ALASKA DEPARTMENT OF HEALTH

&

ALASKA DEPARTMENT OF LAW

JOINT LEGISLATIVE
Fraud, Waste, and Abuse Report

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ALASKA DEPARTMENT OF HEALTH & ALASKA DEPARTMENT OF LAW

JOINT LEGISLATIVE REPORT

The Department of Law (DOL) and the Department of Health (DOH) have prepared this joint report as required by AS 47.07.076. This report provides a high-level review of the efforts of both departments to combat fraud, waste, and abuse in the Alaska Medicaid program. This report includes only 2024 activity and does not repeat information included in the 2023 report, except to make factual corrections.

A note about reporting periods: DOL uses the federal fiscal year (FFY) as its reporting period, whereas DOH uses the state fiscal year (SFY). In one instance, DOH reports on a Centers for Medicare and Medicaid Services reporting year (RY).

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Positions and Programs Dedicated to Fraud, Waste, and Abuse (Number of Positions and Funding Sources)

DEPARTMENT OF LAW (DOL)

Criminal Division - Medicaid Fraud Control Unit (DOL - MFCU)

Funding: 75% federal and 25% state general fund

- Attorneys: 3
- Accountant: 1
- Investigators: 6
- Law Office Assistant: 1
- Paralegal: 1

Civil Division

Funding: 50% federal and 50% state general fund

- Attorneys: 1.25 attorneys
- Paralegal: 0.5
- Other (Law Office Assistant): 0.25

DEPARTMENT OF HEALTH (DOH)

Office of the Commissioner – Medicaid Program Integrity Office (DOH – MPI)

Funding: 50% federal and 50% state general fund

DOH - MPI has statewide responsibility for the following:

- Management, oversight, and maintenance of
    - Independent contract audits required by AS 47.05.200
    - Recoveries made pursuant to the Improper Payment Information Act
    - Payment suspension process, including those resulting from credible allegations of fraud
    - Medical assistance claims reviews and audits
    - Provider audit and sanction appeals
    - The Alaska Medical Assistance Excluded Provider list
- Coordination of
    - Unified Program Integrity Contract (UPIC) audits
    - Payment error rate measurement (PERM) program
    - Provider overpayment recovery and reporting
    - Provider sanctions and provider self-audit administration
    - Contact and referral process for the DOL - MFCU

DOH - MPI supports the whole department by

- Serving as the compliance officer contact for Centers for Medicare and Medicaid Services (CMS)
- Providing technical assistance on internal reviews of programs and processes for other divisions
- Assisting with and coordinating efforts of divisional quality assurance units
- Coordinating the department audit committee

Number of Positions and SFY24 Funding:

- Anchorage staff: 6
- SFY24 component budget: $1,139,011

Division of Public Assistance - Fraud Control Unit (DPA – FCU)

Funding: 50% federal and 50% state general fund

DPA- FCU has statewide responsibility for fraud deterrent efforts. Whereas DOL – MFCU focuses on provider fraud, DPA – FCU seeks to deter fraud of individuals receiving benefits. Fraud case referrals often involve benefits received from one or more state programs, most commonly

- Alaska Temporary Assistance Program
- Supplemental Nutrition Assistance Program
- Alaska Medicaid Program
- Adult Public Assistance
- Child Care Assistance Program
- Senior Benefits Program

Number of Positions and SFY24 Funding:

The DPA - FCU unit currently has 14 staff members, though some positions were not filled for the full year. Further, DPA also has Juneau claims collection staff functionally tied to debt collection associated with fraud claims; however, since they do not engage in positive time keeping, the cost of their efforts is not included below.

- Anchorage Staff: 9
- Wasilla Staff: 2
- Fairbanks Staff: 2
- Keani Staff: 1
- SFY24 fraud investigation component budget: $2,408,500

Senior and Disabilities Services - Quality Assurance Unit (SDS – QAU)

Funding: 50% federal and 50% state general fund

SDS - QAU has statewide responsibility for the health and welfare of recipients through the monitoring and oversight of service providers. SDS - QAU primarily

- Conducts investigations and reviews to help ensure quality services are received and recipients' health and safety is maintained, including that of vulnerable adults
- Collaborates with stakeholders and other state agencies to investigate fraud

Additional activities include critical incident report review, investigations, remediation reporting, SDS fair hearings, mortality review, service authorization creation, and utilization review. Depending on the seriousness of the non-compliance, a variety of tools in a graduated sanctions process are used to correct provider non-compliance, including offering technical assistance and training, requiring corrective action requests or plans, levying sanctions as needed, and/or escalating to further investigation.

