6004-F COMPLIANCE PROGRAM

REVISION: 10/1/2019
EFFECTIVE DATE: June 10, 2016
REFERENCES: 42 CFR 438.230(b), 42 CFR 438.608, ACOM Policy 103

Compliance Program Overview

The Corporate Compliance Program consists of the development, maintenance, and implementation of compliance policies and procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Administrative Services Subcontractors, providers and agents) meet all legal and regulatory requirements in the performance of their duties.

The Program provides measures to prevent, detect and correct issues of non-compliance with applicable policies, federal and state regulations, and AHCCCS' contractual requirement to guard against fraud, waste and abuse (FWA).

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

A. 42 Code of Federal Regulation (CFR)

B. Health Insurance Portability and Accountability Act (HIPAA)

C. Arizona Revised Statutes (ARS)

D. Arizona Administrative Code (AAC)

E. The Division's Contract with the Arizona Health Care Cost Containment System (AHCCCS).

F. Centers for Medicare and Medicaid Services (CMS)

Definitions

A. Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary, or which fail to meet professionally recognized standards for health care.

B. Claim – Under the FCA, the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

C. Corporate Compliance Program – a formal program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations. It is designed, structured and implemented to correct identified compliance issues and assist the Division, providers, agents, and subcontractors in meeting legal, regulatory, and contractual obligations pertaining the services provided on behalf of the Division.

D. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

E. Deficit Reduction Act (DRA) –The DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government.

G. Governing Body – The Division as body of persons or officers who establishes the rules and policies, having the authority to exercise governance over its providers, agents and subcontractors.

H. Member – The eligible person enrolled to receive services with the Division.

I. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

J. Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

K. Prevention - Keep something from happening.

L. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

M. Waste - As defined by the Arizona Health Care Cost Containment System (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

Corporate Compliance Structure

The Corporate Compliance Program is designed to fulfill the Division's commitment to foster a culture of compliance and an environment conducive to preventing, detecting and correcting non-compliance issues with all applicable policies, federal and state laws and regulations, and AHCCCS contractual requirements. In addition, the Corporate Compliance Program provides guidance to Division staff, providers, agents and subcontractors in guarding against fraud, waste and abuse all levels of the organization.

The Corporate Compliance Committee monitors, reviews, and assesses the effectiveness of the Corporate Compliance program and the timeliness of reporting to ensure that the Corporate Compliance Program structure facilitates compliance with all legal and governmental requirements.

Corporate Compliance Committee members include:

- Assistant Director/Chief Executive Officer
- Corporate Compliance Office/Deputy Assistant Director
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

- The Chief Compliance Officer, Corporate Compliance Committee, and all other Division Management
- Human Resources Department
- All other Division employees.

Corporate Compliance Program Components

The Corporate Compliance Program is based on the seven key elements of Compliance that facilitate prevention, detection and remediation of non-compliance with federal and state laws and regulations, AHCCCS contractual requirements and DES-DDD internal policies and procedures. The seven key elements are:

1. Written Policies, Procedures and Standards of Conduct
2. Corporate Compliance Program Oversight
3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards
6. Monitoring and Auditing
7. Correcting Areas of Non-Compliance

The Corporate Compliance Program is centered on the Corporate Compliance Plan, compliance policies and procedures, oversight of compliance to law, and contractual obligations, education, monitoring, and enforcement. The Plan:

- Details the process and steps taken to prevent, detect, and remediate instances of non-compliance,
- Adheres to the Division's contract with AHCCCS,
- Is submitted annually to the AHCCCS Office of Inspector General (OIG).

A. Written Policies, Procedures and Standards of Conduct

The Corporate Compliance Program is based on written Policies, Procedures, and Standards of Conduct that facilitate compliance with federal and state laws, regulations, and AHCCCS contractual requirements.

