

SB

41

SFIN

FILE

SENATE COMMITTEE REPORT First Committee of Referral

DATE: 2/26/03

FURTHER: Judiciary
Finance

Date of 5-Day Notice: 2/20/03
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 3.13.03

Health, Education and Social Services Committee considered

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41

SB 41 MEDICAID COSTS AND CRIMES

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

and recommends:

be replaced with _____ CS for SS for SB 41 (HES)

adopt previous _____ CS _____

attached amendment(s)

adopt Letter of Intent by _____ Committee

further referral to _____ Committee

Senate Bill:

same title

new title

House Bill:

same title

technical title

new: SCR # _____

NEW FISCAL NOTE(S):

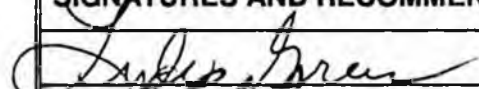
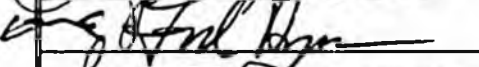
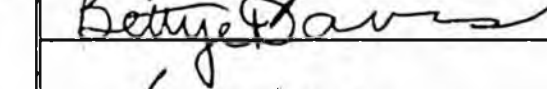
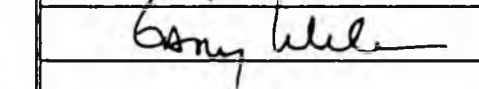
Department	Date	Fiscal	Zero	FN#
* HES	3/17	✓		1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

* rec'd this forthcoming FN 3/18

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:		DO PASS	DO NOT PASS	NO REC	AMEND
	Green	✓			
	* Dixon	✓			
	Davis			✓	
	Wilken	✓			
CHAIR:					

SENATE FINANCE COMMITTEE

SIGN-IN

SB 41-MEDICAID COSTS AND CRIMES

NAME: Kevin Henderson Subject/Bill No: SB 41

Co./Dept./Title: Div. of Medical Assistance Phone: 465-5821

Address: P.O. Box 110660, Omaha Zip: 68111

Do you wish to testify? Yes No Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? Yes No Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? Yes No Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? Yes No Respond To Questions

SENATE FINANCE COMMITTEE REPORT

REPORTED OUT

APR 15 2003

SENATE FINANCE
COMMITTEE

DATE: 4/15/03

FURTHER:

DATE TURNED
IN TO OFFICE: 16 April 2003

Finance Committee considered SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41

SB 41 MEDICAID COSTS AND CRIMES

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

and recommends:

- be replaced with _____ CS SB 41 (FIN)
- adopt previous _____ CS _____ (_____)
- attached amendment(s)
- adopt Letter of Intent by _____ Committee
- further referral to _____ Committee

Senate Bill:

- same title
- new title

House Bill:

- same title
- technical title
- new: SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
<u>H455</u>	<u>3/19/03</u>	<u>66.5</u>		<u>#1</u>

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
<i>Adrian Taylor</i>	✓			
<i>Ben Green</i>	✗			
<i>Ben Green</i>			✓	
COCHAIR: <i>Lyle Green</i>	✓			
COCHAIR: <i>Ben Green</i>	✓			

REPORTED OUT
FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

APR 15 2003

SENATE FINANCE
COMMITTEE

Fiscal Note Number: 1
Bill Version: CSSSSB 41(HES)
S) Publish Date: 3/18/03
Dept. Affected: Health & Social Services
BRU Medical Assistance Admin
Component Health Purchasing Group

Revision Date/Time (Note if correction):

Title MEDICAL CARE AND MEDICAID FRAUD

Sponsor GREEN

Requester _____

Component No. 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services	66.5	65.7	66.9	68.1	69.4	70.7
Travel						
Contractual		1,024.9	1,045.4	1,066.3	1,087.6	1,109.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0

CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	49.9	818.0	834.2	850.8	867.8	885.0
1003 GF Match	16.6	272.6	278.1	283.6	289.2	295.0
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0

Estimate of any current year (FY2003) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill creates more accountability from providers, recipients, and the Department of Health and Social Services (DHSS) in the administration of the Medicaid and CAMA programs, primarily through provider audits. The department is ordered to contract for independent financial audits in order to identify overpayments and criminal violations. This bill establishes named criminal acts for medical assistance fraud and corresponding degrees of felony or misdemeanor crimes. This bill provides for disenrollment of a health care provider for fraud or misconduct involving a controlled substance.

Prepared by: Kevin Henderson

Phone 465-5821

Division Medical Assistance

Date/Time 03/17/2003

Approved by: Joel S. Gilbertson, Commissioner

Date 03/17/2003

Agency Department of Health and Social Services

ANALYSIS CONTINUATION
ESTIMATED EXPENDITURES

The department has limited experience with contracting for provider audits. Audits for which DHSS has contracted in the past did not include the search for illegal activity required by this bill. Factoring in our limited experience, we make the following assumptions:

The .75% sample of all enrolled providers required by this bill means at least 75 providers would have to be audited each year. We estimate that two of the provider audits would be medical facilities, which require a more complex audit. The remaining 73 providers chosen by the contractor would be a cross section of provider types who exhibited characteristics that indicate recovery was likely.

To estimate the cost of an audit, we started with the historical cost of both facility and non-facility audits and increased that amount by 50%. This increase is to compensate for the added requirements of this bill, including the search for illegal activity, using a contractor with attorney staff, and the higher cost of short term contracting with a firm large enough to complete the complexity and number of audits required. The FY04 base cost of a facility audit is \$26,100 per audit and there would be at least 2 of these completed per year. The base cost of a non-facility audit is \$13,050 and there would be at least 73 of these per year.

DMA would require one full-time auditor (Range 16) to coordinate the non-facility audits, assist in management of the contract, and coordinate fair hearings as a result of DMA recovery enforcement. Additional administrative costs of equipment, supplies, office space, travel, etc are factored in.

Expenditures are anticipated to grow at an annual rate of 2%. Federal Medicaid match is calculated at 75%.

FISCAL NOTE
FN # 1

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CSSSSB 41(HES)

ANALYSIS CONTINUATION
ESTIMATE OF RECOVERIES

Of the 75 providers audited each year, we estimate that 75% of them will result in a claim for recovery. We estimate a 1 to 2 ratio of audit costs to recoveries. Historically, for every 1\$ of the cost of an audit we recovered \$2.

Annual growth in recovery of Medicaid and CAMA is estimated at 4%, which is a balance between inflationary growth in medical costs and a reduction in the frequency of provider violations and related recoveries as the program matures. We anticipate no recovery in FY04, because that year will be needed to develop, advertise, and award a contract for audit and recovery functions. In addition, some regulations changes will be needed in order to make a clear distinction between rate-setting audits and financial/misconduct audits.

Estimated recovery is shown below:

FY04	FY05	FY06	FY07	FY08	FY09
\$0	\$1,567.5	\$1,630.2	\$1,695.4	\$1,763.2	\$1,833.8

Section 3: AS 47.05.200(c) requires recovered overpayments obtained because of an audit to be deposited with the Department of Revenue.

AMENDMENT

OFFERED IN THE SENATE

BY SENATOR GREEN

TO: CSSSSB 41(JUD)

- 1 Page 6, lines 4 - 8:
- 2 Delete all material.
- 3 Insert
- 4 "(2) "claim" includes a request for payment for medical assistance
- 5 services under applicable state or federal law or regulations, whether the request is in
- 6 an electronic format or paper format, or both;"
- 7
- 8 Page 7, line 6. following "services":
- 9 Insert "or "medical services"
10 assistance"
- 11 Page 7, lines 6 - 7:
- 12 Delete "available to a medical assistance recipient"
- 13 Insert "that may qualify for reimbursement under AS 47.07 or AS 47.08"

SENATE FINANCE COMMITTEE
4/15/2003 COMMITTEE ACTION

Bill Number	SB 41		
Amendment	#1		
Motion	amend		
<i>Motion by</i>	Green		
<i>Objection by</i>	no		
<i>Removed</i>			
<i>Second Objection by</i>			
<u>Committee Member</u>	Y	<u>Vote</u>	N
Senator Taylor			
Senator Bunde			
Senator Hoffman			
Senator Olson			
Senator Stevens			
Co-Chair Green			
Co-Chair Wilken			
<u>Tally</u>			
Yea			
Nay			
Absent			
<u>MOTION</u>	Pass		

SENATE FINANCE COMMITTEE
4/15/2003 COMMITTEE ACTION

Bill Number	SB 41		
Amendment	#1		
Motion	adopt		
<u>Motion by</u>	Green		
<u>Objection by</u>	Wilken		
<u>Removed</u>	✓		
<u>Second Objection by</u>			
<u>Committee Member</u>	<u>Y</u>	<u>Vote</u>	<u>N</u>
Senator Stevens			
Senator Taylor			
Senator Bunde			
Senator Hoffman			
Senator Olson			
Co-Chair Green			
Co-Chair Wilken			
<u>Tally</u>			
Yea			
Nay			
Absent			
<u>MOTION</u>	PASS		

COMMITTEE SUBSTITUTE FOR SPONSOR SUBSTITUTE FOR SENATE BILL 41
SPONSOR STATEMENT BY SENATOR LYDA GREEN

An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions.

