, who reports directly to AHCCCS' director. The Inspector General supervises two Deputy Inspectors General. According to AHCCCS, fraud investigative and support staff have increased from 22 full-time equivalents (FTE) as of July 2007 to a total of 63 FTE positions, including the Inspector General, as of April 2012. Five of these positions were vacant. The OIG's staff are divided among five units:

- **Fraud Prevention (12 filled FTEs, 2 vacancies)**—Staff in this unit conduct a pre-approval investigation of certain applicants who apply for Medicaid services. These applicants are referred to this unit by Medicaid eligibility caseworkers (See Finding 1, page 13, for more information on this pre-approval investigation).
- **Member Compliance (13 filled FTEs, 0 vacancies)<sup>2</sup>**—This unit investigates suspected fraud committed by AHCCCS members (See Finding 2, pages 21 through 29, for more information on member investigation processes). It also coordinates efforts with DES' Office of Special Investigations if the AHCCCS member is also receiving other program benefits, such as benefits from the Supplement Nutrition and Assistance Program.
- **Provider Registration (14 filled FTEs, 2 vacancies)**—This unit conducts the registration process for all providers, such as doctors and home healthcare agencies, that want to provide services to AHCCCS members, including verifying that the provider meets the requirements for professional licensure, certification,

The AHCCCS Director reported that one of his first actions as Director was to create the OIG in 2009.

<sup>1</sup> CMS developed the Medicaid Integrity Institute to meet the training and education needs of state Medicaid program integrity employees.

<sup>2</sup> The 13 filled positions include the deputy inspector general, who oversees the Member Compliance and Fraud Prevention units.

or registration (See Finding 1, pages 11 through 13, for more information on the provider registration process).

- **Central/Provider Compliance (13 filled FTEs, 1 vacancy)**<sup>1</sup>—Staff in this unit investigate suspected fraud and abuse committed by AHCCCS providers such as billing for services not rendered or billing for a higher level of service than rendered. The OIG’s administrative services division is also housed in this unit.
- **Investigative Analysis (5 filled FTEs, 0 vacancies)**—This unit performs background work that assists the member and provider compliance units with their investigations, such as conducting criminal history background checks. Staff in this unit also run ad hoc reports or perform data analytics using information from AHCCCS’ management information system to obtain information about specific Medicaid services rendered or to identify patterns in the data that might suggest provider fraud or abuse.

Table 5 shows the cost of the OIG’s activities during fiscal years 2010 through 2012. According to AHCCCS, the increase in expenditures during fiscal years 2011 and 2012 is due to the addition of 5 FTEs, which were initially approved as part of its fiscal year 2011 appropriation.

Table 5: Office of the Inspector General Expenditures  
Fiscal years 2010 through 2012  
(Unaudited)

	2010	2011	2012
Personal services and related benefits	\$2,645,000	\$2,823,400	\$3,146,888
Other operating expenditures	217,100	282,100	221,945
<b>Total</b>	<b>\$2,862,100</b>	<b>\$3,105,500</b>	<b>\$3,368,833</b>

Source: Auditor General staff analysis of expenditure information provided by AHCCCS for fiscal years 2010 through 2012.

<sup>1</sup> The 13 filled positions include the deputy inspector general, who oversees the Central/Provider Compliance, Investigative Analysis, and Provider Registration units.

## FINDING 1

The Arizona Health Care Cost Containment System (AHCCCS) has several processes in place to help prevent and detect provider and member fraud and abuse, but should continue to enhance its training and data analysis. Specifically, AHCCCS has established programs for registering and reviewing providers and for determining that applicants are eligible to participate in the Medicaid program, and it regularly reviews whether participating health plans have all elements of mandatory programs for preventing and detecting fraud and abuse. AHCCCS also provides training designed to help health plans, providers, and eligibility caseworkers identify fraud and abuse, and it uses a contractor to analyze data for patterns that could signal that fraud or abuse is occurring. However, to ensure that eligibility caseworkers are aware of new trends in fraud and abuse and to ensure that it is using the most current techniques for analyzing data to identify fraud patterns, AHCCCS should develop and implement a plan to regularly update its Medicaid fraud and abuse prevention and detection training and continue to identify and implement improved fraud detection data analysis techniques.

## AHCCCS has processes in place to prevent and detect fraud, but can continue to enhance its training and data analysis

### AHCCCS has processes in place that help prevent provider and member fraud and abuse

AHCCCS has established various processes that help prevent ineligible providers and members from participating in Arizona's Medicaid program. First, to help ensure that only qualified providers are registered to provide Medicaid services in the State, AHCCCS has implemented or is in the process of implementing all the provider registration processes the federal government has established. Second, to help ensure that only eligible members are receiving Medicaid benefits, AHCCCS conducts a pre-approval investigation of applicants referred by Medicaid eligibility workers. Third, to help ensure that its contracted health plans comply with contractual requirements to prevent and detect fraud and abuse, AHCCCS has established a contractor oversight process.

AHCCCS has established or is establishing required provider registration activities—AHCCCS has established or is in the process of implementing procedures that ensure it complies with all federally mandated provider registration requirements and that only qualified providers are registered to provide Medicaid services. Specifically:

- **Registration of medical providers**—AHCCCS' Office of Inspector General (OIG), registers all medical providers who provide services to AHCCCS members. According to federal regulation, the registration process includes a background screening of all providers, including verification that the provider meets the requirements for professional licensure, certification, or registration, and is not excluded from providing Medicaid services per the U.S. Department of Health and Human Services' List of Excluded Individuals and Entities.<sup>1</sup>
- **Background checks**—According to federal requirements, AHCCCS must require providers to consent to criminal background checks, including fingerprinting for medical provider owners that have more than 5 percent ownership interest. However, according to a U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), rule issued in February 2011, Medicaid agencies will

<sup>1</sup> 42 CFR §§455.410, 455.412, 455.436, and 455.440

not be required to conduct criminal background checks on, or collect fingerprints of, providers, agents, or managing employees of high risk providers until CMS issues additional guidance about the process.<sup>1</sup> Therefore, according to AHCCCS, it is awaiting CMS' guidance before implementing criminal background checks as a component of the provider registration process. AHCCCS does require potential providers to disclose any criminal history on the provider registration application forms. This process is in accordance with federal requirements, which allows AHCCCS to refuse to enter into or renew an agreement with a provider if the provider owner or managing employee has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or Title XX Services Program.<sup>2,3</sup>

- **Provider agreements**—All medical providers must sign a provider agreement. By signing the agreement, the medical provider agrees to abide by 29 specific requirements (See textbox for examples of key requirements).

#### Key provider participation agreement requirements

- Complying with all federal and state laws, regulations, and standards.
- Complying with AHCCCS policy guidelines, including policies related to appropriate billing.
- Maintaining, retaining, safeguarding, and making all records available to AHCCCS for inspection and audit.
- Complying with AHCCCS rules and Arizona Administrative Code when adjudicating claims disputes or grievances.
- Referring all incidents of potential fraud or abuse identified to the OIG.

Source: Auditor General staff analysis of AHCCCS' provider registration agreement.

- **Unannounced site visits**—The Federal 2010 Patient Protection and Affordable Care Act (Act) requires that the OIG take additional steps in the provider registration process, including performing unannounced site visits (See textbox, page 13). CMS determined that these unannounced site visits should occur for all designated moderate and high-risk providers, which AHCCCS has determined would include rehabilitation centers and non-Medicare certified home healthcare facilities.<sup>4</sup> The purpose of these site visits is to ensure that information submitted to the OIG is accurate, and to determine

<sup>1</sup> 76 *Federal Register*, 5862, §11(A)(4)(d)

<sup>2</sup> 42 CFR §455.106

<sup>3</sup> Title XX of the Social Security Act references block grants to states for social services and elder justice.

<sup>4</sup> According to AHCCCS, it established a list of moderate and high-risk provider types based on Medicare regulations related to the categorical risk of providers. AHCCCS also reported that some home healthcare facilities have not gone through the Medicare certification process prior to registering with AHCCCS. AHCCCS requires only that these facilities are licensed with the Arizona Department of Health Services prior to beginning the provider registration process.

The Federal 2010 Patient Protection and Affordable Care Act requires that the OIG perform unannounced site visits to its providers.

compliance with federal and state provider enrollment requirements. According to information the OIG provided, it began performing pre-enrollment site visits in January 2012 and will perform unannounced post-enrollment site visits for all moderate- and high-risk providers during the provider reenrollment process, which takes place every 5 years.

The OIG is also taking steps to help prevent duplicate site visits. In addition to performing unannounced site visits of Medicaid providers, the Act requires Medicare to perform unannounced site visits of its providers. According to the OIG, in an attempt to prevent duplicated efforts between Medicare and Medicaid, the OIG has requested that the CMS furnish it with Arizona Medicare provider screening data, including the results of site visits for moderate- and high-risk Medicare providers. According to the OIG, having access to this information allows the OIG to determine whether Medicare has denied enrollment or terminated providers that may also be Medicaid providers.

- **Periodic federal review**—The OIG’s provider registration practices are subject to oversight and review every 3 years from the CMS. In 2010, the CMS published its most recent review of the OIG. This review identified a series of recommendations for improving AHCCCS’ provider registration practices. For example, the review recommended that the OIG modify the provider enrollment applications to capture the full range of required ownership, control, and relationship information for each provider, which would enable the OIG to easily determine the interrelationships between provider entities, related organizations, and subcontractors. Based on auditors’ review of the provider registration process, it appears the OIG has implemented the 2010 CMS recommendations. According to the OIG, in May 2012, the CMS was in the process of completing its 2012 review of the OIG. According to the OIG, this review would include determining whether the OIG had implemented the prior review’s recommendations.

AHCCCS conducts pre-approval investigations to ensure its members are eligible to receive benefits—The OIG has also implemented a pre-approval investigation process to prevent ineligible persons from receiving Medicaid benefits. AHCCCS and/or the Department of Economic Security (DES) determine each applicant’s eligibility in accordance with federal and state require-

### New federal provider registration requirements

- Renew registration every 5 years and pay an enrollment/renewal fee.
- Receive a site visit prior to enrollment for moderate- and high-risk providers, and be subject to unannounced site visits.
- Undergo a licensure verification.
- Undergo criminal background checks as applicable.

Source: Auditor General staff analysis of requirements outlined in the Federal 2010 Patient Protection and Affordable Care Act and 42 CFR §§455.412, 455.414, 455.432, and 455.434.

A 2010 CMS review identified a series of recommendations for improving AHCCCS’ provider registration practices, which the OIG appears to have implemented.

ments.<sup>1</sup> These requirements focus on applicants' financial status and other conditions, such as legally residing in the United States.<sup>2</sup>

The OIG's Fraud Prevention Unit (Unit) conducts pre-approval investigations for certain Medicaid applicants. The investigations are based on referrals from DES eligibility workers, who conducted approximately 82 percent of Medicaid eligibility determinations as of July 1, 2011.<sup>3</sup> AHCCCS officials said the Unit focuses on select DES referrals for these preapproval investigations because it does not have enough staff to take pre-approval investigation referrals from all eligibility case workers.

These investigations focus on persons whose applications raise issues that appear to need further review. DES policy cites several reasons for referring cases for investigation, including when it appears that the applicant provides supporting documentation that has been altered, that the applicant's expenses appear to exceed income, or the applicant provides conflicting answers during the eligibility interview. Unit investigators attempt to complete a pre-approval investigation within 3 days of receiving the referral from DES.<sup>4</sup> During the investigation, the investigator conducts a visit to the applicant's home to help determine the veracity of statements made or documents provided during the application process. The investigator must call DES with the results of the investigation immediately following the visit and complete a written report of his/her findings within 30 days of the referral date. According to AHCCCS, DES generally makes the eligibility determination after the Unit calls with the investigation's results.

These investigations have identified a number of people who are found to be ineligible. According to the OIG, in fiscal year 2012, the Unit finished 5,334 pre-approval investigations resulting in 1,867 cases, or 35 percent, of the applicants being determined ineligible for benefits. According to the OIG, this resulted in estimated cost savings to the program of approximately \$16.9 million.

AHCCCS oversees its contracted health plans' efforts to prevent and detect fraud and abuse—AHCCCS has established requirements related to preventing and detecting fraud and abuse in its health plan contracts and associated *Contractor Operation Manual (Manual)*.<sup>5</sup> Consistent with federal regulation, AHCCCS requires its contracted health plans to implement a manda-

<sup>1</sup> AHCCCS has an intergovernmental agreement with DES to conduct Medicaid eligibility because DES performs this function for other programs, such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families program.

<sup>2</sup> For a more complete discussion of AHCCCS eligibility requirements, see the Arizona Office of the Auditor General's Report on AHCCCS Medicaid Eligibility Determination, Report No. 12-02.

