

Arizona Health Care Cost Containment System

AHCCCS contracts with health plans to provide healthcare services to members in the State but has not timely investigated fraud or abuse incidents and reviewed health plans, correctly made all eligibility determinations, ensured health plans oversee providers in 2 key areas, and established all Housing Program and Administrator oversight processes

Performance Audit and
Sunset Review

September 2022
Report 22-112

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General





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September 29, 2022

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Ms. Jami Snyder, Director
Arizona Health Care Cost Containment System

Transmitted herewith is the Auditor General's report, *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review*. This report is in response to a September 19, 2018, 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 to provide a quick summary for your convenience.

As outlined in its response, the Arizona Health Care Cost Containment System (AHCCCS) agrees with all the findings and plans to implement all the recommendations. My Office will follow up with AHCCCS in 6 months to assess its progress in implementing the recommendations.

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

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

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AHCCCS contracts with health plans to provide healthcare services to members in the State but has not timely investigated fraud or abuse incidents and reviewed health plans, correctly made all eligibility determinations, ensured health plans oversee providers in 2 key areas, and established all Housing Program and Administrator oversight processes

Audit purpose

To determine whether AHCCCS investigated fraud or abuse incidents within its time frame goals, made appropriate eligibility determinations, timely reviewed contracted health plans, ensured that health plans verified provider performance, and ensured providers addressed findings related to services provided to members with a serious mental illness (SMI); and to provide responses to the statutory sunset factors.

Key findings

- AHCCCS has met or is taking steps to meet its statutory objective and purpose in some areas we reviewed by contracting with health plans and directly reimbursing some providers to provide both physical and behavioral health services to more than 2.4 million members throughout the State and requiring its contracted health plans to meet established provider network adequacy standards and address identified service gaps.
- Although AHCCCS has processes to help it meet its statutory objective and purpose for the areas we reviewed, we identified some deficiencies in these processes or opportunities to enhance them. For example, AHCCCS:
 - Has taken more than 1 year to investigate more than half of potential fraud or abuse incidents that were open as of May 2022, potentially resulting in unnecessary payments and difficulty investigating cases, and reported lacking sufficient investigative staff to timely investigate these cases.
 - Has not correctly made some eligibility determinations, resulting in the Centers for Medicare and Medicaid Services identifying improper payments and projecting the potential for additional improper payments between July 1, 2019 and June 30, 2020.
 - Has not reviewed contracted health plans once every 3 years as required and lacked processes for ensuring its health plans verified provider performance prior to reimbursing them for incentive payments made to providers.
 - Lacks formal processes for ensuring that findings and recommendations resulting from 3 separate reviews of behavioral health services provided to members with an SMI are addressed.
 - Has not established some formal processes for overseeing the Housing Program and its Administrator.

Key recommendations

AHCCCS should:

- Conduct a workload/cost analysis to evaluate whether its funding and staffing level is sufficient for timely investigating fraud or abuse incidents and work with the Legislature to revise its appropriations as needed.
- Develop and implement a risk-based approach to sample and review denied eligibility determinations and disenrollment decisions to ensure these decisions are appropriate.
- Review contracted health plans every 3 years as required and establish processes for ensuring health plans verify provider performance prior to disbursing incentive payments, that providers address SMI findings, and for overseeing its Housing Program and Administrator.



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AHCCCS has taken more than 1 year to initiate and/or complete its preliminary investigation for more than half of potential fraud or abuse incidents that were open as of May 2022	
Untimely fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases	
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The Arizona Auditor General has released the third in a series of 3 audit reports of the Arizona Health Care Cost Containment System (AHCCCS) as part of AHCCCS' sunset review. The first performance audit determined whether AHCCCS complied with State and federal regulations and AHCCCS policies when disenrolling members from Medicaid and children's health insurance coverage.¹ The second performance audit focused on AHCCCS' administration of certain behavioral health services and determined whether AHCCCS ensured peer and recovery support specialists (PRSS) providing services to AHCCCS members complied with all State and federal requirements and provides information about the AHCCCS Housing Program.² This sunset review determined whether AHCCCS investigated fraud or abuse allegations within its time frame goals, made accurate eligibility determinations, conducted reviews of its contracted health plans within required time frames, ensured that health plans verified provider performance and that providers addressed behavioral health services findings, ensured compliance with conflict-of-interest requirements, and timely addressed applicant and member eligibility appeals. This sunset review report also includes responses to the statutory sunset factors.

AHCCCS provides healthcare coverage to low-income individuals, children, and families

AHCCCS provides healthcare coverage for eligible low-income individuals, children, and families living in Arizona. As of August 2022, approximately 2.4 million Arizonans were enrolled in AHCCCS, 38 percent of whom were children.³ Most of these Arizonans receive healthcare coverage through Medicaid, a joint federal/state healthcare program for individuals.⁴ However, AHCCCS also provides healthcare coverage to low-income children who are not eligible for Medicaid through the Children's Health Insurance Program—also known as KidsCare.⁵

AHCCCS members receive a full range of medical services through the following 4 primary program areas:

- **AHCCCS Complete Care**—As shown in Table 1 (see page 2), as of August 2022, more than 2 million AHCCCS members were enrolled in AHCCCS Complete Care.⁶ AHCCCS Complete Care provides a wide range of physical healthcare services, such as doctor's visits, immunizations, prescriptions, lab and x-ray

¹ Arizona Auditor General report 22-103 *Arizona Health Care Cost Containment System—Member Disenrollment Processes*.

² Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

³ The percent of children is as of July 2022 because AHCCCS publishes information about the demographics of the populations it serves quarterly.

⁴ Medicaid is a healthcare coverage program administered by states within broad federal guidelines. The federal government pays most Medicaid programs' costs. During fiscal year 2022, AHCCCS estimated that its revenues would total nearly \$21.5 billion, including approximately \$17.35 billion in federal Medicaid monies; nearly \$2.73 billion in State monies, including \$1.82 billion from the State General Fund and approximately \$900 million from State agencies; and approximately \$1.38 billion from other sources, such as county and tobacco tax revenues (see Table 2, pages 10 through 11, for more information).

⁵ The Children's Health Insurance Program is a healthcare coverage program administered and operated by states within broad federal guidelines that receives funding from both the federal government and states.

⁶ This figure does not include the 48,773 AHCCCS members determined to have a serious mental illness (SMI); who receive their healthcare services, including behavioral health services through Regional Behavioral Health Authorities (RBHAs); and are separately reported under Table 1 (see page 2).

services, hospital services, emergency care, and dialysis to low-income adults and children.⁷ In addition to these services, members also receive behavioral health services, such as counseling, substance abuse treatment, telephone crisis response, and residential behavioral health services, including services in a structured living environment for up to 24 hours per day. AHCCCS Complete Care services are provided to members enrolled in 13 different programs, such as AHCCCS' Adult Program, Pregnant Woman Program, and the Young Adult Transitional Insurance Program (see Appendix A, pages a-1 through a-4, for more information on these 13 programs).

- Arizona Long Term Care System (ALTCS)**—As of August 2022, 66,584 members were receiving ALTCS services through AHCCCS. In addition to providing the same services available to members enrolled in AHCCCS Complete Care, ALTCS members receive services such as hospice, case management, home-delivered meals, care within assisted living and nursing facilities, and home and community-based services, including attendant care services, nursing services, a home health aide, or home therapy.
- Children's Health Insurance Program (also known as KidsCare)**—As of August 2022, 66,825 children were receiving KidsCare services through AHCCCS' Complete Care. The KidsCare program provides the same services available to children enrolled in Medicaid, including services such as eye exams, glasses, dental screening and treatment, and hearing exams.
- RBHAs**—Although most AHCCCS members receive behavioral health services through AHCCCS Complete Care, as of August 2022, 48,773 AHCCCS members were receiving healthcare services, including behavioral health services, through RBHAs.^{8,9} These AHCCCS members, including members with an SMI, receive physical healthcare and behavioral health services, such as an assigned case manager to help them coordinate behavioral health services, permanent supportive housing, and if needed, access to assertive community treatment, which consists of a team of providers that coordinates care if the member requires more individualized behavioral healthcare needs exceeding standard case management.¹⁰ See Arizona Auditor General report 22-111, *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services* for more information on RBHAs and behavioral health services and Sunset Factor 6, page 32, for more information about AHCCCS' Housing Program.

Table 1
Number of members receiving care under each of AHCCCS' primary program areas August 1, 2022
 (Unaudited)

AHCCCS program area	Number of members enrolled
Complete Care ¹	2,053,773
ALTCS ²	66,584
KidsCare	66,825
RBHAs	48,773
Partial Services ³	198,116
Total population	2,434,071

¹ Includes 148,692 fee-for-service members and 12,944 children involved with the State's foster care system who receive healthcare services through the Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP).

² Includes all members receiving ALTCS services regardless of which program they are enrolled in.

³ These members are enrolled in other programs, such as Federal Emergency Services, which is a program that pays for emergency healthcare services for individuals who meet all eligibility requirements for Medicaid, except the citizenship requirement.

Source: Auditor General staff analysis of AHCCCS' August 2022 Population Highlights and Population by Health Contractor reports.

⁷ Members under the age of 21 receive additional services through AHCCCS Complete Care, such as eye exams, glasses, dental screening and treatment, and hearing exams.

⁸ RBHAs are State-contracted agencies that operate as managed care organizations within a specific geographic service region of Arizona to coordinate the delivery of physical healthcare and behavioral health services to members with an SMI. Additionally, AHCCCS has intergovernmental agreements with 5 tribal regional behavioral health authorities (TRBHA)—Colorado River Indian Tribes, Gila River, Navajo, Pascua Yaqui, and White Mountain Apache—to provide behavioral healthcare services to Native American members. Native American members with an SMI have the choice of enrolling with a RBHA or with a TRBHA for healthcare coverage.

⁹ This number includes individuals determined to have an SMI and that are enrolled in RBHAs, TRBHAs, or the American Indian Health Program (AIHP).

¹⁰ An SMI is a chronic and long-term mental health condition that impacts a person's ability to perform day-to-day activities or interactions. According to AHCCCS' policies, individuals can request an assessment with a provider to receive an SMI designation. Members with an SMI do not need to be Medicaid eligible to receive healthcare services from AHCCCS.

Individuals must apply for and be determined eligible to receive Medicaid or KidsCare coverage

To receive Medicaid or KidsCare through AHCCCS, an individual must apply to AHCCCS and provide proof of meeting specific eligibility requirements. Although each program has different eligibility requirements (see Appendix A, pages a-1 through a-4, for each program's eligibility requirements), every AHCCCS applicant must:

- Be an Arizona resident.¹¹
- Be a United States citizen or qualified noncitizen.^{12,13}
- Furnish a valid social security number.^{14,15}

Applicants can apply for Medicaid and KidsCare coverage online, over the phone, through the mail, by utilizing a community assistor organization (see next paragraph for more information), or in person at an Arizona Department of Economic Security (ADES) Family Assistance Administration office. Specifically, AHCCCS has an intergovernmental agreement with ADES that requires ADES to review applications and determine applicant eligibility for most AHCCCS programs. According to AHCCCS data, in May 2022, approximately 75 percent of applications and the associated eligibility determinations were processed and made by AHCCCS' eligibility determination system, while ADES and AHCCCS performed about 83 percent and 17 percent of the remaining eligibility determinations, respectively. ADES generally makes eligibility determinations for programs such as the Adult Program and the KidsCare Program, while AHCCCS generally completes determinations for the ALTCS, Freedom to Work, and Young Adult Transitional Insurance programs.

AHCCCS has established several mechanisms to help applicants through the application process, including providing guidance in both English and Spanish on the types of documentation applicants must submit to demonstrate compliance with eligibility requirements. For example, applicants who apply online have access to a help feature that explains what the applicant must fill in and the types of acceptable documentation the applicant can submit. AHCCCS further reported that it is in the process of resuming a chat feature for applicants who apply online that would allow applicants to ask questions while completing their application, but was not able to provide an estimated date for implementing this feature. AHCCCS also provides a helpline, and applicants can visit an ADES Family Assistance Administration Office for assistance. Finally, AHCCCS' website and online application provide information on organizations that can assist applicants through the application process. Specifically, as of May 2022, AHCCCS reported that 211 organizations throughout the State are available to help applicants apply for healthcare coverage. Assistor organizations meet with applicants, and during this meeting, the assistor organization will fill out the application based on the information the applicant provides and help the applicant submit required documentation. Figure 1 (see page 4) shows the number of assistor organizations available in each Arizona county. Although some Arizona counties have no or a limited number of assistor organizations available to help applicants in those counties, applicants can obtain assistance over the telephone or by visiting an assistor organization in another county.

According to AHCCCS, its data system automatically processes applications received and makes decisions on whether to approve the application, request additional information, or deny the application. However, if the application cannot be processed by AHCCCS' data system, an AHCCCS or ADES eligibility worker reviews the application and supporting documentation to determine if the applicant is eligible for healthcare coverage.

¹¹ 42 Code of Federal Regulations (CFR) §435.403(a), Arizona Revised Statute (A.R.S.) §36-2983(E), and Arizona Administrative Code (AAC) R9-22-305(3).

¹² 42 CFR §435.406, A.R.S. §36-2983(E), and AAC R9-22-305(4)(5).

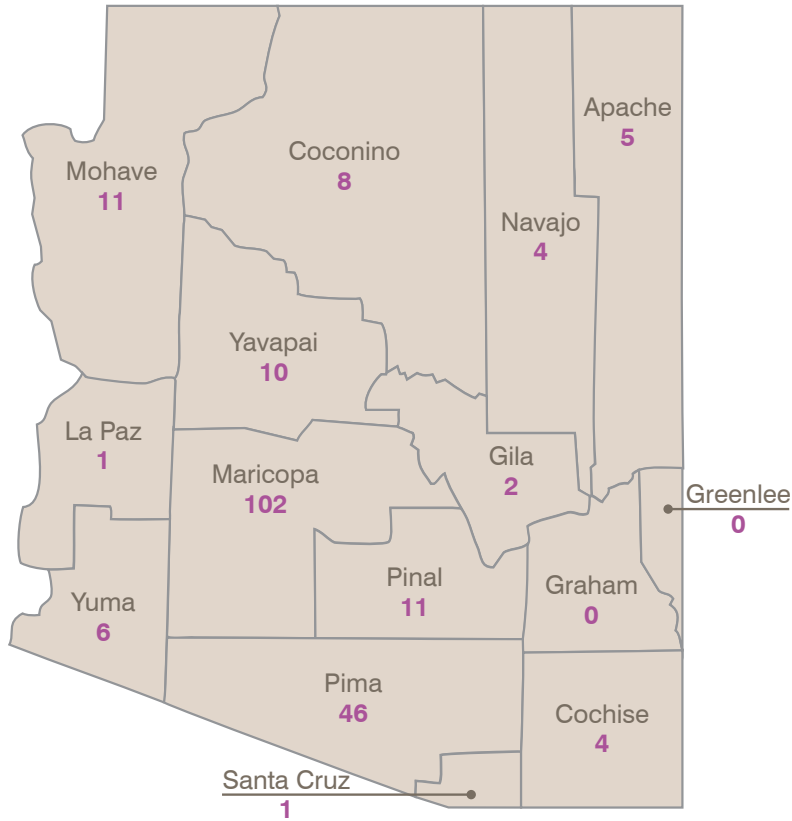
¹³ Qualified noncitizens include permanent residents who have stayed in the United States for more than 5 years, refugees, and asylum seekers.

¹⁴ Federal regulations establish exceptions to providing a social security number, such as for individuals who are not eligible to receive a social security number.

¹⁵ 42 CFR §435.910, A.R.S. §36-2983(D), and AAC R9-22-305(4).

If the eligibility worker needs additional information to determine whether an applicant is eligible for healthcare coverage, the worker sends the applicant a letter, email, or text message requesting the additional information needed to determine eligibility.¹⁶ Applicants are given at least 15 days from the date of the notification to provide the additional information.

Figure 1
Number of assistor organizations available in each county
As of June 2022
(Unaudited)



Source: Auditor General staff analysis of AHCCCS' list of assistor organizations by zip code and information on zip codes within each county.

Majority of AHCCCS members receive services through contracted health plans

AHCCCS was established in 1982 as the nation's first state-wide Medicaid program designed to provide healthcare coverage to eligible individuals primarily through a managed care system. Under a managed care system, AHCCCS contracts with entities, known as health plans (contracted health plans). These contracted health plans must meet several requirements, including establishing processes for receiving, investigating, and resolving grievances from members; assigning new members to a primary care physician; and developing an adequate provider network that provides all required healthcare services to enrolled members. Accordingly, contracted health plans contract with healthcare providers, such as physicians and hospitals, to provide healthcare services to AHCCCS members. All healthcare providers must be registered with AHCCCS to provide healthcare services to AHCCCS members. Requirements for provider registration include submitting a provider enrollment application with all required documentation, maintaining applicable professional licensure or certification, and obtaining a national provider identification number from the Centers for Medicare and

¹⁶ AHCCCS only sends email or text message requests to applicants who have opted to receive email or text message notifications.

Medicaid Services (CMS). According to the Kaiser Family Foundation, as of July 2021, 40 states used managed care systems to provide healthcare services to at least some of their members, and 21 of these states, including Arizona, had more than 85 percent of their members enrolled in managed care systems.¹⁷

When a member is approved for an AHCCCS program, he/she can choose in which contracted health plan to enroll and can change his/her health plan enrollment once a year. However, contracted health plans that a member may choose from vary depending on where the member lives and whether the member is enrolled in a program that provides AHCCCS Complete Care services, ALTCS services, or RBHA services. As of August 2022, AHCCCS had contracts with 7 health plans to provide AHCCCS Complete Care services, 4 health plans to provide ALTCS services, and 3 RBHAs to serve individuals with an SMI (see Figure 2, page 6, for more information on AHCCCS contracted health plans availability by county).¹⁸ As of September 2022, approximately 88 percent of AHCCCS members were enrolled in 1 of these contracted health plans.

To cover the cost of providing members' healthcare services, AHCCCS pays the contracted health plans a monthly capitation amount that is designed to cover members' healthcare needs for that month (see textbox below for information on capitation payments). The contracted health plan receives this monthly capitation payment for each member enrolled in the health plan, regardless of whether the member received healthcare services during the month.

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 enrollment, and the use and cost of medical services provided, capitation payment amounts are determined using mathematical and statistical methods. Monthly capitation payments paid to AHCCCS' contracted health plans vary by individuals based on factors such as age, contracted health plan, geographical service area, and care system. See below for example monthly capitation payments.

