



STATE OF ARIZONA
OFFICE OF THE GOVERNOR

KATIE HOBBS
GOVERNOR

EXECUTIVE OFFICE

May 7, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

**Re: Arizona Response to CMS Letter on Provider Revalidation
Strategy and Program Integrity**

Dear Administrator Oz:

Thank you for your letter of April 23, 2026 regarding Medicaid provider revalidation. Arizona and our Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS) share your commitment to Medicaid accountability, integrity, and responsible stewardship. My administration inherited one of the most significant behavioral health fraud schemes in Medicaid history, and responded directly, transparently, and in close partnership with CMS to stop the fraud and hold accountable the bad actors who defrauded taxpayers. Arizona has since built a program integrity infrastructure that is among the most robust in the nation.

This letter highlights the substantial program integrity work already underway. Arizona's experience has made it a national resource on Medicaid fraud detection and disruption, and we welcome continued collaboration with CMS to share that expertise. Further, and as requested, Arizona intends to undertake a swift revalidation of its high-risk providers, and is committed to working in partnership with CMS to develop a comprehensive provider revalidation strategy as requested.

I. Arizona's Robust and Innovative Program Integrity Infrastructure

Arizona is proud of its existing program integrity infrastructure, which stretches across every dimension of the fraud, waste, and abuse (FWA) continuum.

A. Provider Enrollment and Revalidation

Consistent with provider integrity efforts, under my administration AHCCCS has already completed or is actively pursuing the following to eliminate and prevent FWA:

- The provider enrollment portal, APEP,¹ has been continuously enhanced to strengthen screening and fraud prevention controls, including expanded third-party screenings, Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data matches, integration of exclusion lists from other jurisdictions, adverse action indicators with restricted approvals, and enhanced audit and tracking functionality.
- Expanded LexisNexis screenings for providers now include bankruptcies, judgments, liens, relatives and associates, and business associates, along with requiring owner middle name disclosure.
- AHCCCS staff utilize additional public resources in screening processes, such as the Arizona Corporation Commission, the National Plan and Provider Enumeration System (NPPES), licensure records and other available public resources to ensure all individuals required to be disclosed on enrollment applications are properly disclosed and screened.
- The agency has added specialized questions for group biller enrollments to capture rendering and servicing providers, closing loopholes that might have allowed excluded providers from other state or federal programs.
- AHCCCS has implemented out-of-state enrollment safeguards, including new enrollment types, required disclosures, banner warnings, and supervisory approval for out-of-state servicing locations.
- AHCCCS deployed AHCCCS Provider Connect, a comprehensive proactive communication technology ecosystem, which is modeled after the agency's successful member initiative during the Public Health Emergency.
- The risk-tiered provider screening allows limited-risk providers to undergo a standard comprehensive review of credentialing and Office of the Inspector General (OIG)/System for Award Management (SAM) checks; moderate-risk providers require on-site visits; and high-risk providers must submit fingerprints for criminal background checks in addition to site-visits.
- Call center agents can now submit fraud, waste, and abuse (FWA) reports on behalf of members, ensuring that information gathered through member contacts is systematically captured.
- A triaging methodology ensures highest-priority quality-of-care concerns are addressed promptly while investigations proceed.

B. Arizona's Managed Care Model as a Program Integrity Tool

Arizona has operated a capitated managed care Medicaid program for more than four decades, longer than virtually any other state. The vast majority of Arizona's Medicaid members belong to private health plans, or managed care organizations (MCOs). AHCCCS's managed care model has consistently produced lower per-member costs and stronger program integrity outcomes than fee-for-service alternatives, because it aligns health plan financial incentives with the state's interest in appropriate, efficient care.

¹ In Arizona, all Medicaid providers are required to enroll through a portal, the AHCCCS Provider Enrollment Portal (APEP), which allows for a single electronic system of record with standardized data capture, required documentation, and automated validation. Revalidations are also conducted directly through APEP, which requires providers to resubmit and attest to updated licensure, ownership, and disclosure information.

Under capitated contracts, MCOs bear the financial risk of inappropriate utilization, a powerful private-sector incentive to detect and prevent fraud. Arizona's MCO partners operate sophisticated utilization management programs and credentialing systems, all subject to AHCCCS contractual requirements. The result is a managed care sector that functions as an active partner in program integrity.

In the next year, AHCCCS will begin the procurement process for its major MCO contracts, AHCCCS Complete Care (ACC) and ACC-Regional Behavioral Health Authority (ACC-RBHA). As it does so, the agency is considering embedding next-generation program integrity and additional cost-sustainability requirements directly into the contractual architecture of Arizona's managed care program.