<sup>3</sup> See the Arizona Office of the Auditor General's Report on AHCCCS Medicaid Eligibility Determination, Report No. 12-02.

<sup>4</sup> OIG officials reported that many of these investigations are completed within 24 hours.

<sup>5</sup> According to the health plan contracts, all AHCCCS guidelines, policies, and manuals are incorporated by reference into the contract, and the contractor is responsible for complying with the requirements set forth in the guidelines, policies, and manuals.

The OIG reported that its Fraud Prevention Unit identified 1,867 applicant cases that were ineligible for benefits in fiscal year 2012, resulting in an estimated cost savings of approximately \$16.9 million.

tory compliance program that is designed to guard against fraud and abuse.<sup>1</sup> This mandatory compliance program includes several elements, such as establishing written policies, procedures, and conduct standards that ensure that the health plan and its staff understand and comply with federal and state fraud and abuse requirements (see textbox).

To ensure that health plans are performing required fraud and abuse prevention and detection activities, in addition to meeting numerous other contract requirements, AHCCCS conducts two contractual reviews that are relevant to fraud and abuse prevention and detection. Specifically:

- **General contract review**—AHCCCS performs a triennial review of each contracted health plan. These reviews typically assess compliance with some general requirements related to fraud and abuse prevention and detection such as healthcare claims administration and processing.
- **Focused fraud and abuse contract reviews**—In addition to the triennial review, and in response to heightened scrutiny of Medicaid fraud and abuse prevention and detection practices generally and from within AHCCCS, during May and June 2012, AHCCCS conducted a focused audit of six items at each contracted health plan related to fraud and abuse prevention and detection. For example, in this focused audit, AHCCCS reviewed items such as whether the health plan had established a compliance program designed to prevent and detect fraud and abuse. AHCCCS determined that the contracted health plans were in full compliance with all six elements reviewed. However, according to AHCCCS, if it had determined that a health plan had not met contractual requirements, the health plan would be required to develop a corrective action plan. If upon followup by AHCCCS the health plan did not appear to be making attempts to correct deficiencies, other penalties could be applied, such as monetary sanctions or termination of the contract.

### Key compliance program requirements

- Written policies, procedures, and conduct standards that ensure compliance with all applicable federal and state requirements.
- A compliance officer and a compliance committee that assists the compliance officer in monitoring the effectiveness of the compliance program and timeliness of reporting fraud.
- Effective training and education for health plan staff and providers, including training on the provisions in the federal False Claims Act.
- Internal monitoring and auditing processes, including prompt responses to problems detected.

Source: Auditor General staff analysis of AHCCCS health plan contracts.

<sup>1</sup> 42 CFR §438.608

## AHCCCS should regularly update its fraud and abuse training and continue to enhance its data analysis capabilities

Although AHCCCS has established measures to help prevent and detect fraud and abuse, it should enhance its efforts in two areas. First, AHCCCS provides Medicaid fraud and abuse training to health plans, providers, and eligibility caseworkers, but can increase its training effectiveness by developing and implementing a plan to regularly update its training. Second, similar to practices in other states, AHCCCS uses an analytical tool to detect patterns indicative of provider fraud and abuse, but should continue working to increase its data analysis capabilities.

**OIG should regularly update its fraud and abuse training**—Although the OIG develops and provides training on Medicaid fraud and abuse to the contracted health plans, registered providers, and eligibility caseworkers, it should develop a plan for regularly updating this training to reflect current fraud and abuse prevention and detection trends. The CMS' *Guidelines for Addressing Fraud and Abuse in a Managed Care System* suggest that states educate members and providers about fraud and abuse identification and reporting and train managed care organizations on prevention, detection, reporting, and investigation of fraud and abuse. In line with these guidelines, the OIG has provided the following training:

- **Training for contracted health plans and providers**—The OIG makes training available for its contracted health plans and providers on AHCCCS' Web site. Among other things, this training provides the definition of fraud and identifies avenues for reporting suspected fraud and abuse to the OIG. Although the OIG does not require its contracted health plans or providers to complete the online training, as previously indicated, AHCCCS requires the contracted health plans to provide training related to fraud and abuse to their staff and contracted providers. In addition, the OIG reported that, when it meets quarterly with its contracted health plans, it discusses changes in regulations and new trends in fraud and abuse.
- **Training for eligibility caseworkers**—The OIG has also developed mandatory computer-based training for AHCCCS and DES eligibility caseworkers. Similar to the training that AHCCCS provides to its contracted health plans, this training also defines fraud and how to report fraud and abuse to the OIG. In addition, this training provides examples of fraud cases. According to the OIG, it plans to update and provide more extensive training to DES eligibility caseworkers in 2012 about the fraud referral process.<sup>1</sup> Further, it is using DES' policies and procedures related to fraud referrals, and working with DES management to develop this training. According to OIG officials, after this

<sup>1</sup> The OIG has not yet established specific dates for this training.

The OIG reported that it plans to update and provide more extensive training to DES eligibility caseworkers in 2012 about the fraud referral process.

training has been initially implemented, the OIG will continue to provide additional training about new issues in Medicaid fraud and abuse as the need arises.

- **Information for the public**—The OIG provides information on its Web site to help educate citizens on the topic of Medicaid fraud and abuse. Specifically, similar to the training that AHCCCS provides for its contracted health plans and eligibility workers, AHCCCS defines fraud and provides avenues for reporting suspected fraud and abuse to the OIG for the public.

Although the OIG has developed Medicaid fraud and abuse training, it does not have a plan for updating its fraud and abuse training for eligibility caseworkers on a regular basis. For example, the OIG's training for eligibility caseworkers is not regularly updated based on emerging member fraud and abuse trends as identified by OIG investigations. Therefore, eligibility caseworkers may not be aware of these trends. To enhance the effectiveness of its training, the OIG should develop a formal plan to regularly update its fraud and abuse prevention and detection training and other guidance based on current trends and practices identified by its staff. The OIG should determine the frequency of the updated training that it offers and also determine whether it could use avenues other than formalized training to offer guidance on the latest trends in fraud and abuse prevention and detection such as e-mail notifications or policy bulletins.

**AHCCCS should continue to enhance its fraud and abuse detection efforts**—AHCCCS should continue to enhance its data analysis capabilities. AHCCCS uses a contractor, EDI Watch, Inc., to help detect fraud and abuse. According to AHCCCS, it forwards medical claims data to the contractor every 3 months. The contractor analyzes the claims data using algorithms, which look for known fraud patterns, such as providers billing for services not provided. The contractor then returns the results to the OIG for further review and potential investigation. In addition, according to AHCCCS, in June 2012, it entered into a partnership with the CMS and a CMS contractor to obtain additional claims data matching information. Specifically, the OIG will have access to a single repository that contains both Arizona Medicare and Medicaid information. According to the CMS contractor, this data-matching capability will allow the OIG to identify improper billing and utilization patterns that would not be identified if the Medicare and Medicaid data sets were reviewed independently. Further, the OIG reported that it has requested access to the CMS' Medicare Fraud Investigation Database (database). The database is a nation-wide repository for Medicare fraud and abuse investigations, cases, and payment suspensions. According to the OIG, the database would be a useful reference tool for state Medicaid agencies because states could use the Medicare information to help combat Medicaid fraud and abuse. For example, states could use the database information about a Medicare provider that has been suspended for engaging in fraudulent activities to suspend that same provider from providing Medicaid services.

AHCCCS uses a contractor to evaluate its claims data to identify known fraud patterns, such as providers billing for services not provided.

Based on discussions with the CMS and state Medicaid officials from California, Illinois, Maryland, and Texas, data analysis techniques are an essential practice in detecting and preventing fraud and abuse.<sup>1</sup> However, no specific use of these techniques has been established as a best practice because they are regularly evolving. For example, these states all reported that they had implemented or were in the process of upgrading analytical tools with capabilities similar to the EDI Watch analytical tool such as looking for known fraud patterns for a given provider. In addition, these states reported that they were looking into implementing data tools with social network analysis capabilities. These capabilities would allow for an evaluation of potential linkages across providers and institutions to identify larger fraud schemes. For example, one state reported that social network analysis software will allow it to see relationships between a provider and a member that have the same address. A provider billing for services for a member living in the same household could be a potential indicator of fraud. At the time of the audit, AHCCCS did not have the capability of performing social network analysis.

As required by Laws 2011, Ch. 31, AHCCCS awarded a contract to establish mechanisms that reduce erroneous and fraudulent payments. To fulfill this legislative requirement, on December 12, 2011, AHCCCS entered into a contract with three companies for data analytics consulting services. Under this contract, AHCCCS plans to issue project orders for specific consulting services tasks. AHCCCS issued its first project order for consulting services on March 6, 2012. According to AHCCCS, the goal for the first project order was to have a contractor use the EDI Watch tool to identify leads, validate leads, and then conduct investigations based on the leads. AHCCCS indicated that one of the three contractors showed some interest in the project order, but ultimately AHCCCS did not receive any responses. According to AHCCCS, it plans to contact the contractors to determine why they did not respond and decide the next steps for issuing another project order. Additionally, since data analysis techniques are regularly evolving, AHCCCS should continue to identify areas where its data analysis capabilities can be enhanced and work to improve these methods.

## Recommendations:

- 1.1 The OIG should develop and implement a formal plan to regularly update its Medicaid fraud and abuse prevention and detection training and other guidance based on trends its staff identify. The OIG should determine the frequency of the updated training that it offers and also determine whether it could use avenues other than formalized training to offer guidance on the latest trends in fraud and abuse prevention and detection, such as e-mail notifications or policy bulletins.

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<sup>1</sup> On April 11, 2012, CMS officials identified Illinois, Texas, and Maryland as innovators in data analysis techniques. In addition, another state's audit report cited California for its data analysis practices.

AHCCCS should continue to identify areas where its data analysis capabilities can be enhanced.

1.2 AHCCCS should continue to identify areas where its fraud detection data analysis capabilities can be enhanced and work to implement improved methods.



## FINDING 2

The Arizona Health Care Cost Containment System's (AHCCCS) Office of Inspector General (OIG) needs to enhance its processes for investigating potential fraud and abuse cases. Auditors' review of the OIG's investigative case data as of July 3, 2012, found that although many cases are investigated and closed within 180 days, many are also taking more than 1 year to investigate and close or have been waiting to be assigned for investigation for more than 1 year. To ensure the most important cases are being worked first, the OIG's Member Compliance unit should reevaluate the factors it considers when screening and prioritizing cases for investigation and develop and implement a written case-screening policy. The Provider Compliance unit should also develop a formal screening process with clear guidelines for deciding which cases to prioritize for investigation. In addition, both the Member and Provider Compliance units should strengthen policies regarding supervisory case reviews. Further, auditors' review of OIG records showed instances of incomplete or inaccurate investigative information. Therefore, the OIG should take steps to ensure the completeness and accuracy of this information.

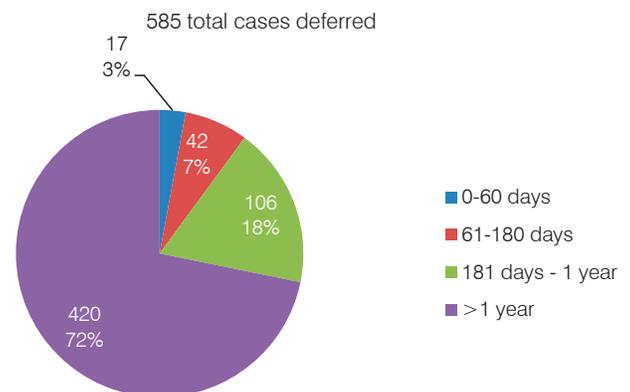
# AHCCCS should enhance processes for investigating cases of suspected fraud and abuse

## Many fraud and abuse referrals not investigated in a timely manner

The OIG does not consistently investigate cases of suspected fraud and abuse in a timely manner. First, the OIG places many fraud and abuse referrals it cannot investigate right away in deferred status, and many deferred cases are not opened for 1 year or more. Second, although the OIG resolves many of the cases it opens for investigation fairly quickly, auditors found that about 28 percent of investigations the OIG resolved during fiscal years 2010 through 2012 took from 6 months to more than 1 year to resolve. Third, many investigations that were assigned to an investigator during this audit had been open for 1 year or more. Specifically:

- **Many suspected fraud and abuse case referrals are deferred for investigation**—A sizeable number of fraud and abuse referrals are not opened for investigation right away, and in many cases, are not opened for 1 year or more. Specifically, auditors' review of data provided by OIG staff found that more than 580 cases were in deferred status as of July 3, 2012; that is, they had yet to be opened for investigation.<sup>1</sup> As shown in Figure 1, 72 percent of these cases had been deferred for investigation for more than 1 year, including 2 provider fraud cases that had been deferred for more than 5 years.

