

ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

February 5, 2014

1:38 p.m.

MEMBERS PRESENT

Senator Bert Stedman, Chair
Senator Peter Micciche, Vice Chair
Senator Pete Kelly
Senator Johnny Ellis

MEMBERS ABSENT

Senator Kevin Meyer

COMMITTEE CALENDAR

OVERVIEW: PROGRAM INTEGRITY AND FRAUD CONTROL IN THE MEDICAID AND PUBLIC ASSISTANCE PROGRAMS

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

WILLIAM STREUR, Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska

POSITION STATEMENT: Presented information on "Program Integrity and Fraud Control, Public Assistance & Medicaid."

ANDREW PETERSON, Assistant Attorney General & Director
Medical Fraud Control Unit
Department of Law (DOL)
Anchorage, Alaska

POSITION STATEMENT: Presented information on the "Alaska Medicaid Fraud Control Unit (MFCU)."

ACTION NARRATIVE

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CHAIR BERT STEDMAN called the Senate Health and Social Services Standing Committee meeting to order at 1:38 p.m. Present at the

call to order were Senators, Kelly, Ellis, and Chair Stedman. Senator Micciche arrived shortly thereafter.

**OVERVIEW: PROGRAM INTEGRITY AND FRAUD CONTROL IN THE MEDICAID
AND PUBLIC ASSISTANCE PROGRAMS**

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CHAIR STEDMAN announced that the only order of business would be overviews entitled, "Program Integrity and Fraud Control in the Medicaid and Public Assistance Program" and "Alaska Medicaid Fraud Control Unit." He noted there would be no public testimony today.

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WILLIAM STREUR, Commissioner, Department of Health and Social Services (DHSS), Juneau, Alaska, presented information on "Program Integrity and Fraud Control, Public Assistance & Medicaid." He referred to the partnership between DHSS and the Department of Law on this issue. He began with a statement that "there are a lot of Alaskans in need." He noted DHSS's budget of \$2.66 billion this year and the need to spend wisely, appropriately, and honestly in order to reach those in most need of care. He said it was the right thing to do and the practical thing to do. The department must ensure that the funding goes to where it can have the greatest impact.

COMMISSIONER STREUR explained that recipient fraud is primarily controlled through the Public Assistance Fraud Control Unit in DHSS and through the Welfare Fraud Section, Office of Special Prosecutions & Appeals in the Department of Law (DOL). Provider fraud is controlled by the Medicaid Fraud Control Unit (MFCU).

He said Medicaid fraud is either recipient fraud or provider fraud. The greatest financial impact of fraud is to the provider. Recipient fraud involves a great deal of prevention. The mission of Medicaid Program Integrity (MPI) is to preserve and protect the integrity of the Medicaid program by proactively developing strategies to identify, deter, and prevent fraud, waste and abuse. There are seven staff in MPI who conduct provider claim reviews, manage the audits, and coordinate provider overpayment recovery and reporting. They also manage the Recovery Audit Contract required by the Affordable Care Act. He added that MPI is the liaison with DOL's MFCU.

COMMISSIONER STREUR remarked that MPI manages the audit contract established under AS 47.05.200. In partnership with Myers & Stauffer, LC, MPI does 70 audits a year.

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SENATOR MICCICHE asked if the audits are random on a net basis.

COMMISSIONER STREUR said they are random. He explained that MPI randomly selects 65 audits and five are targeted. They address several criteria; have they been audited recently and do they have audit history.

He continued to explain about the MPI section, highlighting its accomplishments. Last year MPI identified \$6,235,000 in overpayments, of which they recovered \$4,962,000. They suspended payment to 56 providers based on credible allegations of fraud. He suggested the department is only beginning efforts in that area.

He said MPI also re-procured the audit contract required by state statute and issued 70 final provider audits conducted by Myers & Stauffer, LC. MPI initiated the Recovery Audit Contract required by the Affordable Care Act. He clarified that the department contracts as a state, but goes through the federal process to conduct the 142 audits. He opined that MPI should work more closely with MFCU in this area due to the great opportunity for recovery. He concluded that MPI participated in four on-site investigations in collaboration with MFCU, the Office of the Inspector General, and the FBI.

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COMMISSIONER STREUR discussed the Division of Public Assistance's role in preventing fraud. Public Assistance Fraud Control investigates allegations of applicant and recipient fraud, collaborates with federal and state agencies, and works on administrative sanctions and/or criminal prosecutions. The Division has offices in Anchorage, Fairbanks, Wasilla, and Kenai.

COMMISSIONER STREUR discussed the Division's role in data mining - looking at databases for ineligible uses of aid programs. The Alaska Corrections Offender Management System helps identify felons illegally collecting benefits. The Division attempts to maximize existing information systems to prevent fraud.

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COMMISSIONER STREUR highlighted Public Assistance Fraud Control accomplishments in FY 13. He spoke of the \$9,270,000 saved by targeting cost avoidance, investigating fraud claims, and providing direct savings. Identifying ineligible applicants

before payments are made makes up the largest part of the savings. There was \$1,680,008 saved in applicant fraud, \$6,455,987 saved in categorically ineligible investigations, and \$441,558 saved in recipient fraud. From 12 fraud convictions, \$198,475 in court-ordered restitution was recovered.

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ANDREW PETERSON, Assistant Attorney General, Director, Medical Fraud Control Unit, Department of Law, Anchorage, Alaska, presented information on the "Alaska Medicaid Fraud Control Unit (MFCU)." He referred to the Omnibus Budget Reconciliation Act of 1993. It requires states to establish MFCUs with performance standards and guidelines and minimum personnel requirements. If the standards are met, the Federal Financial Participation Grant will fund 75 percent of MFCU operations.