Since 1999, the costs of the Medicaid program have risen throughout the nation at an average rate of 11 percent per year. Alaska's Medicaid program has averaged annual increases of 20 percent, or more than \$100 million per year, bringing the total projected program costs in FY2004 to just under \$1 billion (\$695 million in federal funds and \$289 million in state funds).

Factors such as increased participant enrollments, increased use of health services, and the increasing costs of pharmaceuticals and long-term care are the greatest contributors to the rise in Medicaid program costs. While we have limited ability to contain these cost factors, we can control program integrity by targeting waste and fraud.

Nationally, the error rate of overpayments in the Medicare program is 7 percent, a number that could be inferred to the Medicaid program as well. In addition, the commonly held perception of the amount of fraud committed against the Medicaid program nationwide is 10 percent. Whether these two numbers are inclusive of one another or should be compounded, they represent a sizeable amount of spending -- between \$70 and \$170 million -- in Alaska's Medicaid program on activities that are, at best, questionable and at worst, criminal.

To preserve the integrity and fiscal viability of Alaska's Medicaid program, the system should be held to rigorous controls and frequent scrutiny. Relevant law should be in place to prosecute those who commit fraud and abuse related to medical care. Alaska has no specific health care criminal theft statutes. Currently, in order to prosecute those who commit Medicaid fraud, prosecutors must use criminal statutes related to actions coincidental to the misconduct. Alaska theft statutes require proving the conduct was intentional, a very high standard to meet for a crime where there is no crime scene or physical evidence. Consequently, there have been relatively few prosecutions. Senate Bill 41 provides the legal tools for the fiduciaries of the Medicaid program to establish program integrity and maintain maximum fiscal control.

The legislation establishes the crime of medical assistance fraud, defines the elements that constitute the fraud, and classifies the crime committed as either a felony or a misdemeanor. It requires independent financial audits to identify errors, overpayments, and criminal violations made to, or by, Medicaid providers and requires administrative action within 90 days of receipt of each audit. It completes the loop between the Department of Health and Social Services and the Department of Law by requiring copies of all audits be provided to the Attorney General and by directing the Attorney General to notify the Department of Health and Social Services of any charges of misconduct filed against a Medicaid provider. Such notice requires the Department to undertake a complete review of any outstanding claims of that provider. Finally, Senate Bill 41 provides that financing of the audits may be made from the recovery, due to the audits, of misspent funds.

It is vital that the State of Alaska administer its Medicaid program in a manner that ensures effective, long-term cost containment while providing needed medical care to its intended recipients. Medicaid providers must operate honestly, responsibly and in accordance with the law. Those who do not should be held accountable. Senate Bill 41 provides the State with the means to better implement this philosophy.

ALASKA STATE LEGISLATURE

Interim:

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Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

State Capitol
Juneau, Alaska 99801-1162
(907) 465-6000
1-877-465-6001
Fax (907) 465-3605

SENATOR LYDA GREEN

SENATE BILL 41 SPONSOR STATEMENT

An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program

Since 1999, the costs of the Medicaid program have risen throughout the nation at an average rate of 11 percent per year. Alaska's Medicaid program has averaged annual increases of 20 percent, or more than \$100 million per year, bringing the total projected program costs in FY2004 to just under \$1 billion (\$695 million in federal funds and \$289 million in state funds).

Factors such as increased participant enrollments, increased use of health services, and the increasing costs of pharmaceuticals and long-term care are the greatest contributors to the rise in Medicaid program costs. While we have limited ability to contain these cost factors, we can control program integrity by targeting waste and fraud.

Nationally, the error rate of overpayments in the Medicare program is 7 percent, a number that could be inferred to the Medicaid program as well. In addition, the commonly held perception of the amount of fraud committed against the Medicaid program nationwide is 10 percent. Whether these two numbers are inclusive of one another or should be compounded, they represent a sizeable amount of spending -- between \$70 and \$170 million -- in Alaska's Medicaid program on activities that are, at best, questionable and at worst, criminal.

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The legislation establishes three specific crimes of misconduct involving Medicaid services, defines the actions constituting those crimes, and classifies the type of crime committed as either a felony or a misdemeanor. It clarifies the circumstances under which controlled substances may be prescribed. It requires independent financial audits to identify errors, overpayments, and criminal violations made to, or by, Medicaid providers and requires administrative action within 90 days of receipt of each audit. It completes the loop between the Department of Health and Social Services and the Department of Law by requiring copies of all audits be provided to the Attorney General and by directing the Attorney General to notify the Department of Health and Social Services of any charges of misconduct filed against a Medicaid provider. Such notice requires the Department to suspend payment to, and undertake a complete review of, that provider. Finally, Senate Bill 41 provides that financing of the audits may be made from the recovery, due to the audits, of misspent funds.

Senate Bill 41
Sponsor Statement
Page 2

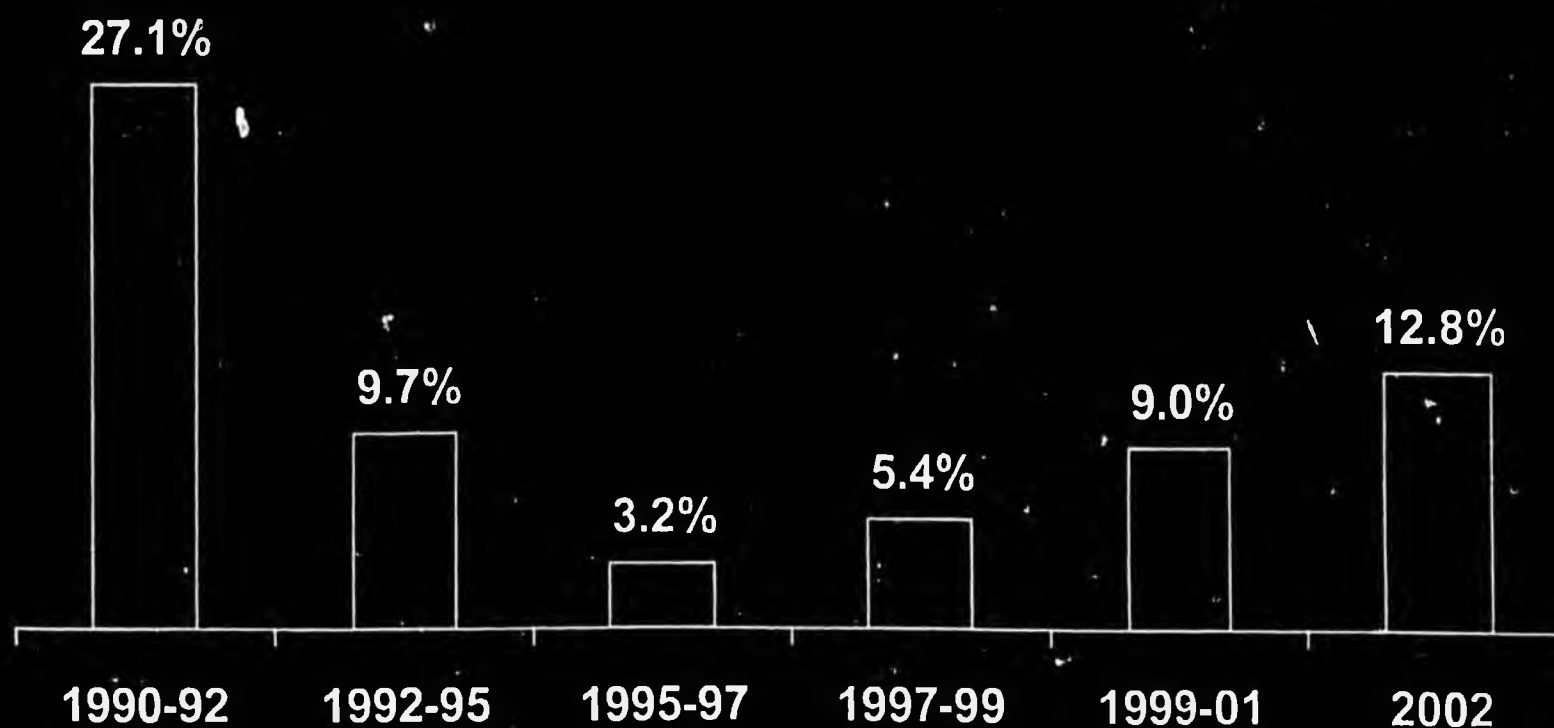
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Provided by Sen. Green

Figure 13

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, 2000. For 2001-2002: Health Management Associates surveys for the Kaiser Commission on Medicaid and the Uninsured.