Figure 1: Age of Deferred Cases As of July 3, 2012 (Unaudited)



Source: Auditor General staff analysis of unaudited data obtained from the OIG's case management system for cases in a deferred status as of July 3, 2012.

<sup>1</sup> Although auditors found some inaccurate dates and could not verify some dates in the information provided by the OIG, auditors determined that the data were sufficiently reliable for the purpose of assessing case processing time frames (See Appendix A, page a-ii, for more information on data validation).

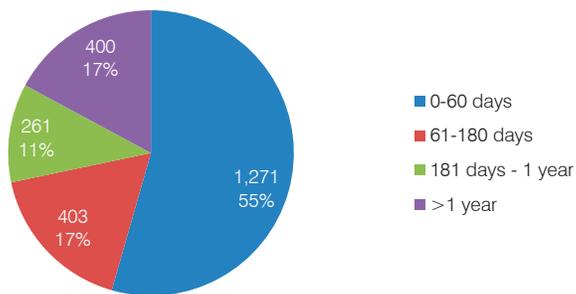
- **Closed case data shows that many investigations take a long time to resolve**—Although the OIG resolves many of the cases it opens

for investigation fairly quickly, some investigations take a long time. As shown in Figure 2, of the more than 2,300 cases the OIG resolved between fiscal years 2010 and 2012, auditors found that 1,674 of those cases, or approximately 72 percent, were processed within 180 days after receiving the case referral.<sup>1</sup> Most of the cases processed within 180 days were resolved without criminal prosecution or civil settlement and included complaints that fell outside of the OIG’s jurisdiction, or allegations that could not be substantiated.

However, auditors found that many cases took much longer to resolve. Specifically, as shown in Figure 2, approximately 660 cases took more than 180 days to resolve, with 400 of these cases taking more than 1 year to resolve. For example, auditors found that one case remained open but unworked for 1 year due to other investigative priorities. Another case remained open for 4 years before resolution, and OIG officials could provide no explanation for why the case took this much time to resolve.

Figure 2: Investigative Case-Processing Time For Cases Closed In Fiscal Years 2010 through 2012 (Unaudited)

2,335 total cases closed



Source: Auditor General staff analysis of unaudited data obtained from the OIG’s case management system for cases closed during fiscal years 2010 through 2012.

- **Open case data shows that many investigations remain open for a long time**—Auditors found that although most cases assigned for investigation as of July 3, 2012, were fairly new, having been under investigation for 180 days or less, many cases were older, having been open for a year or more. As shown in Figure 3 (see page 23), auditors’ analysis found that 182 of the 300 cases open as of July 3, 2012, or approximately 61 percent of the cases assigned to OIG investigators, had been open for 180 days or less.<sup>2</sup> However, 41 cases (13.7 percent) had been open between 181 days and 1 year, and 77 cases, (25.6 percent) had been open for more than 1 year, including 3 cases that had been open for investigation for more than 4 years.

OIG officials stated that there are many factors that may influence the time it takes to investigate a referral, such as the time needed to subpoena information, and a lack of experienced investigative staff resulting from high staff turnover. AHCCCS has been able to obtain additional staff to help address the number of unopened cases and improve the timeliness of its investigations, but this action alone appears unlikely to resolve these issues. If referrals are not investigated in a timely manner, either due to an initial deferral or a lengthy investigation, the OIG risks compromising its ability

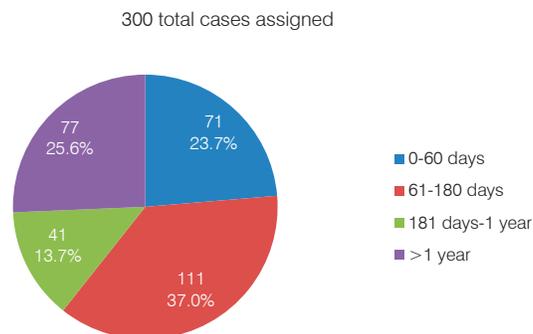
OIG officials stated that the time needed to subpoena information and a lack of experienced investigative staff resulting from high staff turnover influence the time it takes to investigate a referral.

<sup>1</sup> The count of cases closed within 180 days included residency projects, which involve the verification of residency for Medicaid applicants. These residency projects involve hundreds of potential Medicaid recipients and generally take less time than a fraud and abuse investigation to complete—usually between 1 day and 2 weeks. OIG officials reported that prior to fiscal year 2012, the Member Compliance unit performed residency projects. In fiscal year 2012, these residency projects were transferred to the Fraud Prevention Unit.

<sup>2</sup> Auditors calculated the amount of time a case had been open based on the investigator assignment date, which does not include any time a case may have spent in deferred status.

to gather evidence and follow leads that might become stale as the cases age. OIG officials have attributed the increasing number of deferred cases and the increases in investigation time to a lack of available staff to investigate referrals, and they have included a request for additional staff in budget submissions for each of fiscal years 2011 through 2013.<sup>1</sup> In 2011, the OIG was authorized to hire five additional staff members. An OIG official reported that all five positions had been filled as of July 2011, with three of these positions designated for investigative staff and the other two positions designated for administrative staff within the OIG. However, given the number of cases awaiting an investigation and the age of the cases, additional measures will be needed.

Figure 3: Age of Assigned Cases As of July 3, 2012 (Unaudited)



Source: Auditor General staff analysis of unaudited data obtained from the OIG's case management system for cases assigned for investigation as of July 3, 2012.

## Additional efforts needed to ensure highest priority cases are worked first and investigations progress as quickly as possible

The OIG should enhance its case prioritization and supervisory review processes. If the OIG is unable to open all of its fraud and abuse investigations in a timely manner, it should have a process in place to ensure that the cases with the best chance of resulting in a recovery or cost savings to AHCCCS are prioritized for investigation. However, the OIG lacks a formalized process for prioritizing fraud and abuse investigations. To help ensure that its staff focus on the most important cases, the OIG should (1) reevaluate the factors considered by the Member Compliance unit when assigning priority levels and develop and implement a written policy to guide Member Compliance staff in prioritizing cases, and (2) establish a case-screening process to guide its Provider Compliance unit in making decisions about when to open, close, or defer cases for investigation. In addition, the OIG should strengthen its supervisory review policies in both the Member and Provider Compliance units to ensure that investigations are completed as quickly as possible and that policies are consistent with its practices.

### OIG lacks formalized processes for prioritizing fraud investigations—

Standards for successful investigations highlight the importance of establishing and documenting a process for investigative case screening. Such a process becomes even more important if all cases cannot be opened and investigated in a timely manner. Therefore, a critical part of such a process is deciding which cases should

Standards for successful investigations highlight the importance of establishing and documenting a process for investigative case screening.

<sup>1</sup> The OIG's request for additional staff for fiscal year 2013 was specific to Provider Registration unit staff in order to compensate for the additional workload imposed by new provider enrollment requirements required by the 2010 Federal Patient Protection and Affordable Care Act.

**Recovery**—Reclamation of monies paid erroneously because of Medicaid fraud or abuse by members or providers.

**Cost savings**—Savings to AHCCCS as a result of discontinuing benefits for members found to be erroneously receiving Medicaid benefits because of Medicaid fraud or abuse, or as a result of preventing ineligible applicants from receiving benefits in the first place.

Source: Auditor General staff analysis of information provided by the OIG.

receive priority. The Commission on Accreditation for Law Enforcement Agencies, which published *Standards for Law Enforcement Agencies (Standards)*, recommends a case-screening system with the objective of assigning available personnel to investigations that have the best chance of being resolved.<sup>1</sup> According to the *Standards*, adherence to such a practice should provide administrators with improved management control over the productivity of investigations. This objective is important because many cases referred for investigation may not be able to be resolved and result in a recovery and/or cost savings (see textbox). For example, auditors' analysis of the OIG's closed case data found that approximately 67 percent of the provider fraud cases closed in fiscal year 2012 did not result in a criminal prosecution or civil settlement agreement. Reasons that these cases did not result in recoveries included investigative findings indicating that no fraud or abuse was found, and identification of billing errors that the contracted health plans were directed to correct.

The OIG's Member Compliance unit, which investigates alleged fraud and abuse cases involving AHCCCS members, and its Provider Compliance unit, which investigates alleged fraud and abuse cases involving AHCCCS providers, use different approaches to informally prioritize cases for investigation. Specifically:

- **Member Compliance unit lacks written guidelines for case prioritization—**  
The Member Compliance unit does not have written guidelines for prioritizing the member fraud and abuse case referrals it receives. Instead, staff reported that when making decisions about whether to open, close, or defer a case, they consider factors such as whether the case has been referred by law enforcement, or can be resolved quickly and with a minimum of effort, such as complaints related to Arizona residency concerns or members with other health insurance responsible for paying some or all of the member's healthcare costs. Although Member Compliance unit staff reported attempting to implement an informal case prioritization system that included three priority levels, an AHCCCS official said almost all cases appear to fall within the highest priority level.
- **Provider Compliance unit lacks written guidelines for case-prioritization—**  
The Provider Compliance unit also does not have written case-prioritization guidelines, but reported that its staff have prioritized fraud and abuse case referrals for investigation as high, medium, or low priority through a case-by-case consideration of factors such as the egregiousness of the reported fraud and the potential for recovering monies. However, without a formalized process, the Provider Compliance unit risks inconsistently prioritizing cases, which could compromise its ability to focus on cases with the best chance of recovery.

<sup>1</sup> Commission on Accreditation for Law Enforcement Agencies, Inc. (2006). *Standards for law enforcement agencies*. (5th ed.). Fairfax, VA: Author.

Without a formalized case-prioritization process, the OIG's Provider Compliance unit risks inconsistently prioritizing cases.

Establishing and implementing written case-screening processes would help both units target their investigative efforts. These case-screening processes could also help the OIG reduce the number of unopened cases for investigation by identifying alternatives to deferring cases for later investigation. These case-screening processes should incorporate the following:

- **A prioritization system defining when cases should be immediately assigned, deferred, or closed**—Consistent with the *Standards*, the OIG should reevaluate the factors it considers when assigning priority levels for member fraud cases to help its investigative staff focus its efforts on the cases that have the best chance of being successfully resolved. In addition to the factors it already considers, the OIG should leverage the experience of its staff and the outcomes of previously closed member fraud and abuse cases to help identify common characteristics that lead to a recovery or cost savings such as the type of fraud or abuse, the referral source, the quality of initial evidence provided, whether the member had previous referrals, or the amount of capitation payments. For example, as shown on page 1 (see textbox), the average monthly capitation payment for an ALTCS member is \$3,000 per month, while the capitation payment for a male age 14-44 in the Acute Care program is \$138 per month. Once the OIG has reevaluated the factors it will consider when prioritizing cases for investigation, it should establish a written policy indicating how it will prioritize cases as well as decide when cases should be immediately assigned, closed, or deferred.

In addition, the OIG should develop and implement a case screening and prioritization process for its Provider Compliance unit that will allow its staff to focus their efforts on the cases that have the best chance of being successfully resolved. Factors considered and established in the OIG's Member fraud case screening and prioritization process could also be used in its provider fraud case screening and prioritization process. For example, information gained from an analysis of closed cases could be used to identify important factors to consider in the initial case-screening processes, such as the type of fraud or abuse, the amount of suspected fraud or abuse, the referral source, the quality of the initial evidence provided, and whether the provider has any previous referrals.

- **Greater emphasis on closing out cases that are not likely to result in a recovery or cost savings**—Once these case-screening processes are established, the Member and Provider Compliance units should use them to reassess and reprioritize cases as they move them from deferral to assignment to an investigator to ensure these cases still warrant investigation. In doing so, the OIG should close out cases that are not likely to result in a recovery or cost savings, given the factors of the case.

The OIG should leverage experience its staff and the outcomes of previously closed cases to identify additional factors that lead to a recovery or cost savings.

The OIG has not established investigative time frames, but supervisors hold meetings to discuss case progress at 60-day intervals.

- **A formal process for referring nonfraud provider cases to health plans for investigation**—Although the OIG refers some nonfraud provider cases to AHCCCS’ contracted health plans for additional review, this process is not formalized. Therefore the OIG should formalize its process for referring nonfraud cases to its contracted health plans. In formalizing this process, the OIG should also establish baseline factors for determining if it will investigate a case or if a case should be referred to the contracted health plans for additional review. For example, the OIG refers some cases that appear to be related to billing errors and not fraud or abuse to the contracted health plans.

**AHCCCS should strengthen supervisory case review policy—**

Although the OIG has not established a standard for how long an investigation should take, in practice, supervisors hold meetings with investigative staff at 60-day intervals to discuss investigative activities. The OIG’s policy requires a written summary report of all investigative activities for open cases at either 60- or 90-day intervals; however, according to the OIG, this policy is not being followed because it instead conducts 60-day meetings to discuss investigative activities.