Pursuant to the Deficit Reduction Act of 2005, written Policies address the Federal False Claims Act, administrative remedies for false claims/statements, civil and criminal penalties for false claims/statements, and whistleblower protections under law. See Operations Manual Policy 6002-N Fraud and False Claims, Provider Manual Chapter 20 Fraud, Waste and Abuse, and Provider Manual Chapter 21 False Claims Act.

B. Corporate Compliance Program Oversight

The Divisions Chief Compliance Officer and Corporate Compliance Committee provides Division-wide oversight to ensure compliance with Program and Fiscal Integrity. The Chief Compliance Officer is responsible for the strategy, implementation and oversight of the Division's Compliance Program.

The Corporate Compliance Program is structured to include Division staff responsible for the oversight of compliance related activities to include but not limited to:

1. Risk assessment and management of internal and external compliance
2. Development, implementation and/or monitoring of training and educational events for all Division staff, subcontractors, providers, and agents pertaining Corporate Compliance.
3. Provide technical assistance to all Division staff, subcontractors, providers and agents regarding compliance
4. Documentation of all referrals suspecting potential FWA or other issues of non-compliance
5. Development and monitoring of corrective action plans
6. Timely processing of referrals deemed credible of FWA and submission to AHCCCS OIG
7. Reporting to, and providing reports to, the Corporate Compliance Committee

C. Training and Education

1. Mandatory Training
    a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:
        i. Compliance
        ii. Article 9
        iii. HIPAA (annually)
        iv. Standards of Conduct for State Employees
        v. Fraud Awareness (annually)
        vi. Business Continuity
        vii. Diversity
        viii. AHCCCS Overview
    b. The Division trains employees as appropriate to their job functions, including but not limited to:

i. Support Coordination/Member Services

ii. Network/Provider Relations

iii. Medical Management

iv. Quality Management

v. Claims/Business Operations

c. The Division provides refresher training to all employees as appropriate to their job functions, and as needed

2. Training Materials

The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by the Corporate Compliance Unit.

3. Effective Lines of Communication

a. The Division provides updates to their personnel via the following formats:

i. Unit meetings/AMS

ii. Statewide meetings

iii. E-mails

iv. Echo Employee Newsletter

v. Policies and Procedures

b. The Division may provide updates to contracted providers in the following formats:

i. Provider/Coordination meetings

ii. Vendor Blasts/e-mails

iii. Policies and Procedure Manuals

iv. Contract monitoring units.

D. Enforcement of Standards

1. Evaluate the ability of prospective providers to perform the activities to be delegated, and using accepted risk assessment criteria, as needed.

2. Establish a written agreement (as defined by the Division's contract with AHCCCS) that:

a. Specifies activities and reporting responsibilities delegated to the contractor

b. Provides for revocation of such delegation, and application of sanctions

c. Includes other specific requirements, as stated in the Division's contract with AHCCCS.

3. Retain authority to direct delegated contract requirements

4. Communicate deficiencies to the provider so the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Monitoring/Auditing and Enforcement

1. The Division monitors compliance via:

a. Compliance-related reports based on Division and Provider/AdSS data,

b. Investigations of allegations of non-compliance,

c. Review of functional areas and related systems,

d. Assessment of mechanisms to facilitate prevention, detection and remediation of non-compliance,

e. Internal and external audits.

2. Reporting of Non-Compliance to the Division

The Division maintains open lines of communication to support Division personnel, subcontractors, providers, agents, members, and all other individuals in reporting non-compliance. Toll-free hotlines and dedicated email addresses are identified in Division publications and available on the Division website for this purpose.

3. Correcting Areas of Non-Compliance

Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:

a. May conduct a preliminary fact-finding to determine the nature of the incident,

b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases),

c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.

d. Responds to compliance issues to the extent required by law and within the mandated timeframes.

e. Enforces compliance and takes corrective actions as appropriate.

The Division generates regular compliance-related reports that include, but are not limited to:

a. Grievance System Report

b. Resolution System Report

c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims

d. Claims Dashboard

e. Encounters Report

f. Support Coordination Reports.

g. HIPAA violations report