K A I S E R C O M M I S S I O N O N
Medicaid and the Uninsured

ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language	Actuals FY98	Actuals FY99	Actuals FY00	Actuals FY01	Actuals FY02	Enacted FY03	Projected FY04 20% increase
Medical Assistance							
Medicaid	366,536.5	395,689.5	470,709.0	583,893.6	693,679.7	820,036.5	984,043.8
General Purpose	129,731.2	131,522.9	145,514.7	152,791.1	192,921.5	173,294.8	207,953.8
Federal	231,329.7	261,315.7	307,508.4	387,431.9	461,846.9	579,552.0	695,462.4
Other	5,475.6	2,850.9	17,685.9	43,670.6	38,911.3	67,189.7	80,627.6
Total	366,536.5	395,689.5	470,709.0	583,893.6	693,679.7	820,036.5	984,043.8
 % Increases from Prior Year		7.95%	18.96%	24.05%	18.80%	18.22%	20.00%
 Total Medicaid Expenditures FY 99 - FY 02:				2,143,971.8			
Average annual increase between FY 99 and FY 02				20.60%			

Source: figures obtained from Legislative Finance Division
Presented by T. Carpenter of Senator Green's staff

2/24/2003

Figure 15

Factors States Reported as Among the "Top Three" Increasing Medicaid Spending

Number of states reporting:



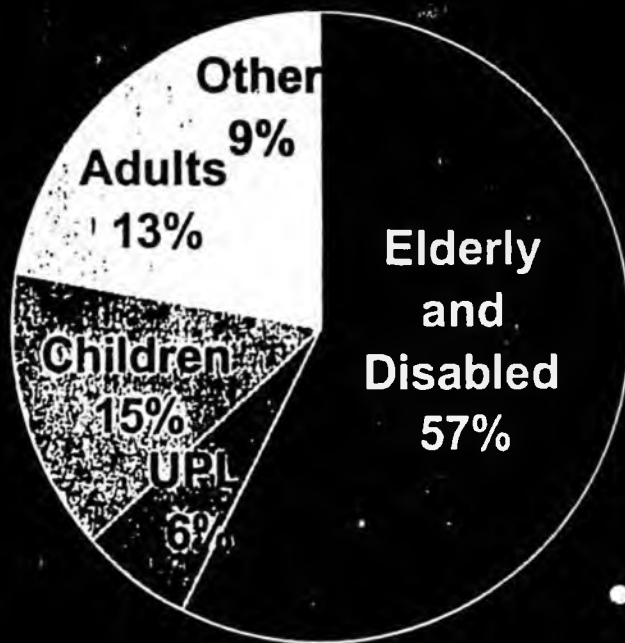
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

K A I S E R C O M M I S S I O N O N
Medicaid and the Uninsured

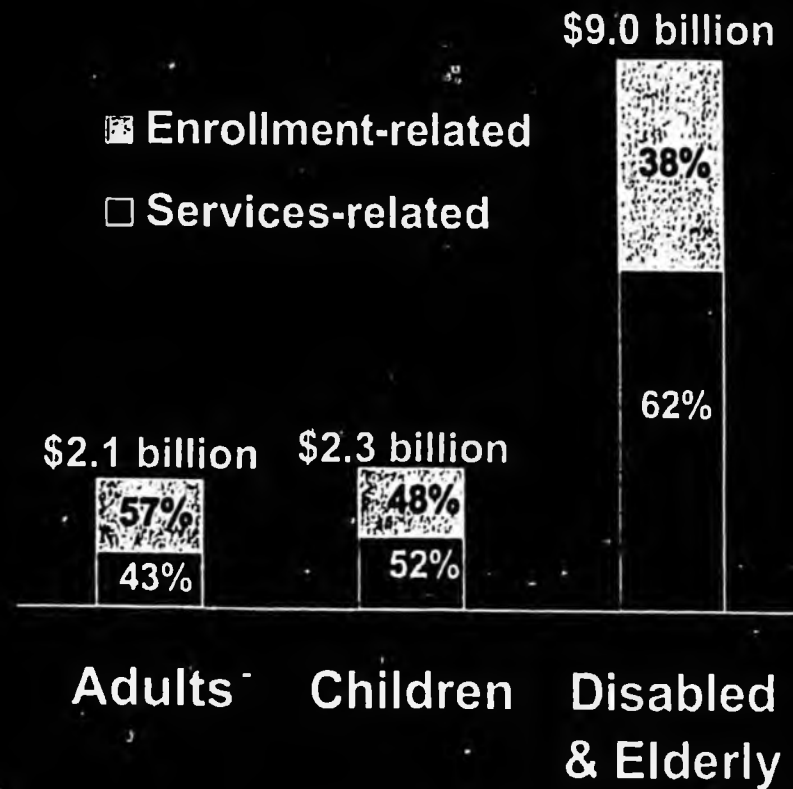
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002