Auditors did not find any specific best practice information related to fraud and abuse investigation timeliness. Performance standards established by the U.S. Department of Health and Human Services, Office of Inspector General, which were updated in June 2012, indicate only that fraud investigations should be completed in an appropriate time frame based on the complexity of the cases. However, the Arizona Office of the Auditor General has found that Arizona health regulatory boards should resolve complaints against licensees within 180 days from the time the complaint was received until it was closed. This time frame includes opening, investigating, and resolving the complaint. Auditors found that the OIG completed approximately 72 percent of the more than 2,300 investigations conducted between fiscal years 2010 and 2012 within 180 days of receiving the referral. However, other benchmarks may be more appropriate.

Additionally, auditors found that some other states have established time frames for conducting specific investigative activities. For example, Tennessee allows a 60-day time period for investigators to request and evaluate documentation, following which it decides whether to refer a case for prosecution, impose a civil penalty, or close the case. In addition, Texas has established an 8-week default investigative time frame and requires that investigators complete a detailed case plan at the beginning of an investigation that outlines the steps that should be taken during the 8-week time frame. Texas may take action to resolve a case at any point during this time frame, including closing the case or pursuing administrative penalties and overpayment amounts.<sup>1</sup>

<sup>1</sup> Tennessee and Texas reported providing exceptions to allow investigators to continue working a case beyond established time frames if a reasonable likelihood exists that the investigation will result in a successful conclusion.

To help ensure that the OIG's fraud and abuse investigations are being conducted in as timely a manner as possible, the OIG should strengthen its policy regarding supervisory case reviews to reflect its practice of conducting 60-day case reviews. In addition, its policy should require that, during its reviews of fraud and abuse investigations, supervisors and staff discuss whether an investigation should continue or be closed. If continued, supervisors and staff should discuss the next steps required and should also review whether cases are progressing in a timely manner. The decisions made during this review should be documented.

## OIG should establish procedures to ensure completeness and accuracy of investigative information

The OIG should establish procedures for ensuring the completeness and accuracy of its investigative information. Complete and accurate information is important for various case management functions, including assessing investigation timeliness, determining whether any new provider or member referrals have received previous referrals, and developing the case screening process discussed previously. However, auditors noted some problems with the completeness and accuracy of the OIG's data. Specifically, auditors' review of a sample of 30 case files out of the 513 total member and provider fraud cases closed in calendar year 2011 found that some case management information could not be verified. For example, 6 of the 24 cases reviewed were missing case file documentation supporting the date the referral was assigned for investigation.<sup>1</sup> Additionally, 4 of the 24 cases were missing case file documentation supporting the date the investigation was completed. Without hardcopy documentation supporting dates entered into the case management system, the OIG cannot ensure the accuracy of information in its case management system.

In addition, auditors identified some case management data inaccuracies. For example, OIG staff had either omitted or mistyped the provider's unique identification number into the case management system for 7 of the cases reviewed. Ensuring accuracy of provider identification numbers would be important for determining whether providers have had previous referrals. In another example, 6 of the 24 cases reviewed had inaccurately recorded the date the case was assigned to an investigator, although 4 of the 6 dates differed by less than 2 weeks. OIG staff reported that a new case management system is in development, and is expected to be operational some time in calendar year 2014. In the meantime, its current case management system is undergoing enhancements, one of which will allow for automatic population of demographic information, such as member and provider identification numbers. These enhancements, which are expected to be implemented by October 2012, will address some, but not all, of the inaccuracies found during auditors' review.

Auditors noted some problems with the completeness and accuracy of the OIG's case management data.

<sup>1</sup> Six of the cases auditors reviewed did not require assignment or case completion dates because they were investigated by other entities, such as the Arizona Attorney General's Medicaid Fraud Control Unit.

To ensure the OIG has complete and accurate information that can be effectively used for management purposes, the OIG should (1) establish a formal case closeout procedure to ensure that case management information and archived records contain all important documents and information; (2) complete development and implementation of its new case management system; and (3) ensure that key fields in its case management information system, such as provider identification numbers and dates, are accurate.

## Recommendations:

- 2.1 The OIG should enhance its processes for investigating fraud and abuse cases in a timely manner. Specifically:
  - a. To improve its member fraud case screening and prioritization process, the OIG should reevaluate the factors it considers when assigning priority levels for member fraud cases. In addition to the factors it already considers, the OIG should consider past trends in previously closed member fraud and abuse cases to identify common characteristics that lead to a recovery or cost savings. Further, information gained from an analysis of closed cases could be used to identify important factors to consider in the initial case-screening processes, such as the type of fraud or abuse, the referral source, the quality of initial evidence provided, whether the member had previous referrals, and the amount of capitation payments;
  - b. Once it has reevaluated the factors it will consider when prioritizing cases for investigation, the OIG should establish a written member fraud case screening and prioritization policy for its Member Compliance unit indicating when cases should be immediately assigned, closed, or deferred;
  - c. The OIG should develop and implement a written case screening and prioritization policy to determine when provider fraud cases should be assigned, closed, or deferred for its Provider Compliance unit;
  - d. Once these case screening and prioritization processes are established, the Member and Provider Compliance units should use them to reassess and reprioritize cases as they move them from deferral to assignment to an investigator to ensure these cases still warrant investigation, and close out any cases that are not likely to be successfully resolved given the factors of the case;
  - e. The OIG should formalize its process for referring nonfraud cases to its contracted health plans. In formalizing this process, the OIG should

establish baseline factors for determining if it will investigate a case or if a case should be referred to the health plans for additional review;

- f. The OIG should strengthen its policy regarding supervisory case reviews to reflect its practice of conducting 60-day case reviews. The policy should further require that, during these reviews, supervisors and staff should discuss whether an investigation should continue or be closed. If continued, supervisors and staff should discuss the next steps required, and should also review whether cases are progressing in a timely manner. In addition, the decisions made during this review should be documented.

2.2 To ensure the OIG has complete and accurate information that can be effectively used for management purposes, the OIG should:

- a. Establish a formal case closeout procedure to ensure that case management information and archived records contain all important documents and information;
- b. Complete development and implementation of its new case management system; and
- c. Ensure that key fields in the case management information system, such as provider identification numbers and dates, are accurate.



## FINDING 3

The Arizona Health Care Cost Containment System's (AHCCCS) Office of Inspector General (OIG) needs to make several changes in its processes for recovering Medicaid payments made in cases of fraud or abuse to ensure maximum benefit to the State. Auditors identified four problem areas. First, based on auditors' review of civil settlement documentation, it is not clear if the OIG is seeking the maximum amounts allowed by statute and rules in civil settlements. Second, the OIG has not established adequate procedures to ensure federally mandated reporting of recoveries is accurate. Auditors' review of a sample of cases found errors totaling approximately \$12,800. Third, the OIG has not established a formal collection policy or program, making it more difficult to collect the more than \$2 million in recovery debts that are more than 90 days past due. Finally, the OIG lacks adequate cash-handling procedures. As a result, the OIG should:

- Better document factors considered in determining settlement amounts;
- Accurately report recovery amounts to the federal government;
- Improve its collections program; and
- Improve its cash-handling procedures.

# AHCCCS' OIG should improve procedures related to its recovery processes

## Settlement decisions should be clearly documented

One of the first steps in the recovery process is establishing a repayment amount. Repayment amounts are established in two ways: (1) in criminal cases, by a court through restitution agreements when a member or provider has been convicted of a criminal offense; or (2) in civil cases, by the OIG through civil settlement agreements.<sup>1</sup> As shown in Table 6, in calendar year 2011, the OIG reached civil settlements totaling almost \$3.3 million.<sup>2</sup>

Table 6: Repayment Amounts Established by 2011 Civil Settlements (Unaudited)

OIG Unit	Cases Settled	Repayment Amounts
Investigative Analysis	24	\$ 741,813
Member	23	385,488
Provider	49	2,172,445
<b>Totals</b>	<b>96</b>	<b>\$ 3,299,746</b>

Source: Auditor General staff analysis of data obtained from the OIG's case management system in February 2012 for cases that were closed between January 1, 2011 and December 31, 2011.

Administrative rules provide the OIG with guidelines on what specific circumstances to consider when determining civil settlement amounts, including civil assessments and penalties above the original amount paid to providers or benefits paid on behalf of members. These circumstances are of two types: mitigating circumstances, which would tend to reduce settlement amounts, and aggravating circumstances, which would tend to increase them. For example, one of the mitigating circumstances outlined in the rules is whether a provider took prompt corrective action after a billing error was discovered, while an example of an aggravating circumstance is whether a provider has forged, altered, recreated, or destroyed records.

<sup>1</sup> Some civil settlements are established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which returns to states recoveries from cases that affect multiple jurisdictions.

<sup>2</sup> In calendar year 2011, in addition to the civil settlement agreements, there was also nearly \$1.2 million in court-ordered restitution established.

The OIG does not consistently document the specific mitigating or aggravating circumstances considered in its settlement decisions.

Because the OIG is not consistently documenting how its consideration of such circumstances impacted its settlement decision, it is unclear if it is pursuing the maximum civil settlement amounts allowed by state law and rules. Auditors reviewed 30 cases closed during calendar year 2011, three of which resulted in civil settlements established by the OIG with providers.<sup>1</sup> In two of the three settlements, the specific mitigating or aggravating circumstances considered in the settlement decision were not documented. Specifically:

- **Case 1**—The OIG established repayment of \$900,000, but the investigative report indicated that a provider had fraudulently billed for services that were not needed and identified a much greater amount—more than \$4 million as a loss to AHCCCS. There is no documentation indicating why the OIG did not seek to recover the full amount identified as an overpayment by the investigator and instead settled for the lower amount.
- **Case 2**—In this case, the OIG established repayment of the original amount billed in error plus investigative costs, but did not assess any penalties. However, the case file did not clearly explain whether mitigating or aggravating circumstances were present or otherwise considered in the settlement decision. Therefore, it is unclear whether the OIG's decision to not assess penalties was appropriate.
- **Case 3**—In this case, the OIG established repayment of the actual overpayment plus investigative costs and a 20 percent penalty. Unlike the previous two cases, the settlement agreement specifically indicated that no mitigating factors were found in the investigation and cited the specific aggravating factors considered in arriving at the settlement decision, including a statement that the provider knew or should have known that services billed were not permitted to be claimed.

By inconsistently documenting the specific mitigating and aggravating circumstances, it is not clear that the OIG is seeking the maximum amount allowed by state laws and rules based on the facts of the case. Therefore, the OIG should document, in its investigative case files, the specific considerations used to arrive at a settlement decision.

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<sup>1</sup> Auditors' review included 21 provider cases and 9 member cases. Of the 21 provider cases, 3 had civil settlements executed by the OIG. The additional provider cases were resolved through other means, including civil settlements reached by federal entities, or determinations that no fraud or other improper payments were found (See Appendix A, page a-ii through a-iii, for additional information on the sample and auditors' review).

## AHCCCS needs additional procedures to ensure federal recovery reporting is accurate

After a recovery amount is established in a civil settlement or restitution agreement, AHCCCS must report these amounts to the federal government. As explained in the Introduction (see pages 7 through 8), the federal government's contribution to Arizona's Medicaid program is then reduced proportionately in a future period by the recovery amounts reported. However, the OIG lacks sufficient procedures for accurately reporting recoveries to the federal government. Auditors' reviewed a sample of 25 cases with recovery values totaling almost \$1.1 million out of 117 cases with recoveries that were reported to the federal government between January 1, 2011 and March 31, 2012, and identified four reporting errors that resulted in an erroneous reduction of approximately \$12,800 of the federal share of monies to AHCCCS. Specifically:

- **Federal share inappropriately reduced by approximately \$2,700 because the OIG did not clearly identify that investigative costs were included**—AHCCCS is allowed to recover its investigative costs in civil settlements.<sup>1</sup> However, since investigative costs are subject to a lower rate of reduction in the federal share of monies to the State when compared to recoveries, the OIG must clearly indicate when investigative costs have been incurred along with recovery values. For example, investigative costs, when included in a civil settlement, reduce the federal share by only 50 percent, while recoveries awarded can reduce the federal share by as much as 76 percent.<sup>2</sup> For two of the four cases with errors, the OIG did not clearly indicate that its investigative costs were included with the recovery amounts reported. Since investigative costs are subject to a lower rate of reduction in federal monies to the State, this resulted in an erroneous reduction of approximately \$2,700 in federal funding.
- **Federal share inappropriately reduced by approximately \$9,000 because of miscalculation**—In one case, the OIG correctly determined how much an ineligible person had to repay, but then it inadvertently doubled the recovery calculation when reporting the case value to the federal government. This resulted in an erroneous reduction of approximately \$9,000 in federal funding to the State.
- **Federal share inappropriately reduced by nearly \$1,100 by failing to reflect adjustment in reported amount**—In another case, the OIG included a provision within the settlement agreement allowing for a reduction in the repayment amount if it was paid by a specified date. According to OIG payment records, the discount was honored, but the OIG did not communicate the necessary adjustment to the

The OIG lacks sufficient procedures to prevent reporting errors from occurring.

