Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Alaska Comprehensive Program Integrity Review

Final Report

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Reviewers:
Barbara Davidson, Review Team Leader
Margi Charleston
Gretchen Kane
Debra Tubbs

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Alaska Medicaid Program. The MIG review team conducted the onsite portion of the review at the Alaska Finance and Management Services offices. The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of three separate divisions under three separate Commissioners. The Program Integrity Unit, which is called the Performance/Quality Assurance (P/QA) section, is located under the Assistant Commissioner for Finance Management Services. The Medicaid Management Information System (MMIS), surveillance and utilization review subsystem (SURS) and provider enrollment are located under the Deputy Commissioner for Medicaid and Health Care Policy in the Health Care Services (HCS) division. The Division of Senior and Disability Services (DSDS) that oversees the waiver programs is located under the Deputy Commissioner for Family, Community and Integrated Services. Each of these three divisions has a quality assurance section that is responsible for Medicaid program integrity in Alaska. This report describes five effective practices, three regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Alaska improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Alaska's Medicaid Program

The Department of Health and Social Services (DHSS) administers the Alaska Medicaid Program. As of January 1, 2010, the program served a total of 105,000 beneficiaries. Medicaid expenditures that were paid within the MMIS during SFY 2009 were $1,051,067. Total expenditures paid outside the MMIS were $19,780,000. The State had 7,716 providers participating in fee-for-service (FFS). The Federal medical assistance percentage (FMAP) for Alaska for Federal fiscal year (FFY) 2009 was 50.53 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 58.68 percent in the first three quarters of FFY 2009 and 61.12 percent in the fourth quarter.

Performance/Quality Assurance Section

In Alaska, three separate divisions of DHSS are the organizational components dedicated to fraud and abuse activities. At the time of the review, the P/QA section had seven full-time equivalent staff focusing on Medicaid program integrity and HCS had three full-time equivalent staff. The table below presents the total number of investigations, number of administrative actions, identified overpayments, and amounts recouped in the past four State fiscal years (SFYs) as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations*	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	61	2	not tracked	not tracked
2007	82	1	$8,881,604	$2,199,070
2008	14	1	$4,474,181	$1,905,181
2009	114	1	$2,165,604	$1,072,604

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Full investigations are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Alaska complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of May 3, 2010, the MIG review team visited the Finance and Management Services P/QA section and the MFCU offices. The team conducted interviews with numerous staff from the P/QA section, the State's provider enrollment contractors, the Home and Community Based Services waivers (HCBS) area, the American Indian/Alaskan Native Health area, non-emergency medical transportation (NEMT) area, and the MFCU. In addition, the team conducted sampling of provider enrollment applications, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Finance and Management Service's P/QA section, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and NEMT.

Alaska operates a Medicaid expansion Children's Health Insurance Program (CHIP) under Title XIX of the Social Security Act. The expansion program operates under the same billing and provider enrollment policies as Alaska's Title XIX Medicaid program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

This review focused on the activities of DHSS as they relate to program integrity. Unless otherwise noted, Alaska provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DHSS provided.

RESULTS OF THE REVIEW

Effective Practices

As part of its comprehensive review process, CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Alaska reported monthly audit committee meetings, a low Payment Error Rate Measurement (PERM), comprehensive MMIS edits, criminal background checks, and periodic recertification of waiver providers.

Monthly Audit Committee meetings to ensure program integrity

The DHSS has an Audit Committee which meets monthly and includes representatives from each of the Medicaid divisions and the P/QA section, the Medicaid director, and the assistant commissioner for Finance Management Services P/QA section. The Committee is led by the program integrity manager and its primary functions are: (1) provide guidance, input and recommendations on the audit selection process; (2) provide guidance, input and recommendations on audit related policies, procedures, and methodologies; and (3) provide a forum for communication to help ensure a coordinated departmental audit, review and quality assurance effort.

PERM error rate

Alaska participated in the PERM pilot project that concluded in early 2008. As a result of this project, a clear PERM communication plan and PERM collaboration procedures were developed and implemented. The communication plan included utilizing the quality assurance sections within the HCS division, as well as the fiscal agent and public information team, to educate the provider community on the importance of keeping good medical records and the importance of the PERM process in general. The PERM collaboration plan clearly defined the roles each State agency would play in the PERM process. A coordinated effort from the State systems unit, Public Assistance, the HCS divisions and the P/QA section led Alaska to the PERM error rate of 0.59 percent, which was the lowest in the nation for 2008.