Factors Behind Expenditure Growth for Beneficiaries



Total Increase = \$15.7 billion

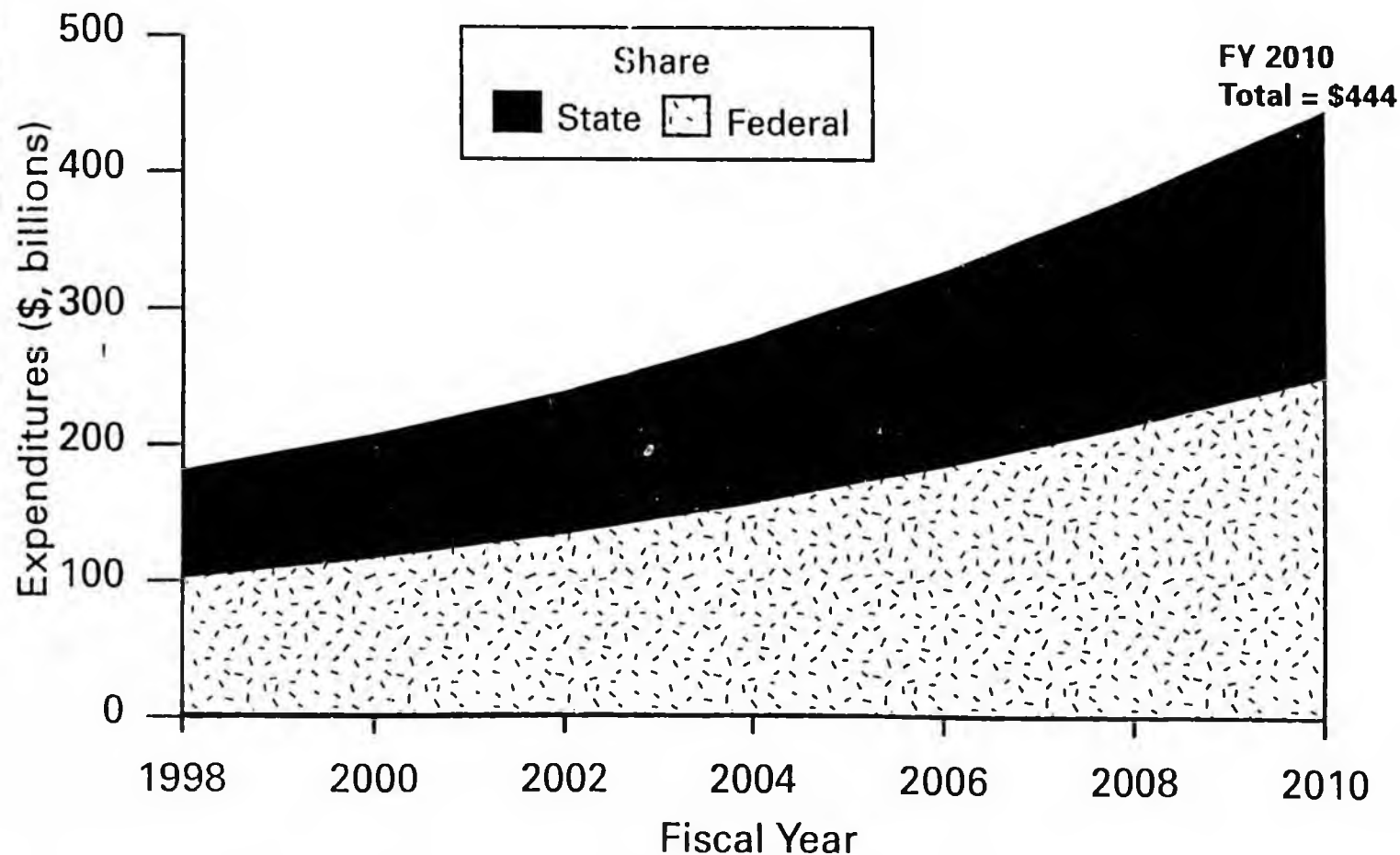


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

**K A I S E R C O M M I S S I O N O N
M e d i c a i d a n d t h e U n i n s u r e d**

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years 1998-2010

Spending is projected to grow to \$444 billion in FY 2010.

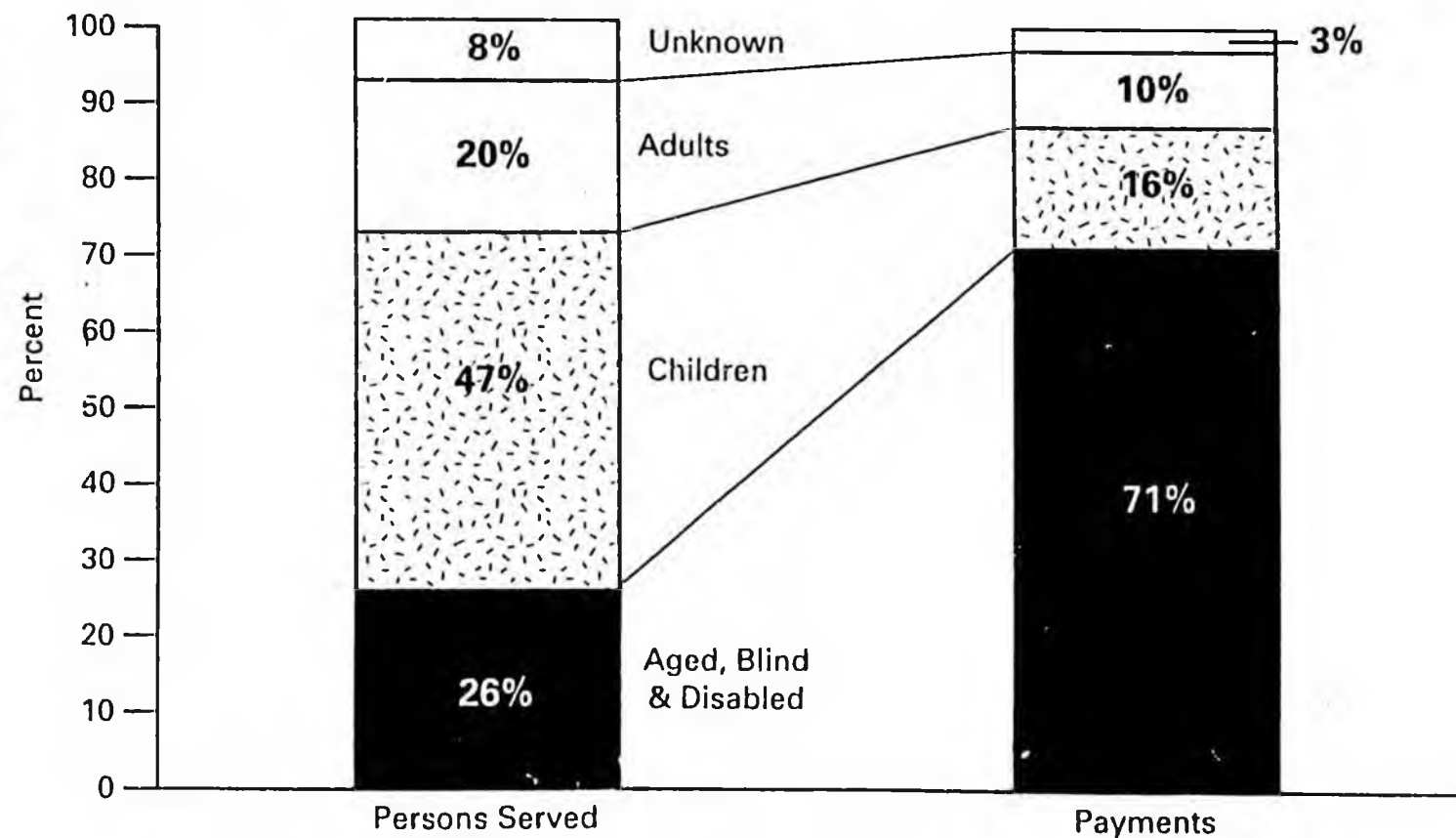


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors -- case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.10 Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 1998

Payments for the elderly, blind and disabled account for 71 percent of total payments.

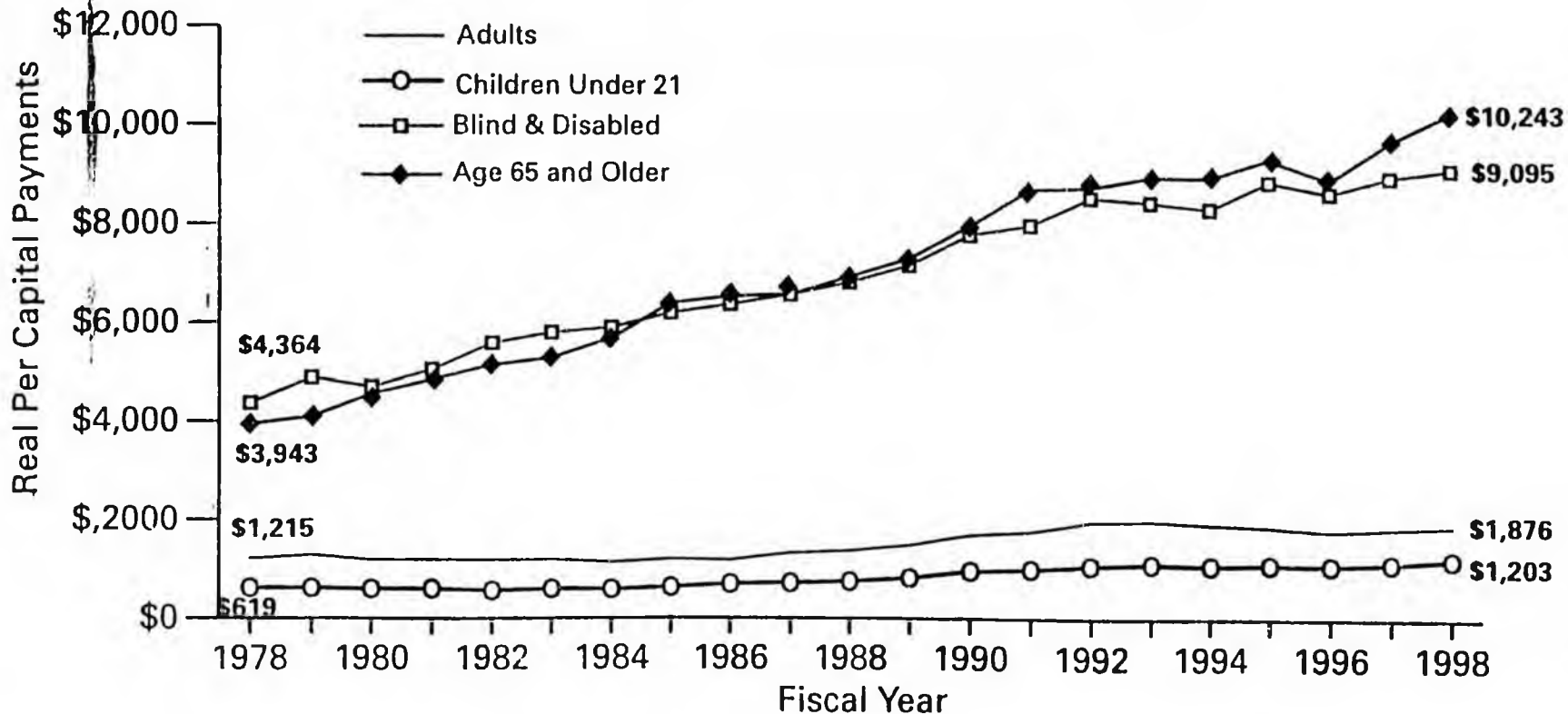


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare); (3) disabled children are included in the aged, blind & disabled category shown above.