<sup>1</sup> A.R.S. §36-2918(B) and AAC R9-22-1102 and R9-22-1103

<sup>2</sup> Investigative costs are classified as administrative expenses, which are funded at a rate of 50 percent by the federal government; therefore, when investigative costs are incurred, AHCCCS must reduce the federal monies to the State by 50 percent.

federal government, resulting in an erroneous reduction of \$1,091 in federal funding to Arizona.

AHCCCS and the OIG need to correct these errors and also determine whether errors are present in the larger body of cases already reported to the federal government. If a state finds errors in its recovery reporting, federal regulation allows it to make corrections in future reporting periods and does not establish a time limit for making corrections.<sup>1</sup> During the March 2012 reporting period, AHCCCS corrected some of the errors identified above, but it should ensure adjustments are made for all errors identified by auditors. Given the amount of errors found in the auditors' sample, AHCCCS should review its prior reporting of recovery amounts to determine if there are additional errors. AHCCCS may want to limit its review to a reasonable time period, such as recoveries reported during fiscal years 2011 and 2012, and based on the findings, determine if it should review additional time periods. Once this review is complete, AHCCCS should report any necessary adjustments to the federal government.

Some steps have been taken to prevent future errors from occurring, but they need to be augmented. At the time of auditors' review, the OIG had not established sufficient procedures for ensuring accurate recovery information was reported to the federal government. However, in February 2012, the OIG began using a standard summary form that will help address some, but not all of the errors auditors identified. Specifically, this form will help ensure that investigative costs, which are subject to a lower rate of reduction in federal monies to the State, are clearly separated from other recovery amounts. However, three additional steps are needed:

- **Reconcile recovery records**—AHCCCS should also establish a process to periodically reconcile its federal recovery reporting records to OIG recovery records to ensure accuracy.
- **Secondary review**—To ensure that the amounts listed on the form are accurate and supported by case file information, and that there are no miscalculations such as duplicated values, the OIG should also conduct a secondary review of the summary form.
- **Tracking potential adjustments**—The new reporting form does not address whether the settlement agreement contains conditions that, if met, could reduce the recovery amount that was initially reported to the federal government. Therefore, to ensure that it reports to the federal government any necessary adjustments to previously reported recovery amounts, the OIG should establish a mechanism for tracking repayment agreements that have conditions potentially affecting amounts collected, such as discounts if repayment is made by a specified date. Such a mechanism would help ensure that the amount of the reduction is reported in a timely manner.

<sup>1</sup> 42 CFR §433.320(c)(2)

In February 2012, the OIG began using a standard form that will help address some of the reporting errors auditors identified.

## Limited collection procedures place recoveries at risk

Once repayment agreements are established, the OIG should have an effective collection program to collect debts owed to the State because amounts owed are often paid over time. The OIG has established some procedures for collecting past due balances, but has not established a formal collection program supported by written policies. Civil settlements and restitution agreements may result in a payment plan if the entire balance cannot be paid at the agreement date, and the OIG is responsible for collecting the balances due. According to unaudited data from the OIG's case management system, as of April 2012, the OIG has been successful in collecting almost \$7.2 million in payments for cases closed between January 1, 2009 and December 31, 2011.<sup>1</sup> However, as shown in Table 7, as of April 2012, there was nearly \$2.2 million in outstanding balances greater than 90 days past due.

**Table 7: Collection Balances Greater Than 90 Days Past Due As of April 2012 (Unaudited)**

Type	Number of Accounts	Amounts Owed
No payments as of April 2012	18	\$ 1,838,431
No payments since December 2011	23	342,487
Totals	41	\$ 2,180,918

Source: Auditor General staff analysis of data obtained from the OIG's case management system in April 2012 for cases that were closed between January 1, 2011 and December 31, 2011.

Past due balances need careful attention, because the longer an account is past due, the more difficult it becomes to collect the outstanding balance. Specifically, according to a member survey conducted by the Commercial Collection Agency Association (CCAA), the CCAA found that the probability of collecting on past due accounts decreases over time.<sup>2</sup> For example, after 1 year, the probability of collection is only 22.8 percent (see textbox). According to unaudited data from the OIG's case management system, as of April 2012, the OIG had a balance of more than \$820,000 in accounts that were greater than 1 year past due.

Uncollected amounts have a double consequence for the State. Not only does the State not recover the money owed, but it also faces an additional loss because it has already, in effect, paid the federal government its share of the anticipated collection. As discussed in the Introduction (See pages 7 through 8), AHCCCS must report to the federal government the recovery amount established in criminal restitution and civil settlement agreements. The federal government's contribution to Arizona's Medicaid program is then reduced

### Collection probabilities based on age of account

Age of Past Due Amount	Probability Of Collection (In Percentage)
3 months	69.6
6 months	52.1
1 year	22.8

Source: Commercial Collection Agency Association, 2004

<sup>1</sup> Amounts associated with cases closed before or after this period are not represented in this figure.

<sup>2</sup> Commercial Collection Agency Association. (2004). *Collectability of delinquent commercial debts at time intervals after the due date*. Retrieved May 31, 2012, from <http://www.ccaacollect.com/10-18-04COLLECTABILITYCHART.pdf>

proportionately in a future period by the recovery amounts reported regardless of whether or not Arizona has collected the amount due. Therefore, to ensure the State recovers its share, it needs to collect all the balances due, or show that it has made an appropriate collection effort to be eligible to recapture monies previously reported to the federal government in cases where a provider has declared bankruptcy or gone out of business (See page 37 for more information on recapture).

The OIG has established some procedures for collecting past due balances, but it has not established a formal collection program supported by written policies. In addition, it is not making use of all available collection tools. To ensure it effectively collects debts owed to the State, the OIG should establish a broader range of tools and procedures and formalize these practices into a written collections policy. At a minimum, the OIG's written policy should include the following requirements:

- **Monthly aging and followup on past due balances**—The OIG ages its past due balances, but does not do so on a monthly basis as required by the *State of Arizona Accounting Manual*. For example, at the time of auditors' review in June 2012, the OIG was in the process of following up on an aging report from February 2012. According to the OIG, limitations in staffing coupled with a large volume of past due accounts prevent a more frequent followup. Additionally, according to the OIG, collection followup is sometimes performed in person, which is not the most effective follow-up method as compared to phone or written contact. According to a report released by the Washington State Auditor, which identifies best practices for improving the collection of state debt, making contact with the debtor within 30 days of delinquency, including using phone contacts as part of all follow-up efforts, and sending reminder letters periodically are cited as best practices.<sup>1</sup>
- **A letter of credit for provider civil settlements**—The OIG does not require providers to obtain a letter of credit as part of civil settlement agreements. According to officials from the State of Tennessee's Medicaid agency's Program Integrity Unit, Tennessee sometimes requires providers to secure a letter of credit from a bank as a means of guaranteeing payment to the state in the event that a provider defaults on the repayment. By including a requirement for letters of credit in civil settlement agreements with providers, the OIG could better ensure provider repayment.
- **Pursuit of state tax and lottery intercepts**—According to the OIG, state tax intercepts are conducted for past due member accounts in accordance with statute, which allows state agencies to intercept tax refunds to satisfy debts the taxpayer owes to the State.<sup>2</sup> Although the OIG uses these intercepts for persons receiving services, it has not attempted to extend this intercept to providers. In addition, the OIG has not previously conducted state lottery intercepts as part

<sup>1</sup> Washington State Auditor (2008). *Performance audit report: Collection of state debt* [Report No. 1000012]. Olympia, WA: Author.

<sup>2</sup> A.R.S. §42-1122

Delinquent accounts are not aged on a monthly basis as required by the *State of Arizona Accounting Manual*.

of its collection procedures, which is permissible under statute.<sup>1</sup> OIG officials stated they were not aware that tax intercepts could be performed on providers, or that the state lottery intercept option was available.

- **Assessment of interest in accordance with civil settlement agreement provisions**—The OIG should ensure interest is assessed according to interest provisions contained in civil settlement agreements for past due accounts and develop a means of tracking interest assessments. Although the OIG’s civil agreements contain a provision to assess a 10 percent interest penalty per year on the original balance if payment is more than 14 days late, interest is rarely assessed. OIG officials stated that they usually do not assess interest on past due accounts because they feel doing so is not effective in encouraging additional collection. However, because this provision is included in the official agreement, the OIG has a responsibility to fulfill the terms of the agreement as a fiduciary of public funds. Auditors’ analysis of past due accounts revealed that the OIG could have assessed nearly \$260,000 in interest for accounts closed between January 1, 2009 and January 31, 2012. Additionally, according to the OIG, the information system used to track accounts cannot automatically assess interest on past due accounts. OIG officials said they have not established an alternative method for assessing or tracking interest.
- **Development and implementation of a mechanism to document all collection efforts**—Federal regulations do not require states to refund the federal share if the provider has declared bankruptcy or gone out of business, but the State must show that it has made an appropriate effort to collect despite these conditions.<sup>2</sup> The OIG should identify the specific collection efforts required by CMS to comply with these requirements and ensure its written policy reflects these requirements. The OIG should also determine if some provider accounts that are presently past due may be eligible for recapture under these guidelines and carry out the necessary collection activities before adjusting federal reporting.
- **Referral of bad debts to the Attorney General’s Debt Collection Program**—The OIG should refer accounts that are severely delinquent or otherwise difficult to collect to the Arizona Attorney General’s Debt Collection Program (Program). The Program accepts debt referrals from all state agencies and charges no up-front cost for case referrals. Although the Program keeps 35 percent of any monies it collects to help cover the costs of its collection efforts, all monies collected are effectively maintained within the State. According to the Attorney General’s Office, the Program is legally empowered to use effective collection practices, such as wage garnishments and property liens, to collect state debts, and the Program’s collectors are composed of experienced collectors as well as licensed attorneys. Additionally, according to the Attorney General’s Fiscal Year 2011 Annual Report, the Program collected \$11.3 million that state agencies had been unable to collect.

The OIG rarely assesses interest on past due accounts as required by settlement agreement provisions.

<sup>1</sup> A.R.S. §5-525

<sup>2</sup> 42 CFR §433.318

## Cash-handling practices not consistent with *State of Arizona Accounting Manual (Manual)* requirements

The OIG lacks basic cash-handling controls to protect the payments it receives from loss or theft. Between January 1, 2009 and December 31, 2011, the OIG received at least \$7.2 million for cases closed during this time period in the form of checks, money orders, and cashier's checks, which are collectively defined as "cash" by the *Manual*.<sup>1</sup> Although the OIG has a *Receipt of Money and Negotiable Instruments* cash-handling policy, neither this policy nor the OIG's actual cash-handling practices reflect all of the requirements set forth in the *Manual*. Although auditors did not identify any actual instances of loss or theft, current practices increase the OIG's exposure to such events. The OIG should ensure that its policy and cash-handling practices align with all relevant cash-handling requirements in the *Manual*. The following practices need strengthening:

- **Segregation of cash-handling functions**—The OIG has delegated the cash-handling function almost entirely to one person and, thus, has not appropriately separated cash-handling responsibilities as required by the *Manual*. This person is responsible for receiving payments through the mail, adjusting internal accounting records to reflect payment receipts, and preparing the payments for deposit (the actual deposit is made by a separate division).

To ensure that cash collections are adequately safeguarded, the *Manual* requires more than one person to be involved in processing and recording payments. Specifically, the *Manual* requires that an official record for all payments received through the mail be maintained by at least two people who do not have direct access to change accounting records and who do not participate in other cash-handling functions, such as deposit preparation or reconciliation. According to the OIG, payments are received entirely by mail, but a separate mail log is not maintained as required by the *Manual*. In addition, payments should be restrictively endorsed immediately upon receipt by personnel responsible for opening the mail and maintaining the mail log. At the completion of entering all payments to the mail log, both employees should sign and date the mail log, and provide the payments to a third OIG staff member to record in the OIG's accounting records. This staff member should then provide the signed and dated mail log to a supervisor who does not have access to update the accounting records for a daily reconciliation.

- **Daily and monthly reconciliations**—At the time of auditors' review, the OIG did not conduct any form of independent reconciliation between deposit summaries and receipt records, nor were the OIG's accounting records reconciled to the State's accounting system. The *Manual* requires cash collections to be

<sup>1</sup> Collections figures represent cases closed between January 1, 2009 and December 31, 2011. Amounts associated with cases closed before or after this period are not represented.

