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

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 then 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