Source: HCFA-2082.

**Figure 2.12 Average Real Medicaid Payments per Person Served,
Fiscal Years 1978-1998**

Per capita payments for the elderly, blind and individuals with disabilities more than doubled while per capita payments for children and adults had modest growth rates.



Note: (1) Data shown above are expressed in 1998 dollars; (2) for FY 1998 "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments; (3) the term "adults" as used above refers to a category of non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

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ALASKA MEDICAID FRAUD CONTROL UNIT

Message Hotline to Report Medicaid Fraud 1-907-269-6279

The Alaska Medicaid Fraud Control Unit (MFCU) has been part of the Attorney General's Office since January 1992. The unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds. The Director of the MFCU is Assistant Attorney General Donald R. Kitchen, a career criminal prosecutor with more than a quarter century of experience in the criminal justice system. There are 47 MFCU's across the U.S.

Although the vast majority of health care providers are honest and dedicated to providing the highest quality health care to their patients, Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and threatens the integrity of the Medicaid program. Nationally, it is estimated that Fraud, Waste and Abuse account for 10 to 20 percent of the payments made by Medicaid. If the National trends hold true for the State of Alaska, these percentages equate to 30 million to 70 million Medicaid dollars annually, resulting in a substantial reduction in moneys available to provide necessary medical services to needy Alaskans.

Fraud is "intentional" deception or misrepresentation which results in an "unearned benefit", usually in the form of an excess payment. While health care fraud can take many forms, the most common involves billing for services not performed or billing for more expensive services than those actually provided. Medicaid patients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Medicaid. An unscrupulous provider can generate a fraudulent Medicaid payment simply by filing a false claim with an eligible recipient's identification number and a valid procedure code.

Examples Of Fraud Schemes In Health Care

- BILLING FOR SERVICES NOT RENDERED
- BILLING FOR HIGHER LEVEL OF SERVICES THAN ACTUALLY PERFORMED
- BILLING FOR MORE SERVICES THAN ACTUALLY PERFORMED
- CHARGING HIGHER RATES FOR SERVICES TO MEDICAID THAN OTHERS
- CODING BILLINGS TO GET MORE REIMBURSEMENT

- PROVIDING AND BILLING FOR UNNECESSARY SERVICES
- MISREPRESENTING AN UNALLOWABLE SERVICE IN A MEDICAID BILLING
- FALSELY DIAGNOSING SO MEDICAID WILL PAY FOR MORE SERVICES

**ALASKA DIVISION OF
MEDICAL
ASSISTANCE**



**ALASKA
DEPARTMENT OF
LAW**

If you suspect Medicaid health care fraud or patient abuse, do your part to protect the integrity of the Medicaid program and the public resources that fund it! Contact the Medicaid Fraud Control Unit Hotline at 1-(907) 269-6279 and ask to speak to an investigator or simply leave a message. Our fax is 1-(907) 269-6202. Or call the Crimestoppers Hotline at 1-(907) 561-7867. You need not give your name and you may be eligible for a reward.

*Alaska Medicaid Fraud Control Unit
Office of Special Prosecutions and Appeals
310 K Street, Suite 308
Anchorage, AK 99501*

E-MAIL at medfraud@law.state.ak.us

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[manuals](#) | [webmail](#) | [intranet](#) | [employee directory](#) | [privacy policy](#) | [law home](#)

Provided by Sen. Green

**Testimony
Before the Finance Committee
United States Senate**

Improper Payments

**Statement of
Michael F. Mangano
Acting Inspector General**

April 25, 2001

**Office of Inspector General
Department of Health and Human Services**

Good morning Mr. Chairman. My name is Michael F. Mangano. I am the Acting Inspector General for the Department of Health and Human Services (HHS). It is my pleasure to be here today to give you an update on our work with regard to improper payments in Departmental programs.

Today, I will provide an overview of the types of payment errors revealed by our most recent Health Care Financing Administration (HCFA) audit. Over the past five years, the Office of the Inspector General (OIG) has undertaken audits of Medicare's fee-for-service claims to estimate the extent of payments that did not comply with Medicare laws and regulations. These payment errors, comprised of improper provider billings, make up the largest category of inappropriate payments in the Medicare program. These errors can include simple billing mistakes as well as fraudulent billings. We continue to believe that most health care providers do their best to provide high quality care and are honest in their dealings with Medicare. At the same time, we must be concerned about all errors, even those which are totally innocent. Our annual measurement of Medicare payment errors not only allows HCFA to focus on the areas where increased compliance is needed, but also enables HCFA to identify approaches to building a better Medicare program.

I will also describe instances of specific inappropriate payments made as a result of the complex, antiquated, and incompatible technology environment in which Departmental programs operate. These examples include Medicare and Medicaid payments made on behalf of deceased or incarcerated beneficiaries, as well as Temporary Assistance for Needy Families (TANF) payments made to fugitive felons. Taken together, these problems indicate systemic vulnerabilities which could lead to much more serious losses of funds if not remedied.

MEDICARE PAYMENT ERROR RATE

We recently released our report *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments* (A-17-00-02000) in which we present the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled \$11.9 billion, or about 6.8 percent of the \$173.6 billion in processed fee-for-service payments reported by HCFA. It is important to note that this is an error rate estimate and not a fraud estimate. These improper payments could fall on a continuum anywhere from simple inadvertent mistakes to outright fraud and abuse.

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. We found that the contractors' claim processing controls were generally adequate for: (1) ensuring beneficiary and provider Medicare eligibility; (2) pricing claims based on information submitted; and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments. Our historical analysis of payment errors from FY 1996 through FY 2000 identified four major payment error categories: medically unnecessary services, unsupported services, coding errors, and noncovered services.

Medically unnecessary services, the largest error category this year, amounted to \$5.1 billion in improper payments. This category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. The following is an example of services that were determined not medically necessary:

- A physician was paid \$3,305 for 40 hypnotherapy sessions with an Alzheimer's patient. The medical records stated that the patient was neither attentive nor cooperative during the initial mental status exam. Since the patient could not participate in that exam, the medical reviewer determined that hypnotherapy treatment was not medically necessary, reasonable, or appropriate for a 95 year old Alzheimer's patient.

Unsupported services represented the largest error category in three of the last 5 years. In FY 2000, they accounted for an estimated \$4.3 billion in improper payments. Such services include those where there is insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed (\$2.3 billion) or where there was no documentation to support the services provided (\$2 billion). An example of unsupported services follows:

- A hospital was paid \$722 for outpatient radiation therapy services. The medical records contained no documentation to support the provision of these services. After repeated unsuccessful attempts to obtain such documentation, the claim was denied.

Coding errors represented \$1.7 billion in improper payments (the net of upcoding and downcoding errors). For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. Physician and inpatient Prospective Payment System (PPS) claims accounted for over 90 percent of the coding errors over the 5 years reviewed. An example of incorrect coding includes:

- A hospital was paid \$19,452 for providing a diagnostic related group service to a patient admitted with a chronic inflammation of the membrane lining the abdominal wall. The principal diagnosis code was shown as another infection. The medical reviewers concluded that the diagnosis code should have been related to an infection due to a dialysis catheter. As a result, \$7,125 was denied.

Noncovered services and other errors consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. Such services include most routine physical examinations; eye and ear examinations to prescribe or to fit glasses or hearing aids; and, most routine foot care.