Average weighted monthly capitation payment for AHCCCS Complete Care as of October 1, 2021¹

Members under the age of 1	Members age 1 through 20	Members age 21 or over ²
\$670.94	\$213.52	\$410.40

¹ To calculate the weighted average monthly payment rate for each age group, we calculated the State-wide enrollment percentage in each contracted health plan for each age group and then multiplied these percentages by each health plan's effective capitation rate for that age group as of October 1, 2021 (see Appendix B, pages b-1 through b-3, for more information on how we calculated this weighted average capitation payment).

² Although some adults are no longer eligible for AHCCCS healthcare coverage after age 64, a few AHCCCS Complete Care programs do allow members age 65 and older to receive AHCCCS healthcare coverage (see Appendix A, pages a-1 through a-4, for more information about these programs).

Source: Auditor General staff analysis of AHCCCS' posted capitation rates as of October 1, 2021, its website, and population statistics for each contractor as of October 1, 2021.

In addition to the monthly capitation payment, federal regulations allow state Medicaid agencies to establish incentive programs with the goals of improving the quality of care members receive and reducing healthcare costs.¹⁹ Accordingly, AHCCCS has established 2 types of incentive payments for its contracted health plans and their contracted providers (see textbox, page 7, for more information about these 2 incentives). Specifically:

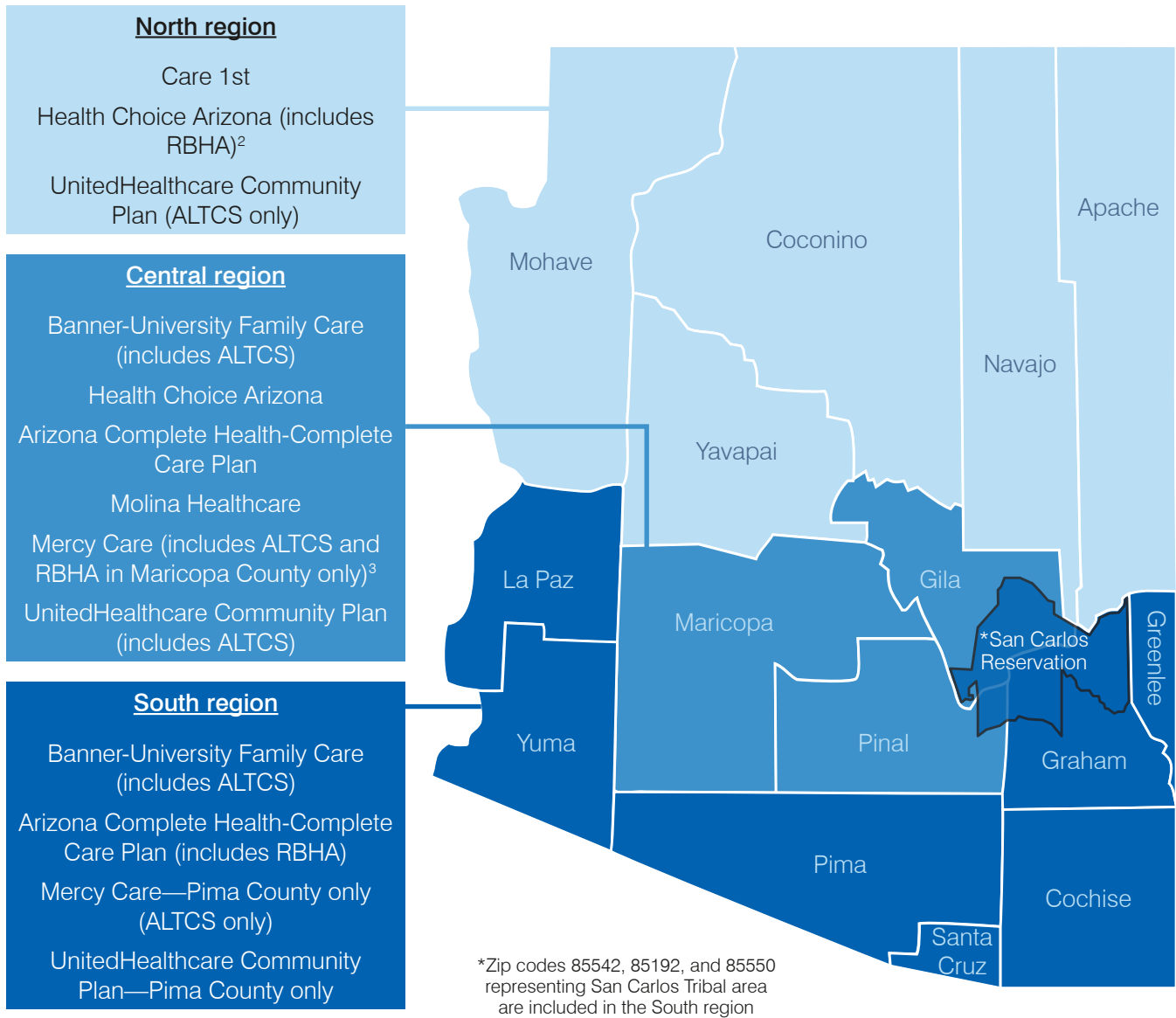
- For its contracted health plan incentive, AHCCCS has adopted specific performance measures based on the CMS Core Set measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures

¹⁷ Gifford, K., Lashbrook, A., Barth, S., Nardone, M., Hinton, E., Guth, M., Stolyar, L., & Rudowitz, R. (2021). *States respond to COVID-19 challenges but also take advantage of new opportunities to address long-standing issues: Results from a 50-state Medicaid budget survey for state fiscal years 2021 and 2022*. San Francisco, CA: Kaiser Family Foundation. Retrieved 1/24/22 from [States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues – Delivery Systems – 9814 | KFF](#).

¹⁸ AHCCCS also contracts with the DCS CHP to provide healthcare services to children involved with the State's foster care system.

¹⁹ 42 CFR §438.6.

Figure 2
AHCCCS contracted health plans by region¹
As of August 2022
(Unaudited)



¹ Each of the 7 contracted health plans that provide AHCCCS Complete Care also provide KidsCare. Additionally, some contracted health plans provide services in more than 1 region. Finally, AHCCCS contracts with ADES' Division of Developmental Disabilities to provide ALTCS services to individuals with developmental disabilities across all regions and with DCS CHP to provide services to children involved with the State's foster care system across all regions.

² RBHA members will transition their health plan coverage from Health Choice Arizona to Care 1st effective October 1, 2022.

³ RBHA members residing in Pinal and Gila Counties will transition their health plan coverage to Mercy Care when it expands its coverage to include both counties effective October 1, 2022.

Source: Auditor General staff analysis of AHCCCS' contracted health plan service maps.

established by the National Committee for Quality Assurance (NCQA) to evaluate contracted health plan performance.^{20,21} Contracted health plans must meet these performance measures to receive an incentive payment. AHCCCS has contracted with an external quality review organization to annually validate whether each contracted health plan met national Medicaid benchmarks for established performance measures and to submit the results of its analysis to AHCCCS. For example, in calendar year 2021, the external quality review organization determined that 5 of 7 Arizona Complete Care contracted health plans met or exceeded the national Medicaid mean (for HEDIS Measurement Year 2020) for performance measures for following up with AHCCCS members within 7 and 30 days following hospitalization for a mental illness. However, it determined that only 2 of 7 contracted health plans met or exceeded the national Medicaid mean (for HEDIS Measurement Year 2020) for the performance measure for providing members with breast cancer screening. AHCCCS staff reported that it annually determines incentive payment amounts for each contracted health plan based on the results of the external quality review organization's analysis. Specifically, when a contracted health plan meets national benchmarks for the performance measure, it receives the AHCCCS-determined incentive payment for that performance measure. Contracted health plans that do not meet national benchmarks for performance measures do not receive the associated incentive payment.

- For the provider incentive, AHCCCS requires its contracted health plans to develop and prescribe performance measures for their providers, and then verify that providers have met or exceeded these performance measures before requesting AHCCCS reimbursement for incentive payments they have made to providers. Based on our review of AHCCCS documentation, it has established some processes for reviewing contracted health plan reported information regarding performance measures providers have met and amounts that contracted health plans have disbursed to their providers as incentive payments, prior to reimbursing contracted health plans for these incentive payments (see Sunset Factor 2, pages 19 through 23, for additional information about these processes).

In addition to its managed care system, AHCCCS also provides healthcare services to some of its members on a fee-for-service basis. Specifically, because federal law prohibits states from requiring Native Americans to enroll in a contracted health plan, AHCCCS allows Native Americans to choose either to enroll in a contracted health plan or enroll in its fee-for-service system.²² Additionally, AHCCCS uses its fee-for-service system to pay for healthcare coverage for other individuals, such as individuals who qualify for emergency healthcare services and who are not eligible for comprehensive health care coverage and individuals not enrolled in an AHCCCS program but who are temporarily enrolled in Medicaid by a hospital for the purpose of providing healthcare services to the individual.^{23,24} As of September 2022, approximately 12 percent of AHCCCS members were

Contracted health plan and provider incentives

Contracted health plan incentive—AHCCCS withholds 1 percent of the monthly capitation payments due to each contracted health plan and then annually awards withheld monies to the health plans based on meeting the established performance measures.

Provider incentive—Contracted health plans pay these incentive payments to providers if they meet certain performance measures specified in their contracts and then AHCCCS reimburses the contracted health plans.

Source: Auditor General staff analysis of AHCCCS' incentive payment policies and procedures.

²⁰ NCQA is a national independent nonprofit organization that is contracted by government entities and private sector clients to measure and improve the quality of healthcare services. NCQA collects data on behalf of CMS.

²¹ According to CMS, HEDIS is a set of standardized performance measures designed to provide information for reliable comparison of health plan performance.

²² 42 USC §1396u-2(a)(2)(C).

²³ AHCCCS provides emergency healthcare services to individuals who meet all Medicaid eligibility requirements, except the citizenship requirement.

²⁴ Certain hospitals are allowed to temporarily enroll individuals in Medicaid immediately if the individual meets specific federal criteria.

enrolled in its fee-for-service system. Finally, in contrast to its managed care system, in its fee-for-service system, AHCCCS pays enrolled providers directly for the services they provide to AHCCCS members based on an established reimbursement rate for each service provided.²⁵

During COVID-19 public health emergency, AHCCCS was required to keep providing healthcare coverage to members

In January 2020, the U.S. Department of Health & Human Services declared a COVID-19 public health emergency in response to the COVID-19 pandemic. During this declared public health emergency, which as of July 2022, had been extended through October 2022, the federal government temporarily increased the federal share of Medicaid funding provided to states.²⁶ To receive this increase in federal Medicaid funding, state Medicaid agencies, including AHCCCS, must continue to provide healthcare coverage to members and are allowed to disenroll members only if the member has died, moved out of state, or requested to withdraw from healthcare coverage.²⁷ This change to require continued coverage for enrolled members who may otherwise have been disenrolled has contributed to AHCCCS' membership increasing from approximately 1.9 million members in January 2020 to over 2.4 million members as of August 2022.

Organization and staffing

As of May 13, 2022, AHCCCS reported having 1,112 filled full-time equivalent (FTE) positions and 128 vacancies assigned to its various divisions and offices. According to AHCCCS, it comprises the following 11 divisions and offices:

- **Division of Business and Finance (52 FTEs, 8 vacancies)**—Responsible for developing and monitoring AHCCCS' budget; processing employee payroll; processing payments to vendors, managed care contractors, and fee-for-service providers; and compiling financial reports.
- **Division of Community Advocacy & Intergovernmental Relations (35 FTEs, 0 vacancies)**—Responsible for promoting recovery, resiliency, and wellness for members with mental health and substance use challenges by ensuring members are aware of peer support and family support services that are available to them and their families and delivering presentations and trainings to the community. This division is also responsible for communicating with CMS, the Governor's Office, and Arizona tribal communities. In addition, this division is responsible for providing information to the public and facilitating various committees, councils, and workgroups that meet to address healthcare needs.
- **Division of Fee-for-Service Management (104 FTEs, 12 vacancies)**—Responsible for paying provider claims, issuing prior authorizations for certain physical and behavioral health services, providing ongoing training, completing clinical claims reviews, providing customer service to providers, and completing healthcare and quality management activities for the fee-for-service population.
- **Division of Grants Administration (26 FTEs, 8 vacancies)**—Responsible for pursuing and managing federal grants that AHCCCS receives, including overseeing and monitoring contractors paid with federal grant monies.
- **Division of Health Care Management (147 FTEs, 21 vacancies)**—Responsible for procuring contracts

²⁵ In addition to the 2 types of incentive payments available to contracted health plans and their providers in its managed care system, AHCCCS has also implemented a differential adjusted incentive payment for fee-for-service providers that increases the amount fee-for-service providers are paid if they achieve AHCCCS-designated performance measures that improve a patient's care experience and health or that reduce the cost of care.

²⁶ In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act, which provided a temporary 6.2 percent increase in federal spending available to state Medicaid agencies. The federal spending increase and corresponding state responsibility to provide continuous coverage remains in place through the end of the fiscal quarter and month, respectively, in which the Public Health Emergency for COVID-19 ends.

²⁷ In addition, federal regulations prohibit states from using federal Medicaid monies to pay for incarcerated individuals' Medicaid coverage.

with and monitoring the performance of AHCCCS' contracted health plans. This division is also responsible for developing actuarially sound capitation rates for all contracted health plans.

- **Division of Human Resources and Development (13 FTEs, 3 vacancies)**—Responsible for recruiting employees, managing employee benefits, developing staff, handling employee relations, and researching and performing workforce analytics.
- **Division of Member and Provider Services (471 FTEs, 56 vacancies)**—Responsible for determining whether individuals, children, and families who apply for healthcare through AHCCCS are eligible for Medicaid or KidsCare coverage, enrolling members into contracted health plans, overseeing Medicaid eligibility decisions made by ADES, registering providers, and communicating with AHCCCS members.
- **Information Services Division (135 FTEs, 12 vacancies)**—Responsible for developing, supporting, and safeguarding information technology systems and services necessary to support AHCCCS' functions.
- **Office of the Director (17 FTEs, 1 vacancy)**—Responsible for providing strategic direction and planning, managing AHCCCS' business processes, and ensuring the implementation of administrative policies and procedures that support Medicaid coverage delivery in Arizona.
- **Office of the General Counsel (35 FTEs, 1 vacancy)**—Responsible for providing legal counsel to AHCCCS administration, ensuring compliance with privacy requirements, developing administrative rules, overseeing the AHCCCS grievance and appeals system, managing provider claims disputes when a provider challenges payments or denials of claims, and assisting with scheduling administrative hearings when a member appeals an AHCCCS or contracted health plan decision.
- **Office of Inspector General (77 FTEs, 6 vacancies)**—Responsible for detecting and preventing fraud, waste, and abuse within the AHCCCS program. This includes conducting audits of providers and members, performing civil and criminal investigations to detect, prevent, and refer for prosecution any provider, subcontractor, member, entity, person, or employee involved in Medicaid fraud, waste, or abuse and recovering State and federal dollars when fraud, waste, or abuse occurs.

Revenues and expenditures

AHCCCS receives federal monies along with State and other monies, such as county and tobacco tax revenues, to operate Arizona's Medicaid program. As shown in Table 2 (see pages 10 through 11), during fiscal year 2022, AHCCCS estimated that its revenues would total nearly \$21.5 billion, including approximately \$17.35 billion in federal Medicaid monies, nearly \$2.73 billion in State monies—\$1.82 billion from the State General Fund and approximately \$900 million received from State agencies for various purposes—and approximately \$1.38 billion from other sources, such as county and tobacco tax revenues. AHCCCS' fiscal year 2022 estimated expenditures totaled more than \$21.16 billion, with about \$15.77 billion, or 74.5 percent, consisting of capitation payments paid to contracted health plans and an estimated \$2.65 billion, or 12.5 percent, paid directly to fee-for-service providers. AHCCCS' estimated fiscal year 2022 revenues and expenditures were approximately \$3.57 billion and \$3.33 billion more, respectively, than fiscal year 2021 revenues and expenditures because as required by the federally declared public health emergency, AHCCCS did not disenroll ineligible members. As a result, the number of members that it served increased. The federal government has also temporarily increased its share of federal monies provided to state Medicaid agencies that complied with public health emergency requirements by 6.2 percent (see page 8 for more information on the public health emergency requirements).

Table 2
Schedule of revenues, expenditures, and changes in fund balances
Fiscal years 2020 through 2022

(In millions)
(Unaudited)

	2020 (Actual)	2021 (Actual)	2022 (Estimate)
Revenues			
Federal ¹	\$12,031.7	\$14,309.0	\$17,347.5
State ²	2,524.6	2,439.6	2,728.3
County ³	119.2	123.0	187.1
Medical assessment ⁴	358.8	776.3	968.7
Other ⁵	237.5	238.5	229.0
Total revenues	15,271.8	17,886.4	21,460.6
Expenditures			
Capitated payments ⁶			
Complete Care	7,659.3	9,802.1	11,101.9
Long-term care	3,122.2	3,330.9	3,849.6
KidsCare	75.5	106.6	145.6
Other ⁷	782.0	819.4	677.5
Fee-for-service ⁶			
Complete Care	1,630.6	1,739.2	2,388.7
Long-term care	176.9	162.3	171.2
KidsCare	4.9	3.4	5.9
Other ⁷	64.3	52.2	79.5
Other ⁸	1,114.4	1,444.0	2,408.8
Administrative	317.8	371.8	337.1
Total expenditures	14,947.9	17,831.9	21,165.8
Net change in fund balance	323.9	54.5	294.8
Fund balances, beginning of year	371.3	695.2	749.7
Fund balances, end of year	\$695.2	\$749.7	\$1,044.5

¹ Federal revenues are monies received from various federal grant programs, such as the U.S. Department of Health & Human Services, Medicaid Assistance Program. The Medicaid Assistance Program provides monies to States for payments of medical assistance on behalf of eligible individuals, including children. Additionally, the amount increased by 6.2 percent during fiscal years 2020 through 2022 because the federal government temporarily increased the federal share of Medicaid funding provided to states in response to the COVID-19 pandemic (see page 8 for additional information).

