

103 FRAUD, WASTE AND ABUSE

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2903, 2918 and 2957; A.A.C. R9-22-702; 42 CFR 438.608, 42 CFR 455.2, 12-23, 100-106, and 436; State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act, Federal False Claims Act

DELIVERABLES: Attestation of Disclosure Information: Ownership and Control and Persons Convicted of a Crime; Change in Contractor Organizational Structure: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information; Corporate Compliance External Audit Plan; Corporate Compliance Plan; Corporate Compliance: Executive Audit Summary; Corporate Compliance: External Auditing Schedule; Corporate Compliance: External Auditing Schedule-Changes; Exclusions Identified Regarding Persons Convicted of a Crime; Recovered Overpayment; Report Alleged Fraud/Waste/Abuse of the AHCCCS Program

Purpose

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (The Division or DDD). The purpose of this policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste, and abuse, involving services funded by the Division. This policy also addresses additional responsibilities regarding compliance with broader program integrity, regulatory, and programmatic requirements.

Definitions

- A. **Abuse of the Program** - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program. 42 CFR 455.2.
- B. **Administrative Services Subcontract** - An agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
 - 1. Claims processing, including pharmacy claims
 - 2. Credentialing, including those for only primary source verification
 - 3. Management Service Agreements
 - 4. Service Level Agreements with any division or subsidiary of a corporate parent owner; providers are not AdSS.
- C. **Corporate Compliance Officer** - The on-site management official designated by each AdSS to implement, oversee and administer the AdSS' compliance program. The Corporate Compliance Officer must be available to all of the AdSS's employees, and possess the authority to access and provide records, and make independent referrals to the AHCCCS Office of Inspector General (42 CFR 438.608).
- D. **Credible Allegation of Fraud** - A credible allegation of fraud may be an allegation, which

has been verified by the State, from any source, including, but not limited to, the following:

1. Fraud hotline complaints
 2. Claims data mining
 3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis (42 CFR 455.2).
- E. Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law (42 CFR 455.2).
- F. Managing Employee - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (42 CFR 455.101).
- G. Provider - Any person or entity that furnishes Division-funded services.
- H. Waste - Overutilization or inappropriate utilization of services. Misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Policy

A. Authority

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations, relating to fraud, waste, and abuse, involving the programs administered by AHCCCS. Pursuant to 42 CFR 455.12-23 and an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

1. Pursuant to A.R.S. § 36-2918, AHCCCS-OIG has the authority to issue subpoenas and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony, as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the Office.
2. Pursuant to A.R.S. §§ 36-2918 and 2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to \$2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.
3. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG

to access the National Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

4. If AHCCCS-OIG determines that a credible allegation of fraud exists, AHCCCS-OIG may suspend payments to providers pursuant to 42 CFR 455.23.

B. AdSS Responsibilities

The AdSS must:

1. Have in place internal controls, policies, and procedures, to prevent, detect, and report fraud, waste, and abuse activities to the Division.
2. Have a Corporate Compliance Program that complies with the AdSS's contract with the Division and with all state and federal laws. The program must be developed by a plan that includes:
 - a. Program integrity goals and objectives
 - b. Descriptions of internal and external controls employed by the AdSS
 - c. The AdSS's corporate compliance activities
 - d. The roles and responsibilities of the AdSS's staff, as they relate to the Corporate Compliance Program.

The Division has adopted Attachment B of the AHCCCS Operations Manual, Policy 103. The AdSS can use the sample provided under Attachment B for guidance on how to present such compliance activities. The AdSS's written Corporate Compliance Plan must be submitted to the Division annually as specified in Section F3, Contractor Chart of Deliverables.

3. Have Corporate Compliance Plan that includes a program integrity audit/review program designed to identify fraud, waste, and abuse.

This program must ensure that the AdSS tracks inadequate billing practices and identifies emerging trends in an effort to provide technical assistance to contracted providers and avoid future occurrences of problematic billing.
4. Provide the external auditing schedule and executive summary of all individual provider audits to the Division as specified in Section F3, Contractor Chart of Deliverables.
 - a. The External Audit Plan shall include the following information using Attachment C:
 - i. Provider Name,
 - ii. AHCCCS ID #,
 - iii. Location,

- iv. Provider Type,
 - v. Audit Type,
 - vi. Planned Audit Date,
 - vii. Audit Look-Back Period
 - viii. Total number of In-Network Providers, and
 - ix. Number of Providers to be audited
- b. The External Audit Plan shall include the following information using Attachment C:
- i. Location,
 - ii. Agency Name/Provider,
 - iii. Date(s) of Audit,
 - iv. AHCCCS ID,
 - v. Provider Type,
 - vi. Audit Type, and
 - vii. New/Follow-up Audit.
- c. The Executive Summary shall include at a minimum:
- i. A summary statement regarding audits, trends, and any countermeasures implemented by the contractor,
 - ii. Copies of the report for each audit scheduled and completed,
 - iii. In the event that an audit was not timely completed, the Executive Summary shall include a reason why the audit was not completed and a date when the audit will be completed in the future, and
 - iv. Estimated dollar amount at risk.
5. Obtain and disclose the information regarding ownership and control, and disclosure of information on persons convicted of crimes in accordance with 42 CFR 455.100-106, 42 CFR 455.436, State Medicaid Director Letters 08-003 and 09-001, and the contractual provisions contained in the contract.

The AdSS must also obtain and disclose the same information regarding its subcontractors. The results of the Disclosure of Ownership and Control and the Disclosure of Information on Persons Convicted of Crimes must be held by the AdSS. The AdSS must disclose to the Division the identity of any person excluded from participation in federal healthcare programs.