Since we developed the first error rate for FY 1996, HCFA has closely monitored Medicare payments and has instituted appropriate corrective actions. The HCFA has also worked with provider groups to clarify

reimbursement rules and to impress upon healthcare providers the importance of fully documenting services. Additional initiatives on the part of the Congress, HCFA, the Department of Justice, and the Office of Inspector General have focused resources on preventing, detecting, and eliminating fraud and abuse. All of these efforts, we believe, have contributed to reducing the improper payment rate by almost half -- from \$23 billion, or about 14 percent of Medicare program expenditures, in FY 1996 to \$11.9 billion, or about 6.8 percent of the \$173.6 billion in Medicare payments, in FY 2000.

The decrease in improper payments has had a positive effect on Medicare's financial situation. From 1991 to 1996, the Congressional Budget Office (CBO) reported that Medicare's rate of inflation averaged 10.9 percent per year. In FY 1998, the rate of inflation for the Medicare fee-for-service program dropped to the lowest in the program's entire history (since 1965) -- 1.5 percent. Overall, CBO calculated the average Medicare inflation rate for FY 1997 to FY 2000 at 3.2 percent. CBO commented that: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules." (The Budget and Economic Outlook: Fiscal Years 2002-2011, CBO, January 2001)

As of 1996, the Trustees of the Medicare Part A Trust Fund projected that the Trust Fund would be insolvent in 1999. However, over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. One of the primary contributing factors cited by the Trustees has been "the continuing efforts to combat fraud and abuse." (Status of the Social Security and Medicare Programs, Trustees Annual Report, March 1999). We believe that these positive economic findings with respect to the financial integrity of the Medicare program, which will positively impact on both taxpayers and beneficiaries, are due in large part to the fact that the vast majority of health care providers are engaged in submitting accurate claims to HCFA and providing high quality, medically necessary services.

INAPPROPRIATE MEDICARE AND MEDICAID PAYMENTS

Numerous OIG audits and investigations have revealed instances where antiquated and complex computer systems have resulted in inappropriate payments being made on behalf of Medicare beneficiaries and Medicaid recipients. Several recent OIG audits and inspections examined whether the Medicare or Medicaid programs were being billed for services which occurred after the date of a beneficiary's death and whether these programs were paying for such services. We have also recently completed work to identify inappropriate payments made on behalf of incarcerated Medicare beneficiaries.

Payments Made on Behalf of Deceased Beneficiaries

Medicare Services: In our inspection, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), we found that Medicare paid an estimated \$20.6 million in 1997 for services that started after a beneficiary's date of death. These payments were made because of several system problems. Approximately \$12.6 million was paid because Medicare had not yet received beneficiary date of death information from the Social Security Administration (SSA) Master Beneficiary Record at the time the claim was processed. For example, for one beneficiary who died in May 1997, HCFA did not receive the date of death information until October 1997. This delay allowed three months of rental payments for a nebulizer to be paid in June, July, and August 1997.

The remaining \$8 million was paid for services where the beneficiary's date of death was in its system at the time the claim was processed and approved for payment, but HCFA's Common Working File system, the system used by fiscal intermediaries and carriers to process fee-for-services claims, did not prevent the claims from being paid. Over half of the \$8 million was for durable medical equipment claims. For example, for one beneficiary who died in November 1997, HCFA received the date of death information in

that same month. However, in January 1998, HCFA paid claims on behalf of that beneficiary for durable medical equipment items with service dates in December of 1997.

We also found some payments for services where HCFA's Enrollment Database, which contains entitlement data for Medicare beneficiaries, and the Common Working File contained different dates of death. In one example, a beneficiary received four services relating to ambulance transport on May 12, 1997. Although data from the Enrollment Database indicated that the beneficiary died on May 9, 1997, the Common Working File contained a different date of death of May 13, 1997. In such examples, we found no indication of which file contained the accurate date of death and therefore do not know whether or not the claims were paid in error.

As a result of our findings, we recommended that HCFA require contractors to conduct annual post-payment reviews to identify and recover payments made for services after death; revise their Common Working File system edit to ensure that durable medical equipment payments are not made for deceased beneficiaries; and periodically reconcile date of death information between the Enrollment Database and Common Working Files. In January 2001, HCFA implemented the system change necessary to revise the Common Working File edits to prevent payment of durable medical equipment services billed after the beneficiary's date of death. HCFA has also recently issued instructions to Medicare contractors requiring them to conduct the necessary post-payment review activities to identify payments made on behalf of deceased beneficiaries. However, HCFA indicated that there is no way to systematically compare the Enrollment File and Common Working File to determine which date of death is accurate without a manual review; therefore, they will need to take into account contractor workload while implementing this recommendation.

Medicaid Services: In 1994, the OIG began an initiative to work more closely with State Auditors in reviewing the Medicaid program. Through this initiative, the OIG/State Audit Partnership Plan was developed to expand Medicaid program audits and allow State Auditors to apply methodologies we have successfully used in our Medicare audits. As an example, the State of Ohio's Office of the Auditor examined whether Medicaid was paying for services on behalf of deceased recipients (*Payments for Medicaid Services to Deceased Recipients*, A-05-00-00045). The audit determined that, during a period of almost 6 years, the Ohio Department of Human Services (ODHS) paid \$82 million for services to Medicaid recipients after the recipients' date of death. This amount consisted of 115,000 payments to over 4,000 different providers for services provided to almost 27,000 apparently deceased recipients. The average time to discover and recover an overpayment was just over five months after the recipient's date of death. About 93 percent of the unrecovered payments were in four categories of service: skilled nursing facility (75 percent of the unrecovered payments), intermediate care facility (7 percent), pharmacy (6 percent), and durable medical equipment (5 percent).

Subsequent analysis by the Ohio Department of Human Services confirmed that information in the Medicaid recipient master file is not always accurate. Ohio auditors determined that almost 30 percent of 34,330 Medicaid recipients who died during 1997, according to the Ohio Department of Health's Vital Statistics file, did not have a date of death entered on the recipient master file (meaning that providers could still bill and be reimbursed for Medicaid services). Moreover, 4.6 percent of the 24,463 recipients who had a date of death on the recipient master file had a death date that differed from the Vital Statistics death date by more than one day.

The Office of the Auditor recommended that the Ohio Department of Human Services recover the outstanding amount ~~when feasible~~ and cost effective, make corrections to prevent additional overpayments from being made for deceased recipients, and seek legislative authority to develop and apply sanctions against providers who do not timely report a recipient's death or who bill for or retain unearned

reimbursements. The State has now recovered all of the overpayments identified in this audit.

Payments Made on Behalf of Incarcerated Beneficiaries

Medicare Payments: We are currently conducting a series of audits on Medicare payments provided on behalf of beneficiaries who were in the custody of Federal, State, or local law enforcement agencies at the time services were provided. Under current Federal law and regulations, payments for such services are generally unallowable. The State or other government component operating the prison is presumed to be responsible for the medical needs of its prisoners.

The rules for determining whether Medicare will pay are complex and administratively cumbersome. Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Regulations at 42 Code of Federal Regulations (CFR) 411.4(b)(1) and (2) state the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities *unless* the authorities require that all individuals pay for such services and enforce that requirement by pursuing collection for repayment. The State or other Government component operating the prison is presumed to be responsible for the medical needs of its prisoners. According to HCFA's procedural manuals for its contractors, this is a rebuttable presumption that may be overcome only at the initiative of the Government entity. The entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. It must pursue collection, including the filing of lawsuits to obtain liens against an individual's assets outside the prison and income from non-prison sources.

The Social Security Administration, on the other hand has a simple rule regarding payments to prisoners. A person's Social Security benefits are suspended if he/she is incarcerated for a month or more.

In our report *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries* (A-04-00-05568), we found that the Medicare program is vulnerable to improper payments for services provided to incarcerated beneficiaries. According to data provided to us by the SSA, there were 38,600 Social Security beneficiaries entitled to Medicare who were incarcerated as of July 2000. We used this data to determine whether Medicare claims have been paid on behalf of any of these beneficiaries during Calendar Years 1997 through 1999. To date, we have identified \$32 million in Medicare fee-for-service payments on behalf of 7,438 incarcerated beneficiaries during Calendar Years 1997 through 1999. We also found that some incarcerated beneficiaries were enrolled in Medicare managed care plans during their incarceration.