² State revenues included State General Fund appropriations of approximately \$1.7 billion in both fiscal years 2020 and 2021, and an estimated \$1.82 billion in fiscal year 2022. According to AHCCCS, the remaining State revenues were monies received from State agencies for various purposes. For example, AHCCCS received monies from ADES related to services provided to the Developmental Disabilities Medicaid Program in fiscal years 2020 through 2022. These monies, representing the State's matching portion, along with the federal share, were returned as capitated payments to ADES to pay for the healthcare of Developmental Disabilities Medicaid Program members who are eligible for the Arizona Long Term Care System.

³ County revenues support the long-term care and complete care programs through A.R.S. §11-292 and include monies deposited into the Budget Neutrality Compliance Fund, established in accordance with A.R.S. §36-2928, to provide funding for costs associated with the implementation of the Proposition 204 expansion (see footnote 5, page 11, for additional information). Proposition 204 shifted some county functions to the State and the counties are required to compensate AHCCCS for the services it provides.

⁴ Medical assessment revenues were monies received from hospitals to help pay for an expansion of Medicaid enrollment eligibility to individuals meeting specific eligibility criteria under the Affordable Care Act of 2010 and Proposition 204 (see footnote 5, page 11, for additional information). This assessment along with State General Fund appropriations, certain tobacco tax revenues, and federal monies pay for the full cost of the expansion.

Table 2 continued

- ⁵ Other revenues primarily consist of monies that were authorized for AHCCCS expenditures by voters, such as tobacco settlement monies, gaming revenues, and tobacco tax revenues 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) provided a portion of gaming revenues to be used for a trauma and emergency services program.
- ⁶ Capitated payments were fixed monthly payments paid in advance to AHCCCS' contracted health plans for each enrolled member (see textbox on page 5 for additional information). In addition, the fee-for-service expenditures were payments from AHCCCS to healthcare providers in its fee-for-service system to pay for healthcare services of AHCCCS members who receive services from these providers (see pages 7 through 8, for additional information). Both of these expenditures increased between fiscal years 2020 and 2022 as AHCCCS experienced an increase in the number of its members in response to the federally declared COVID-19 public health emergency (see page 8 for additional information). Specifically, AHCCCS' membership increased from approximately 1.9 million members in January 2020 to over 2.4 million members as of August 2022, thereby increasing the healthcare expenditures incurred by AHCCCS.
- ⁷ According to AHCCCS, the other capitated and fee-for-service expenditures includes various expenditures such as provider and hospital rate incentives and targeted investments, an AHCCCS strategy to provide financial incentives to eligible AHCCCS providers for developing systems for integrated care.
- ⁸ According to AHCCCS, other expenditures include various expenditures such as Medicare premiums, reinsurance, and hospital supplemental programs, non-Medicaid behavioral health services, and hospital directed payments associated with the Health Care Investment Fund. For example, in fiscal year 2021, according to AHCCCS it paid approximately \$28 million for hospital directed payments associated with the Health Care Investment Fund, a fund established by Laws 2020, Ch. 46, that utilizes an assessment on hospitals to increase the base reimbursement level for hospital and other services; \$425 million for Medicare (Part B) premiums to cover medically necessary services such as doctor services, laboratory services, and diabetes screening; and \$364 million to pay for reinsurance, a stop-loss program for partial reimbursement after a deductible is met.

Source: Auditor General staff analysis of the Arizona Financial Information System *Accounting Event Transaction File* and the State of Arizona *Annual Financial Report* for fiscal years 2020 and 2021, and AHCCCS-provided financial information for fiscal year 2022, as August 25, 2022.



AHCCCS has taken more than 1 year to initiate and/or complete its preliminary investigation of more than half of potential fraud or abuse incidents open as of May 2022, potentially resulting in unnecessary payments and difficulty investigating cases

Federal regulations require AHCCCS to identify and perform a preliminary investigation of potential incidents of fraud or abuse committed by members and providers, and AHCCCS has established time frame goals for doing so

Federal regulations require AHCCCS to identify potential incidents of fraud or abuse committed by AHCCCS members and providers and conduct a preliminary investigation to determine whether there is a sufficient basis to conduct a full investigation (see textbox for definition of fraud and abuse).²⁸ Based on the results of its preliminary investigation, AHCCCS may either close the case, complete a full investigation, and/or refer the case to another agency. Specifically, if:

- There is reason to believe that a member abused the Medicaid program, AHCCCS must conduct a full investigation of the abuse incidents.
- There is reason to believe that a member defrauded the Medicaid program, AHCCCS must refer the case to the appropriate law enforcement agency, such as the Arizona Attorney General, county attorneys, or the Federal Bureau of Investigation (FBI).²⁹
- A provider is suspected of fraud or abuse, it must refer the case to the Arizona Attorney General's Medicaid Fraud Control Unit (MFCU) for a full investigation and if necessary, prosecution of the provider.³⁰

Fraud—An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. For example, an applicant submits false or fraudulent information on his/her application form, and because of this information, he/she is approved for healthcare coverage.

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: Arizona Auditor General staff analysis of 42 CFR §455.2 and A.R.S. §36-2905.04.

²⁸ 42 CFR §455.1 et seq.

²⁹ According to AHCCCS, the majority of provider fraud incidents are prosecuted under A.R.S. §13-2310, which covers fraudulent schemes and artifices.

³⁰ As allowed by federal code, the Arizona Attorney General has established the MFCU to investigate and prosecute suspected fraud committed by AHCCCS providers.

Although federal regulations and/or State laws do not establish time frame requirements for AHCCCS to complete its preliminary investigation of potential fraud or abuse incidents, AHCCCS has established time frame goals for doing so.

AHCCCS has taken more than 1 year to initiate and/or complete its preliminary investigation for more than half of potential fraud or abuse incidents that were open as of May 2022

As shown in Figure 3, see page 14, based on our review of AHCCCS' fraud and abuse investigation log as of May 11, 2022, AHCCCS:

- **Had not assigned 77 percent of member potential fraud or abuse incidents received for investigation, with the majority of these incidents being unassigned for more than 1 year**—When AHCCCS receives or identifies potential fraud or abuse incidents committed by members, AHCCCS staff determine whether to assign the incident for immediate investigation or hold the incident to investigate at a later date. However, as of May 2022, AHCCCS had not assigned for investigation 1,093, or 77 percent, of 1,419 member potential fraud or abuse incidents it had received. Further, based on our review of AHCCCS' fraud or abuse investigation log, 833, or approximately 76 percent, of 1,093 member potential fraud or abuse incidents had not been assigned for investigation for more than 1 year.
- **Had not completed its preliminary investigation for at least 52 percent of member potential fraud or abuse incidents within established time frame goals**—Once assigned to an investigator, AHCCCS has established time frame goals for completing its preliminary investigation into potential member fraud or abuse incidents within 3 to 365 days.³¹ However, AHCCCS had not completed its preliminary investigation of assigned potential member fraud or abuse incidents within its established time frame goals. For example, 171, or more than 52 percent, of 326 potential member fraud or abuse incidents assigned for investigation as of May 2022 had been open for longer than 1 year, including at least 4 cases where AHCCCS should have completed its preliminary investigation within 3 days.
- **Had not completed its preliminary investigation of more than half of potential provider fraud or abuse incidents for more than 1 year**—Unlike potential member fraud or abuse incidents, AHCCCS immediately initiates an investigation of all potential provider fraud or abuse incidents it receives. According to its memorandum of understanding (MOU) with the Arizona Attorney General, AHCCCS should conduct prompt preliminary investigations to determine if there is sufficient basis to warrant a full investigation and make all efforts to complete preliminary investigations and refer them to the MFCU within 3 months of receiving the potential fraud or abuse incidents.³² However, based on our review of AHCCCS' fraud or abuse investigation log, 1,012, or 87 percent, of 1,155 potential provider fraud or abuse incidents had been open for preliminary investigation for more than 3 months, including 690, or nearly 60 percent, that had been open for longer than 1 year.

Untimely fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases

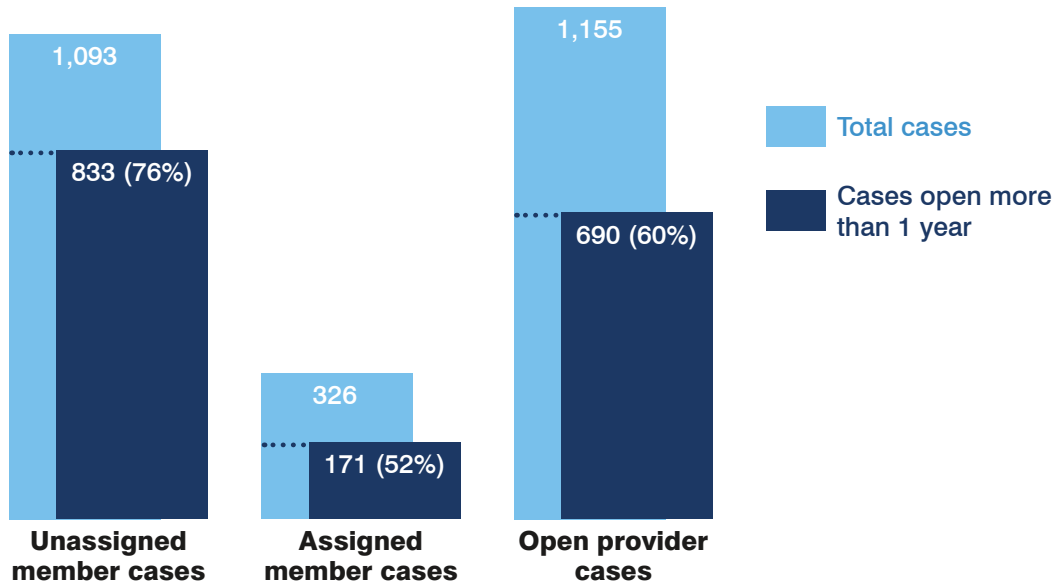
AHCCCS reported that in fiscal year 2022, it investigated and resolved 1,309 provider and 1,068 member fraud or abuse incidents and estimated that it either recovered or saved approximately \$48.1 million in State and

³¹ The number of days to complete its investigation of potential member fraud or abuse incidents is based on the priority level AHCCCS assigns to the incident. For example, after assigning a case for investigation, AHCCCS has established a time frame goal of 3 days for completing its investigation of incidents involving members who are not Arizona residents, while it has established a time frame goal of 1 year to investigate incidents involving members who are self-employed.

³² According to its MOU with the Arizona Attorney General, if a preliminary investigation cannot be completed within 3 months, AHCCCS is required to discuss the case with Arizona Attorney General officials and provide an update on the investigation's status every 90 days.

federal monies.³³ However, if potential fraud or abuse incidents are not investigated and resolved in a timely manner, AHCCCS potentially continues to pay thousands of dollars each year to provide healthcare coverage for a member who may have obtained this coverage fraudulently. Untimely investigations could also delay efforts to recover fraudulent payments and make recovering improper payments more difficult. Finally, AHCCCS risks compromising its ability to gather evidence and follow leads that might become stale as cases age (see textbox, page 15, for a case example).

Figure 3
More than half of unassigned, assigned, and open potential member and provider fraud or abuse incidents had been open for more than 1 year
As of May 11, 2022
(Unaudited)



Source: Arizona Auditor General staff analysis of AHCCCS member and provider fraud or abuse investigation log.

AHCCCS reported insufficient investigative staff affects its ability to investigate potential fraud or abuse incidents in a timely manner, and it does not prioritize all incidents it receives for investigation

AHCCCS reported 2 factors that have contributed to it not meeting its time frame goals. First, AHCCCS reported that the COVID-19 pandemic has delayed their investigations. For example, AHCCCS reported that between March 2020 and December 2021, investigators were not able to conduct in-person visits to homes and schools as part of their investigations, which impacted their ability to verify the reported number of members living in the home and contributing to the household. AHCCCS reported that as of January 2022, it was able to resume conducting in-person visits. Second, AHCCCS reported that staff turnover and an insufficient number of investigators has impacted its ability to investigate potential fraud or abuse incidents in a timely manner. During fiscal year 2022, AHCCCS reported that 12 investigators resigned, but that it also hired 12 investigators. However, AHCCCS reported that it takes a year to train new investigators, and until this training is complete, new investigators are assigned a limited number of cases to investigate. In addition, as of July 25, 2022, AHCCCS reported 6 vacant investigator positions. Despite these vacancies and its workload, AHCCCS has not performed a workload analysis to determine the number of investigators it needs to complete investigations within established time frames and then, based on this analysis, work with the Legislature to obtain additional investigative resources.

³³ The \$48.1 million in recoveries and savings also includes recoveries and savings from other activities, such as independent audits of providers.

Case example

AHCCCS received a potential member fraud or abuse incident in August 2014. AHCCCS staff reported that this incident alleges that another adult was living in and contributing financially to the household and that had this individual's income been included in the household's application, the household would not have been eligible for AHCCCS healthcare coverage. As allowed by its process, AHCCCS deferred this incident and did not assign it for investigation until October 2018, 4 years later. However, once assigned, AHCCCS' preliminary investigation was not completed within 1 year as outlined by its policy. AHCCCS reported that staff investigator turnover and the COVID-19 pandemic contributed to the delays in investigating this incident. As of July 2022, nearly 8 years later, AHCCCS reported it is still performing its investigation and is having difficulty in subpoenaing needed information from the member and the member's employer because the member has moved and changed jobs multiple times since AHCCCS first received the incident.

As of July 2022, these members are still enrolled in AHCCCS healthcare coverage. As a result, AHCCCS has continued, for nearly 8 years, to pay hundreds of dollars every month in capitation payments for members who may be ineligible for healthcare coverage.

Source: Arizona Auditor General staff analysis of AHCCCS-provided case information.

Additionally, although AHCCCS has established a policy and procedure for assigning member potential fraud or abuse incidents for investigation and has established time frame goals for completing these investigations once assigned based on the case priority, it has not established policies or time frames for prioritizing and completing potential provider fraud or abuse incidents that it has opened for investigation. Our 2012 performance audit on *Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes* also reported on AHCCCS' untimely fraud and abuse investigations.³⁴ We recommended that AHCCCS develop screening and prioritization policies for investigating and resolving fraud and abuse cases. In response to our recommendations, AHCCCS developed a case screening and prioritization policy for both potential member and provider fraud or abuse incidents that directed which cases should be investigated first, such as those with the most serious allegation(s) or that involved multiple fraud or abuse incidents for the same provider or member. However, AHCCCS reported that it stopped prioritizing potential provider fraud or incidents because it decided it would open all these cases for investigation. Because AHCCCS is not meeting the 3-month time frame for preliminarily investigating more than half of these cases and either closing them or forwarding them to the MFCU as required, AHCCCS should reinstitute a prioritization policy for investigating provider fraud or abuse incidents, such as those with the most serious allegations, to help ensure that at a minimum, high-priority cases are preliminarily investigated within 3 months.

Recommendations

AHCCCS should:

1. Conduct a workload/cost analysis to evaluate whether its funding and staffing level is sufficient for investigating potential provider and member fraud or abuse incidents within its established time frames and work with the Legislature to revise its appropriations, as needed.
2. Develop and implement policies and procedures, including time frames, for prioritizing and completing potential provider fraud or abuse incidents to help ensure that at a minimum, high-priority incidents are preliminarily investigated within 3 months.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the finding and will implement the recommendations.

³⁴ Arizona Auditor General report 12-06 *Arizona Health Care Cost Containment System—Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes*.



Pursuant to A.R.S. §41-2954(D), the legislative committees of reference shall consider but not be limited to the following factors in determining the need for continuation or termination of AHCCCS. The sunset factor analysis includes findings and associated recommendations.

Sunset factor 1: The objective and purpose in establishing AHCCCS and the extent to which the objective and purpose are met by private enterprises in other states.

AHCCCS was established in 1982 to administer Arizona’s Medicaid program, which provides healthcare coverage to eligible low-income individuals and families living in Arizona. In addition, AHCCCS provides healthcare coverage to low-income children who are not eligible for Medicaid through its KidsCare program. To help meet this objective and purpose, AHCCCS is responsible for reviewing applications for healthcare coverage to determine if the applicant is eligible to receive Medicaid or KidsCare coverage, ensuring that only eligible applicants are enrolled in Medicaid or KidsCare coverage and disenrolling members who are no longer eligible, investigating allegations of fraud or abuse committed by members and providers, overseeing contracted health plans to ensure they are complying with AHCCCS policies and delivering quality healthcare, and providing members with access to behavioral health services.

AHCCCS’ statutory purpose helps the State comply with federal regulations, which requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. As of May 2022, all 50 states had designated a single state agency to administer or supervise the administration of its Medicaid program. We contacted 4 states—Colorado, Florida, Washington, and Wyoming—and found that none use private enterprises to administer or supervise the administration of their Medicaid programs.³⁵

Sunset factor 2: The extent to which AHCCCS has met its statutory objective and purpose and the efficiency with which it has operated.

AHCCCS has met or is taking steps to meet its statutory objective and purpose in some areas we reviewed. For example, as discussed in Sunset Factor 3, pages 23 through 27, AHCCCS contracts with health plans and directly reimburses some service providers to provide both physical and behavioral health services, including telehealth services, to more than 2.4 million members throughout the State as of August 2022 and requires its contracted health plans to meet established provider network adequacy standards and address identified service gaps.

Additionally, although AHCCCS has implemented various processes to help it meet its statutory objective and purpose, we either identified some deficiencies in the processes we reviewed or opportunities to enhance them. For example, although AHCCCS participates in 2 separate federal programs that assess the appropriateness of its eligibility determinations, it has not reviewed some categories of eligibility determinations or required ADES to review its eligibility determinations to ensure they comply with State and federal requirements. Additionally, AHCCCS reviews contracted health plans to assess their performance but has not reviewed each health plan once every 3 years, as required. Further, although AHCCCS has some processes for reviewing contracted health plan reported information regarding provider performance measures and incentive payments, it does not have processes for ensuring that its contracted health plans verify performance measure

³⁵ We identified 4 states—Colorado, Florida, Washington, and Wyoming—for comparison based on several factors including overall population size, percentage of state population receiving Medicaid services, and the percentage of the state Medicaid population that is served by contracted health plans.

information. AHCCCS also lacks formal processes for ensuring that findings and recommendations resulting from 3 separate behavioral health services reviews are addressed, lacks some policies and procedures for overseeing the Housing Program and its Administrator, and has not fully complied with 2 statutory behavioral health services reporting requirements. Finally, AHCCCS has not established written procedures for all Arizona Strategic Enterprise Technology Office (ASET)-required information technology (IT) procedures to help protect its IT infrastructure and sensitive data. Specifically, AHCCCS:

- **Has not ensured the appropriateness of some eligibility determination decisions—**

State Medicaid agencies are required to participate in 2 CMS review programs—the Payment Error Rate Measurement (PERM) review and Medicaid Eligibility Quality Control (MEQC) Program—that assess the appropriateness of these agencies’ eligibility determinations (see textbox for more information on these 2 review programs). AHCCCS’ most recent PERM review occurred in 2021 and this review found that AHCCCS did not correctly process all eligibility determination approvals it reviewed. Specifically, CMS reviewed a random sample of 106 claims paid on behalf of AHCCCS members and identified 16 of these claims, totaling \$19,629, as improper payments because AHCCCS did not correctly process the member’s eligibility determination. For example, AHCCCS had approved 14 members’ eligibility and subsequently made payments on their behalf without collecting or verifying required documentation. Based on the error rate determined by CMS, it projected that an estimated \$1.77 billion, or 16 percent, of all payments AHCCCS made between July 1, 2019 and June 30, 2020, could be improper because it did not comply with eligibility determination requirements. Similarly, the AHCCCS 2021 MEQC review found errors in verifying and including income information when making eligibility decisions.