Number of Positions and SFY24 Funding:

- Anchorage Staff: 16
- SFY24 component budget: $2,050,474[i]

Health Care Services - Quality Assurance Unit (HCS - QAU)

Funding: 50% federal and 50% state general fund

HCS – QUA ensures that providers follow state and federal enrollment guidelines for the Alaska Medicaid Program. Monitoring starts with provider enrollment and continues through to post-payment claims review and pattern analysis to detect potential over utilization. HCS - QAU carries out these responsibilities by the management and administration of:

- Provider enrollment
- Surveillance and Utilization Review Subsystem (SURS)
- The Care Management Program (CMP)
- The Alaska Medicaid Coordinated Care Initiative
- Fair hearings

HCS - QAU generally takes an educational/informational approach to correcting provider behaviors though escalates to DOH - MPI and DOL - MFCU for cases that warrant further investigation.

Number of Positions and SFY24 Funding:

- Anchorage Staff: 11
- SFY24 component budget: $1,344,775

Division of Behavioral Health - Medicaid Provider Assistance Services Section (DBH – MPASS)

Funding: 50% federal and 50% state general fund

DBH – MPASS provides education to providers to ensure state and federal regulations are followed and has oversight of

- Autism services
- Psychiatric residential treatment facilities (PRTF)
- The Administrative Services Organization (ASO) contract with Optum, which is responsible for all 1115 Waiver Medicaid claims processing and select state plan claims processing through November 1, 2024

DBH - MPASS also monitors incident reports in PRTF facilities, conducts provider technical assistance, issues approvals for enrollment in the Alaska Medicaid program, and conducts reviews of provider policy and procedure prior to issuing approval. In instances where normal methods fail to correct provider patterns, DOH - MPASS collaborates with the DOH- MPI to determine appropriate actions.

Number of Positions and SFY24 Funding:

- Anchorage Staff: 5
- SFY24 component budget: $746,451

Actions Taken to Prevent Fraud, Waste, and Abuse

DEPARTMENT OF LAW (DOL)

Criminal Division - Medicaid Fraud Control Unit (DOL - MFCU)

Including cases from prior fiscal years, the unit began with 188 open cases, added 50 new cases, and closed 58 cases by the end of FFY24. There are 196 active cases[ii].

The following actions occurred in FFY24:

- Individuals criminally charged: 13
- Criminal convictions[iii]: 4
- Cases with a civil resolution[iv]: 0

Civil Division:

- Audit appeals referred to the Office of Administrative Hearings: 9
- Sanction appeals referred to the Office of Administration Hearings: 1

DEPARTMENT OF HEALTH (DOH)

Office of the Commissioner – Medicaid Program Integrity Office (DOH – MPI)

- Incoming referrals from incoming complaints: 21
- Audits issued under AS 47.05.200: 55
- Audits issued by UPIC: 6
- Focused reviews: 114
- Self-audits received and processed: 72

Division of Public Assistance - Fraud Control Unit (DPA – FCU)

DPA - FCU received 135 fraud referrals for the Alaska Medicaid program:

- Applicant or Early Fraud Detection Investigations: 0
- Categorically Ineligible Investigations: 109
- Recipient or Post Certification Investigations: 26

The DPA - FCU completed 143 investigations involving the Alaska Medicaid Program:

- Applicant or Early Fraud Detection Investigations: 0
- Categorically Ineligible Investigations: 85
- Recipient or Post Certification Investigations: 58
- Closed cases for reasons other than fraud pertaining to the Alaska Medicaid program: 1,210

Senior and Disabilities Services - Quality Assurance Unit (SDS – QAU)

- Intakes to SDS - QAU: 18,055
- Investigations/over-utilizations referred to the DOH - MPI and/or the DOL - MFCU: 11

- Investigations conducted: 123
- Substantiated allegations: 60
- Providers that received formal technical assistance: 25
- Providers required to submit a Corrective Action Plan: 19
- Notice to Correct letters sent to providers: 60
- Terminated from the Alaska Medicaid Program: 1
- Mortality cases reviewed during Mortality Review Task Committee: 782

Health Care Services – Quality Assurance Unit (HCS – QAU)

- SURS cases opened: 102
- Recoveries in SFY24: $125,143
- Recipients assigned to the CMP: 1,126
- Cost savings estimate for recipients assigned to the CMP: $5,000,000

Division of Behavioral Health – Medicaid Provider Assistance Services Section (DBH – MPASS)

- Technical assistance calls: 12
- Individual provider technical assistance: 34 agencies
- Provider self-disclosure cases: 3
- Providers with corrective action plans: 0

Status of Prior Years' Initiatives Taken to Prevent Fraud, Waste, and Abuse

The following initiatives began in previous years and work is ongoing in SFY24:

- DOH - MPI has partnered with CMS and the Centers for Program Integrity (CPI), Division of State Partnership (DSP) on a Medicare-Medicaid data sharing initiative to help identify fraud, waste, and abuse that overlap both programs. This partnership resulted in the identification of overpayments during the Public Health Emergency (PHE) where a provider was billing both for drive-through COVID testing and for a high-level evaluation and management code (otherwise known as an office visit), when, in actuality, no office visit was performed. Overpayments were identified at close to $200,000. Additionally, an audit of one out-of-state pharmacy has identified potential overpayments exceeding $300,000 primarily for the use of very expensive anti-fungal drugs in footbaths and soaks. Both audits are currently in appeal status.