6. Submit annually Attachment A in the AHCCCS Operations Manual, Chapter 103, Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime, as specified in Section F3, Contractor Chart of Deliverables, attesting that the information has been obtained and verified by the AdSS, or upon request, provide this information to the Division.
 7. Comply with Section 6032 of the Deficit Reduction Act.
 8. Ensure all employees, subcontracted providers, and members receive adequate training and ongoing education on all of the following aspects of the Federal False Claims Act provisions:
 - a. The administrative remedies for false claims and statements
 - b. Any state laws relating to civil or criminal penalties for false claims and statements
 - c. The whistleblower protections under such laws.
 9. Ensure adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees, contracted providers, and members to report fraud, waste, and abuse without fear of retaliation.
 10. Ensure an internal reporting process that is well defined and made known to all employees.
 11. Conduct research and proactively identify changes for program integrity that are relevant to their program, and periodically review and revise the fraud, waste, and abuse policies or guidance from the Division or AHCCCS to reflect such changes due to rules, regulations, or new initiatives.
 12. Regularly attend and participate in Division work group meetings.
 13. Respond promptly and no later than 30 days to requests for information from the Division.
 14. Cooperate with the Division regarding any allegation of member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702.
 15. Have a method of verifying with Division members that the Division members received the services billed by providers, to identify potential service/claim fraud. The AdSS must perform periodic audits through member contact and to report the results of these audits to the Division as described in this Manual, Policy 424.
 16. Be in compliance with all state and federal laws and regulations related to fraud, waste, and abuse, even if not directly detailed in this policy.
- C. Reporting Responsibilities
1. Fraud, Waste, and Abuse
 - a. If an AdSS discovers, or is made aware, that an incident of alleged fraud,

waste, or abuse has occurred, the AdSS must immediately report the incident to AHCCCS-OIG within ten business days, by completing and submitting the reporting form available on the AHCCCS-OIG webpage under Report Suspected Fraud or Abuse of the Program. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.

- b. If the AdSS identifies an incident that warrants self-disclosure, the incident must be reported within ten business days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.
- c. Once the AdSS has referred a case of alleged fraud, waste, or abuse to AHCCCS-OIG, the AdSS must take no action to recoup or otherwise offset any suspected overpayments.
- d. In the event AHCCCS-OIG feels it would be beneficial to seek additional and/or clarifying details regarding a referral from the AdSS, AHCCCS-OIG may first choose to request preliminary review work from the AdSS in order to expand the allegation and to obtain further documentation that will support an investigation by AHCCCS-OIG.
- e. If AHCCCS-OIG chooses to seek additional and/or clarifying details regarding a referral from the AdSS, the AdSS will have 30 business days or more to provide the requested documentation, or provide an update as to the status of completing such request.
- f. Once AHCCCS-OIG receives a referral, it will conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
- g. AHCCCS-OIG will notify the AdSS when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation.
- h. If it is determined by AHCCCS-OIG not to be a fraud, waste, or abuse case, AHCCCS-OIG will return the matter to the AdSS for disposition in accordance with any applicable laws and/or contracts.
- i. The AdSS agrees that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste, or abuse. The AdSS assigns to AHCCCS the right to recoup any amounts overpaid to a provider as a result of fraud, waste, or abuse. If the AdSS receives anything of value that could be construed to represent the repayment of any amount expended due to fraud, waste or abuse, the AdSS must forward that recovery to AHCCCS-OIG within 30 days of its receipt. The AdSS relinquishes any and all claims to any monies, received by AHCCCS as a result of any program integrity efforts, that include, but are not limited to:
 - i. Civil monetary penalties and/or assessments
 - ii. Civil settlements and/or judgments

- iii. Criminal restitution.
- j. The AdSS must also report to AHCCCS, as specified in Contract, Division Medical Policy 950, any credentialing denials including, but not limited to:
 - i. Those which are the result of licensure issues
 - ii. Quality of care concerns
 - iii. Excluded providers
 - iv. Alleged fraud, waste, or abuse.
- D. The Division's Corporate Compliance Responsibilities Related to Fraud, Waste, and Abuse
 - 1. Conduct pre-fact findings of viable allegations of member and provider fraud.
 - 2. Oversee, monitor, and be the focal point for, the Division's compliance program, with the authority to review all documents and functions as they relate to fraud, waste and abuse prevention, detection and reporting.
 - 3. Maintain and monitor a tracking system of fraud, waste, and abuse investigations.
 - 4. Ensure all employees, AdSS, providers, and members receive adequate training and information regarding fraud, waste and abuse prevention, identification and reporting. Assure employees, AdSS, providers, and members that they can report fraud, waste, and abuse without fear of retaliation.
 - 5. Take contract action to include, but not be limited to, enrollment suspense of provider payments when there is a credible allegation of fraud.
 - 6. Develop and maintain open channels of communication with AdSS to combat fraud, waste, and abuse at all levels in the system.
 - 7. Develop and maintain open channels of communication with AHCCCS OIG in the prevention and detection of fraud, waste, and abuse.
 - 8. Refer to AHCCCS OIG cases of potential member billing in violation of A.R.S. § 36-2903.01(L) and A.A.C. R9-22-702.
 - 9. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of AdSS and providers to ensure their compliance.
 - 10. Ensure the Division is in compliance with its federal obligations regarding disclosure of ownership and control, managing employees database exclusion, and checks, and criminal convictions checks, and all other federal requirements related to provider screening and enrollment.