PERM review—Once every 3 years, CMS contractors and state Medicaid agencies review sampled cases to help ensure that these state Medicaid agencies are meeting several requirements, such as making appropriate eligibility determination decisions to approve, deny, or disenroll an individual from healthcare coverage.

MEQC—During the 2 years when a state Medicaid agency is not undergoing a PERM review, it is required to develop a ‘pilot program’ to evaluate its processes for determining the appropriateness of eligibility decisions to approve, deny, or disenroll an individual from healthcare coverage. At the conclusion of the 2-year MEQC pilot program, state Medicaid agencies are required to provide CMS with a report that includes the results of its review.

Source: Auditor General staff review of federal regulations for and CMS documents on the PERM and MEQC programs.

As of May 2022, AHCCCS had developed corrective action plans to address both the PERM and MEQC findings and was awaiting CMS review and approval of these corrective action plans. In the meantime, AHCCCS reported that it has begun implementing some of the corrective actions specified in its MEQC corrective action plan.

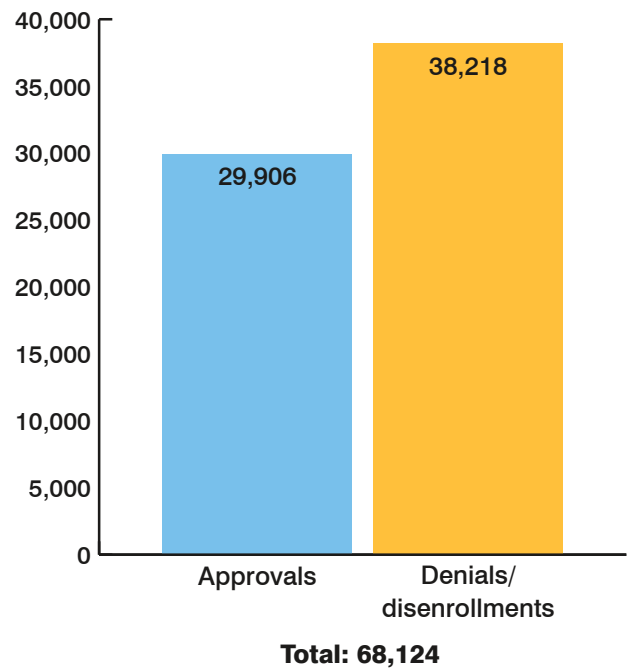
In addition to participating in these 2 CMS reviews, AHCCCS also reviews some eligibility determination decisions made by its and ADES’ staff to verify that these decisions comply with State and federal requirements. However:

- **AHCCCS does not review applications denied and disenrollment decisions its staff make to ensure they are appropriate**—As shown in Figure 4 (see page 18), AHCCCS eligibility workers denied or disenrolled more applicants/members in March through June 2022 than they approved. Although AHCCCS’ quality assurance team reviews a random sample of approved eligibility determinations for enrollment in healthcare coverage to ensure members met eligibility requirements, these quality assurance reviews do not include a review of denied eligibility determinations or members who are disenrolled from healthcare coverage. As a result, AHCCCS cannot ensure the appropriateness of these decisions. According to AHCCCS, except for reviewing these determinations/decisions for new eligibility workers as part of their training, it does not review denials and disenrollment decisions because applicants and members can appeal them. Further, AHCCCS reported that it does not review denials and disenrollment decisions because a sample of these decisions are reviewed as part of the MEQC, and it has focused on reviewing approved eligibility determinations to help ensure

State and federal monies are used only for eligible members. However, AHCCCS does erroneously deny or disenroll individuals/members. For example, AHCCCS' 2021 MEQC review found that nearly 12 percent of sampled denial and disenrollment decisions had errors. Additionally, as discussed on page 22, our 2022 performance audit of AHCCCS' member disenrollment processes found that AHCCCS had improperly disenrolled 50 Native American children and may have improperly disenrolled another 108 Native American children from KidsCare between July 1, 2018 and March 31, 2021, contrary to regulations.³⁶

- **ADES staff make the majority of eligibility determinations, but AHCCCS did not require ADES to review these decisions**—AHCCCS' intergovernmental agreement with ADES requires ADES to review a sample of eligibility decisions its eligibility workers made to determine if the decisions were appropriate and then develop and implement corrective action plans to address identified errors. Despite this requirement, AHCCCS reported that in August 2021, ADES stopped performing these reviews because it needed its quality assurance reviewers to process the increased number of applications received as a result of the COVID-19 pandemic. However, by not reviewing eligibility determinations processed by its eligibility workers, ADES cannot identify incorrect determinations and error trends among its eligibility workers that may indicate the need for additional training to ensure applications are processed appropriately. Although AHCCCS reported that it has reviewed a random sample of ADES eligibility determinations, provided its findings to ADES, and required ADES to respond with corrective actions, it has not required ADES to perform these reviews in accordance with its intergovernmental agreement. AHCCCS staff reported that ADES resumed its review of eligibility determinations in May 2022 and that AHCCCS will be reviewing the results of these eligibility determination reviews.

Figure 4
AHCCCS denied or disenrolled 38,218 of 68,124 applicants/members in March through June 2022



Source: Auditor General staff analysis of AHCCCS eligibility determination data.

- **Has not reviewed contracted health plans once every 3 years as required**—Federal regulations and AHCCCS' policies require AHCCCS to conduct a review of each contracted health plan at least once every 3 years to assess whether the contracted health plans have complied with regulations and their contractual obligations, such as whether the contracted health plans have developed and implemented processes for handling grievances and appeals.³⁷ AHCCCS conducted 22 reviews of contracted health plans between 2016 and 2021 but did not conduct 5 of these reviews within the required 3-year time frame. Additionally, it did not complete required reviews of 7 contracted health plans. As a result, AHCCCS does not have timely information that these reviews would provide to help ensure its contracted health plans comply with all regulations and policies, meet contract and performance requirements, and take corrective action to address identified deficiencies. Although AHCCCS reported that it collects monthly, quarterly, and annual information and data from its contracted health plans, which it uses to assess their performance, this process does not satisfy the requirement to review its contracted health plans once every 3 years. AHCCCS officials reported various reasons for not performing these reviews within the required 3 years, but primarily

³⁶ Arizona Auditor General report 22-103 *Arizona Health Care Cost Containment System—Member Disenrollment Processes*.

³⁷ 42 CFR §§438.358(b)(iii); and §438.364.

cited its focus on ensuring continued access to care for members and provider viability during the federally declared COVID-19 public health emergency. However, AHCCCS may have been able to at least conduct a partial review of these contracted health plans during this time.

- **Has not verified contracted health plan reported information regarding provider performance measures prior to reimbursing contracted health plans for incentive payments made to providers**—As previously discussed in the Introduction, see page 7, AHCCCS requires its contracted health plans to prescribe performance measures for their providers and then verify that providers have met or exceeded these performance measures before requesting AHCCCS reimbursement for incentive payments they have made to providers. Although AHCCCS has established some processes for reviewing contracted health plan reported information regarding provider performance measures and incentive payments, it does not have processes for ensuring that contracted health plans verify performance measure information prior to reimbursing contracted health plans for these incentive payments. By not verifying this information, at a minimum using a risk-based approach, it may reimburse contracted health plans for incentive payments paid to providers who did not meet performance measures.
- **Has not established written procedures for all ASET-required IT requirements**—Arizona State agencies are required to establish IT security and data procedures consistent with the Arizona Department of Administration's (ADOA) ASET State-wide policies and credible industry standards. ASET's policies are intended to help State agencies implement recommended IT security procedures and to protect the State's IT infrastructure and the data contained therein.³⁸ Although AHCCCS had written procedures in some areas required by ASET, it lacked written procedures in several areas. For example, AHCCCS lacked written procedures for:
 - **Network and system logging and monitoring**—AHCCCS has not established written procedures for logging and monitoring—a process that involves determining what data should be logged, how frequently logs should be monitored, and how logs should be protected from unauthorized access (see textbox for descriptions of logging, monitoring, and patches). By not establishing network and system logging and monitoring procedures, AHCCCS may not be tracking and monitoring critical actions on IT systems and networks that would detect improper actions by people with access to its IT systems.
 - **Patch management**—AHCCCS has not established written procedures for patch management—a process that involves testing patches for effectiveness and potential side effects before installation and installing security-relevant patches within 30 days of release from the vendor. By not establishing patch management procedures, AHCCCS may not timely install security-relevant patches, potentially allowing hackers the opportunity to exploit associated vulnerabilities and potentially gain unauthorized access to IT systems.

Logging—A method of tracking critical actions on IT systems.

Monitoring—Reviewing IT system logs to identify improper actions.

Patches—Periodically issued updates to products to correct security vulnerabilities or improve the usability and performance of the product.

Source: Auditor General staff review of ASET policies and guidance.

In July 2022, AHCCCS completed a written action plan for establishing ASET-required IT and data security procedures, focusing on the IT security areas with the highest risks first. According to the action plan, AHCCCS will establish IT security procedures by April 2023.

- **Lacked formal processes for ensuring that findings and recommendations resulting from 3 separate reviews of behavioral health services provided to members with an SMI are addressed**—AHCCCS contracts with 2 different external consultants to conduct 3 separate reviews and/or assessments

³⁸ Beginning September 24, 2022, responsibilities for IT security transitioned to the Arizona Department of Homeland Security.

of behavioral health services provided to members with an SMI in Maricopa County.³⁹ Specifically, AHCCCS contracts with an external consultant to assess whether the delivery of specific behavioral health services adheres to the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration standards. Additionally, AHCCCS contracts with another external consultant to perform 2 separate reviews that assess the provision, quality, and availability of specific behavioral health services to members with an SMI. Each of these 3 reviews can result in findings and recommendations for improved services. Although AHCCCS reported that it requires the contracted health plan responsible for providing these services to work directly with service providers to implement improvement activities in response to these reviews and assessments and meets quarterly with this contracted health plan to review its progress and services, it has not established policies and procedures for doing so.⁴⁰ For example, it does not have a documented process for overseeing its contracted health plan's process for ensuring that service providers address identified deficiencies and recommendations by requiring them to develop and implement corrective actions, reviewing and monitoring the corrective actions, and verifying the implementation of corrective actions or reported improvements. Therefore, AHCCCS cannot ensure that its contracted health plan is working with service providers to address deficiencies and that corrective actions resulted in improved services to members with an SMI.

- **Has not established some policies and procedures for overseeing the Housing Program and its Administrator**—Through its Housing Program, AHCCCS provides housing rental subsidies to qualifying AHCCCS members with an SMI and some members with a general mental health and/or substance use disorder.⁴¹ These subsidies are used to help AHCCCS members pay for the costs of leasing housing in the State. AHCCCS contracts with a Housing Administrator to manage and operate its Housing Program, with specific responsibilities for standardizing housing practices, such as managing the housing wait list and conducting housing-quality inspections; improving overall customer service; and ensuring accountability for AHCCCS's housing resources. To help oversee the Housing Program and Administrator, AHCCCS reported that it is developing policies and procedures for periodically inspecting a sample of housing units, reviewing a random sample of participant files, and a timeline for reviewing Housing Administrator records, and plans to implement the policies, procedures, and timeline beginning in early 2023. Once implemented, these procedures will help ensure that AHCCCS members reside in housing units that comply with federal housing quality standards; and that the Housing Administrator maintains required information regarding members' eligibility for housing and applicable lease information in participant files.

The Housing Administrator contract also requires AHCCCS and the Housing Administrator to establish and track Housing Program performance against established benchmarks.⁴² Specifically, AHCCCS has incorporated several different performance measures, such as the timeliness of annual housing quality inspections and the timeliness of member income reexaminations, into its Housing Administrator contract and requires the Housing Administrator to track and quarterly report to AHCCCS on its performance relative to these measures. AHCCCS reported that it is collecting baseline data to establish benchmarks for the performance measures and plans to require the Housing Administrator to begin reporting on its performance relative to the benchmarks. AHCCCS further reported that it plans to finalize and implement the benchmarks in October 2022, and once established, the Housing Administrator will be required to quarterly report its performance against the benchmarks, along with corrective actions and associated timelines that it will undertake to address performance that falls below the benchmarks. However, AHCCCS has not established policies and procedures for this process, including monitoring its Housing Administrator's efforts to address performance that falls below the benchmarks. Doing so will not only

³⁹ Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

⁴⁰ According to AHCCCS, it also monitors individual member service delivery and adherence to health plan contract requirements.

⁴¹ Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

⁴² The benchmarks are based on Section 8 Management Assessment Program (SEMAP) criteria. SEMAP is a U.S. Department of Housing and Urban Development (HUD) program that establishes criteria to assess housing agencies providing HUD housing vouchers across 14 key areas, including the timeliness of inspections and the accuracy of rent determinations.

help AHCCCS hold the Housing Administrator accountable for its performance but will help ensure that AHCCCS members receive housing services consistent with established requirements and standards.

- **Has not fully complied with 2 statutory behavioral health services reporting requirements**—A.R.S. §36-3432 requires AHCCCS to submit a report to the Legislature and Governor on its annual system plan, which should provide information on the development and implementation of a comprehensive behavioral health service system for children, including identification of services, estimated number of members, and an appropriations request.⁴³ However, AHCCCS reported that it has not submitted this information to the Legislature and Governor since 2017 because effective October 1, 2018, it integrated physical and behavioral health services and no longer maintained some information specific to children’s behavioral health services. In response to our inquiries, AHCCCS reported it could work to determine how to address this reporting requirement. Additionally, A.R.S. §36-3405(D) requires AHCCCS to submit a monthly report to the Legislature and Governor that includes the number of persons served, units of service, and amount of monies provided for member services for each RBHA, by Medicaid and non-Medicaid categories. The report should also include RBHA administration and case management expenses. Although AHCCCS’ report includes the number of members served, it does not include the units of service and the amount of monies provided for member services for each RBHA, and RBHA administration and case management expenses. AHCCCS reported that because it has integrated physical and behavioral health services, it cannot separately provide information on behavioral health administrative expenses. It also did not identify an AHCCCS report that includes information on case management expenses and members’ units of service or provide an explanation for not reporting this required information. Finally, although the *Behavioral Health Annual Report* includes expenditure information per behavioral health category, this is an annual rather than monthly report.
- **Has taken more than 1 year to initiate and/or complete its preliminary investigation of more than half of potential fraud or abuse incidents that were open as of May 2022, potentially resulting in unnecessary payments and difficulty investigating cases**—Federal regulations require AHCCCS to identify and perform preliminary investigations of potential incidents of fraud or abuse committed by members and providers and AHCCCS has established time frame goals for completing these investigations. However, as of May 2022, AHCCCS:
 - Had not assigned 1,093, or 77 percent, of 1,419 potential member fraud or abuse incidents it had received for investigation, with the majority of these cases being unassigned for more than 1 year.
 - Had not completed its preliminary investigation for at least 52 percent of 326 assigned potential member fraud or abuse cases within established time frame goals.
 - Had not completed a preliminary investigation and referred 1,012, or 87 percent, of 1,155 potential provider fraud or abuse incidents to the Arizona Attorney General within 3 months, as prescribed by its MOU with the Arizona Attorney General, including 690, or nearly 60 percent, that had been open for longer than 1 year.

Untimely potential fraud or abuse incident investigations could result in AHCCCS making unnecessary payments for members who fraudulently obtained AHCCCS coverage and compromise AHCCCS’ ability to investigate fraud or abuse incidents. We recommended that AHCCCS conduct a workload/cost analysis to evaluate the adequacy of its funding and staff level for investigating potential provider and member fraud or abuse incidents, and develop and implement policies and procedures, including time frames, for prioritizing and completing potential provider fraud or abuse incidents. See Finding 1, pages 12 through 15, for more information.

⁴³ Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

- Terminated health insurance coverage for some Native American children contrary to regulations; and failed to timely disenroll members from healthcare coverage who were no longer eligible, resulting in unnecessary spending**—State and federal regulations exempt Native Americans from paying premiums for KidsCare.⁴⁴ However, between July 1, 2018 and March 31, 2021, AHCCCS improperly disenrolled 50 Native American children and did not reinstate their KidsCare coverage as required, and disenrolled another 108 Native American children without consistently requesting or providing opportunity to submit required documentation. In addition, AHCCCS untimely disenrolled 769 AHCCCS members who requested to withdraw from healthcare coverage between April 2020 and March 2021, resulting in an estimated \$260,400 in unnecessary spending. Further, AHCCCS and ADES did not consistently submit Medicaid enrollment data to the federal government in fiscal year 2021 to identify and disenroll members improperly enrolled in Medicaid coverage, SNAP, and/or TANF benefits in more than 1 state and did not timely disenroll some AHCCCS members who moved out of State. We recommended that AHCCCS implement monitoring and review processes to ensure Native American children are disenrolled from KidsCare for reasons that comply with State and federal regulations and that it fix data system issues that contributed to members not being disenrolled in a timely manner, implement monitoring processes for ensuring that Medicaid enrollment data is submitted to the federal government, and timely disenroll members who move out of State.
- Did not ensure that all peer specialists met qualification and supervision requirements to provide peer support services to AHCCCS members**—AHCCCS requires its contracted health plans to make available peer support services to members with behavioral health disorders to aid in their recovery.⁴⁵ Peer support services consist of various supportive activities, including assisting AHCCCS members with identifying needs and recovery goals, accessing resources in the community, and understanding and positively adapting to behavioral health challenges using coaching and role modeling. State and federal requirements outline several qualification and supervision requirements for peer specialists, including completing peer support training, being qualified as behavioral health paraprofessional or technician, and receiving required supervision.