The OIG has not established adequate separation of duties for its cash-handling functions.

reconciled to the totals of invoices, cash register tapes or receipts, books, mail logs, etc., by someone who has no access to cash. Additionally, the *Manual* requires each agency to reconcile its internal accounting records to the State accounting system at least monthly, and this reconciliation must be documented. In this case, an OIG employee or another AHCCCS employee should conduct a reconciliation between the OIG's case management system and the state accounting system. Conducting a reconciliation between receipt records, deposits, and accounting systems is a basic yet critical function of cash-handling that helps to detect accounting record errors and payment theft or loss.

## Recommendations:

- 3.1 To show that AHCCCS is pursuing the maximum civil settlements allowed by state laws and rules, the OIG should document, in its investigative case files, the specific considerations used to arrive at a settlement decision.
- 3.2 To ensure that the federal government's contribution to Arizona's Medicaid program is not inappropriately reduced, AHCCCS and the OIG should:
  - a. Make adjustments to federal reporting for all errors identified by auditors' review.
  - b. Review past reporting of recovery amounts for prior periods, such as fiscal years 2011 and 2012, to determine if there are additional errors, making reporting adjustments as necessary. Based on the results of the review, determine if additional periods should be reviewed.
  - c. Establish a process to periodically reconcile its federal recovery-reporting records to OIG recovery records to ensure the accuracy of reported amounts.
  - d. Conduct a secondary review of completed recovery-reporting forms to ensure the information on the forms, including recovery calculations and investigative costs, are accurate and supported by case file information.
  - e. Establish a mechanism for tracking payment agreements that have conditions potentially affecting amounts collected to ensure that when the conditions are met that it reports to the federal government in a timely manner any needed adjustments to previously reported recovery amounts.
- 3.3 To ensure the State collects the monies owed to it, the OIG should establish a formal collection program supported by a written policy that requires the following:

- Aging of delinquent accounts each month, along with monthly written and phone contact for delinquent account holders;
  - A letter of credit in provider civil settlements;
  - State tax intercepts for members and providers, and state lottery intercepts for all delinquent account holders;
  - Assessment and tracking of interest;
  - A determination of the specific collection efforts required by the CMS to comply with collection regulations for recapturing amounts previously reported to the CMS that are later determined uncollectible due to a provider going bankrupt or out of business, and ensure its written policy reflects these requirements;
  - Adjustment of recovery amounts previously reported to the federal government when a provider has declared bankruptcy or gone out of business and the OIG has made an appropriate collection effort; and
  - Referral of bad debts or severely delinquent accounts to the Arizona Attorney General's Debt Collection Program.
- 3.4 To ensure it adequately protects the payments it receives from loss or theft, the OIG should revise its internal cash-handling policy and practices to align with the *Manual's* requirements to include:
- Separating cash-handling duties by assigning two employees who do not have access to accounting records to open mailed payments, restrictively endorse payments immediately upon receipt, record payments in a mail log, sign and date the log each day, and make the log available for a daily reconciliation.
  - Requiring a third person to separately enter the payments received into the OIG's case management system.
  - Conducting a daily reconciliation between the payments received, signed and dated mail log, and report of payments recorded for the day from the OIG's accounting records. This reconciliation should be performed by somebody who does not have the ability to update the accounting record and has no access to cash.
  - Requiring an OIG employee or another AHCCCS employee to conduct and document a monthly reconciliation between the OIG's accounting records and the State's accounting system.

## Other Pertinent Information

Auditors identified two other areas related to Medicaid fraud and abuse prevention, detection, and recovery where no recommendations were identified:

- First, consistent with federal requirements, AHCCCS contracts for recovery audits that will identify Medicaid underpayments and overpayments for its fee-for-service programs. Additionally, AHCCCS has researched and continues to research whether these audits can be used for its managed care program.
- Second, the federal government provides a 10 percent incentive on Medicaid fraud and abuse recoveries to states that enact a group of qualifying laws and rules.

## Recovery audits and federal incentive information

### Recovery audits required for Medicaid fee-for-service programs, but not for managed care programs

Medicaid agencies are required to contract for recovery audits to identify underpayments and overpayments made in Medicaid fee-for-service programs. Based on the results of a Medicare recovery audit demonstration project, federal regulations were expanded to also require recovery audits for all state Medicaid agencies. As required, AHCCCS has contracted for recovery audits for its fee-for-service program. However, recovery audit contracts are not required for managed care programs because the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), has not identified a viable managed care recovery audit model. AHCCCS has researched and continues researching the feasibility of conducting recovery audits for managed care programs in anticipation that the CMS may require these audits in the future.

Medicaid recovery audit requirement grew out of Medicare demonstration project—The federal requirement for recovery audits began with the Medicare program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established a 3-year demonstration project to determine if recovery audits could be effectively used to detect and correct past improper payments in the Medicare fee-for-service program. According to a June 2008 CMS report, recovery audit contractors succeeded in correcting more than \$1.03 billion of improper Medicare payments. More than 96 percent of these improper payments were overpayments that were collected from providers. The remaining 4 percent were underpayments that were repaid to providers. Due to the success of the demonstration project, Congress passed the federal Tax Relief and Healthcare Act of 2006, which required all state Medicare programs to contract for recovery audits by January 1, 2010.

The requirement for Medicaid recovery audits followed shortly thereafter. Specifically, in March 2010, the Federal Patient Protection and Affordable Care Act required that all state Medicaid agencies establish a recovery audit contractor program to identify Medicaid underpayments and overpayments and recoup overpayments no later than December 31, 2010, or seek an exception from the CMS. AHCCCS requested that the CMS allow it demonstration authority to establish a recovery audit contractor program more suitable to a managed care model. AHCCCS' Medicaid program is

based primarily on a managed care model rather than fee-for-service; the fee-for-service population accounts for only about 10 percent of all AHCCCS members (See Introduction, pages 1 through 2, for a more complete explanation of managed care and fee-for-service). Subsequent federal regulation allowed states to exclude Medicaid managed care claims from review by recovery audit contractors. However, the CMS indicated that if a model for managed care recovery audits is identified, it may create a regulation for such audits.<sup>1</sup>

**Arizona fee-for-service recovery audits identified less than \$2,300 in improper payments**—As required, AHCCCS has contracted for recovery audits for its fee-for-service program. In July 2011, AHCCCS contracted with Recovery Audit Specialists, LLC, an Arizona state-wide contractor for cost recovery services, to serve as the recovery audit contractor for Arizona’s Medicaid fee-for-service program. The contractor is performing three simultaneous AHCCCS fee-for-service recovery audits: pharmacy benefits, fee-for-service medical claims, and reinsurance claims. AHCCCS has indicated that a review of 3 years of its fee-for-service claims data has identified less than \$2,300 in improper payments as follows:

- **Pharmacy benefits**—According to AHCCCS, it worked with its fee-for-service pharmacy benefits contractor, CVS Caremark, to provide the recovery audit contractor with all fee-for-service members’ prescription transactions from October 1, 2007 through September 30, 2010. AHCCCS reported that the value of these transactions totaled \$25.5 million. According to AHCCCS, after the recovery audit contractor completed its review of the fee-for-service pharmacy claims, it informally indicated that it found no improper payments.
- **Fee-for-service medical claims**—According to AHCCCS, it provided the recovery audit contractor with all fee-for-service medical claims from fiscal years 2008 through 2010. AHCCCS reported that these claims totaled nearly \$2.4 billion in provider payments. The recovery audit contractor indicated to AHCCCS that it had completed its review of these fee-for-service medical claims and identified \$2,274 in medical claims overpayments.
- **Health plan reinsurance claims**—Reinsurance is a part of AHCCCS’ managed care system. Reinsurance costs occur when AHCCCS partially reimburses its contracted health plans for managed care member services costs that exceed a specific amount in any one contract year. For example, if a long-term care member without Medicare is hospitalized and has medical costs above \$20,000 in one contract year, AHCCCS’ reinsurance will cover 75 percent of the medical costs above that amount.<sup>2</sup> Reinsurance payments are in addition to the monthly capitation payments. According to AHCCCS, it

<sup>1</sup> *Federal Register*, 76(180), 57836-57837

<sup>2</sup> This amount applies to long-term care health plan contractors who have up to 1,999 members. If a long-term care health plan contractor has 2,000 or more members, the medical costs would have to be over \$30,000 before AHCCCS’ reinsurance coverage begins.

A recovery audit contractor identified only \$2,274 in medical claims based on its review of nearly \$2.4 billion in AHCCCS fee-for-service claims.

provided the recovery audit contractor with all reinsurance payments made by AHCCCS to its health plans from July 1, 2006 through June 30, 2009, totaling \$830 million. The recovery audit contractor informally advised AHCCCS that it found no errors in reinsurance payments.

The contractor informed AHCCCS and the Arizona Department of Administration it would issue one final report for Arizona as soon as it completes an accounts payable audit at another state agency and all three AHCCCS audits. In May 2012, the contractor indicated to AHCCCS that it was nearly finished with all state audits and would begin work on the final audit report.

AHCCCS will pay very little to the firm conducting these audits, but its costs to support the audit effort have been substantial. Under federal regulation, AHCCCS will make payments to the recovery audit contractor on a contingent basis, and only from amounts recovered.<sup>1</sup> However, AHCCCS indicated that it has spent \$179,672 in AHCCCS personnel and IT costs to help complete these audits.

**AHCCCS conducting research on how to conduct managed care recovery audits**—AHCCCS has researched and continues to research whether recovery audits can be used for its managed care program. As previously mentioned, CMS, as the primary federal agency that provides oversight of state Medicaid activities, adopts guidance for compliance with federal laws, including those regarding Medicaid fee-for-service recovery audits, that AHCCCS and other state Medicaid agencies must follow. However, the CMS reported that it has not identified a viable model for the use of recovery audit contractors in a managed care system and has exempted managed care systems from using recovery audit contractors. The CMS has stated that when a viable model is identified, it may develop additional rules related to the use of recovery audit contractors in a managed care system. In the meantime, in August 2012, AHCCCS posted a Request For Information to seek information about approaches for conducting recovery audits for Medicaid managed care programs. As indicated in the Introduction (see page 1), under AHCCCS' managed care program, AHCCCS contracts with health plans that coordinate and pay for the medical services AHCCCS members receive from providers. To cover the costs of coordinating and paying for members' healthcare, the contracted health plans receive a fixed monthly amount known as a capitation payment. Therefore, one issue related to managed care recovery audits is who (i.e., the State or health plan) has the authority to retain any Medicaid overpayments identified by the recovery audit contractor.

CMS reported that it has exempted managed care systems from using recovery audit contractors until it can identify a viable model for their use in such systems.

<sup>1</sup> 42 CFR §455.510

## States can increase Medicaid share recovery by 10 percent when specific laws and rules are established

The federal government has established a financial incentive for states that have enacted qualifying laws and rules, collectively referred to as State False Claims Acts, which relate to Medicaid fraud and abuse penalties and reporting. Under the incentive, states with qualifying State False Claims Acts are able to reduce the amount owed to the federal government when improper payments are discovered. As discussed in the Introduction (see pages 7 through 8), the State is required to report to the federal government recovery amounts established in criminal restitution and civil settlement agreements. The federal government's contribution to Arizona's Medicaid program is then reduced proportionately in a future period by the recovery amounts reported. However, if a state has enacted qualifying laws and rules, the reduction in the federal government's contribution will be 10 percent less than required. For example, if Arizona reported recovery agreement amounts totaling \$1,000, and the federal government contributed 66 percent of the monies for Arizona's program, the amount of the federal recovery in a future period would be \$660 without the incentive and \$560 with it. The guidelines to qualify for the incentive have been in effect since August 2006.

### States qualifying for the federal incentive

California	Michigan
Connecticut	Nevada
Georgia	New York
Hawaii	Rhode Island
Illinois	Tennessee
Indiana	Texas
Iowa	Virginia
Massachusetts	Wisconsin

Source: Auditor General staff analysis of information available on the CMS' Web site as of July 16, 2012.

The U.S. Department of Health and Human Services, Office of Inspector General (HHS OIG), in consultation with the U.S. Attorney General, performs State False Claims Acts reviews to determine if states applying for the federal incentive have established qualifying laws. As of July 2012, 16 states qualified for the federal incentive (see textbox). However, in 2010, there was a change to federal law requiring states that are presently qualified for the incentive to make a change to their state laws in order to keep the incentive. Fourteen of the 16 states presently qualified for the incentive have received notice from the HHS OIG that their incentive is set to expire between March and August 2013 if state laws are not updated to reflect the federal regulation.