Comprehensive edits in MMIS

In 1994, Alaska began using an effective software product and continues to update it every other year in order to capture new billing codes. The goal is to prevent money from being paid on duplicate claims, unbundled claims, claims after date of death, concurrent claims, drug-to-drug conflict claims, and mutually exclusive services claims. According to the State, the amount of money not paid due to the comprehensive pre-payment edits from October 1, 2009 to June 2010 was $5,351,587.51.

Criminal background checks in various programs

The DSDS has a highly effective process to ensure that all participants of the HCBS waiver programs receive thorough criminal background checks. The DSDS oversees the four waiver programs and utilizes Alaska's Background Check Unit (BCU) to ensure all waiver program service providers and employees receive criminal background checks that meet State and Federal guidelines including: waiver contractors, home health agencies, personal care provider agencies, program managers, employees, patient care attendants, clinical practitioners, hospitals, laboratories, assisted living facilities, long term care facilities, etc.

The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) checks are done on applicants and those individuals listed on the agency organizational chart. A second check is done once the provider is enrolled. The provider sends a list of all its current employees and a list of new employees to the State BCU which performs the criminal background check. Initially, the BCU runs a check on all employees through the LEIE. On a monthly basis, the DSDS prompts the BCU to perform HHS-OIG database checks of all providers and institutions that require Alaska State certification surveys.

Prior to issuing provisional clearance allowing an individual to become a direct care provider, the BCU conducts an extensive background check which includes fingerprinting. The background check includes records from both Alaska and those states the individual has lived in during the past 10 years. The BCU is required to search the following records: Alaska Public Safety Information Network; Alaska Court System/Court View and Name Index; Juvenile Offender Management Information System; Centralized Registry (employee misconduct registry); Certified Nurse Aide Registry; National Sex Offender Registry; HHS-OIG; and any other records/registries the Department deems applicable.

Initial and periodic recertification of waiver program providers

Prior to participation in Alaska's HCBS waiver programs, providers are required to be certified by the DSDS and enrolled with the fiscal agent. New providers are required to be recertified after one year of participation in HCBS waiver programs. For ongoing participation in the waiver programs, providers are required to recertify every two years. Each certification and recertification process requires the provider to also be enrolled by the fiscal agent as a Medicaid provider.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosure and reporting requirements.

Alaska does not capture all required ownership, control, and relationship information from FFS, waiver, and NEMT providers, the fiscal agent, and administrative services contractors. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

This is a repeat finding from the CMS Region X program integrity review conducted in September 2005 and the MIG Division of Field Operations (DFO) director consultation in April 2008. Alaska provider enrollment is handled by the fiscal agent. Disclosures are not collected by Alaska from its FFS providers, waiver providers, and NEMT providers during the enrollment process. Alaska's provider enrollment form does not require the provider to submit full and complete disclosures. Specifically, the current provider enrollment form, dated February 2010, does not provide space for the provider to report the full disclosures at § 455.104(a)(1)(2)(3). The provider agreement requires complete disclosures be submitted within 35 days only after a request by Alaska.

Based upon responses to the review guide and interviews with the Alaska provider enrollment staff and the fiscal agent, it was determined that the information required under 42 CFR § 455.104 is not collected from the fiscal agent or the administrative service contractors. Even if such information was collected, Alaska does not require the fiscal agent or the administrative service contractors to update disclosure information when there is an organizational change.

***Recommendations*:** Modify provider enrollment forms and contracts to require and collect disclosures. Develop and implement policies and procedures for administrative contractors to update disclosure information when there is an organizational change.

Alaska does not require the submission of disclosure of business transactions to the Secretary. (Uncorrected Repeat Finding)
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

This is a repeat finding from the CMS Region X review in 2005. The Alaska provider agreement requires that business transaction information be submitted to the Alaska DHSS within 35 days upon request. The agreement does not reference the submission requirement to the Secretary.