C. Law Enforcement Partnerships and Enforcement Actions

AHCCCS has built deep, formalized integration with law enforcement at every level, including:

- Expanded partnerships with the FBI, IRS Criminal Investigations, Arizona Attorney General's Office, county prosecutors, Adult Protective Services, tribal police, and local law enforcement statewide.
- Establishing a dedicated, joint liaison with the AG's Medicaid Fraud Control Unit (MFCU) to accelerate joint investigations and data sharing.
- Increased criminal prosecutions and HHS OIG exclusion referrals; non-automatic reinstatement requirements are enforced.
- Building frontline detection capacity by delivering fraud scheme trainings to city police, fire departments, zoning officials, tribal police, and APS investigators.
- Since 2023, initiating more than 364 Credible Allegation of Fraud (CAF) payment suspensions under 42 C.F.R. § 455, immediately removing payment incentive upon credible allegation.
- Fully implementing state exclusion authority under A.R.S. § 36-2930.05 with administrative rules adopted.
- Joint licensing and closure reviews with the Arizona Department of Health Services; an information-sharing MOU that ensures licensing actions trigger enrollment review without delay.
- Compliance reviews of providers billing \$5M+ for False Claims Act requirements, targeting the highest-volume billers.

The results are measurable. More than 100 individuals have been indicted as a result of the agency's actions, with prosecutions continuing in partnership with the U.S. Attorney's Office.

Arizona looks forward to continuing its partnership with the Department of Justice (DOJ) via the recently announced West Coast Health Care Fraud Strike Force. We were proud that the announcement highlighted a number of cases that were referred to the DOJ by AHCCCS's talented OIG investigators. Additionally, AHCCCS has experience deploying strike forces, most notably in 2023–24, utilizing a 3-team, 16-investigator strike force to investigate behavioral health providers. Among other results, the strike force team identified 137 quality-of-care issues and immediately initiated member

protections. They also identified non-operational locations and improper billing practices.

D. Beyond Pay-and-Chase: Claims Integrity and Program Integrity Governance
Arizona joins CMS in recognizing that FWA cannot be defeated with pay-and-chase tactics alone. AHCCCS has implemented several initiatives to proactively identify and stop FWA:

Prepayment Review

Prepayment review is among the most cost-effective program integrity tools available. AHCCCS has significantly expanded its use:

- 100% prepayment review for providers with unusual billing patterns, prior FWA referrals, or high per-member cost.
- Additional triggering codes include per diem behavioral health codes with a history of abuse, substance use disorder (SUD) claims for children, therapy and home care training codes.
- Documentation requirements for 11 behavioral health codes: providers must submit an assessment, treatment plan, and progress note, tying payment to evidence of an actual clinical relationship.
- Licensed Behavioral Health Consultants hired to review and refine prepayment criteria and provide technical assistance to providers.
- New prepayment review vendor contractually required to report any FWA suspicions, extending detection capacity through vendor relationships.

System-Level Claims Controls

- Updated Online Claims Submission System (May 2023): providers may only submit claims for associated provider IDs; billers must submit current photos at billing, directly targeting identity-based fraud.
- Billing codes restricted to qualified provider types (e.g., Multi-Systemic Therapy limited to trained/certified providers).
- Edits deny group counseling billed as provided in a member's home.
- Edits prevent payment for services billed for incarcerated members.
- ID.me onboarded for claims submissions; electronic payment registration mandated for all providers.

Data Analytics and Monitoring

- New data monitoring reports: Top Paid FFS (fee for service) Providers; Members with Highest Cost of Services; Providers with Highest Claim Volume; Trending Code Utilization; Billing Trends for New Providers; Billing Trends by Provider Type.
- AI-informed analytics deployed through Alivia FWA Finder, applying machine learning to identify anomalies at scale.
- External forensic auditor engaged for post-payment analysis, with recommendations under internal review.

- Created the Office of Data Analytics (ODA), which hosts Monthly Operations and Analytical Review Committee and reviews medical economics metrics to identify population-level cost and utilization anomalies.

Enterprise-Wide Program Integrity Governance

- Standing FWA meetings across all AHCCCS divisions.
- Department of Fee for Service Management (DFSM) Operations Committee (formed January 2024): cross-divisional body addressing financial, IT, enrollment, FWA, and clinical functions for FFS members.
- Cross-divisional collaboration between OIG, State Health Licensing, Member and Provider Enrollment, and Quality of Care.
- Robust Self-Disclosure Program for voluntary provider reporting and repayment.
- MCO contracts require FWA referral reporting and program integrity audit plans; AHCCCS OIG holds sole authority to dispose of all FWA matters, including those originating in managed care.

E. Ongoing Commitment to Cost Containment Through Innovation and Reform
Program integrity and cost containment are inseparable. Arizona is building a culture of continuous improvement, and is proud to be leading the nation in several areas.

AI-Informed Claims Prepayment Review System

In July 2026, AHCCCS will launch what is believed to be the nation's first AI-informed Medicaid prepayment review system. The system ranks claims by FWA risk before payment, concentrating review resources on the highest-risk claims while minimizing delays for compliant providers.

AI-driven risk scoring is paired with expert clinical oversight, with automated tools informing rather than replacing human judgment. This reflects Arizona's commitment to catching problems before money goes out the door, rather than relying on post-payment recovery, which is costlier, less effective, and yields only a fraction of improper payments.