- DOH - MPI publishes a list of excluded providers in Alaska to help prevent fraud, waste, and abuse by identifying providers who may have been convicted of medical assistance fraud or other barring conditions. Excluded providers are not allowed to enroll in the Alaska Medicaid program unless they have been reinstated by the U.S. Department of Health and Human Services, Office of the Inspector General. The list is updated as needed.

Initiatives Taken to Prevent Fraud, Waste, and Abuse

During SFY24, DOH - MPI recovered over $3.6 million in overpayments paid to providers. Also, during SFY24, DOH - MPI continued to work with CMS' CPI and DSP on a Medicare-Medicaid data sharing initiative to help identify fraud, waste, and abuse that overlaps both programs. The DSP has hired contractors known as Unified Program Integrity Contractors (UPIC) to perform data analysis and identify potential problem providers based on their review of both Medicaid and Medicare claims data. Several leads developed through this partnership and resulted in identification of overpayments where providers were overbilling for high-level evaluation and management (office visit) codes. In addition, the UPIC has started audits of one behavioral health provider and one health professional group.

Examples of Issues Uncovered, *i.e.,* Vulnerabilities in the Medicaid Program (Including Suggestions from Meyers and Stauffer)

- No interface between the Background Check Program and MMIS, which can allow Medicaid providers to receive payment for services without having a valid background check on file
- Failure to require all direct service providers to enroll as rendering providers, including chore, respite, and behavioral health state plan services providers

Recommendations to Increase Effectiveness of Fraud, Waste, and Abuse Mitigation Measures and Initiatives

- Revisit and address gaps in the background check process under AS 47.05.300
- Home and Community Based Waiver regulations should mirror Personal Care Assistant (PCA) regulations regarding documentation requirements
- Require enrollment of all direct service providers
- Ensure all provider audits and SURS reports are vetted by the appropriate Medicaid division and the DOH - MPI prior to release

Dollar Return for Efforts, Including Cost Avoidance

DEPARTMENT OF LAW (DOL)

Criminal Division - Medicaid Fraud Control Unit (DOL - MFCU)

Restitution ordered from criminal convictions resolved during FFY24

- Restitution recovered from all outstanding matters: $388,718[v]
- Recoveries from nationwide false claims cases: $57,064

Civil Division:

- Amount awarded in OAH orders: $0
- Amount awarded in superior court orders: $0
- Amounts agreed upon and recovered in settlements: $900,080

DEPARTMENT OF HEALTH (DOH)

Office of the Commissioner – Medicaid Program Integrity Office (DOH – MPI)

- Recoveries: $3,646,723
- Cost Avoidance: $0
- Total Program Return to State: $3,646,723
- Return on Investment: $3.20 returned for every $1.00 spent

Division of Public Assistance - Fraud Control Unit (DPA – FCU)

- Recoveries: $11,945
- Cost Avoidance: $8,204

Senior and Disabilities Services – Quality Assurance Unit (SDS – QUA)

- Recoveries: $32,126

Health Care Services – Quality Assurance Unit (HCS – QAU)

- Recoveries: $125,143
- Care Management Cost Avoidance: $5,000,000

Division of Behavioral Health – Medicaid Provider Assistance Services Section (DBH – MPASS)

- Recoveries: $36,285

Examples of Prosecuted and/or Prevented Instances of Fraud, Waste, and Abuse

DEPARTMENT OF LAW (DOL)

Criminal Division - Medicaid Fraud Control Unit (DOL - MFCU)

DOL - MFCU investigative activities in FFY24 focused on complex, institutional/corporate entities and vulnerable-recipient investigations. Following are several examples of the unit's more complex investigations:

- Unit investigators have continued to closely scrutinize a complex, corporate record-integrity and corporate governance matter, resulting in multiple interviews of corporate personnel
- Additionally, DOL - MFCU investigators have opened investigations into Medicaid Care Coordinators who commit fraud against the Medicaid system by

    - Submitting fraudulent billing sheets
    - Failing to provide adequate care to recipients in assisted living
- Finally, DOL - MFCU is close to finalizing its investigation into a dental group taking advantage of rural Alaskans through settlement or formal charges

Additionally, DOL – MFCU has ongoing cases involving

- Drug diversion
- Emergent and non-emergent transportation provider fraud
- False billings by
    - Dentists
    - Physicians
    - Board certified behavior analysts
    - Advanced nurse-practitioners

Moving forward, DOL – MFCU plans to maintain its focus on complex, institutional/corporate entities, while at the same time, amplifying efforts on smaller PCA and simple travel billing cases. Further, the unit will continue to prioritize investigations involving improper or illegal opioid prescription—*including fentanyl*—by physicians and advanced nurse-practitioners.