However, our review of a random sample of 23 of 951 peer specialists reported as employed during the quarter of October 1, 2021 through December 31, 2021, found that 21 of them lacked documentation demonstrating they met both State and federal qualification requirements to be a peer specialist and/or were not supervised according to requirements. By not ensuring that peer specialists meet required qualifications and receive required supervision, the quality of peer support services provided to members may be compromised. We recommended that AHCCCS ensure peer specialists meet qualification requirements and receive required supervision by developing and implementing monitoring processes, such as assessing compliance with these requirements during its contracted health plan 3-year reviews.

Recommendations

AHCCCS should:

- Develop and implement a risk-based approach to sample and review denied eligibility determinations and disenrollment decisions to ensure these decisions are appropriate.
- Ensure that ADES develops and implements a process for reviewing its eligibility determination decisions, including denials and disenrollments, and monitor this process, as required by its intergovernmental agreement with ADES.
- Conduct performance reviews of its contracted health plans once every 3 years, as required by federal regulations and its policies.

⁴⁴ Arizona Auditor General report 22-103 *Arizona Health Care Cost Containment System—Member Disenrollment Processes*.

⁴⁵ Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

6. Develop and implement a risk-based approach for ensuring that its contracted health plans verify their providers have met required performance measures prior to reimbursing its contracted health plans for provider incentive payments.
7. Implement and use its action plan to guide its efforts in establishing written IT and data security procedures in line with ASET requirements and credible industry standards.
8. Develop and implement policies and procedures for overseeing its contracted health plan's process for ensuring that its service providers address identified deficiencies and recommendations resulting from the 3 reviews and/or assessments of behavioral health services provided to members with an SMI in Maricopa County, such as ensuring the contracted health plan requires its service providers to develop and implement corrective actions, reviews and monitors the corrective actions, and verifies the implementation of corrective actions or reported improvements.
9. Consistent with its plans, develop and implement policies and procedures for overseeing its Housing Program and Housing Administrator by periodically inspecting a sample of housing units and reviewing a random sample of participant files; and requiring the Housing Administrator to take action to address deficiencies, such as through the development and implementation of corrective action plans.
10. Consistent with its plans, finalize and implement benchmarks for evaluating the performance of its Housing Administrator based on established performance measures.
11. Develop and implement policies and procedures for monitoring Housing Administrator performance against its established benchmarks and requiring the Housing Administrator to take action to address performance that falls below the benchmarks, such as through the development and implementation of corrective action plans.
12. As required by A.R.S. §36-3432, prepare and submit an annual report on its annual system plan that provides information on the development and implementation of a comprehensive behavioral health service system for children, including the identification of services, estimated number of members, and an appropriations request. If AHCCCS determines that it cannot meet all or some portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable.
13. As required by A.R.S. §36-3405(D), prepare and submit a complete monthly report that has all required elements, including units of service, amount of monies provided for member services for each RBHA, by Medicaid and non-Medicaid categories, and RBHA administration and case management expenses. If AHCCCS determines that it cannot meet portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the findings and will implement the recommendations.

Sunset factor 3: The extent to which AHCCCS serves the entire State rather than specific interests.

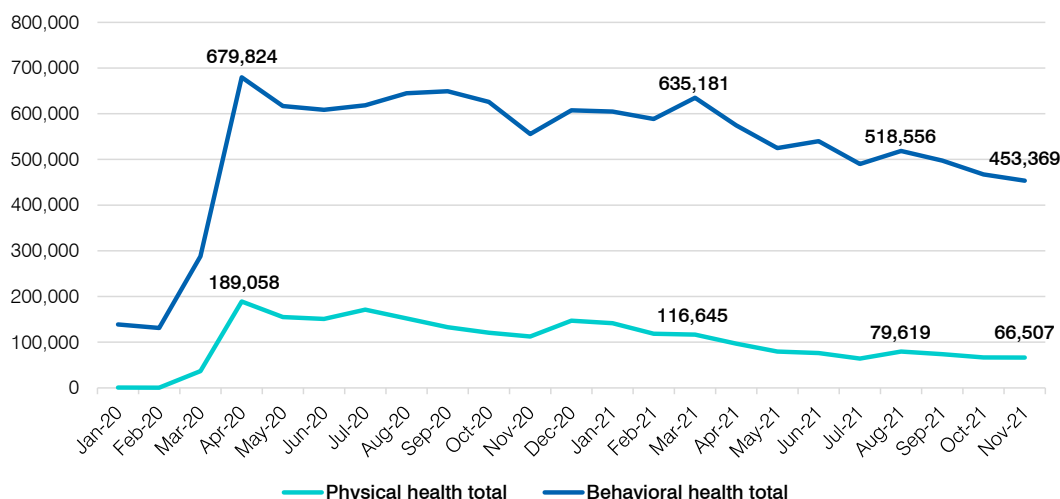
AHCCCS serves the entire State by contracting with health plans to provide a variety of healthcare services, including telehealth services, to enrolled members throughout the State and requires its contracted health plans to meet established provider network adequacy standards and address identified service gaps. AHCCCS also complies with some conflict-of-interest requirements, but we found that it should enhance its conflict-of-interest processes. Specifically, AHCCCS:

- **Contracts with health plans to provide healthcare services to its members**—AHCCCS' contracted health plans provide healthcare services in every Arizona county, and AHCCCS members can select a contracted health plan for their healthcare services based on the county in which they live and the services for which they qualify. As of August 2022, 7 contractors provide healthcare services through AHCCCS Complete Care to AHCCCS members and at least 2 contracted health plans provide healthcare services in each Arizona county. In addition, 4 contracted health plans provide ALTCS services and 3 RBHAs provide

healthcare services to members with an SMI.⁴⁶ Fee-for-service members can receive treatment from any AHCCCS registered provider who accepts AHCCCS fee-for-service payments.

In addition to providing in person healthcare services, AHCCCS' contracted health plans are required to provide a variety of services, including behavioral health services, through telehealth technologies, which are mechanisms for providing healthcare to individuals remotely using technology, such as cell phones or computers. According to the National Conference of State Legislatures, telehealth services benefit individuals because they increase access to care without the individual needing to find transportation or travel long distances and allow patients to receive care more quickly than in-person visits.⁴⁷ As shown in Figure 5, beginning in April 2020, the use of telehealth services increased dramatically but had decreased as of November 2021.

Figure 5
Nearly 870,000 AHCCCS members used telehealth services in April 2020, but use decreased to nearly 520,000 members in November 2021
 (Unaudited)



Source: Auditor General staff review of AHCCCS' telehealth use documentation.

- Has established provider network adequacy standards State-wide, and requires and works with contracted health plans to address service gaps**—Federal regulations require AHCCCS to develop and enforce network adequacy standards for delivering healthcare services to AHCCCS members.⁴⁸ Specifically, state Medicaid agencies must develop network adequacy standards that require a contracted health plan to provide specific services, such as primary care, behavioral health, pharmacy, and pediatric dental services to members enrolled in that health plan and considers factors such as time and distance between providers and members for these network adequacy standards. Accordingly, AHCCCS has established network adequacy standards that require contracted health plans to establish provider networks that can provide the specific services to AHCCCS members within so many minutes or miles from the member's home. Additionally, as specified in their contracts, if contracted health plans are unable to provide services through their established provider networks, they must provide timely and adequate coverage of these services through out-of-network providers.

⁴⁶ AHCCCS also contracts with DCS CHP to provide healthcare services to children involved with the State's foster care system.

⁴⁷ Enlund, S. (2021). *The telehealth explainer series: A toolkit for state legislatures*. Denver, CO: National Conference of State Legislatures. Retrieved 3/9/22 from [The Telehealth Explainer Series: A Toolkit for State Legislators \(ncsl.org\)](https://www.ncsl.org/legislative-services/telehealth-explainer-series).

⁴⁸ 42 CFR §438.68.

Although the contracted health plans generally complied with AHCCCS' network adequacy standards in 2021, some healthcare services, including pediatric dental and pharmacy services, were not available to some members within the required minutes or miles from the member's home (see Table 3, page 26, for more information on services the contracted health plans did not provide within AHCCCS' established time and distance requirements).⁴⁹ As a result, AHCCCS members may experience delays in obtaining some medical and/or dental services. As specified in their contracts, the contracted health plans must continually assess provider network sufficiency using various sources of data, such as member grievances and appeals and service utilization data, to identify service gaps. AHCCCS reported that if a service gap is identified, the contracted health plan is asked to develop steps to address gaps, including short-term interventions when a gap occurs. For example, AHCCCS reported that 1 of its contracted health plans worked in coordination with a pediatric dental office in Northern Arizona to provide dental services through mobile dentistry and tele-dentistry, and provided transportation to dental offices in neighboring counties to address the lack of pediatric dental services in Apache and Coconino Counties. Additionally, AHCCCS works with its contracted health plans, stakeholders, and the Legislature to address provider network gaps. For example, according to AHCCCS, there are no skilled nursing facilities in the State that accept pediatric patients. To address this service gap, during the 2022 legislative session, the Legislature appropriated monies to enhance the reimbursement rate for pediatric skilled nursing facilities and AHCCCS provided data and information to the Legislature regarding this legislation. Finally, according to AHCCCS and as previously discussed, the availability of telehealth services has helped to address the unavailability of some services in some areas. According to AHCCCS' documentation, these telehealth services include primary care physician and cardiologist-provided services.

- **Has not complied with some State conflict-of-interest requirements and some practices were not fully aligned with recommended practices designed to help ensure that employees/public officers comply with State conflict-of-interest requirements**—Statute requires public officers and employees of public agencies to avoid conflicts of interest that might influence or affect their official conduct.⁵⁰ These laws require employees/public officers to disclose substantial financial or decision-making interests and then refrain from participating in matters related to the disclosed interests. To help ensure compliance with these statutory requirements, the *ADOA State Personnel System Employee Handbook* and conflict-of-interest disclosure form (disclosure form) require State employees to disclose if they have any business or decision-making interests, secondary employment, and relatives employed by the State at the time of initial hire and anytime there is a change. The ADOA disclosure form also requires State employees to attest that they do not have any of these potential conflicts, if applicable, also known as an “affirmative no.” In addition, A.R.S. §38-509 requires public agencies to maintain a special file of all documents necessary to memorialize all disclosures of substantial interest and to make this file available for public inspection.

Additionally, in response to conflict-of-interest noncompliance and violations investigated in the course of our work, such as employees/public officers failing to disclose substantial interests and participating in matters related to these interests, we have recommended several practices and actions to various school districts, State agencies, and other public entities.⁵¹ Our recommendations are based on guidelines developed by public agencies to manage conflicts of interest in government and are designed to help ensure compliance with State conflict-of-interest requirements by reminding employees/public officers


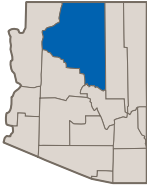


⁴⁹ AHCCCS contracts with an external quality review organization and as part of this contract, the organization is required to work with AHCCCS to review and validate contracted health plan's compliance with AHCCCS' established network adequacy standards.

⁵⁰ A.R.S. §38-501 et seq.

⁵¹ See, for example, Arizona Auditor General reports 21-402 *Higley Unified School District—Criminal Indictment—Conspiracy, Procurement Fraud, Fraudulent Schemes, Misuse of Public Monies, False Return, and Conflict of interest*; 19-105 *Arizona School Facilities Board—Building Renewal Grant Fund*; and 17-405 *Pine-Strawberry Water Improvement District—Theft and misuse of public monies*.

of the importance of complying with the State’s conflict-of-interest laws.⁵² Specifically, conflict-of-interest recommended practices indicate that all public agency employees and public officers complete a disclosure form annually. These recommended practices also indicate that agencies develop a formal remediation process to help ensure that identified conflicts are appropriately addressed.

Table 3
Counties where contracted health plans did not meet AHCCCS’ network adequacy standards for some services
As of October 2021
(Unaudited)

County	Service	Total members	Number of members not meeting time/ distance standards	Percent of members outside time and distance standards
	Adult behavioral health outpatient and integrated clinic	4,892	934	19%
	Pediatric behavioral health outpatient and integrated clinic	3,140	654	21%
	Pediatric dentist	3,570	950	27%
	Adult primary care physician	1,721	227	13%
	Pediatric primary care physician	3,570	456	13%
	Pharmacy	8,032	1,372	17%
	Pediatric dentist	6,664	881	13%
	Pharmacy	14,222	1,539	11%
	Pediatric dentist	322	131	41%
	Pediatric dentist	1,787	643	36%

Source: Auditor General staff analysis of data from the 2021 external quality review organizations report.

AHCCCS has complied with some State conflict-of-interest requirements by requiring its staff to complete the ADOA disclosure form when hired. AHCCCS has also implemented some of the recommended

⁵² Recommended practices we reviewed included: Organization for Economic Cooperation and Development. (2022). *Recommendation of the council on OECD guidelines for managing conflict of interest in the public service*. Paris, France. Retrieved 1/7/2022 from <https://legalinstruments.oecd.org/public/doc/130/130.en.pdf>; Ethics & Compliance Initiative. (2016). *Conflicts of interest: An ECI benchmarking group resource*. Arlington, VA. Retrieved 1/7/2022 from <https://www.ethics.org/wp-content/uploads/2021-ECI-WP-Conflicts-of-Interest-Defining-Preventing-Identifying-Addressing.pdf>; and Controller and Auditor General of New Zealand. (2020). *Managing conflicts of interest: A guide for the public sector*. Wellington, New Zealand. Retrieved 3/4/2021 from <https://oag.parliament.nz/2020/conflicts/docs/conflicts-of-interest.pdf>.

practices, such as developing and implementing policies and procedures to require (1) employees to complete a new disclosure form when a conflict arises during employment and to disclose if they are also employed elsewhere, and (2) management to review and remediate potential conflicts of interest.

Additionally, in July 2022, AHCCCS required all employees to complete the ADOA disclosure form. However, although AHCCCS maintains records of the disclosure statements each employee signs, it does not store all disclosures of a substantial interest in a special file for public inspection, as required by statute.⁵³

Further, AHCCCS had not fully aligned its conflict-of-interest process with recommended practices. Although not required by statute or ADOA, AHCCCS did not annually remind its employees to complete a disclosure form when their circumstances change or provide periodic conflict-of-interest training to its employees related to their unique programs, functions, or responsibilities.

AHCCCS reported that by January 2023, it plans to (1) require all AHCCCS staff members to sign the current ADOA disclosure form, (2) develop and implement a process for reminding employees annually to complete a disclosure form when their circumstances change, (3) develop and implement a special file for substantial interest disclosures, and (4) require staff to complete conflict-of-interest training annually.

Recommendation

14. AHCCCS should implement its plans to comply with State conflict-of-interest requirements and recommended practices by:
 - a. Ensuring all staff complete the current ADOA conflict-of-interest disclosure form, including requiring its staff to disclose whether they or a relative have a substantial interest in any decision of a public agency.
 - b. Developing and implementing a process for reminding employees to annually complete a disclosure form when their circumstances change.
 - c. Developing and implementing a special file for substantial disclosures and making this file available for public inspection.
 - d. Developing and implementing annual conflict-of-interest training.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the finding and will implement the recommendations.

Sunset factor 4: The extent to which rules adopted by AHCCCS are consistent with the legislative mandate.

Based on our review of a sample of 15 of 40 AHCCCS statutes and associated rules, AHCCCS has generally adopted the required rules for these 15 statutes.⁵⁴ However, it has not developed some rules required by statute. Specifically:

- A.R.S. §36-2905.06 requires AHCCCS to adopt rules requiring some members to be fingerprinted at the time of enrollment in statutorily specified AHCCCS programs. AHCCCS reported that it has not developed these rules because CMS did not approve adding a fingerprint requirement for members and stated that it would withdraw federal matching funds if AHCCCS proceeded with this requirement. However, AHCCCS reported that it has not worked with the Legislature to either revise or remove this statutory requirement.

⁵³ A.R.S. §38-509.

⁵⁴ To help conduct this assessment, we used an AHCCCS-provided list of 41 statutes that AHCCCS determined required rules. However, based on our review of this list, we determined that 3 of the 41 statutes did not require AHCCCS to develop rules. In addition, we identified 2 additional statutes that were not on AHCCCS' list that require AHCCCS to develop rules.

- A.R.S. §36-2930.05 requires AHCCCS to adopt rules for excluding providers who have been convicted of certain crimes, such as neglect or abuse of a patient or fraud, from providing services to AHCCCS members.⁵⁵ AHCCCS must adopt rules specifying the processes for (1) determining how long the provider is to be excluded, (2) appealing the exclusion, and (3) requesting reinstatement following an exclusion. As of April 2022, AHCCCS reported that it had not adopted rules for A.R.S. §36-2930.05 because there is ongoing litigation surrounding this requirement to exclude providers.

Recommendations

AHCCCS should:

15. Work with the Legislature to either revise or remove A.R.S. §36-2905.06, which requires it to adopt rules requiring members to be fingerprinted at the time the member is enrolled in a healthcare coverage program.
16. Adopt rules for excluding providers who have been convicted of certain crimes, as required by A.R.S. §36-2930.05, once litigation surrounding this requirement is resolved.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the finding and will implement the recommendations.

Sunset factor 5: The extent to which AHCCCS has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

AHCCCS has encouraged input from the public before adopting its rules and informed the public as to its actions and their expected impact on the public. Specifically, AHCCCS informed the public of its rulemakings and their expected impacts and provided opportunities for public input as part of various rulemakings it conducted between May 2020 and April 2022 that involved rewarding hospital providers that have improved patient care and health while reducing the cost of care, distributing monies to hospitals for providing graduate medical education programs, and changing the reimbursement rate for certain services. For these rulemakings, AHCCCS published notices of its proposed rulemakings in the Arizona Administrative Register and included a statement detailing the impact on the public. Additionally, AHCCCS provided contact information in the notices for AHCCCS staff who would receive public input about the proposed rulemaking and allowed the public to submit written comments on proposed rule changes for at least 30 days after it published the first notice. AHCCCS received public input for 5 of the proposed rulemakings we reviewed. Specifically, 4 organizations provided comments on the rules AHCCCS was proposing to adopt.