***Recommendation*:** Modify provider agreements to include language specific to 42 CFR § 455.105.

Alaska does not report to HHS-OIG adverse actions taken on provider applications.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

All providers of Medicaid services are enrolled by the fiscal agent. However, the fiscal agent does not make independent decisions about a provider's participation such as denial of enrollment, termination, suspension of contract, settlement, or sanction. All enrollment issues are reported to HCS which makes the decisions about participation. The HCS does not report adverse actions it takes to limit a provider's participation to HHS-OIG in accordance with the regulation.

***Recommendation*:** Develop and implement policies and procedures to report adverse actions to HHS-OIG.

Vulnerabilities
The review team identified six areas of vulnerability in Alaska's program integrity practices. These included the P/QA section not being an integral program component of DHSS, not utilizing the authority to withhold payments, and not following CMS guidance for referrals to the MFCU. Additional issues include not capturing managing employee information during enrollment, inadequate policies, and not conducting complete exclusion searches.

Not maintaining a centralized program integrity function. (Uncorrected Repeat Vulnerability)
Alaska's program integrity functions are spread among three separate entities, limiting the State's ability to identify, investigate and refer fraud. The P/QA section, as identified on the DHSS organizational chart, is housed in Finance Management Services. The Medicaid director, MMIS, SURS and provider enrollment are housed in the HCS division. The DSDS is housed in Family, Community and Integrated Services. Each division reports to a different Assistant or Deputy Commissioner who, in turn, reports to the Commissioner of DHSS. Each division is responsible for its own programmatic quality assurance.

The majority of the program integrity efforts, as indicated by the P/QA section policies and procedures, are focused on the legislatively required 75 annual audits that are conducted by a contractor, the CMS PERM review, and the 25 SURS reports that are requested by HCS. The P/QA section essentially functions as the liaison between DHSS and the MFCU but has no direct authority over the program activities in the DHSS divisions.

The current SURS functions are performed by the fiscal agent. Since the HCS division has the responsibility for contractor oversight, the 25 quarterly SURS reports are reported to HCS if there are aberrant overpayments, but are not necessarily reported to the P/QA section. The fraud and abuse hotline is managed by the same SURS fiscal agent. Complaints that come into the hotline are initially reviewed by the fiscal agent and if it determines there is a problem, the complaint is referred to HCS, but not to the P/QA section.

The HCS reviews the data, both the reports and any complaints, and if needed, will refer it back to the fiscal agent for further information. The fiscal agent may obtain medical records or any other additional information that HCS deems relevant. The HCS re-reviews all the information obtained by the fiscal agent and refers the complaints it deems appropriate to the relevant divisions for quality assurance.

If HCS determines that a recoupment is needed, the case is sent to the P/QA section. The P/QA section reviews the case and if it concurs and determines that the provider meets the "reckless disregard" standard (Alaska's statutory definition of medical assistance fraud) then the P/QA section refers the case to the MFCU.

The current process limits the P/QA section's initial involvement and ability to trend, identify and conduct preliminary fraud and abuse investigations as identified in 42 CFR § 455.14. The P/QA section may not even be aware of hotline complaints and the quarterly reports that SURS produces. These complaints and reports could generate cases for preliminary investigations by the P/QA section.

The DHSS' lack of acknowledgement of an organizational P/QA section with all program integrity functions being consolidated under the P/QA section manager has been identified in the CMS Region X review, the April 2008 MIG DFO director consultation and the Alaska State Legislative Budget and Audit Committee report of February 2010 which recommended that "the state Medicaid director and the DHSS commissioner take action to improve the agency's utilization control and program integrity function." The State has failed to address the recommendations of any of these reviews, and continues to run a program integrity function that is less effective than it could be if it were consolidated under a single unit. Suggested changes would improve the capability of the State to investigate and pursue overpayments and fraud.

***Recommendations*:** Organize all program integrity functions in a centralized unit. Apply appropriate resources to conduct preliminary investigations mandated by 42 CFR § 455.14. Under the new Affordable Care Act the State will have more responsibility to identify and pursue fraud, abuse and overpayments, and a strong P/QA section would enhance the State's ability to do this.