DEPARTMENT OF HEALTH (DOH)

Division of Public Assistance - Fraud Control Unit (DPA – FCU)

During the COVID PHE, many flexibilities were implemented and CMS mandated continued eligibility. With these rules in place, reaching the burden of proof for prosecution of cases was difficult to achieve. As processing returns to regular certification as unwinding concludes, prosecutions may return to normal levels.

Since then, DPA - FCU focused on high-risk cases, including individuals residing outside of Alaska and still receiving Adult Public Assistance and/or Senior Benefits with accompanying State of Alaska paid Medicaid, including buy-in for the Medicare Premium Assistance/Medicare Savings Programs. During SFY24, DPA - FCU successfully prosecuted a Defendant and Authorized Representative with associated Medicare buy-in premiums having been paid by the State of Alaska while the Defendant resided outside of the state and country. An additional component of the total Medicaid loss for this case included Medicaid claims for PCA services, fraudulently billed by the Authorized Representative and paid on behalf of the Defendant. DPA - FCU is continuing to focus on these types of cases as long as the loss exceeds $10,000 – the return on investment threshold required for prosecution by DOL to balance extradition costs.

Senior and Disabilities Services – Quality Assurance Unit (SDS – QAU):

After investigations resulted in the identification of fraud and in addition to the delivery of required provider training, SDS - QAU also implemented these escalating remediations:

- Issued “notices to correct” for a variety of reasons
    - Notices of this nature are an effort to correct non-compliant behavior, offering providers an opportunity to make pre-sanctioned adjustments to come into compliance
- Required corrective action plans as the result of substantiated allegations

- Referred to DOH - MPI and/or DOL – MFCU, resulting in recoveries
- Terminated an agency from Medicaid for failing to follow regulations

Most Recent Payment Error Rate

The Medicaid and Children's Health Insurance Program (CHIP) are programs that the federal Office of Management and Budget have identified as programs at high risk of improper payments. CMS measures these improper payments annually through the payment error rate measurement (PERM) program. Two of the 3 programs the PERM reviews are applicable in Alaska: fee-for-service claims and eligibility determinations. As specified by CMS[vi], "It is important to note that the improper payment rate is not a 'fraud rate' but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements."

CMS conducts PERM reviews for all 50 states in 3 cycles, with about 17 states in each cycle. DOH - MPI coordinates the data processing and medical record portions of the PERM review. Alaska's most recent review examined SFY23 data and is referenced by its reporting year (RY), in this case RY24.

Preliminary PERM review results were released November 18, 2024. Alaska has 90 days to review and respond to all findings before the review becomes finalized. Regardless of any changes made in this process, Alaska must submit a PERM Corrective Action Plan addressing RY24 error rates no later than February 15, 2025.

Alaska's preliminary RY24 error rates represent a substantial improvement over the previous PERM cycle from RY21. Its overall RY24 error rate is preliminarily 9.67%, including a fee-for-service error rate of 0.24% combined with a Medicaid eligibility error rate of 9.45%. Alaska's overall CHIP error rate is preliminarily listed at 27.14%, consisting of a fee-for-service error rate of 0.98% and a CHIP eligibility error rate of 26.42%.

Results from the Medicaid Eligibility Quality Control Program

The eligibility portion of PERM was conducted by an outside contractor hired by CMS. The current round of Medicaid Eligibility Quality Control (MEQC) reviews the period from January 1, 2024 through December 31, 2024. The results of this MEQC are expected to be released August, 2025. DPA – QCU staff play a vital role in the review process by participating in sections of the review as requested by the contractor as well as conducting full MEQC reviews.

Endnotes

[i] Resulting from a formula error, in the 2023 report, SDS reported the SFY23 cost as $2,176,360; the corrected amount is $1,980,167

[ii] For more information on any of these cases, visit www.law.alaska.gov/department/criminal/mfcu.html or contact Assistant Attorney General, Kaci Schroeder at kaci.schroeder@alaska.gov

[iii] Convictions relate to convictions that occurred in FFY24. However, some cases may have originally been filed in years prior to FFY24

[iv] Prosecutions deferred in exchange for an agreement to pay back the money and pay an additional civil penalty

[v] This amount represents all funds collected and disbursed to crime victims

[vi] https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm