Fact Sheet: AHCCCS Provider Payment Suspensions

Contact: Cliff Summerhill, PIO
PIO@azahcccs.gov
Phone: 602-727-2584

Background & Findings

- The Arizona Health Care Cost Containment System (AHCCCS) Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans.

- These investigations led to the announcement that the AHCCCS Office of Inspector General (OIG) suspended payments to more than 100 registered providers of Medicaid services based on credible allegations of fraudulent billing activities. These provider payment suspensions are known as Credible Allegations of Fraud (CAF) suspensions. The total number of suspensions are expected to increase as the investigative process evolves. A list of these suspended providers, along with prior suspensions since 2019 and provider terminations since May 1, 2023, is posted on the AHCCCS Provider Suspensions and Terminations web page. This list will be updated regularly.

- According to federal regulation 42 CFR 455.2, 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 tips verified by further evidence,

    - (2) Claims data mining, or

    - (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

- Once a credible allegation of fraud determination is made, AHCCCS is *required* to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation and findings, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS.

- AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation, the US Department of Health and Human Services, the US Attorney's Office, the Internal Revenue Service, and local and tribal law

enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law.

Arizona's Swift Response

AHCCCS's primary focus and top priority any time a CAF payment suspension is issued is to ensure that enrolled members are safe, sheltered, and able to receive the health care services they need. AHCCCS is working with its network of health plans, tribes, behavioral health partners, and other state agencies to mobilize a coordinated transition of care plan for affected members and connect them with resources or services they may need, such as:

- A dedicated hotline at 2-1-1 (press 7) for individuals who have been impacted by the closure of a sober living home or residential facility. More resources, and a Member Guide for American Indian Health Plan enrollees are posted on www.211Arizona.org/MMIP. Law enforcement agencies are equipped with 2-1-1 handout cards and a guidance document describing how to help affected members.
- Mobile crisis teams ready to deploy when members need hands-on, immediate behavioral health services,
- Coordination of immediate housing, transportation, and needed health services related to a provider closure.

AHCCCS has enacted holistic, system-wide strategies to find and eliminate fraudulent billing, including recommendations from the Arizona Attorney General's Office:

- Moving three behavioral health provider types to the high-risk category for new applicants and revalidating providers, which requires on-site visits, fingerprinting, background checks, a registration fee, and additional disclosures,
- Creating a trend report of all providers registering for the at-risk provider types and closely monitoring any billing anomalies,
- Stopped processing provider requests for retro-enrollment, which stops the allowance of retro-billing based on an earlier approved provider enrollment date,

And for claims coming directly to AHCCCS:

- Reviewing all existing claims edits which differ from national standards and setting specific rates for current "by report" billing that pay a percentage of the total billed amount instead of a standard rate,
- Creating system reporting to flag concerning claims (volume, services per day, services for minors) for review prior to payment,
- Setting billing thresholds to deny claims for multiple services that should not be billed on the same day,
- Hiring a forensic auditor to review all claims since 2019 to identify other bad actors in the system, suggest policy changes, and train staff, and

- Flagging claims for overlapping services by different providers that should not be provided on the same day.

Going forward, AHCCCS will implement additional measures to detect and prevent potential fraudulent activity, including, but not limited to:

- Requiring visual attestation of individual billers,
- Implement new agency rules that allows AHCCCS to exclude individuals affiliated with suspended or terminated providers, and
- Requiring third-party billers to disclose terms of compensation.