We are in the process of determining the amount of Medicare payments made on behalf of incarcerated beneficiaries which may be improper. We are concerned, however, because, in general, no Medicare payments should be made for services rendered to prisoners unless certain strict conditions are met by the government component (i.e., Federal, State, or local) which operates the prison. We are now determining if the government components operating prisons meet the strict conditions for Medicare payments to be allowable. The development underway includes researching State laws to determine if prisoners are required to repay their medical expenses. If such a law exists, the government entity must then prove that it enforces this requirement. Examples we are investigating include:

- Medicare paid ~~\$25,425~~ for services to an inmate charged with killing his mother.
- In another State, Medicare paid a facility \$17,283 on behalf of nine inmates who were incarcerated

for various crimes including arson, attempted assault, breaking and entering, and burglary.

The HCFA does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments. To minimize this risk, we recommend that HCFA formalize its efforts to obtain additional data from SSA in the daily transmission of enrollment data, which identifies incarcerated beneficiaries, and design and implement system controls in the Enrollment Database and Common Working File to alert contractors when a Medicare claim is submitted for services for an incarcerated beneficiary. We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained during our review.

Medicaid Payments for Inmates of Public Institutions: We are in the process of reviewing Medicaid payments for services provided to inmates of public institutions. Our involvement began with information received from the Louisiana Office of Legislative Auditor. The Auditor was concerned that the Louisiana Department of Health and Hospitals was including the cost of services provided to inmates in determining its Medicaid net uncompensated care costs for disproportionate share hospital payments made to State operated hospitals. The Louisiana Office of Legislative Auditor had interpreted that neither disproportionate share hospital payments nor Federal financial participation payments are allowable for services provided to inmates of public institutions, specifically prisoners in a penal institution.

Based on audit work to date, we found that HCFA has not established a definitive coverage policy that is consistent with the intent of the governing statute that generally prohibits Federal financial participation payments for inmates of public institutions. The current Medicaid coverage policy contains a provision allowing for Federal financial participation payments for services provided to inmates of public institutions when the inmate is an inpatient in a medical institution. We believe this provision is contrary to the intent of the Medicaid statute. We believe the intent was to ensure that Medicaid funds are not used to finance care that has traditionally been the responsibility of the State and local governments. Also, HCFA has no specific guidance on the availability of disproportionate share hospital payments to hospitals for uncompensated care provided to inmates. We expect to complete our review this summer.

Other OIG Work

In addition to the improper payments described above, we have also done extensive work through audits and inspections to identify duplicate payments made in the Medicare and Medicaid programs. For example, we have examined if Medicare fee-for-service payments were made on behalf of beneficiaries enrolled in Medicare managed care plans. This work involves identification of specific overpayments, as well as identification of the system vulnerabilities, which have allowed such payments to occur. Additionally, we have work underway to identify whether Medicare payments are being made on behalf of deported aliens. Preliminary results indicate that such payments are being made.

TANF BENEFICIARIES WHO ARE FUGITIVE FELONS

The problems of ensuring the appropriateness of payments in a complex program environment are not limited to Medicare and Medicaid. This is illustrated in the following account of income assistance payments which we discovered were being made to fugitive felons.

The U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance, oversees the Temporary Assistance for Needy Families (TANF) program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 increased the flexibility of the States in

operating the TANF program. The Act allows States to provide assistance so that children may be cared for in their own home; promote job preparation, work and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation and maintenance of two parent families. Section 408 of the Act identifies prohibitions and other requirements for the TANF program including a requirement that States not use any part of the grant to provide assistance to any individual who is fleeing to avoid prosecution, custody or confinement after conviction for a felony, as defined under the laws of the place from which the individual flees.

Project Cornhusker is an initiative of our Office to reduce fraudulent TANF payments in the metropolitan area of Omaha, Nebraska. This is the first such joint project we have undertaken with local law enforcement to identify individuals with felony fugitive warrants who are recipients of federal assistance in violation of the Welfare Reform Act of 1996. As part of this effort, the active felony warrants for Douglas County, including Omaha, were matched with the active TANF beneficiary files maintained by the Nebraska Department of Health and Human Services. This computer match produced 64 wanted individuals.

On March 21 and 22, 2001, OIG agents assisted the Douglas County Sheriff's Office and the Omaha Police Department in the arrest of 24 individuals wanted for felonies committed in their jurisdiction. These arrests were made possible because of the cooperation of the Nebraska Department of Health and Human Services, local police and OIG. Twelve additional arrests were made without OIG assistance.

The majority of the arrested subjects were wanted for non-violent crimes, such as felony theft, bad checks, burglary and crimes against property. Three subjects were arrested on warrants for assault, one with a deadly weapon. Specific information concerning some of the arrests are identified below:

- A subject was arrested and found to have three Social Security cards in another individual's name. He also had a birth certificate in that subject's name with two passport photos of himself. This information was sent to the Social Security Administration, Office of Inspector General, Office of Investigations.
- An individual was arrested and found to be in possession of black tar heroin.
- Upon request, an individual present during the arrest of a TANF recipient produced identification. A check of law enforcement records showed that the individual was currently wanted in Louisiana for failure to pay court ordered child support. He was subsequently arrested on that charge.

Because of the success of this effort, we are considering replicating this type of joint initiative in the future.

MODERNIZING DEPARTMENT INFRASTRUCTURE

The Secretary of the Department of Health and Human Services has named reforming the management of the Department's operations as one of his top priorities. Specific priorities include improving the management of HCFA and making appropriate investments in Department management and infrastructure.

Improve the Management of the Health Care Financing Administration: The demands on HCFA have grown dramatically in the last few years. On the one hand, the agency needs adequate resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs; on the other hand, it must be recognized that patients, providers and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. The Department has

therefore begun a thorough examination of HCFA's missions, its competing demands, and its resources.

Invest in Department Management and Infrastructure: The Secretary has noted that one of the major challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing its programs.

In the area of financial management, the Secretary has proposed an additional \$50 million investment in a unified financial accounting system. The OIG has found major problems with the Department's current system structure, which involves separate accounting systems operated by multiple agencies. Department plans to replace these antiquated systems with one or two unified financial management systems should help to increase standardization, reduce security risks, and allow HHS to produce timely and reliable financial information needed for management decision-making, and provide accountability to the external customers.

In the information technology arena, the Secretary has proposed \$30 million to improve information technology systems through investments in the Information Technology, Security and Innovation Fund. As seen in my examples today, these systems are highly antiquated, incompatible, and vulnerable to exploitation. The Secretary has proposed that funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize vulnerabilities while maximizing cost savings and the ability to share information.

We fully support these proposals and continue to promote adequate departmental resources to ensure efficient and effective claims processing, policy development and regulation, and quality assurance. We remain concerned that the currently inadequate internal controls leave the Medicare program vulnerable to potential loss of funds, misstated financial statements, disclosure of sensitive information, and disruption of critical claim processing. Further, out-of-date and overly complex computer systems are not adequately preventing inappropriate program payments.

Over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. The expanded solvency projection provides a window of opportunity to develop a departmental technology infrastructure for the 21st century. Over time, such an investment will lead to further savings -- by reducing payment errors of all types and by making program operations more efficient.

This concludes my testimony. I would be happy to answer any questions.

**DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF MEDICAL ASSISTANCE
INTERNAL CONTROL OVER MEDICAID
PAYMENTS**

January 31, 2003

06-30018-03

In 2001 and 2002, CMS formally solicited state directors to participate in the Medicaid payment accuracy measurement (PAM) demonstration project. Eight states participated in the 2001 PAM project, and 15 states are participating in the project that began in 2002. Participating states received reimbursement for 100% of the total PAM Project costs in the first year, and 100% in the second year for those states who piloted the CMS PAM Model. Alaska's DMA did not apply for grants in either year.

In our view, the measurement of improper payments should be an integral part of program integrity, directing management to areas that most need attention and guiding corrective action. Management can target high-risk areas and focus limited resources where the greatest impact can be made. An ongoing periodic measurement of payment accuracy can be a valuable tool in evaluating the effectiveness of internal controls.

DMA should seek PAM funding, or failing that, consider conducting the study using the PAM methodology. The findings from such an effort could serve as a baseline for establishing benchmarks for assessing current performance and for setting future performance goals, thus increasing agency accountability. Understanding the extent of Improper Medicaid payments would facilitate division policymakers' ability to evaluate the effectiveness and efficiency of program integrity efforts. As such, the Legislature and DMA should consider the decrease in submission of inadequately documented claims as a mission and measure for the agency (See Recommendation No. 13).

Recommendation No. 7

DMA's director should provide for a full-time, ongoing service provider audit function.