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MR. PETERSON discussed the areas MFCU focuses on. It investigates and prosecutes medical assistance fraud, allegations of abuse or neglect, and financial exploitation or misappropriation of patient assets. These areas are regulated by federal grants and relate to agencies that receive Medicaid dollars. Other areas of focus, separate from criminal prosecution, are global recoveries through the National Association of Medicaid Fraud Control Units, and civil suits by the state.

He said MFCU also has limitations. It does not focus on non-Medicaid cases, investigating or prosecuting recipient fraud, or data mining. He explained that MFCU is part of the Department of Law and falls under the Attorney General's Office, and it is independent from the Department of Health and Social Services.

Another requirement for federal funding is that MFCU have an assistant attorney general for prosecuting, a financial auditor or CPA, and at least one chief investigator. He described the unit members.

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MR. PETERSON reported on the funding for MFCU. The funding year is in federal fiscal years. Funding increased from 2011 to 2012 due to the legislature's funding of three additional investigators, totally 6 investigators plus an auditor. The number of investigations decreased intentionally because of collaboration with DHSS to improve the quality of the referrals. Investigators no longer have to spend time screening cases. The

number of convictions has increased, beginning in 2013, from one to nineteen. So far in 2014, there have been 25 convictions.

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MR. PETERSON shared Medicaid fraud statistics. The FBI Financial Crimes Report from 2010 to 2011 estimates that between 3 percent and 10 percent of total billings nationwide are fraudulent.

SENATOR MICCICHE asked about the statute of limitations on past fraud cases.

MR. PETERSON explained that the statute of limitations is generally 5 years; however, it can be up to 8 years for fraud cases, but no more than one year past the date of discovery. He explained that when he took over the unit, there were many old cases, but the decision was to address the new ones. He used home health care as an example of old cases that can be looked at because the providers can be identified; Alaska is ahead of the curve in this area.

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MR. PETERSON noted that fraud schemes are becoming more sophisticated and tend to be carried out nationwide. Efficient deterrence requires agency cooperation. The best way to deter fraud is to collaborate with other agencies.

He described MFCU's collaboration with the Department of Health and Social Services (DHSS). Through coordinated Medicaid Division meetings, Program Integrity, Quality Assurance, Health Care Services, Behavioral Health, and Department of Law, meet together to identify cases of concern, problems, and limitations.

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MR. PETERSON highlighted collaboration with other agencies such as the Alaska State Troopers, Municipality of Anchorage & APD, Office of Inspector General (OIG) Agents, FBI, Immigrations and Customs Enforcement, other federal agencies like SSA, DEA, USPS, and Departments of Labor, Commerce, and Corrections.

He discussed health care fraud referral sources: DHSS, online website, private citizens, recipients, police, providers, and other government agencies. MFCU screens referrals and investigates them or refers them to other agencies.

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MR. PETERSON turned to Medicaid payment suspensions. There are a total of 62 suspensions based on credible allegation of fraud from 10/12 to the present. He described the process of payment suspension. He gave examples of areas in which there have been payment suspensions; a home health care agency, a transportation service provider, two medical practices, and 58 individual home health care attendants. The cost savings estimate is about \$15 million.

CHAIR STEDMAN asked if that is a projection of loss over time.

MR. PETERSON understood that it was an estimate of future savings.

He described prosecutions from October of 2012 to the present where MFCU charged 72 criminal cases. Those cases focused in areas such as personal health care attendants billing for services not provided, double billing for time, travelling internationally, and billing while recipient is hospitalized. There were three cases against assisted living home employees for endangering the welfare of a vulnerable adult, and fraud by a doctor and an office manager.

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MR. PETERSON highlighted resolved cases. Between October 2012 and the present, there were 44 criminal convictions where the individuals were suspended from providing Medicaid services and had to provide restitution. Judgments totaling \$226,931 were secured. There were also two civil resolutions. There are a number of pending cases and ongoing investigations. The estimated potential recovery is between \$1.3 million to \$3 million if allegations are proven.

MR. PETERSON discussed notable cases. He described State v. Batac where the defendant was employed by the Municipality of Anchorage as a tax assessor and at Home Depot. The defendant billed Medicaid for PCA services while working and traveling. The total amount of fraud equaled \$64,665.47 and she received a felony conviction and was sentenced to one year in jail followed by probation for 10 years. She has the option of paying back the money for reduced probation.

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He said another case was State v. Gunes and involved an Anchorage taxi driver convicted for fraudulently billing Medicaid \$100. He was accepting Medicaid vouchers for rides that

were prohibited and submitting false claims. Anchorage suspended his chauffer license for five years and revoked his taxi permit.

He discussed an allegation for services not provided by the Anchorage Transportation Company.

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He highlighted a personal care attendant (PCA) case where 29 defendants were charged on July 9, 2013. The case was jointly investigated with \$362,000 in fraudulent billing identified.

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MR. PETERSON talked about the value of cooperation between agencies in order to efficiently utilize limited financial resources and the expertise of many, as well to identify weaknesses and solutions for improving the program. He indicated that Alaska is quite innovative in regulating home health care programs and for getting results due to a high level of agency cooperation. The sentinel effect is a general deterrence because it leads to a decrease in fraudulent billing and savings from deterring fraud and/or suspending providers.

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CHAIR STEDMAN referred to the budget increment to the Department of Law a few years ago. He commented on the positive results from that funding.

SENATOR MICCICHE thanked Mr. Peterson for his hard work.

CHAIR STEDMAN thanked Commissioner Streur and commended the good team effort.

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There being no further business to come before the committee, Chair Stedman adjourned the Senate Health and Social Services Standing Committee at 2:22.