According to Laws 2011, Ch. 31, §36, the Legislature expressed its intent that AHCCCS comply with the federal False Claims Act. However, this expression of intent does not mandate AHCCCS to comply with the federal False Claims Act. Additionally, Arizona statutes and regulations would need to be revised to allow AHCCCS and other state agencies, including the Arizona Attorney General's Office, to comply with the federal False Claims Act. Table 8 (see page 45) describes the requirements that states must meet to comply with the federal False Claims Act and thus qualify for the incentive, as well as Arizona's present status under each requirement. Although Arizona statutes conform to some of the requirements of the federal False Claims Act, statutes would need to be revised for Arizona to fully comply and thus qualify for the incentive. For example, Arizona statutes would need to more closely align with federal qui tam regulations. Qui tam regulations provide a financial incentive to reward citizens who bring lawsuits on behalf of the state against individuals and/or entities that have defrauded the state and/or federal government.

Table 8: Federal Requirements for 10 Percent Recovery Incentive and Arizona's Status in Meeting Those Requirements Since August 2006

Requirement Since August 2006	Arizona's Status
Establish liability to the state for false or fraudulent claims, as described in the federal False Claims Act (Act), with respect to Medicaid spending.	<b>In Place:</b> Arizona Revised Statutes (A.R.S.) §36-2918 establishes liability to the State for false or fraudulent claims.
Contain provisions that are at least as effective as those in the Act in terms of rewarding and facilitating qui tam actions for false or fraudulent claims. <sup>1</sup> For example, if a qui tam suit is successful, the federal government pays the individual bringing the action at least 15 percent of the proceeds of the action.	<b>Partially in Place:</b> Arizona permits the person who brings suit on behalf of the State (called a qui tam suit) to collect only attorney's fees and costs, but does not otherwise provide a financial incentive to the citizen for bringing suit.
Contain a requirement for filing an action under seal (the filing does not become public) for 60 days while under review by the state Attorney General.	<b>Not in Place:</b> Arizona does not have a requirement to file suit under seal for 60 days; rather, Arizona permits citizens to make a request to the Attorney General 60 days before filing the suit.
The state's false claim penalty must include a civil penalty of not less than \$5,000 and not more than \$10,000, plus three times the amount of damages sustained by the government.	<b>Partially in Place:</b> A.R.S. §36-2918(B) allows for a civil penalty not to exceed \$2,000 for each item or service claimed and an assessment not to exceed twice the amount claimed for each item or service.

<sup>1</sup> Under qui tam provisions, private persons may file lawsuits in court against individuals and/or entities that defraud the government.

Source: Auditor General staff analysis of 42 USC §1396h, 31 USC §§3729-3730, and A.R.S. §§36-2918, 35-212, and 35-213.

A.R.S. §35-213 permits a person who brings suit on behalf of the State (referred to as a qui tam suit) to collect only attorney's fees and costs, but does not otherwise provide a financial incentive to the person for bringing the suit.



## APPENDIX A

# Methodology

This appendix provides information on the methods auditors used to meet the audit objectives.

This performance audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Auditor General and staff express appreciation to the Arizona Healthcare Cost Containment System (AHCCCS) Director and his staff for their cooperation and assistance throughout the audit.

Auditors used the following specific methods to meet the audit's objectives:

- To gain an understanding about the state and federal requirements for preventing, detecting, investigating, and recovering monies from, and reporting overpayments from fraud and abuse cases to, the federal government, auditors reviewed federal and state laws and regulations; AHCCCS' State Plan for Medicaid; the intergovernmental agreements between AHCCCS and the Department of Economic Security (DES) and the Arizona Attorney General's Medicaid Fraud Control Unit, and AHCCCS' Office of Inspector General's (OIG) policy manual. Auditors also obtained, validated, and analyzed a download from the OIG case management system that the agency relies upon to record the time frames for fraud referral, investigation and resolution, and recovery and collection amounts. Additionally, auditors conducted interviews with AHCCCS staff regarding their roles and any policies, procedures, and processes the agency relies upon to prevent, detect, and investigate fraud and abuse cases as well as recover monies.
- To determine the OIG's effectiveness for preventing and detecting fraud and abuse, auditors reviewed AHCCCS' managed care contracts and *Contractor Operations Manual*; and Medicaid fraud and abuse prevention and detection training materials provided by AHCCCS to its contracted health plans, AHCCCS and DES eligibility workers, and the public. Further, auditors reviewed the OIG's fraud and abuse prevention and detection processes such as the provider registration process and the member pre-approval investigations process. Finally, to gain an understanding of both common and best practices for Medicaid fraud and abuse prevention, detection, and investigative practices in other states, auditors contacted the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), and individual states, including California, Florida, Illinois, Maryland, Tennessee, and Texas.<sup>1</sup>
- To determine the OIG's timeliness in investigating fraud and abuse cases, auditors analyzed a download of the OIG's case management system that included more than 2,300 cases that were closed between fiscal years 2010 and 2012 and 880 cases that were either assigned for

<sup>1</sup> Auditors selected contact states based on various factors. For example, a CMS official identified Illinois, Texas, and Maryland as innovators in data analysis techniques. In addition, another state's audit report cited California for its data analysis practices. Finally, Tennessee was chosen because the size of its Medicaid population and percentage of population in managed care is similar to Arizona.

investigation or deferred as of July 3, 2012. Auditors also reviewed the OIG's investigation policies and procedures, interviewed investigative staff, and reviewed investigative standards including *Standards for Law Enforcement Agencies* published by the Commission on Accreditation for Law Enforcement Agencies, Inc. In addition, auditors selected a sample of 30 out of the 513 OIG provider and member fraud case files that were closed in calendar year 2011 for validation purposes.

To obtain its sample of 30 case files, 6 cases from each of the following five categories were selected:

- Cases closed with a civil settlement and investigative costs assigned
- Cases with a civil settlement that did not include investigative costs
- Cases closed with no action taken, no fraud found, or other similar dispositions
- Cases with a Prosecution Status of "declined"
- Cases randomly selected

To gain reasonable assurance that the data are complete, auditors analyzed the sequencing of case numbers opened in calendar year 2011. To determine data accuracy, auditors tested documentation in the 30 sampled cases against critical date fields in the OIG's case management system, such as case referral date and assignment date. Although auditors found some inaccurate dates and could not verify some dates in the OIG's case management system because hardcopy documentation was not available, auditors determined that the data were sufficiently reliable for the purposes of the audit.

- Auditors also assessed the OIG's policies, procedures, and practices in four areas related to recovering fraud monies. Specifically:
  - To determine if the OIG documented the specific mitigating and aggravating circumstances taken into consideration when formulating settlement amounts, auditors reviewed case file documentation from three randomly selected provider cases closed in calendar year 2011 that had settlement agreements created by the OIG.
  - To determine if recoveries resulting from OIG civil settlements and court-ordered restitutions were reported accurately and in a timely manner, auditors reviewed a sample of 25 cases out of the 117 settlement and restitution cases that were reported to CMS between January 1, 2011 and March 31, 2012, and used restitution agreements and civil settlement

agreements to compare recovery amounts and case completion dates to reported information.

- To determine if the OIG's collection practices were sufficiently controlled and generally effective, auditors interviewed the OIG's collection personnel, and compared the OIG's collection practices to the *State of Arizona Accounting Manual*, and best or common practices for collecting state debt. To gain reasonable assurance that collection values in the case management system were accurate, auditors selected a random sample of ten payments submitted to the OIG between January 1, 2009 and December 31, 2011, and traced the payment details in the OIG's case management system to deposit record packets. Auditors also judgmentally selected nine payments from the deposit record packets and traced source documentation, such as copies of deposited checks, to the OIG's case management system. Auditors determined the reported collection figures to be sufficiently reliable for the purposes of the audit.
- To assess the OIG's cash-handling practices, auditors reviewed the OIG's cash-handling policy, interviewed personnel with cash-handling responsibilities, and compared OIG's practices for segregating cash-handling responsibilities, conducting daily and monthly reconciliations, and performing other cash-handling functions to requirements specified in the *State of Arizona Accounting Manual*.
- To gain an understanding of recovery audits, auditors reviewed federal requirements, information and documentation describing AHCCCS' use of recovery audits for its fee-for-service programs, and AHCCCS' efforts to implement recovery audits for its managed care system. To gain an understanding of the federal financial incentive for states that have enacted State False Claims Acts, auditors reviewed federal and state laws and regulations, and State False Claims Act information provided by the U.S. Department of Health and Human Services, Office of Inspector General.
- Auditors work on internal controls focused on reviewing AHCCCS' processes and written policies and procedures to assess compliance with federal and state requirements for preventing and detecting fraud and abuse (See Finding 1, pages 11 through 19). In addition, auditors also reviewed AHCCCS' policies and procedures for investigating fraud and abuse cases in a timely manner and documenting Medicaid fraud and abuse case investigation results (See Finding 2, pages 21 through 29) Further, auditors reviewed internal controls over four specific areas related to AHCCCS' fraud recovery efforts, including reviewing the OIG's cash-handling policy, procedures, and practices (See Finding 3, pages 31 through 40).

- The information used to develop the report's Introduction section was obtained from AHCCCS documents published on its Web site, such as contracts, AHCCCS' fiscal years 2010 and 2011 audited financial statements and fiscal year 2012 projections, and information from AHCCCS administrators and staff, including internal reports.

# AGENCY RESPONSE

**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



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September 13, 2012

Debra K. Davenport, CPA  
Auditor General  
Office of the Auditor General  
2910 North 44th Street, Suite 410  
Phoenix, AZ 85018

**RE: Medicaid Fraud and Abuse Performance Audit, Revised Draft Report dated  
September 7, 2012**

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the Arizona Health Care Cost Containment System (AHCCCS) Medicaid Fraud and Abuse Performance Audit. We appreciate the efforts of the audit team and plan to consider audit findings and recommendations as we continue to improve the efficiency and effectiveness of 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 63 positions today, an increase of 41 positions. Twenty-five of the positions were transferred in from other divisions as part of the consolidation and five were provided through the legislative process. 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 your auditors, 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) a process your office also positively reviewed, our program integrity collaborations with our health plan compliance officers (CMS), and our civil settlement process (CMS).

The following responses address the recommendations proposed in the Revised Draft Report:

### **Recommendation 1.1**

The OIG should develop and implement a formal plan to regularly update its Medicaid fraud and abuse prevention and detection training and other guidance based on trends its staff identifies. The OIG should determine the frequency of the updated training that it offers and also determine whether it could use avenues other than formalized training to offer guidance on the latest trends in fraud and abuse prevention and detection, such as email notifications or policy bulletins.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

AHCCCS OIG agrees with the importance of training and guidance related to fraud and abuse prevention and detection, and will build on already-established training platforms to implement the findings. One very successful ongoing effort undertaken by the AHCCCS OIG, the Compliance Officer Network Group (CONG), was cited during a 2009 CMS Program Integrity audit, as a "Best Practice." CONG meetings are held semi-annually to gather AHCCCS OIG staff, contracted health plan Compliance Officers, and representation from law enforcement and CMS, for the purpose of training and information-sharing (including current trends). In addition, in January 2012, the AHCCCS OIG began holding 1:1 meetings with individual contracted health plan Compliance Officers to provide guidance and additional training in an environment particularly conducive to information exchange.

To enhance their ability to provide training and offer guidance, OIG staff receives fully subsidized training at the Medicaid Integrity Institute. Training opportunities include didactic material (e.g., foundations of intelligence, interviewing techniques), interaction with other Medicaid agencies regarding new fraud schemes, and review of new literature. This information can then be communicated to the plans and other key partners in 1:1 interactions and in the CONG meetings.

In reference to the recommendations related to the member fraud team, AHCCCS OIG identified a need for additional training for the eligibility workers at the Department of Economic Security (DES) due to worker turnover and changes in their processes and procedures for determining eligibility. On August 29, 2011, the OIG began meetings with DES to discuss the referral process and establish a training program conducive to both agencies. The training will be based primarily on detecting potential fraud.

In addition the Agency developed three specific web based training tools that are on the AHCCCS website. These trainings provide basic program integrity information to the public, health plans and state employees. The OIG has a broad array of resources that are used to provide information and training to a number of different stakeholder groups, and the agency has clearly demonstrated a commitment to continue expansion of current efforts.

## **Recommendation 1.2**

AHCCCS should continue to identify areas where its fraud detection data analysis capabilities can be enhanced and work to implement improved methods.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

AHCCCS OIG continually analyzes areas in which its fraud detection data analysis capabilities can be improved. In addition to a library of mainframe Fraud, Waste, and Abuse (FWA) software programs, the OIG uses a wide variety of products and services to support fraud detection including:

- ACJIS (Arizona Criminal Justice Information System) – Criminal history of individuals
- AZTECS (Arizona Technical Eligibility Computer System) – Child support payments
- AZ Vital Records – Dates of birth/death
- CLEAR – Public and proprietary records on individuals and companies.
- EDI Watch – Data analysis using FWA algorithms and rules.
- EXPERIAN – Credit report information.
- GUIDE (General Unemployment Insurance Development Effort) – Unemployment insurance claims and benefit payments
- Med-Medi – Dual eligible over-billing.
- MIC (Medicaid Integrity Contractor) – Monthly conference calls.
- MVD (Arizona Department of Motor Vehicles) – Vehicle registration and driver license information.
- The Work Number – Employment and income verification.
- WTPY (Wire Third Party Query) – SSN and benefits verification.
- YH12-0007 – OIG consulting contract.

The OIG will continue to enhance and improve its fraud detection data analysis capabilities by adding to its inventory of FWA software programs, and regularly evaluating other fraud detection products and services in order to complement or replace existing solutions.

Since August 2011, the OIG met with over 15 vendors to learn about potential solutions to combat fraud waste and abuse in the Medicaid program. Some solutions under consideration incorporate proactive data analytics, predictive modeling, provider and member screening, and Biometrics/Card swipe technology. The OIG also reached out to CMS in an effort to explore whether there are Medicare solutions that could also work for Medicaid. Currently, the AHCCCS OIG is one of only a few states that CMS has partnered with to develop, test, and pilot some of those solutions (e.g., CMS Advance Provider Screening solution).

## **Recommendation 2.1**

The OIG should enhance its processes for investigating fraud and abuse cases in a timely manner. Specifically:

- a. To improve its member fraud case screening and prioritization process, the OIG should reevaluate the factors it considers when assigning priority levels for member fraud cases. In addition to the factors it already considers, the OIG should consider past trends in previously closed member fraud and abuse cases to identify common characteristics that lead to a recovery or cost savings. Further, information gained from an analysis of closed cases could be used to identify important factors to consider in the initial case-screening processes, such as the type of fraud or abuse, the referral source, the quality of initial evidence provided, whether the member had previous referrals, and the amount of capitation payments.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

In accordance with AHCCCS OIG policy, all referrals of fraud and abuse are reviewed by an OIG Manager or Supervisor for appropriate processing. Managers and Supervisors are encouraged to use professional discretion as well as the full range of OIG staff resources in their decision-making.

The Member Compliance Division already employs a priority system that establishes referrals as 1, 2, or 3. The majority of member-related referrals fall into the Priority 1 category. This is primarily due to the fact that the majority of allegations revolve around the same fraud scheme, i.e., a recipient provided false information on the benefit application in order to become eligible for the program. Because the majority of referrals are for similar fraud schemes, it is difficult to determine which is more egregious than another without further investigation.

The Provider Fraud Unit recognizes the benefits of having a formal process and will include the described method of prioritization in the Unit Modules project that was implemented in July 2011.

The OIG recognizes the benefit of formal written procedures and will draft guidelines that incorporate recommended factors. At the same time, supervisory staff will be allowed to use discretion when determining how to efficiently and effectively manage high volumes of referrals, complaints, and self-generated investigations with a relatively small investigative staff.

- b. Once it has reevaluated the factors it will consider when prioritizing cases for investigation, the OIG should establish a written member fraud case screening and prioritization policy for its Member Compliance Unit indicating when cases should be immediately assigned, closed, or deferred.

*The finding of the Auditor General is agreed to and the recommendation will be implemented.*

As described in 2.1.a, the OIG will expand its informal process, establish a written policy for its member fraud cases, and continue to prioritize when cases will be assigned, closed or deferred.

- c. The OIG should develop and implement a written case screening and prioritization policy to determine when provider fraud cases should be assigned, closed, or deferred for its Provider Compliance Unit.

*The finding of the Auditor General is agreed to and the recommendation will be implemented.*

As described in 2.1a, the OIG will expand its informal process, develop a written case screening and prioritization policy for Provider fraud cases, and continue to prioritize when cases will be assigned, closed or deferred.

- d. Once these case screening and prioritization processes are established, the Member and Provider Compliance Units should use them to reassess and reprioritize cases as they move from deferral to assignment to an investigator to ensure these cases still warrant investigation, and close out any cases that are not likely to be successfully resolved, given the factors of the case.

*The finding of the Auditor General is agreed to and the recommendation will be implemented.*

Upon completion of the enhanced processes, the OIG will use them to reassess and reprioritize cases and will continue to closeout cases that will not likely be successfully resolved.

- e. The OIG should formalize its process for referring non-fraud cases to its contracted health plans, the OIG should establish baseline factors for determining if it will investigate a case or if a case should be referred to health plans for additional review.

*The finding of the Auditor General is agreed to and the recommendation will be implemented.*

- f. The OIG should strengthen its policy regarding supervisory case reviews to reflect its practice of conducting 60-day case reviews. The policy should further require that, during these reviews, supervisors and staff should discuss whether an investigation should continue or be closed. If continued, supervisors and staff should discuss the next steps required, and should also review whether cases are progressing in a timely manner. In addition, the decisions made during this review should be documented.

*The finding of the Auditor General is agreed to and the recommendation will be implemented.*

## **Recommendation 2.2**

To ensure the OIG has complete and accurate information that can be effectively used for management purposes, the OIG should:

- a. Establish a formal case closeout procedure to ensure that the case management information and archived records contain all important documents and information; and

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Member Compliance Division has a formal case close-out procedure. Every case that is opened for investigation must have a written Report of Investigation (ROI) that explains the allegations, reasons for closure, and additional pertinent documentation. The Provider Fraud Unit will develop a similar closeout process.

- b. Complete development and implementation of its new case management system; and

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The new case management system is currently under development. Recognizing the limitations of its internal database, the AHCCCS OIG took action to initiate system enhancements. The upgraded case management system, Background Electronic Tracking History (BETH) will be completed in phases. The first phase is near completion and ready for testing.

- c. Ensure that key fields and case management information system such as provider identification numbers and dates are accurate.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The enhanced case management system will help combat manual/ typographical errors, improving reporting accuracy.

### **Recommendation 3.1**

To show that AHCCCS is pursuing the maximum civil settlements allowed by state laws and rules, the OIG should document, in its investigative case files, the specific considerations used to arrive at a settlement decision.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

Unlike most other states, AHCCCS OIG has a unique power to assess civil monetary payments (inclusive of investigative costs). Because of this, CMS has identified AHCCCS' civil settlement process as a "best practice" for the nation. Although the settlement negotiations are in accordance with regulations outlined in State and Federal statutes and rules, the OIG will review its current policy and procedures and make any changes to improve efficiencies and documentation.

### **Recommendation 3.2**

To ensure that the federal government's contribution to Arizona's Medicaid program is not inappropriately reduced, AHCCCS and the OIG should:

- a. Make adjustments to federal reporting for all errors identified by auditors' review.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

OIG in collaboration with the AHCCCS Division of Business and Finance (DBF) has developed a process to improve efficiencies in the manner in which recovery information is conveyed to DBF.

- b. Review past reporting of recovery amounts for prior periods, such as fiscal years 2011 and 2012, to determine if there are additional errors, making reporting adjustments as necessary. Based on the results of the review, determine if additional periods should be reviewed.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

Enhancements to the case management system will permit a more extensive review of past recovery amounts. OIG will then provide DBF with a complete report of all cases with recoveries for fiscal year 2011 and 2012.

- c. Establish a process to periodically reconcile its federal recovery reporting records to OIG recovery records to ensure the accuracy of reported amounts.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

OIG will implement the review process addressed here with that addressed in Recommendation 3.2(b). Ongoing procedures will be established to provide OIG recovery information to DBF at regularly scheduled intervals.

- d. Conduct a secondary review of completed recovery reporting forms to ensure the information on the forms including recovery calculations and investigative costs are accurate and supported by case file information.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The referenced information is currently recorded in the current OIG case management data base which requires specific queries. The enhanced case management system will address this issue. Embedded edits will require all specified information.

- e. Establish a mechanism for tracking payment agreements that have conditions potentially affecting amounts collected to ensure that when the conditions are met that it reports to the federal government in a timely manner any needed adjustments to previously reported recovery amounts.

*The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

OIG will address this issue through policy and procedures related to the collection of funds.

### **Recommendation 3.3**

To ensure the State collects the monies owed to it, the OIG should establish a formal collection program supported by a written policy that requires the following:

- Aging of delinquent accounts each month, along with monthly written and phone contact for delinquent account holders;
- A letter of credit in provider civil settlements;
- State tax intercepts for members and providers, and state lottery intercepts for all delinquent account holders;
- Assessment and tracking of interest;
- A determination of the specific collection efforts required by the CMS to comply with collection regulations for recapturing amounts previously reported to the CMS that are later determined uncollectible due to a provider going bankrupt or out of business, and ensure its written policy reflects these requirements;
- Adjustment of recovery amounts previously reported to the federal government when a provider has declared bankruptcy or gone out of business and the OIG has made an appropriate collection effort, and;
- Referral of bad debts or severely delinquent accounts to the Arizona Attorney General's Debt Collection Program.

*The finding of the Auditor General is agreed to and the audit recommendations will be implemented.*

OIG will address these issues by establishing written policies and procedures related to the collection of bad debts. OIG has met with members of the debt collection unit at the Attorney General's Office to discuss the possibility of using their services. The OIG also has begun efforts to seek from CMS the federal share related to "uncollectable debt." AHCCCS OIG appears to be the first state Medicaid agency in the country to attempt recovery of the federal share that was reported on the CMS-64, given back to CMS, and later deemed

“uncollectable”. There are many reasons why money reported to CMS was deemed uncollectable: providers may have been convicted and incarcerated, they may have gone out of business, fled, or declared bankruptcy. AHCCCS is attempting to exercise its statutory authority to recover the federal share back from CMS. In addition, AHCCCS will be looking to CMS for guidance related to member fraud reporting on the CMS-64.

#### **Recommendation 3.4**

To ensure it adequately protects the payments it receives from loss or theft, the OIG should revise its internal cash handling policy and practices to align with the *Manual's* requirements, to include:

- Separating cash handling duties by assigning two employees who do not have access to accounting records to open mailed payments, restrictively endorse payments immediately upon receipt, record payments in a mail log, sign and date the log each day, and make the log available for a daily reconciliation.
- Requiring a third person to separately enter the payments received into the OIG's case management system.
- Conducting a daily reconciliation between the payments received, signed and dated mail log, and report of payments recorded for the day from the OIG's accounting records. This reconciliation should be performed by somebody who does not have the ability to update the accounting record and has no access to cash.
- Requiring an OIG employee or another AHCCCS employee to conduct and document a monthly reconciliation between the OIG's accounting records and the State's accounting system.

*The finding of the Auditor General is agreed to and the audit recommendations will be implemented.*

We want to again thank you and your staff for their professionalism in completing this series of audits.

Sincerely,

Thomas J. Betlach  
Director

## Performance Audit Division reports issued within the last 24 months

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<b>10-07</b>	Arizona Department of Agriculture—Sunset Factors	<b>11-10</b>	Arizona Department of Veterans' Services and Arizona Veterans' Service Advisory Commission—Sunset Factors
<b>10-08</b>	Department of Corrections—Prison Population Growth	<b>11-11</b>	Arizona Board of Regents—Tuition Setting for Arizona Universities
<b>10-L1</b>	Office of Pest Management—Regulation	<b>11-12</b>	Arizona Board of Regents—Sunset Factors
<b>10-09</b>	Arizona Sports and Tourism Authority	<b>11-13</b>	Department of Fire, Building and Life Safety
<b>11-01</b>	Department of Public Safety—Followup on Specific Recommendations from Previous Audits and Sunset Factors	<b>11-14</b>	Arizona Game and Fish Commission Heritage Fund
<b>11-02</b>	Arizona State Board of Nursing	<b>12-01</b>	Arizona Health Care Cost Containment System—Coordination of Benefits
<b>11-03</b>	Arizona Department of Veterans' Services—Fiduciary Program	<b>12-02</b>	Arizona Health Care Cost Containment System—Medicaid Eligibility Determination
<b>11-04</b>	Arizona Medical Board	<b>12-03</b>	Arizona Board of Behavioral Health Examiners
<b>11-05</b>	Pinal County Transportation Excise Tax	<b>12-04</b>	Arizona State Parks Board
<b>11-06</b>	Arizona Department of Veterans' Services—Veteran Home	<b>12-05</b>	Arizona State Schools for the Deaf and the Blind
<b>11-07</b>	Department of Corrections—Oversight of Security Operations		
<b>11-08</b>	Department of Corrections—Sunset Factors		
<b>11-09</b>	Arizona Department of Veterans' Services—Veterans' Donations and Military Family Relief Funds		

## Future Performance Audit Division reports

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Arizona Health Care Cost Containment System—Sunset Factors