Not taking advantage of the authority to withhold payments.
The regulation at 42 CFR § 455.23(a) stipulates that the Medicaid agency may withhold Medicaid payments to a provider in cases of fraud or willful misrepresentation. The Alaska Administrative Code provides the State the authority to withhold payments. However, at the time of the review the State had never issued any notices of payment withhold. There is no program integrity policy and procedure to operationalize the use of this State option.

The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

Recommendation: Develop and implement a policy and procedure for withholding payments in cases of fraud or willful misrepresentation.

Not following minimum criteria set forth in CMS guidance for fraud referrals.
A MFCU referral must contain the minimum criteria set forth in the "*Performance Standard For Referrals Of Suspected Fraud From A Single State Agency to A Medicaid Fraud Control Unit"* document released by CMS in September 2008, in conjunction with the "*Best Practices For Medicaid Program Integrity Units' Interactions With Medicaid Fraud Control Units*" Best Practices document. The Alaska program integrity MFCU referral form does not include the P/QA section's calculation of the dollar amount of potential fraud. Since there is insufficient staffing to conduct preliminary investigations, there is little ability to provide the projected amount of potential fraud to the MFCU.

Additionally, DHSS has a verbal understanding with the MFCU that the MFCU will report all criminal convictions to HHS-OIG for exclusions. There is no program integrity policy or procedure outlining this agreement or how the Medicaid State agency will be notified of the exclusions. The memorandum of understanding (MOU) does not contain language specific to this issue.

***Recommendations*:** Modify the fraud referral form to meet the minimum criteria set forth in CMS guidance. Take action to conduct preliminary investigations and collect the information appropriate for referrals to the MFCU. Modify the MOU to include the written language requiring the MFCU to report all criminal convictions to HHS-OIG for exclusions, and to report back to the Medicaid agency.

Not capturing managing employee information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "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 operations of an institution, organization or agency." The Alaska provider enrollment forms do not solicit information on managing employees other than directors or managing employees with health care-related criminal convictions. However, other persons in managing employee positions could be

excluded individuals. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

***Recommendation*:** Modify the provider enrollment form to capture managing employee information.

Not having adequate written policies and procedures. (Uncorrected Repeat Vulnerability)
The HCS has inadequate written policies and procedures for program integrity oversight. The absence of written policies and procedures leaves HCS vulnerable to inconsistent operations and ineffective functioning in the event the HCS loses experienced staff.

For example, Alaska's provider enrollment area does not have written policies, State statute, or administrative codes for action on requests for reinstatement (42 CFR § 1002.215) and notification of State of local convictions of crimes against Medicaid (42 CFR § 1002.230). For the majority of Federal regulations the State has adopted administrative code that provides legal support for action. However, the Alaska Administrative Code referenced for several of the regulations does not fully capture the language at the regulations such as 42 CFR §§ 1002.211 and 1002.212. The team determined that although the Administrative Code is an excellent step, it does not lay out detailed step by step processes that a policy and procedures document would provide. This is a repeat vulnerability from the CMS Region X review in 2005, although the adoption of the administrative code provisions partially addressed this vulnerability.

***Recommendation*:** Develop and implement written policies and procedures to adequately cover program integrity oversight issues. These policies and procedures should detail the steps to take to implement the requirements of the Administrative Code.

Not conducting complete exclusion searches.
The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 12, 2008 providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own staff and subcontractors for excluded parties, including owners, agents, and managing employees. Alaska does not conduct exclusion searches on its fiscal agent, FFS providers, or administrative service contractors that is consistent with this guidance.

Even if Alaska was compliant with the requirements of at 42 CFR §§ 455.104 and 455.106, it does not collect or maintain complete information on owners, officers and managing employees in its MMIS. Therefore the State cannot conduct adequate searches of the LEIE or the Medicare Exclusion Database.

***Recommendation*:** Develop and implement policies and procedures to conduct complete exclusion searches as identified in the SMDLs cited.

CONCLUSION

The State of Alaska applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- an effective process for criminal background checks,
- a requirement for certification and periodic recertification of waiver providers,
- monthly Audit Committee meetings to ensure program integrity,
- a low Payment Error Rate Measurement, and
- comprehensive edits in the MMIS.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHSS to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Alaska to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Alaska will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Alaska has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Alaska on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.