AHCCCS also provides information to the public through its website. For example, AHCCCS has provided information about its plans for the end of the public health emergency and what AHCCCS members can do when the public health emergency ends to maintain their healthcare coverage. Additionally, AHCCCS provides information about its contracted health plans, such as what counties the health plan serves, the health plans' contact information, a tool for identifying which providers are affiliated with the health plan, the results of its contracted health plan reviews, the contracted health plan's audited financial statements, and the services provided by the contracted health plans. If a contracted health plan intends to change ownership, AHCCCS provides an opportunity for members to comment on the proposed change of ownership.

Finally, although AHCCCS provides member enrollment and demographic data, such as gender, race, ethnicity, and age on its website, it provides this data at an aggregate level—for all enrolled AHCCCS members—and does not present an analysis of this data based on the different/specific member subpopulations it serves. For example, members of the public cannot use AHCCCS demographic data to identify the race, ethnicity, or gender of children enrolled in AHCCCS. In addition, AHCCCS does not provide some expenditure information for managed care on its website, including expenditures by county and amounts spent on the various services it provides, such as dental, ambulance, and hospice services. As a result, AHCCCS and stakeholders do

⁵⁵ 42 CFR §1001 et seq. also establishes various mandatory and permissive provider exclusions.

not have access to information that could help identify disparities and patterns of inequity within AHCCCS' provision of healthcare services and demonstrates accountability for how State and federal monies are spent. Based on our review of 4 states' Medicaid agency websites—Colorado, Florida, Washington, and Wyoming—2 states provided more information about member demographics and/or how state and federal monies are spent. For example, Washington has an interactive dashboard that allows the public to view demographic information by subpopulation, such as how many Native American members are male or female and the age of these members. Wyoming's annual Medicaid agency report includes information about expenditures, such as how much was spent on each type of service, by each program, or by each provider.

Recommendation

17. AHCCCS should enhance the demographic and expenditure information on its website, such as providing demographic information by subpopulations and expenditure information by county and service.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the finding and will implement the recommendations.

Sunset factor 6: The extent to which AHCCCS has been able to investigate and resolve complaints that are within its jurisdiction and the ability of AHCCCS to timely investigate and resolve complaints within its jurisdiction.

AHCCCS has established various processes to address appeals and/or complaints of AHCCCS and contracted health plan decisions and requires its contracted health plans to have processes for addressing member grievance and appeals, but has not resolved some appeals in a timely manner or established formal processes for handling all grievances and appeals. Specifically, AHCCCS:

- **Has established processes for reviewing appealed decisions but has not resolved some of these appeals in a timely manner**—As required by State and federal regulations, AHCCCS provides a process for Medicaid applicants or members to request a hearing to appeal an AHCCCS decision.^{56,57} For appeals received from fee-for-service members, such as a denial of a service, rule requires AHCCCS to administratively review the appeal and determine whether to uphold or reverse its decision within 30 days. If the AHCCCS member is unsatisfied with the decision, then AHCCCS proceeds with an administrative hearing, conducted by the Office of Administrative Hearings (OAH). For other appeals, such as appeals involving denial of or disenrollment from healthcare coverage, and according to rule, if AHCCCS does not deny the appeal, AHCCCS must proceed with an administrative hearing, conducted by OAH. According to AHCCCS, in fiscal year 2021, it received 1,361 eligibility and 87 fee-for-service appeals.

AHCCCS is required by State and federal regulations to resolve the appeal and provide the individual with a final decision within 90 days from the date the appeal is filed.⁵⁸ However, AHCCCS did not resolve 40 of 555 eligibility appeals it received during fiscal year 2021 within this time frame. By not doing so, decisions regarding applicants' or members' access to healthcare services is delayed. AHCCCS staff reported that one-third of these appeals were not resolved in a timely manner because its Division of Member and Provider Services erroneously assumed that the appeal had already been forwarded or they were uncertain of the time frame for forwarding the appeal to the Office of the General Counsel, which is responsible for handling these appeals. AHCCCS staff were unable to explain the delays for resolving the remaining appeals.

- **Requires its contracted health plans to handle grievances and appeals from managed care members**—AHCCCS requires its contracted health plans to have processes for addressing grievances received from members, members' representatives, stakeholders, and/or providers who have quality-of-

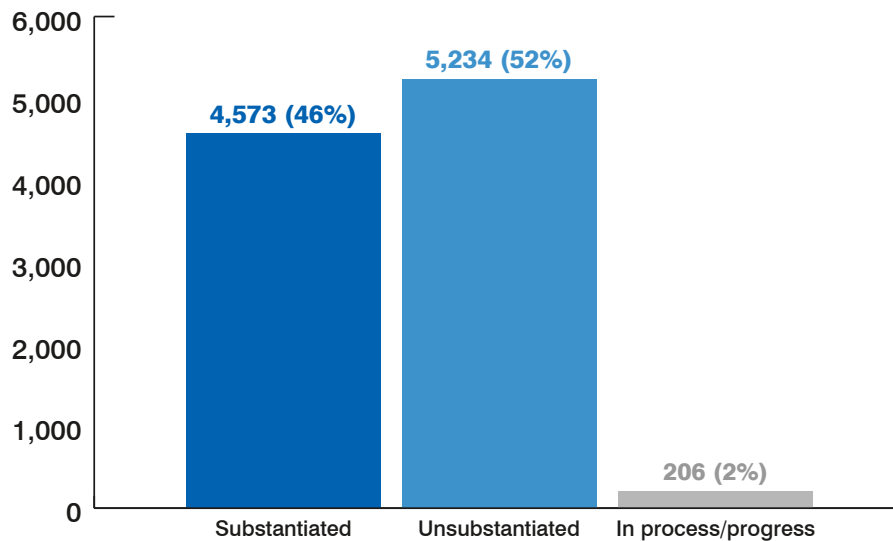
⁵⁶ 42 CFR §431.200 et seq.; AAC R9-34-101; AAC R9-34-301.

⁵⁷ This process only applies to eligibility determinations made by AHCCCS eligibility workers; ADES has a separate eligibility determination appeals process. We did not review ADES' eligibility decision appeals process because it was not within the scope of the audit.

⁵⁸ 42 CFR §431.244; AAC R9-34-111.

care concerns that involve allegations that the care or treatment caused harm or may cause a risk of harm to a member. The contracted health plan must investigate and resolve quality-of-care grievances, and the contracted health plan must submit a report to AHCCCS detailing the steps it took to address the quality-of-care grievance. AHCCCS reported that in fiscal year 2021, its contracted health plans received 10,013 quality-of-care grievances.⁵⁹ As shown in Figure 6, AHCCCS' contracted health plans substantiated nearly half of these grievances. According to AHCCCS policy, if a grievance is substantiated, the contracted health plan is required to follow up with the member to ensure immediate health care needs are met and send a letter to the member providing a contact name/telephone number to call for assistance or to express any unresolved concerns. The contracted health plan must also implement corrective actions to identify and address the reasons leading to the substantiated concern, including educating providers, analyzing and addressing the cause(s) for the concern, and providing ongoing monitoring.

Figure 6
Contracted health plan resolution of 10,013 quality-of-care grievances received in fiscal year 2021
As of July 2022
(Unaudited)



Source: Auditor General staff review of AHCCCS provided information.

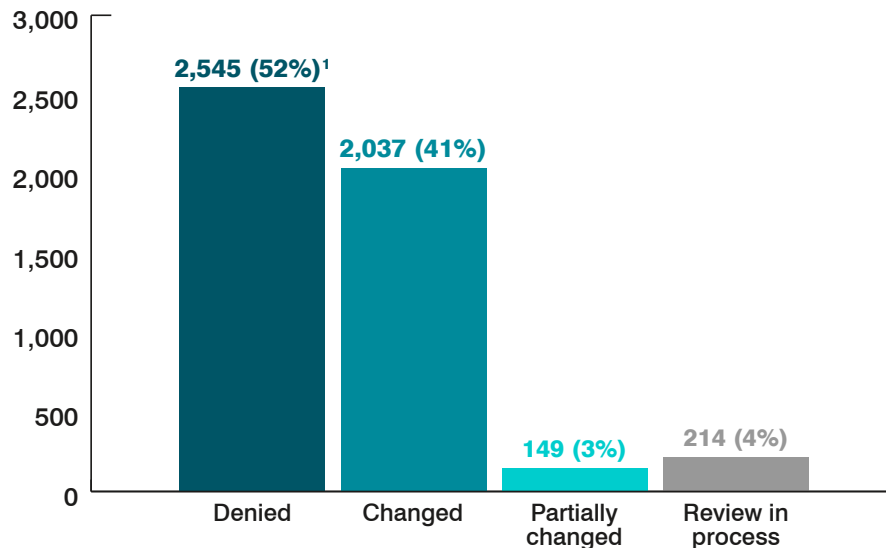
State and federal regulations also require AHCCCS and its contracted health plans to have processes for addressing appeals of contracted health plan actions, such as when the contracted health plan does not authorize a requested service or denies a service payment. In these cases, the contracted health plan is required to notify the member of their right to appeal an adverse benefit determination. The contracted health plan is required to address each appeal it receives and notify the member of the decision. In fiscal year 2021, AHCCCS reported that the contracted health plans received 4,945 appeals of their actions. As shown in Figure 7 (see page 31), for more than half of members' appeals, contracted health plans denied the member's request for a change in a contracted health plans' decision, but changed or partially changed their decisions in nearly 45 percent of appeals. For example, based on a changed decision, the contracted health plan might authorize a previously unauthorized service or approve a denied service payment. The contracted health plan is also required to notify the member that they can request an administrative hearing with OAH if the appeal was not resolved wholly within their favor. However, only 110 of 2,545 members requested an administrative hearing with OAH for their denied appeal.

⁵⁹ The total number of quality-of-care grievances excludes 616 grievances opened in error that AHCCCS approved for closing.

Figure 7

**Number of fiscal year 2021 member appeals contracted health plans denied, changed or partially changed original determination, or were under review
As of July 2022**

(Unaudited)



¹ 110 members out of 2,545 members whose contracted health plans denied their appeals filed a request for an administrative hearing and were scheduled for a hearing at OAH.

Source: Auditor General staff review of AHCCCS provided information.

During its 3-year reviews and per its review process (see pages 18 through 19), AHCCCS is required to assess contracted health plans' compliance with grievance and appeal handling requirements for quality-of-care concerns, other grievances, and appeals. For example, AHCCCS should review whether the contractor has a structure and process for (1) tracking and trending quality-of-care concerns, (2) meeting required grievance and appeal processing time frames, and (3) complying with member grievance and appeal notification requirements. The review process also requires AHCCCS staff to review a sample of quality-of-care grievances to assess whether contracted health plans appropriately resolved these identified concerns. Based on our review of a judgmental sample of 3 contracted health plan reviews AHCCCS conducted between calendar years 2016 and 2021, AHCCCS reported that the contracted health plans had established and followed the required processes for handling member grievances and appeals.⁶⁰

- **Reported reviewing grievances and appeals from Arizona State Hospital (ASH) patients but lacks a formal process for reviewing them and verifying corrective actions taken by ASH adequately address identified concerns**—State regulations require AHCCCS to (1) address grievances filed by ASH patients with an SMI related to allegations of physical abuse, sexual abuse, and death; (2) provide a secondary review and decision on determinations of grievances by ASH; and (3) hold an administrative hearing through OAH for patients who appeal AHCCCS and ASH grievance decisions.⁶¹ ASH, which is operated by the Arizona Department of Health Services, provides long-term inpatient psychiatric care to Arizona residents with mental illnesses who are under court order for treatment. AHCCCS reported that it follows the rules it promulgated for reviewing these grievances and appeals, and if its review identifies a concern or problem with ASH practices, it will require ASH to develop and implement a corrective action plan to address the incident, which it reviews and follows up on to ensure ASH took the specified corrective action. However, AHCCCS has not developed written policies and procedures for this process. Without

⁶⁰ We reviewed a judgmental sample of 3 of 12 contracted health plans reviews AHCCCS conducted in calendar years 2017, 2019, and 2021. For more information on how we selected our sample, see Appendix B, pages b-1 through b-3.

⁶¹ AAC R9-21-404(A)(2) & (B)(2); AAC R9-21-407(A); AAC R9-21-408.

a more formal process, AHCCCS may not fully or consistently review and address these grievances and appeals. In fiscal year 2021, AHCCCS reported receiving 23 grievances and 11 appeals from ASH patients and required ASH to develop corrective action plans in response to 2 grievances where it confirmed instances of physical abuse and sexual abuse. Based on our review of documentation, during fiscal year 2022, ASH reported that it had worked with the involved employees and would be revising its policies and procedures to address the concerns. AHCCCS then determined that ASH had taken adequate corrective actions to address these concerns and closed them, although it did not provide documentation that it had verified ASH's corrective actions.

- **Is developing policies and procedures for handling appeals from members receiving services from its Housing Program**—As reported in our 2022 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services* report, AHCCCS' Housing Program is a community-based permanent supportive housing program that provides rental support through housing subsidies to benefit members with an SMI and some AHCCCS members with a general mental health and/or substance use disorder.⁶² According to its *Housing Program Guidebook*, AHCCCS' contracted housing administrator is required to maintain policies and procedures for handling grievances and appeals from members participating in the Housing Program. Members may file grievances and appeals regarding actions of the Housing Administrator, such as determinations of rental subsidy amounts. The *Housing Program Guidebook* also specifies that members may appeal Housing Administrator decisions to AHCCCS, and as of September 2022, AHCCCS reported that it was developing policies and procedures for handling these appeals. Between October 2021 and May 2022, according to AHCCCS, its Housing Administrator reported receiving 1 grievance and no appeals from Housing Program members.

Recommendations

AHCCCS should:

18. Establish processes requiring its Division of Member and Provider Services to forward eligibility appeals to the Office of the General Counsel immediately upon receipt to help ensure these appeals are reviewed and processed within 90 days of receipt.
19. Train staff in the Division of Member and Provider Services who receive applications for appeals on the process and time frames for submitting eligibility appeals to the Office of the General Counsel.
20. Develop and implement additional appeal-handling procedures, such as monitoring and review procedures, to help ensure that eligibility appeals are timely resolved in compliance with State regulations.
21. Develop and implement policies and procedures for reviewing and resolving grievances and appeals it receives from ASH patients, including procedures that specify when corrective action plans should be developed, and require AHCCCS staff to review and follow up on corrective action plans, and verify corrective actions taken to ensure that ASH has addressed identified concerns.
22. Continue developing and implementing policies and procedures for handling appeals from members receiving services from its Housing Program.

AHCCCS response: As outlined in its [response](#), AHCCCS agrees with the findings and will implement the recommendations.

Sunset factor 7: The extent to which the Attorney General or any other applicable agency of State government has the authority to prosecute actions under the enabling legislation.

The Arizona Attorney General and county attorneys have concurrent authority to prosecute actions related to AHCCCS, as specified in statute.⁶³ For example, both are involved in prosecuting Medicaid fraud cases that AHCCCS refers to them. According to AHCCCS, it typically refers cases involving Medicaid member fraud to

⁶² Arizona Auditor General report 22-111 *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*.

⁶³ A.R.S. §13-3713(G).

the County Attorney where the member resides for prosecution. As allowed by federal regulations, the Arizona Attorney General has established the MFCU to investigate and prosecute suspected fraud committed by AHCCCS providers.⁶⁴ AHCCCS has established a MOU with the Attorney General's MFCU, and according to this agreement, AHCCCS is responsible for conducting a preliminary investigation of suspected fraud or abuse incidents to determine whether there is a sufficient basis to refer the case to the MFCU for a full investigation and prosecution.

Sunset factor 8: The extent to which AHCCCS has addressed deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

According to AHCCCS, there are no deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

Sunset factor 9: The extent to which changes are necessary in the laws of AHCCCS to adequately comply with the factors listed in this sunset law.

As reported in Sunset Factor 4 (see pages 27 through 28), AHCCCS has not complied with A.R.S. §36-2905.06, which requires it to adopt rules for fingerprinting some members at the time of enrollment. AHCCCS reported that it has not developed rules for A.R.S. §35-2905.06 because CMS did not approve adding a fingerprint requirement for members and stated that it would withdraw federal matching funds if AHCCCS proceeded with this requirement. We recommend that AHCCCS work with the Legislature to revise or remove A.R.S. §36-2905.06.

Sunset factor 10: The extent to which the termination of AHCCCS would significantly affect the public health, safety, or welfare.

Terminating AHCCCS would affect the public's health, safety, and welfare if its responsibilities were not transferred to another entity. As of August 2022, approximately 2.4 million Arizonans were enrolled in AHCCCS, 38 percent of whom were children and 6 percent of whom were age 65 or older. To help pay for these healthcare services, in fiscal year 2021, AHCCCS received approximately \$14.3 billion and \$2.4 billion in federal and State monies, respectively.⁶⁵ As previously reported (see page 16), federal regulations require each state to designate a single state agency to administer or supervise the administration of its Medicaid program. Unless another state agency assumed AHCCCS' role as Arizona's Medicaid agency, Arizona would not receive these federal monies, which could result in most, if not all, of the 2.4 million Arizonans losing their healthcare coverage. Additionally, because federal law requires hospital emergency rooms to treat all patients regardless of their ability to pay, the increase in the number of uninsured individuals could put additional financial strain on the State's emergency care system. Finally, because AHCCCS contracts for healthcare services to be provided to its members, terminating AHCCCS would also have a negative impact on AHCCCS' 15 contracted health plans, the healthcare providers that AHCCCS and the contracted health plans contract with, and their employees.

Sunset factor 11: The extent to which the level of regulation exercised by AHCCCS compares to other states and is appropriate and whether less or more stringent levels of regulation would be appropriate.

This factor does not apply because AHCCCS is not a regulatory agency.

Sunset factor 12: The extent to which AHCCCS has used private contractors in the performance of its duties as compared to other states and how more effective use of private contractors could be accomplished.

AHCCCS makes extensive use of private contractors. Specifically, in fiscal year 2021, AHCCCS paid approximately \$14.1 billion in capitation payments to contracted health plans and \$2 billion to healthcare

⁶⁴ 42 CFR §1007.1 et seq.