Provider Training and Technical Assistance

Beginning August 2026, AHCCCS will launch a provider training program targeting the most underappreciated driver of improper payments: billing and documentation errors due to a lack of awareness. The program includes knowledge-based assessments to assess comprehension of billing standards, FWA and documentation requirements to determine where additional technical assistance would be helpful. This outcomes-based vendor payment model will focus on newly registered providers, and will include a documented training record that supports accountability when errors persist after instruction.

Rate-Setting Reforms and Program Reform

Good Medicaid programs are constantly looking for opportunities to reform programs, and to ensure sustainability. Some of Arizona's recent initiatives:

- AHCCCS has partnered with OIG to recalibrate rates for high-risk codes, reducing the financial return on fraudulent billing.

- Home and Community Services (HCBS) programs (administered through Arizona Long Term Care System (ALTCS) waiver authority) have undergone reforms, including enhanced documentation requirements, utilization review, service hour limitations, and targeted policies and rulemaking to modernize the regulatory framework and improve accountability.
- AHCCCS has proposed significant reforms to Applied Behavioral Analysis (ABA) services, which include tightened prior authorization, enhanced documentation standards, service hour limitations, and strengthened provider qualification requirements, protecting access for members with genuine clinical need while reducing program vulnerabilities.
- The Pharmacy & Therapeutics (P&T) Committee establishes AHCCCS's preferred drug list, negotiates supplemental rebates, and implements step therapy and prior authorization to ensure clinically appropriate medications at the lowest cost. Arizona is reviewing P&T processes against national best practices to protect the committee's fiscal and clinical integrity from recurring legislative pressure.

F. Eligibility Integrity and Member-Level Controls

Program integrity in membership is a critical component of FWA prevention efforts. AHCCCS has worked collaboratively on the following:

- Medicaid Management Information System (MMIS) verification and alignment for American Indian Health Plan (AIHP) members, including improved American Indian/Alaska Native race coding, went live September 2025.
- AHCCCS monitors AIHP enrollment change requests for patterns suggesting patient brokering or plan manipulation.
- Enhanced application and screening processes for Community Partner Assistor Organizations (CPAOs) and individual assistors to ensure those who help connect members and applicants to eligibility are not problematic. Revisions included updated applications and attestations, along with a revised contractual agreement with the agency to ensure only qualified entities and individuals assist members. To date, more than 440 additional screenings have been conducted.

G. Containing Cost for Members with the Highest Acuity

Waste is often driven by high member acuity. Like most state Medicaid programs, AHCCCS is seeing meaningful growth in member acuity, driven largely by members with serious mental illness (SMI), those with co-occurring substance use disorders, and children with autism. Members with SMI and children with autism account for a disproportionate share of hands-on care and wrap-around services, and high-cost utilization, including inpatient admissions and crisis services. Their needs routinely span acute medical, behavioral health, and long-term or inpatient services in ways that strain conventional managed care models.

Along those lines, AHCCCS asks CMS to engage as a proactive partner on the following 1115 waiver provisions, which AHCCCS will seek in the fall of 2026 in connection with Arizona's 1115 waiver demonstration, which expires next year. The following waiver authority concepts, among others, would help Arizona in its effort to provide efficient, clinically appropriate care to its most acute members, which will in turn result in more stable and cost-effective utilization:

- Extending and expanding Arizona's Housing and Health Opportunities (H2O) waiver, which has successfully coordinated community-based services for complex SMI members, reducing costly institutional utilization and hospitalization recidivism; and
- Waiving prior authorization timelines for the Extraordinary Care Review process for direct care and habilitation HCBS services. As AHCCCS has discussed with CMS over the last six months, flexibility in these timelines will allow for more effective cost containment and the most efficient ongoing administrative cost. AHCCCS cannot implement these policies in the most efficient and cost-effective manner without federal waiver authority.

II. Moving Forward Together

At the outset of my administration, Arizona confronted Medicaid fraud not by choice but by necessity. We responded with transparency, sustained investment, and institutional reform. The program integrity infrastructure built since 2023 spans enforcement, technology, governance, data analytics, clinical review, law enforcement partnership, and provider education. It stands alongside four decades of managed care excellence that have made Arizona a national model for cost-effective, high-quality Medicaid administration.

AHCCCS will submit a comprehensive revalidation strategy within 30 business days of your letter. We ask CMS to engage as a genuine partner that acknowledges the real costs of these mandates, supports Arizona in securing appropriate federal resources, understands the competing demands of H.R. 1 implementation, collaborates on waiver extensions to contain costs for our most acute members, and approaches this work in a manner that is fair to Arizona's fiscal position.

We welcome the opportunity to discuss any aspect of this response.

Sincerely,

A handwritten signature in black ink, appearing to read 'KH', followed by a long horizontal line extending to the right.

Katie Hobbs
Governor
State of Arizona