As discussed and referred to in various parts of the conclusions section of this report, DMA funded a contract for provider audits in the agency's FY 98, FY 99, and FY 00 operating budgets. These audits were conducted by the Deloitte and Touche Consulting Group (D&T) for a total cost of about \$1.5 million. D&T identified over \$8 million in questioned costs in 173 contract audits. As of 2002, the audits had contributed to the recovery of \$2.2 million in improper claim payments.

In addition to the recovery made of improper Medicaid payments, an audit presence provides an important postpayment control function. An audit function promotes awareness on the part of providers to the importance of submitting billings in accordance with established regulations and provider manual guidance. The \$1.5 million appropriation represented just over one-tenth of one percent of the Medicaid program's expenditures during the same time

Some experts suggest that a statistically valid estimate of fraud might not be possible at all, given the covert nature and level of evidence necessary to meet the legal definition of fraud. In addition, methods to establish fraud might be considerably different than those used to detect other payment errors. Any estimates of the rate of loss due to fraud would be in addition to the above estimates of erroneous payments.

period. Such a comparison, in our view, makes all the possible advantages of an audit function a cost-effective, program integrity tool.

Besides acting as a strategic way to monitor problem providers and acting as a deterrent to possible billing abuses, an ongoing audit presence can also act as an effective channel of communication between DMA managers, MFCU, and the provider community about what practices and controls are effective and which ones are unworkable on a day-to-day basis. The audit function can also serve as an internal quality assurance check to confirm that DMA and FHSC personnel are utilizing various MMIS edits appropriately and carrying out manual reviews in an effective manner. We would encourage the agency to reallocate funding to provide either an in-house audit function through the development of auditor positions or, as before, provide funding for contracting out the function.

Recommendation No. 8

DMA's director should implement more aggressive monitoring of problem providers, particularly prepayment review of claims, and utilize administrative remedies to prevent abusive and unsupported billing practices.

In the conclusions section we discuss DMA's lack of effectiveness in monitoring known problem providers. In particular, we encourage DMA to more often use manual prepayment review of claims to monitor the billing practices of not only problem providers, but as a quality control procedure to evaluate certain types of claims or certain types of providers on rotating or random basis.

Prepayment Review

In the Fall of 2002, DMA was not doing prepayment review of any provider. DMA officials told us that prepayment review was considered a "sanction" and accordingly, under state regulations,³⁶ the division was required to provide the provider due notice and permit them 30 days to appeal.

State regulations list prepayment review as one of a number of sanctions that DMA could impose, either separately or in combination, on a given provider. This does not limit DMA's authority in conducting prepayment review only as part of a formal sanction action. Provider policy statements³⁷ and state regulations³⁸ allow all claims to be subject to "case review" and the division may request provider records that relate to the provision of goods or services on behalf of recipients.

³⁶ State regulations at 7 AAC 43.955(8) list: "100 percent review of provider claims before payment;" as a sanction that "may be invoked [emphasis added]" against providers.

³⁷ The state provider manual states that "Alaska providers should be aware that all claims submitted to [DMA] will be subject to computerized analysis and case review."

³⁸ State regulations at 7 AAC 43.032 states that "at the request of division representative... a provider shall provide records... that relate to the provision of goods or services on behalf of a recipient. ..."

our review of four providers in Anchorage and Juneau,⁴⁸ we noted that substantially all of the services prescribed in the plan of care were rendered by the care coordinator's employer. See Exhibit 7 at right.

Of the four home and community-based providers, we noted that for one provider, all the recipients reviewed, utilized an independent care coordinator.

The independent care coordinator developed the recipient's plan of care using several HC providers for services. This was evident in 36% of the recipients reviewed.

Although care coordinators, working in their respective PNPs, know the services their agency can offer the waiver recipient, this may also lead to over-prescribing care or services and directing services to their own employer. This is a potential conflict of interest using government funds.

We recommend DMA and DMHDD adopt regulations requiring the business relationship between the care coordinators and home care community service agency providers be maintained at arm's length.

Recommendation No. 12

The legislature should consider adopting specific criminal statutes related to Medicaid fraud to enhance the Medicaid Fraud Control Unit's effectiveness.

The lack of either criminal or civil fraud statutes, related specifically to Medicaid, has been raised as a concern in MCFU's past three Annual Reports to the Federal HHS Office of Inspector General. Compared to other states, Alaska is in the minority by what the State does not provide for separate and distinct penalties for individuals engaged in defrauding the Medicaid system. Currently 46 other states/jurisdictions have some form of criminal Medicaid fraud statutes, 45 have some form of civil Medicaid fraud statutes, and 36 have a civil False Claims acts.

Many states have taken a more aggressive stance on Medicaid fraud in recent years. Several states have implemented civil false claims statutes, comprehensive program integrity laws,

Exhibit 7

Distribution Sample of Services provided by Employers of Care Coordinators Involved in Plan of Care (measured by dollars)

Percent	Recipients
100%	49
80 - 99%	10
60 - 79%	2
40 - 59%	0
20 - 39%	2
0 - 19%	2

⁴⁸ Providers were selected for evaluation from a ranking of providers by the amount of Medicaid waiver reimbursements. Four of the higher-reimbursed providers were selected for review.

and tougher sanctions.⁴⁹ In June 2001, the U.S. General Accounting Office issued a report which discussed legislative changes in selected states. This report noted that an increasing number of states are enacting healthcare-specific criminal and civil legislation to enhance the program integrity of Medicaid.⁵⁰

Without specific Medicaid fraud statutes, MFCU must utilize generic criminal laws to prosecute providers who submit unsupported or false billings for reimbursement. Such statutes were designed for such criminal acts as theft, forgery, scheme to defraud, or falsifying business records.

These laws all require MFCU to prove the provider had the mental element of intent. We were told by both the most recent former, and the current, MFCU director that such a requirement makes it difficult to prosecute an individual for fraud involving Medicaid funds. Most states with specific Medicaid fraud statutes require only proof of what is termed a knowing mental element – a less stringent prosecutorial burden than intent. This eliminates the affirmative defense on the part of the accused that they were “willfully ignorant” of program requirements. Adoption of Medicaid fraud statutes will improve MFCU’s effectiveness, which will enhance the overall integrity of the Medicaid program.

Recommendation No. 13

The legislature should include program integrity “mission and measures” statements and performance objectives for DMA.

A major emphasis of DMA is to maintain a good working relationship with service providers participating in the Medicaid program. By doing so, DMA keeps providers willing to participate in the program. A major way DMA strives to maintain this relationship is by expediting payments to service providers. By doing so, DMA promotes accessibility to the covered services for individuals eligible for various types of Medicaid assistance.

From the perspective of DMA managers, such an emphasis is very much consistent with the division’s stated mission “*to maintain access to quality healthcare for all Alaskans and to provide health coverage for Alaskans in need [emphasis added].*” This mission statement has been incorporated into each of the last three annual budget appropriation acts made by legislature.

We suggest the term “access” has a broader, more balanced, meaning. To maintain support for the program, it is important Medicaid is administered in a manner consistent with good financial practices. In order to maintain access to healthcare, it is important the program be accountable. In this context, “access” will be threatened by improper, uncontrolled, or inflated medical expenditures. Financial waste and abuse, that grow out of a weak control environment resulting

⁴⁹ Legislative issues and developments were discussed in *Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles* by Malcolm K. Sparrow Professor of Practice at the John F. Kennedy School of Government, Harvard University.

⁵⁰ The GAO report was entitled MEDICAID: State Efforts to Control Improper Payments Vary.

SENATE COMMITTEE REPORT

DATE: 3/13/03

FURTHER: Finance

DATE TURNED
IN TO OFFICE: 4/14/03

Judiciary Committee considered SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41

SB 41 MEDICAID COSTS AND CRIMES

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

and recommends:

- be replaced with _____ CS SSSB41 (JUD)
- adopt previous _____ CS _____ (_____)
- attached amendment(s)
- adopt Letter of Intent by _____ Committee
- further referral to _____ Committee

Senate Bill:

- same title
- new title

House Bill:

- same title
- technical title
- new: SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
HES	3/17	✓		1

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:		DO PASS	DO NOT PASS	NO REC	AMEND
Ellis	<i>[Signature]</i>	X			
Fench	<i>[Signature]</i>	X			
ogan	<i>[Signature]</i>				
Therriault	<i>[Signature]</i>	X			
Seckins	CHAIR: <i>[Signature]</i>	✓			