⁶⁵ Auditor General staff analysis of the Arizona Financial Information System *Accounting Event Transaction File* and the State of Arizona *Annual Financial Report* for fiscal year 2021.

providers who provided healthcare services to AHCCCS fee-for-service members. These payments represented about 90 percent of AHCCCS expenditures in fiscal year 2021. Additionally, AHCCCS uses private contractors to perform other duties, such as providing expert legal counsel when needed, supporting AHCCCS' in-house actuarial unit in developing capitation rates, and handling third-party liability. We compared AHCCCS' use of private contractors to state Medicaid agencies in Colorado, Florida, Washington, and Wyoming and found that although these states contract for some similar services, they also contract for services that AHCCCS either performs or largely performs itself. For example, all 4 states we contacted do not have in-house actuarial units and contract for all actuarial services.

We did not identify any additional areas where AHCCCS should consider using private contractors.



SUMMARY OF RECOMMENDATIONS

Auditor General makes 22 recommendations to AHCCCS

AHCCCS should:

1. Conduct a workload/cost analysis to evaluate whether its funding and staffing level is sufficient for investigating potential provider and member fraud or abuse incidents within its established time frames and work with the Legislature to revise its appropriations, as needed (see Finding 1, pages 12 through 15, for more information).
2. Develop and implement policies and procedures, including time frames, for prioritizing and completing potential provider fraud or abuse incidents to help ensure that at a minimum, high-priority incidents are preliminarily investigated within 3 months (see Finding 1, pages 12 through 15, for more information).
3. Develop and implement a risk-based approach to sample and review denied eligibility determinations and disenrollment decisions to ensure these decisions are appropriate (see Sunset Factor 2, pages 16 through 23, for more information).
4. Ensure that ADES develops and implements a process for reviewing its eligibility determination decisions, including denials and disenrollments, and monitor this process, as required by its intergovernmental agreement with ADES (see Sunset Factor 2, pages 16 through 23, for more information).
5. Conduct performance reviews of its contracted health plans once every 3 years, as required by federal regulations and its policies (see Sunset Factor 2, pages 16 through 23, for more information).
6. Develop and implement a risk-based approach for ensuring that its contracted health plans verify their providers have met required performance measures prior to reimbursing its contracted health plans for provider incentive payments (see Sunset Factor 2, pages 16 through 23, for more information).
7. Implement and use its action plan to guide its efforts in establishing written IT and data security procedures in line with ASET requirements and credible industry standards (see Sunset Factor 2, pages 16 through 23, for more information).
8. Develop and implement policies and procedures for overseeing its contracted health plan's process for ensuring that its service providers address identified deficiencies and recommendations resulting from the 3 reviews and/or assessments of behavioral health services provided to members with an SMI in Maricopa County, such as ensuring the contracted health plan requires its service providers to develop and implement corrective actions, reviews and monitors the corrective actions, and verifies the implementation of corrective actions or reported improvements (see Sunset Factor 2, pages 16 through 23, for more information).
9. Consistent with its plans, develop and implement policies and procedures for overseeing its Housing Program and Housing Administrator by periodically inspecting a sample of housing units and reviewing a random sample of participant files; and requiring the Housing Administrator to take action to address deficiencies, such as through the development and implementation of corrective action plans (see Sunset Factor 2, pages 16 through 23, for more information).

10. Consistent with its plans, finalize and implement benchmarks for evaluating the performance of its Housing Administrator based on established performance measures (see Sunset Factor 2, pages 16 through 23, for more information).
11. Develop and implement policies and procedures for monitoring Housing Administrator performance against its established benchmarks and requiring the Housing Administrator to take action to address performance that falls below the benchmarks, such as through the development and implementation of corrective action plans (see Sunset Factor 2, pages 16 through 23, for more information).
12. As required by A.R.S. §36-3432, prepare and submit an annual report on its annual system plan that provides information on the development and implementation of a comprehensive behavioral health service system for children, including the identification of services, estimated number of members, and an appropriations request. If AHCCCS determines that it cannot meet all or some portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable (see Sunset Factor 2, pages 16 through 23, for more information).
13. As required by A.R.S. §36-3405(D), prepare and submit a monthly report that has all required elements, including units of service, amount of monies provided for member services for each RBHA, by Medicaid and non-Medicaid categories, and RBHA administration and case management expenses. If AHCCCS determines that it cannot meet portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable (see Sunset Factor 2, pages 16 through 23, for more information).
14. Implement its plans to comply with State conflict-of-interest requirements and recommended practices by:
 - a. Ensuring all staff complete the current ADOA conflict-of-interest disclosure form, including requiring its staff to disclose whether they or a relative have a substantial interest in any decision of a public agency.
 - b. Developing and implementing a process for reminding employees to annually complete a disclosure form when their circumstances change.
 - c. Developing and implementing a special file for substantial disclosures and making this file available for public inspection.
 - d. Developing and implementing annual conflict-of-interest training (see Sunset Factor 3, pages 23 through 27, for more information).
15. Work with the Legislature to either revise or remove A.R.S. §36-2905.06, which requires it to adopt rules requiring members to be fingerprinted at the time the member is enrolled in a healthcare coverage program (see Sunset Factor 4, pages 27 through 28, for more information).
16. Adopt rules for excluding providers who have been convicted of certain crimes, as required by A.R.S. §36-2930.05, once litigation surrounding this requirement is resolved (see Sunset Factor 4, pages 27 through 28, for more information).
17. Enhance the demographic and expenditure information on its website, such as providing demographic information by subpopulations and expenditure information by county and service (see Sunset Factor 5, pages 28 through 29, for more information).
18. Establish processes requiring its Division of Member and Provider Services to forward eligibility appeals to the Office of the General Counsel immediately upon receipt to help ensure these appeals are reviewed and processed within 90 days of receipt (see Sunset Factor 6, pages 29 through 32, for more information).
19. Train staff in the Division of Member and Provider Services who receive applications for appeals on the process and time frames for submitting eligibility appeals to the Office of the General Counsel (see Sunset Factor 6, pages 29 through 32, for more information).

20. Develop and implement additional appeal-handling procedures, such as monitoring and review procedures, to help ensure that eligibility appeals are timely resolved in compliance with State regulations (see Sunset Factor 6, pages 29 through 32, for more information).
21. Develop and implement policies and procedures for reviewing and resolving grievances and appeals it receives from ASH patients, including procedures that specify when corrective action plans should be developed, and require AHCCCS staff to review and follow up on corrective action plans, and verify corrective actions taken to ensure that ASH has addressed identified concerns (see Sunset Factor 6, pages 29 through 32, for more information).
22. Continue developing and implementing policies and procedures for handling appeals from members receiving services from its Housing Program (see Sunset Factor 6, pages 29 through 32, for more information).



AHCCCS has several healthcare coverage programs, each with different eligibility requirements

AHCCCS has established several programs that provide healthcare services to its members within 3 of its program areas—AHCCCS Complete Care, KidsCare, and ALTCS (see Introduction, pages 1 through 2, for more information about these program areas). Although these programs share common eligibility requirements, some have additional program-specific eligibility requirements (see Table 4, pages a-2 through a-4, for more information on these programs and program-specific eligibility requirements). Applicants applying for all or most of these programs must meet the following eligibility requirements:

- Be an Arizona resident.
- Be a U.S. citizen or qualified noncitizen.
- Provide a valid Social Security Number.⁶⁶
- Not be incarcerated.
- Submit a valid application.⁶⁷
- Apply for any cash benefits for which the individual might qualify.⁶⁸
- Give AHCCCS rights to any medical support or medical services payments from any third party.⁶⁹

In addition, many of AHCCCS' programs require applicants to have income at or below a certain percentage of the federal poverty level.⁷⁰

⁶⁶ Caretakers do not need to submit a valid social security number for newborn babies enrolled in the Deemed Newborn Program.

⁶⁷ Individuals do not need to submit a valid application to be enrolled in the Deemed Newborn Program, the Supplemental Security Income (SSI) Cash Program, or the Title IV-E Adoption Subsidy Programs.

⁶⁸ Individuals do not need to apply for any cash benefits for which the individual might qualify if they are enrolled in the Deemed Newborn Program, the SSI Cash Program, the Transplant Extended Eligibility Program, and the KidsCare Program.

⁶⁹ Individuals do not need to give AHCCCS rights to any medical support or medical services payments from any third party to be enrolled in the Deemed Newborn Program, the Supplemental Security Income (SSI) Cash Program, or the Title IV-E Adoption Subsidy Programs.

⁷⁰ Federal poverty level is a measure of income used to help government agencies determine eligibility levels for public assistance programs such as Medicaid. The application of the federal poverty level varies depending on the program and applicant's household composition.

Table 4

AHCCCS' key programs and program specific eligibility requirements

As of June 2022

(Unaudited)

Program	Program-specific eligibility requirements ¹
AHCCCS Complete Care System Programs	
<p>Adults Program—Provides healthcare coverage for low-income Arizonans aged 19 to 64.</p>	<ul style="list-style-type: none"> • Be between the ages of 19 and 64. • Income is at or below 133 percent of the federal poverty level. • Does not qualify for Medicare due to disability or end-stage renal disease. • Adults cannot receive healthcare coverage if they are a child's primary caretaker and the child does not have health insurance.
<p>Breast and Cervical Cancer Treatment Program—Provides healthcare coverage to Arizona women under the age of 65 diagnosed with breast cancer, cervical cancer, or a precancerous lesion.</p>	<ul style="list-style-type: none"> • Be under the age of 65. • Be a woman. • Be diagnosed with breast cancer, cervical cancer, or a precancerous lesion. • Have no third-party insurance that would cover treatment of breast and/or cervical cancer. • Ineligible for any other AHCCCS program.
<p>Caretaker Relative—Provides healthcare coverage to low-income Arizona adults who care for a low-income child.</p>	<ul style="list-style-type: none"> • Income is at or below 106 percent of the federal poverty level. • Be the caretaker for a low-income child.
<p>Child Program—Provides healthcare coverage to low-income Arizonans under the age of 19.</p>	<ul style="list-style-type: none"> • Be under the age of 19. • Income is at or below 147 percent of the federal poverty level if the child is under the age of 1; income is at or below 141 percent of the federal poverty level if the child is between the ages of 1 and 5; income is at or below 133 percent of the federal poverty level if the child is between the ages of 6 and 18.
<p>Continued Coverage Program—Provides up to an additional 4 months of healthcare coverage to caretaker relatives and the children they live with after they become ineligible for healthcare coverage because of an increase in alimony payments.</p>	<ul style="list-style-type: none"> • At least 1 member of the household received healthcare coverage from the Caretaker Relative program for 3 of the previous 6 months. • Household is ineligible for healthcare coverage because of increased alimony or spousal support payments.
<p>Deemed Newborn Program—Provides healthcare coverage to Arizona newborns for their first 12 months of life.</p>	<ul style="list-style-type: none"> • Child's mother must have been determined eligible for healthcare coverage on the day the baby is born.

Table 4 continued

<p>Freedom to Work Program—Provides healthcare coverage to low-income disabled Arizonans ages 16 to 64 who work.²</p>	<ul style="list-style-type: none"> • Be between the ages of 16 and 64. • Be employed. • Income is at or below 250 percent of the federal poverty level. • Have been determined to have a disability or severe impairment by the U.S. Social Security Administration Disability Determination Services. • Pay the Freedom to Work premium.³ • Ineligible for any other AHCCCS program.
<p>Pregnant Woman Program—Provides healthcare coverage to low-income women who are pregnant or who had a baby within the last 60 days.</p>	<ul style="list-style-type: none"> • Be pregnant or have had a baby in the last 60 days. • Income is at or below 156 percent of the federal poverty level.
<p>Supplemental Security Income (SSI) Cash Program—Provides healthcare coverage to Arizonans who receive SSI cash from the Social Security Administration.</p>	<ul style="list-style-type: none"> • Be aged, blind, or disabled and receive SSI Cash from the Social Security Administration.
<p>SSI Medical Assistance Only (MAO)—Provides healthcare coverage to low-income Arizonans, aged 65 or older; blind; or disabled.</p>	<ul style="list-style-type: none"> • Be age 65 or older; or blind; or disabled. • Income is at or below 100 percent of the federal benefit rate or 100 percent of the federal poverty level.⁴
<p>Title IV-E Adoption Subsidy Program—Provides healthcare coverage to Arizonans who receive adoption assistance payments under Title IV-E of the Social Security Act.</p>	<ul style="list-style-type: none"> • Individual must receive adoption assistance payments under Title IV-E of the Social Security Act.
<p>Transitional Medical Assistance—Provides up to 12 months of healthcare coverage to caretaker relatives and the children they live with after they become ineligible for healthcare coverage because of an increase in the household's income.</p>	<ul style="list-style-type: none"> • At least 1 member of the household received healthcare coverage from the Caretaker Relative program for 3 of the previous 6 months. • The household is ineligible for healthcare coverage because of income. • Income is at or below 185 percent of the federal poverty level. • The member whose income caused ineligibility continues to work.
<p>Transplant Extended Eligibility Program—Provides healthcare coverage for Arizonans eligible for a medically necessary transplant but are losing their healthcare coverage because their income exceeds the limit for the program in which they are enrolled.</p>	<ul style="list-style-type: none"> • Was receiving healthcare coverage in any other AHCCCS program except KidsCare, but that coverage is ending because the individual's income is over the program's income limit. • Have too much income to qualify for any other AHCCCS program. • Was approved for a medically necessary transplant and placed on a transplant waiting list before they became ineligible for healthcare coverage. • Able to pay for part of the cost of the transplant.

Table 4 continued

<p>Young Adult Transitional Insurance Program— Provides healthcare coverage to Arizona young adults ages 18 to 26 who were in foster care and enrolled in an AHCCCS program on the day they turned 18.</p>	<ul style="list-style-type: none"> • Be between the ages of 18 and 26. • Was in foster care on the day the individual turned 18. • Was receiving AHCCCS healthcare coverage on the day the individual turned 18.
<p>AHCCCS Complete Care Program—KidsCare Program</p>	
<p>KidsCare Program—Provides healthcare coverage to Arizonans under the age of 19 who do not qualify for Medicaid coverage because their family income is too high.</p>	<ul style="list-style-type: none"> • Be under the age of 19. • Have no health insurance coverage currently and for the previous 3 months. • Have an income above the income limit for Medicaid coverage but income is at or below 200 percent of the federal poverty level. • Pay a premium.⁵
<p>ALTCS Program</p>	
<p>ALTCS Program—Provides healthcare coverage to Arizonans who have a medical need for long term care services.</p>	<ul style="list-style-type: none"> • Have a medical need for long term care. • If the applicant is eligible for SSI Cash Program or the Title IV-E Foster Care or Adoption Subsidy Programs (see above) the applicant also: <ul style="list-style-type: none"> ○ Cannot transfer property to someone else. ○ Cannot have a trust that causes the individual's resources or income to exceed the program's limit. • If the applicant is not eligible for SSI Cash Program or the Title IV-E Foster Care or Adoption Subsidy Programs, the applicant must also: <ul style="list-style-type: none"> ○ Apply for any cash benefits for which individual might qualify. ○ Be aged, blind, or disabled. ○ Have income and resources below a certain dollar amount. ○ Reside in an appropriate ALTCS living arrangement.

¹ Applicants must meet all program specific eligibility requirements, except for applicants for the ALTCS program. Applicants for the ALTCS program must have a medical need for long term care and meet one of the other program specific eligibility requirements.

² Some Freedom to Work members receive ALTCS services.

³ Members enrolled in the Freedom to Work program must, depending on income, pay a monthly premium up to \$35, unless the member is Native American.

⁴ The federal benefit rate (FBR) is the basic benefit amount the Social Security Administration pays to clients who are eligible for the SSI MAO program. The income limit for the SSI MAO program can be calculated using either 100 percent of the FBR or 100 percent of the federal poverty level

⁵ Members enrolled in the KidsCare program must, depending on income and household size, pay a monthly premium that ranges from \$10 to \$70, unless the member is Native American.

Source: Auditor General staff analysis of AHCCCS policy program descriptions and eligibility requirements.



Scope and methodology

The Arizona Auditor General has conducted this performance audit and sunset review of AHCCCS pursuant to a September 19, 2018, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq.

We used various methods to study the issues addressed in this performance audit and sunset review of AHCCCS. These included reviewing State and federal regulations; AHCCCS' website, policy manuals, and various reports; and interviewing AHCCCS staff. In addition, we used the following specific methods to meet the audit objectives:

- To assess AHCCCS' processes for reviewing eligibility decisions, we reviewed CMS resources related to PERM and MEQC reviews, AHCCCS' 2021 PERM and MEQC reviews, and AHCCCS' corrective action plans to address deficiencies identified in these reviews. We also reviewed AHCCCS procedures for conducting internal eligibility reviews. Finally, we reviewed the AHCCCS/ADES intergovernmental agreement that outlines ADES and AHCCCS responsibilities for performing reviews of eligibility determinations completed by ADES eligibility workers.
- To assess AHCCCS' processes for timely investigating potential fraud or abuse incidents, we reviewed AHCCCS provider and member fraud or abuse investigation policies and procedures, including time frame goals for investigating these incidents; AHCCCS data on open provider and member fraud or abuse incidents as of May 11, 2022; AHCCCS-reported information on the number of provider and member fraud or abuse incidents AHCCCS investigated and resolved in fiscal year 2022; and estimated savings from these cases. We also reviewed our 2012 performance audit on *Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes*.⁷¹
- To assess whether AHCCCS completed its reviews of contracted health plans every 3 years as required by federal regulations, we analyzed 3 reviews AHCCCS conducted for its contracted health plans in calendar years 2017, 2019, and 2021, and reviewed its schedule for performing these reviews between 2016 and 2022. We also reviewed AHCCCS' incentive payment policies and procedures, AHCCCS' contract with and a report from AHCCCS' external quality review organization summarizing the results of its contract year 2021 external review of the contracted health plans, and examples of provider incentive payment documentation.
- To assess the extent to which AHCCCS serves the entire State, we reviewed a National Conference of State Legislatures report on the benefits of telehealth, AHCCCS telehealth policies and requirements for contracted health plans, and AHCCCS' data on AHCCCS member telehealth usage between January 2020 and November 2021.⁷² We also reviewed AHCCCS' minimum network adequacy standards that contracted health plans must meet and October 2021 data from AHCCCS' external quality review organization on whether contracted health plans met these standards. In addition, we reviewed a sample of contracted health plan reports completed in calendar years 2020 through 2022 that provide information on steps they

⁷¹ Arizona Auditor General report 12-06 *Arizona Health Care Cost Containment System—Medicaid Fraud and Abuse Prevention, Detection, Investigation, and Recovery Processes*.

⁷² Enlund, S. (2021). *The telehealth explainer series: A toolkit for state legislatures*. Denver, CO: National Conference of State Legislatures. Retrieved 3/9/22 from [The Telehealth Explainer Series: A Toolkit for State Legislators \(ncsl.org\)](https://www.ncsl.org/telehealth-explainer-series).

have taken to address noncompliance with minimum network adequacy standards and explanations for the noncompliance.

- To assess AHCCCS' compliance with the State's conflict-of-interest laws and alignment with recommended practices, we reviewed statutes, recommended practices, AHCCCS conflict-of-interest disclosure statements, and AHCCCS conflict-of-interest and secondary employment disclosure policy.⁷³
- To assess AHCCCS' processes for handling various types of grievances and appeals, we reviewed AHCCCS' fiscal year 2021 data on eligibility determination decision appeals and appeals submitted by fee-for-service members and AHCCCS' processes for notifying applicants and members of their ability to appeal decisions denying or disenrolling them from healthcare coverage. In addition, to determine if contracted health plans have developed processes for handling grievances, we selected 3 AHCCCS reviews of contracted health plans conducted in 2017, 2019, and 2021 and reviewed AHCCCS' assessment of contracted health plan compliance with all 17 grievance-handling standards.⁷⁴ We also reviewed information on the number of quality-of-care grievances that were filed with contracted health plans and appeals filed with AHCCCS in fiscal year 2021, information on the number of grievances and appeals AHCCCS received from ASH patients, and the number and type of corrective actions that AHCCCS required the ASH to implement in fiscal year 2021. Further, we reviewed AHCCCS' *Housing Program Guidebook* for handling grievances and appeals from housing program members and AHCCCS provided information on housing member grievances received between October 2021 and May 2022.
- To obtain additional information for the sunset factors, including determining whether AHCCCS developed rules required by statute, whether it encouraged input from the public before adopting its rules, the extent to which the termination of AHCCCS would affect public health, safety, and welfare, and its use of private contractors, we reviewed AHCCCS' response to the sunset factors, judgmentally selected and contacted 4 states—Colorado, Florida, Washington, and Wyoming—Medicaid agencies, and reviewed AHCCCS statutes to identify those statutes requiring AHCCCS to develop rules and then reviewed a random and judgmental sample of 15 of 40 statutes that require AHCCCS to develop rules.⁷⁵ Further, we reviewed AHCCCS rulemaking completed between May 2020 and April 2022, AHCCCS' MOU with the Arizona Attorney General, AHCCCS' August 2022 member population statistics, and AHCCCS' fiscal year 2022 appropriations report. Finally, we reviewed fiscal year 2021 AFIS data to determine how much AHCCCS paid contracted health plans and fee-for-service providers and contracts and invoices for private contractors that either provide expert legal counsel, support AHCCCS' in-house actuarial unit, or handle third-party liability.
- To obtain information for the Introduction and Appendix A, we reviewed AHCCCS program descriptions, services provided to members in its AHCCCS Complete Care, KidsCare, and ALTCS program areas, and AHCCCS eligibility requirements for AHCCCS programs. We also reviewed AHCCCS application processes, assistance available to individuals applying for healthcare coverage, and a Kaiser Family

⁷³ Recommended practices we reviewed included: Organization for Economic Cooperation and Development. (2022). *Recommendation of the council on OECD guidelines for managing conflict of interest in the public service*. Paris, France. Retrieved 1/7/2022 from <https://legalinstruments.oecd.org/public/doc/130/130.en.pdf>; Ethics & Compliance Initiative. (2016). *Conflicts of interest: An ECI benchmarking group resource*. Arlington, VA. Retrieved 1/7/2022 from <https://www.ethics.org/wp-content/uploads/2021-ECI-WP-Conflicts-of-Interest-Defining-Preventing-Identifying-Addressing.pdf>; and Controller and Auditor General of New Zealand. (2020). *Managing conflicts of interest: A guide for the public sector*. Wellington, New Zealand. Retrieved 3/4/2021 from <https://oag.parliament.nz/2020/conflicts/docs/conflicts-of-interest.pdf>.

⁷⁴ We reviewed 1 of 6 contracted health plans AHCCCS reviewed in calendar years 2016 and 2017 that provided AHCCCS Complete Care services to members; 1 of 3 contracted health plans AHCCCS reviewed in calendar year 2019 that provided ALTCS services to members; and 1 of 3 RBHAs AHCCCS reviewed in calendar year 2021 that provided healthcare services to members.

⁷⁵ We identified 4 states—Colorado, Florida, Washington, and Wyoming—for comparison based on several factors including overall population size, percentage of state population receiving Medicaid services, and the percentage of the state Medicaid population that is served by contracted health plans.

Foundation report on the number of states that use managed care programs.⁷⁶ Further, we calculated a weighted monthly capitation payment for members enrolled in AHCCCS' Complete Care as of October 1, 2021.⁷⁷ Additionally, we reviewed the U.S. Department of Health and Human Services' COVID-19 public health emergency declaration and extensions, AHCCCS' division and office descriptions, and information from AHCCCS on the number of filled and vacant FTE positions as of May 13, 2022, and compiled and analyzed unaudited information from the AFIS *Accounting Event Transaction File* for fiscal years 2020 and 2021, the State of Arizona *Annual Financial Report* for fiscal years 2020 and 2021, and AHCCCS-provided financial information for fiscal year 2022. Finally, we reviewed AHCCCS' list of assistor organizations that help members apply for healthcare coverage through AHCCCS

- Our work on internal controls, including information system controls, included reviewing AHCCCS policies and procedures and, where applicable, testing AHCCCS compliance with these policies and procedures; and assessing compliance with State and federal regulations and AHCCCS/ADES intergovernmental agreement requirements. We reported our conclusion on applicable internal controls in Finding 1 and Sunset Factors 2, 3, and 6.

We selected our audit samples to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

We conducted this performance audit and sunset review of AHCCCS 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.

We express our appreciation to the AHCCCS Director and staff for their cooperation and assistance throughout the audit.

⁷⁶ Gifford, K., Lashbrook, A., Barth, S., Nardone, M., Hinton, E., Guth, M., Stolyar, L., & Rudowitz, R. (2021). *States respond to COVID-19 challenges but also take advantage of new opportunities to address long-standing issues: Results from a 50-state Medicaid budget survey for state fiscal years 2021 and 2022*. San Francisco, CA: Kaiser Family Foundation. Retrieved 1/24/22 from [States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues – Delivery Systems – 9814 | KFF](#).

⁷⁷ To calculate the weighted average monthly payment rate for each age group—members under the age of 1, members age 1 through 20, and members age 21 or over—we calculated the State-wide enrollment percentage in each AHCCCS Complete Care contracted health plan for each age group and then multiplied these percentages by each health plan's effective capitation rate for that age group as of October 1, 2021.

AHCCCS RESPONSE

September 28, 2022

Lindsey A. Perry
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Perry:

Enclosed is the Arizona Health Care Cost Containment System's response to the Auditor General's Sunset Factor Report.

I would like to express my appreciation to the Auditor General's office for its professionalism and collaborative approach throughout the audit process. AHCCCS remains cognizant of its critical role in providing health care coverage to over 2.4 million Arizona residents and is committed to continuing to offer quality care to those served by the program. As noted in the agency's response, AHCCCS has already begun to address many of the concerns identified.

Sincerely,



Jami Snyder
Director

Finding 1: AHCCCS has taken more than 1 year to initiate and/or complete its preliminary investigation of more than half of potential fraud or abuse incidents open as of May 2022, potentially resulting in unnecessary payments and difficulty investigating cases.

Recommendation 1: AHCCCS should conduct a workload/cost analysis to evaluate whether its funding and staffing level is sufficient for investigating potential provider and member fraud or abuse incidents within its established time frames and work with the Legislature to revise its appropriations, as needed.

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

Recommendation 2: AHCCCS should develop and implement policies and procedures, including time frames, for prioritizing and completing potential provider fraud or abuse incidents to help ensure that at a minimum, high priority incidents are preliminarily investigated within 3 months.

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

Response explanation: While there are no federal or state regulations mandating completion of preliminary investigations of high priority fraud or abuse incidents within 3 months, AHCCCS agrees this is a best practice. AHCCCS will further refine its triage process whereby all provider fraud or abuse cases are screened within 3 months of receipt, assigned a priority level, and referred to the Attorney General's office if they are identified for criminal investigation.

Sunset Factor 2: The extent to which AHCCCS has met its statutory objective and purpose and the efficiency with which it has operated.

Recommendation 3: AHCCCS should develop and implement a risk-based approach to sample and review denied eligibility determinations and disenrollment decisions to ensure these decisions are appropriate.

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

Response explanation: While there are no federal or state regulations that mandate quality assurance reviews for eligibility denials and disenrollments, AHCCCS agrees this is a best practice. As such, AHCCCS piloted a process to review negative eligibility determinations beginning in January 2022 and is hiring additional staff to complete these reviews on an ongoing basis.

Recommendation 4: AHCCCS should ensure that ADES develops and implements a process for reviewing its eligibility determination decisions, including denials and disenrollments, and monitor this process, as required by its intergovernmental agreement with ADES.

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

Response explanation: ADES has a process in place to review eligibility determination decisions. Because of the increased workload during the COVID-19 public health emergency, staff were temporarily diverted to complete initial applications. However, effective August 2022, ADES resumed quality assurance reviews on eligibility decisions completed by eligibility staff. These reviews include both approved and denied/disenrolled eligibility decisions. AHCCCS monitors ADES by completing second level reviews of a sample of approved and denied/disenrolled eligibility decisions completed by ADES. AHCCCS and ADES regularly meet to discuss the results of the second level reviews and any errors identified.

Recommendation 5: AHCCCS should conduct performance reviews of its contracted health plans once every 3 years, as required by federal regulations and its policies.

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

Recommendation 6: AHCCCS should develop and implement a risk-based approach for ensuring that its contracted health plans verify their providers have met required performance measures prior to reimbursing its contracted health plans for provider incentive payments.

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

Response explanation: AHCCCS has policies and procedures for, and performs, risk-based audits of each contracted health plan's providers receiving the highest incentive payments, accounting for at least 65 percent of total provider incentive payments by contracted health plan. The audit includes a review of the contracted health plans' incentive calculations and the payment back-up data. No later than January 2023, AHCCCS will develop and implement standard work, documenting the process for verifying provider performance on performance measures prior to reimbursing its contracted health plans for provider incentive payments.

Recommendation 7: AHCCCS should implement and use its action plan to guide its efforts in establishing written IT and data security procedures in line with ASET requirements and credible industry standards.

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

Response explanation: AHCCCS has processes in place that align with ASET requirements and credible industry standards and consistently meets or exceeds the State's target security score. AHCCCS will document these existing processes by April 2023.

Recommendation 8: AHCCCS should develop and implement policies and procedures for overseeing its contracted health plan's process for ensuring that its service providers address identified deficiencies and recommendations resulting from the 3 reviews and/or assessments of behavioral health services provided to members with an SMI in Maricopa

County, such as ensuring the contracted health plan requires its service providers to develop and implement corrective actions, reviews and monitors the corrective actions, and verifies the implementation of corrective actions or reported improvements.

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

Response explanation: No later than December 2022, AHCCCS will finalize and implement policies and procedures for overseeing its contracted health plans' process for ensuring provider adherence to the terms and requirements contained in the Arnold v. Sarn settlement. This will include a requirement that the contracted health plans mandate the development of corrective actions when deficiencies are identified, the periodic review and monitoring of performance and corrective actions as well as verification of implementation of corrective actions or reported improvements.

Recommendation 9: AHCCCS should, consistent with its plans, develop and implement policies and procedures for overseeing its Housing Program and Housing Administrator by periodically inspecting a sample of housing units and reviewing a random sample of participant files; and requiring the Housing Administrator to take action to address deficiencies, such as through the development and implementation of corrective action plans.

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

Response explanation: No later than February 2023, AHCCCS will implement policies and procedures for overseeing its Housing Program and Housing Administrator specific to the inspection of a sample of housing units and the review of a random sample of participant files. The Housing Administrator will be required to take action to address deficiencies, including the development and implementation of corrective action plans.

Recommendation 10: AHCCCS should, consistent with its plans, finalize and implement benchmarks for evaluating the performance of its Housing Administrator based on established performance measures.

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

Response explanation: In October 2022, AHCCCS will finalize and implement benchmarks for evaluating the performance of its Housing Administrator, following the review of baseline data collected in the first year of the Housing Administrator's operation.

Recommendation 11: AHCCCS should develop and implement policies and procedures for monitoring Housing Administrator performance against its established benchmarks and requiring the Housing Administrator to take action to address performance that falls below benchmarks, such as through the development and implementation of corrective action plans.

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

Response explanation: In October 2022, AHCCCS will finalize and implement policies and procedures for monitoring the Housing Administrator's performance against established benchmarks, including the utilization of a quarterly report to document performance. The policies and procedures will require that the Housing Administrator take action when performance falls below the benchmarks, such as the development and implementation of corrective action plans.

Recommendation 12: AHCCCS should, as required by A.R.S. §36-3432, prepare and submit an annual report on its annual system plan that provides information on the development and implementation of a comprehensive behavioral health system for children, including the identification of services, estimated number of members, and an appropriations request. If AHCCCS determines that it cannot meet all or some portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable.

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

Response explanation: As required by A.R.S. §36-3432, AHCCCS will produce and submit the required report on or before November 1 of each year, beginning on November 1, 2023.

Recommendation 13: AHCCCS should, as required by A.R.S. §36-3405(D), prepare and submit a complete monthly report that has all required elements, including units of service, amount of monies provided for member services for each RBHA, by Medicaid and non-Medicaid categories, and RBHA administration and case management expenses. If AHCCCS determines that it cannot meet portions of this reporting requirement, it should work with the Legislature to modify statute, as applicable.

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

Response explanation: AHCCCS will work with the Legislature to modify statute to align reporting requirements with the current, fully integrated delivery system framework.

Sunset Factor 3: The extent to which AHCCCS serves the entire State rather than specific interests.

Recommendation 14: AHCCCS should implement its plans to comply with State conflict-of-interest requirements and recommended practices by:

Recommendation 14a: Ensuring all staff complete the current ADOA conflict-of-interest disclosure form, including requiring its staff to disclose whether they or a relative have a substantial interest in any decision of a public agency.

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

Response explanation: AHCCCS currently has a process in place to collect this information upon hire and if there is a change in the employee's circumstances.

Recommendation 14b: Developing and implementing a process for reminding employees to annually complete a disclosure form when their circumstances change.

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

Response explanation: AHCCCS developed and implemented an annual reminder process in July 2022. All current employees have renewed disclosure forms on file.

Recommendation 14c: Developing and implementing a special file for substantial disclosures and making this file available for public inspection.

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

Response explanation: AHCCCS created an electronic special file in February 2022 and is in the process of auditing disclosure forms and moving substantial disclosure forms to the special file. This process will be completed by January 2023.

Recommendation 14d: Developing and implementing annual conflict-of-interest training.

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

Sunset Factor 4: The extent to which rules adopted by AHCCCS are consistent with the legislative mandate.

Recommendation 15: AHCCCS should work with the Legislature to either revise or remove A.R.S. §36-2905.06, which requires it to adopt rules requiring members to be fingerprinted at the time the member is enrolled in a healthcare coverage program.

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

Recommendation 16: AHCCCS should adopt rules for excluding providers who have been convicted of certain crimes, as required by A.R.S. §36-2930.05, once litigation surrounding this requirement is resolved.

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

Sunset Factor 5: The extent to which AHCCCS has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

Recommendation 17: AHCCCS should enhance the demographic and expenditure information on its website, such as providing demographic information by subpopulations and expenditure information by county and service.

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

Response explanation: AHCCCS will provide additional expenditure reporting on its website. However, any additional demographic filtering of subpopulation data must be in compliance with HIPAA safe harbor provisions (45 CFR 164.514). Moreover, an applicant is not required to disclose race and ethnicity information, thus this information is incomplete and may be subject to misinterpretation.

Sunset Factor 6: The extent to which AHCCCS has been able to investigate and resolve complaints that are within its jurisdiction and the ability of AHCCCS to timely investigate and resolve complaints within its jurisdiction.

Recommendation 18: AHCCCS should establish processes requiring its Division of Member and Provider Services to forward eligibility appeals to the Office of the General Counsel immediately upon receipt to help ensure these appeals are reviewed and processed within 90 days of receipt.

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

Response explanation: In August 2022, the Division of Member and Provider Services provided the Office of the General Counsel with access to a shared tracking document of all appeal requests and actions. In addition, standard work processes have been developed to include responsibilities for both divisions to review and update the tracking document, at minimum, once per day.

Recommendation 19: AHCCCS should train staff in the Division of Member and Provider Services that receive applications for appeals on the process and time frames for submitting eligibility appeals to the Office of the General Counsel.

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

Response explanation: In August 2022, the Division of Member and Provider Services revised the standard work process for processing appeal requests. All staff in the appeals unit have been trained on the process which includes updating the shared appeal tracking document on a daily basis.

Recommendation 20: AHCCCS should develop and implement additional appeal-handling procedures, such as monitoring and review procedures, to help ensure that eligibility appeals are timely resolved in compliance with State regulations.

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

Response explanation: No later than December 2022, AHCCCS will develop and implement policies and procedures to ensure eligibility appeals are resolved timely.

Recommendation 21: AHCCCS should develop and implement policies and procedures for reviewing and resolving grievances and appeals it receives from ASH patients, including procedures that specify when corrective action plans should be developed, and require AHCCCS staff to review and follow up on corrective action plans to ensure that ASH has addressed identified concerns.

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

Response explanation: AHCCCS follows the detailed written administrative rules promulgated by the agency but will further develop its processes by creating internal standard work documents by November 2022. The process for assuring implementation of corrective action plans submitted by ASH will be more clearly defined. AHCCCS will discuss with ASH ways to accomplish enhanced monitoring through the development of policies and procedures or other agreements.

Recommendation 22: AHCCCS should continue developing and implementing policies and procedures for handling appeals from members receiving services from its Housing Program.

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

Response explanation: The AHCCCS Housing Program Guidebook was finalized in July 2022 and contains an outline of the grievance and appeal requirements for the Housing Administrator. The Housing Administrator reports grievance and appeal data on a quarterly basis to AHCCCS. Additionally, AHCCCS is developing internal standard work for instances in which a member appeals the Housing Administrator's determination to the AHCCCS Director of Housing Programs after exhausting all of the Housing Administrator's grievances and appeals procedures.

