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Delivery Order Contracting: A Better Way to Build

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One of the most daunting tasks a facilities professional has to deal with is an increasing deferred maintenance backlog. Few maintenance organizations have sufficient staff and funding, yet these organizations still must find ways to deal with a budget that has been "straight lined" or kept the same for the third or fourth year despite an increase in square footage responsibility. In this environment, you spend hours trying to readjust priorities, only to have more maintenance issues added to your plate.

As we try to deal with this situation, we often struggle to make limited dollars stretch, and we cringe as large portions of the funding we do have are consumed by fees and overhead charges. Also, we struggle with finding ways to obligate or encumber funding and execute projects. Typically, the normal "bid" process takes close to 180 days from the time you start design to the time that you finally give the contractor "notice to proceed." And since many of your deferred maintenance projects are small (less than $1 million, and usually in the $50,000 to $250,000 range), you have to deal with the problem of "quality contractors," or should I say less-than-satisfactory performance by contractors. This is particularly true, since just about anyone with a pickup truck and a tool belt can bond a $250,000 project. As a result, you have a lot of rework, contract management time, and costs that are often higher than budgeted.

In an effort to overcome these problems, a number of years ago the Army developed a program called Job Order Contracting, or JOC. This program has since been adopted by the Department of Defense and many

provided by Dan Cowley

other government agencies. It has also been gaining popularity in the county and local government arenas as well as the university and K-12 markets. JOC is also known as SABER (Simplified Acquisition of Base Engineering Resources) in the Air Force, but is more commonly called DOC or Delivery Order Contracting outside the government arena.

The DOC methodology has been successful as a tool to provide a cost effective, efficient, and quality contracting method that overcomes the often acrimonious environment experienced with the normal "low bid" contract. In addition, it is a performance-based contract that provides incentive for the contractor to do good work in a timely and responsive manner. DOC is a "team" approach to construction that reduces acquisition costs and time and improves response and quality.

What is Delivery Order Contracting?

A Delivery Order Contracting (DOC) is a competitively bid, indefinite quantity, indefinite delivery, general construction contract between a facility owner and a construction contractor. The contract typically has a base year with two to four option years. The contract sets parameters such as the types of work that can be done, location of the work, design criteria and maximum amount of work to be awarded. The contract also has a unit-price book (UPB) with associated specifications that establish a unit price to be paid for each of a multitude of construction line items. A typical UPB (Figure 1) has more than 40,000 line items and covers almost every construction task. Items that are not in the UPB can be negotiated, priced, and added to the UPB at any time. The contractor then "bids" a coefficient that is a markup or markdown to the items in the UPB, rather than a dollar price.

What you then get with a DOC contract is an on-call general contractor where prices for line items of work are predetermined. So when you have a work requirement, you notify the contractor, you conduct the site visit, the contractor develops a cost estimate based on the UPB, you negotiate the delivery order (in other words make sure that line-item selection and quantities are correct), and then issue a delivery order. The contract is easy to manage. However, initially the concept may be difficult to grasp, so let's look at DOC in more detail.

Since DOC is a performance-based contracting method, it is usually solicited using a Request for Proposal (RFP) format so you can evaluate and select the contractor based on performance measures you establish. These are usually a combination of technical expertise, experience, past performance, quality, and price. But if your state procurement laws do not allow use of an RFP methodology, a DOC can also be

acquired by a more traditional Invitation for Bid (IFB). I will discuss both of these approaches in more detail later.

The actual DOC solicitation typically involves the owner specifying a minimum dollar amount of work during the base and each of the following contract option years, usually $50,000 to $200,000, and then defining a potential maximum dollar amount of work each year. These minimum and maximum dollar amounts are often referred to as "volume." The maximum should be significantly higher than the minimum, but it should also be realistic. The potential maximum provides the contractor with a powerful incentive to perform. Maximums reach from $1 million to $15 million or $20 million per year, and are usually in the neighborhood of $5 million to $7 million.

The higher and more realistic the maximum and the more potential option years, the lower the "bid" coefficient you will see. The reason for this is that a DOC contractor experiences his highest costs in the initial contract years as he hires and trains his staff, sets up his facilities, acquires necessary estimating hardware and software, and provides the owner any specified hardware and software under the terms of the contract. This results in a profit margin that is initially lower in the first years and improves with increased contract volume over time. With this in mind you can see that the higher the potential volume and the greater the number of possible option years, the lower the coefficient.

The DOC contract, which is composed of the contract documents, unit price book (UPB), and specifications provide the necessary contract "boilerplate," thus avoiding the necessity of preparing and issuing these documents repeatedly. This reduces acquisition time and effort since specifications and pricing are already in place. All you then do is "issue" delivery orders against the contract. To issue a delivery order all you have to do is notify the contractor of a requirement and then walk the site and discuss the statement of work. The contractor then prepares a cost estimate, using the UPB, any required drawings or plans, and a schedule. This constitutes a "proposal," that you review to ensure the scope is covered, ensure line item selection and quantities are correct, and negotiate any adjustments. When this is complete, a final proposal is submitted and you issue the contractor a "notice to proceed."

It is not unusual for a DOC contractor to provide design support for a client, if desired. If design is required, 100 percent design and full documentation is not necessary since the DOC contract specifications cover these items. As a result, execution of work requirements are far quicker than traditional contracting methods. As can be see in the chart in Figure 2, work on a DOC delivery order requiring design usually starts 70 days before work done under the traditional design/bid/build

method. And when minimal or no design is required, DOC is almost 150 days faster.

Why Should I Have a DOC?

Now that we have had an overview of what DOC is, let's talk about why you should have one. As can been seen from the timeline, DOC lets you compress the acquisition time for projects and enables you to be more responsive to your customers. Since all the unfront documents and procurement is complete, you only have to define the scope of work, and develop, estimate, and negotiate the final proposal.

When I was responsible for facilities at a large metropolitan school district, a new computerized science curriculum was proposed for the high schools. It was presented to the school board in late April, and after the end of the presentation, the superintendent of schools announced that the program would be available at the start of the next school year in early August. The only problem was that this program would require increased power and cooling to the science labs as well as additional local area network wiring. Since the program was only a plan, there had been no design accomplished--only rough cost estimates. With the standard design/bid process, there was no way we could deliver in time. Luckily we had a DOC in place. We called the contractor, did the walk through, and defined the scope of work. The contractor provided us an estimate and was given notice to proceed. All work was completed by the end of June, in time to allow the teachers a month to train on the new system.

- DOC also provides an excellent way to reduce maintenance, repair, and renovation backlog. Since you have a contract and specs in place and a contractor "on-call," you have a ready source to supplement your maintenance staff and to handle those repair and renovation projects that you do not have the available labor or skills to support.

One example that show the effectiveness of DOC is a case studies from Northeast Independent School District (NEISD) in San Antonio, Texas. NEISD was in the processing of installing elevators in three schools to bring them into ADA compliance. Design was started in late January 1995 because NEISD had the chance to fund one of the elevator projects using federal funds, provided the project could be completed by the end of September that year. Northeast had recently awarded a DOC in mid-May, and they removed one of the elevators from the design package and assigned it to their DOC contractor.

As can be seen in Figure 3, that elevator was accepted in time to receive federal funds. The other two elevators proceeded using the normal design-bid process and were completed and accepted 174 days after the DOC

elevator. The cost savings of $4,000 using the traditional bid process did not justify the loss of time.

- Another advantage of DOC is that you can know the cost before committing funds. Avoid "busted" bids and painful change orders because of fixed prices.

- Reduce upfront costs and increase available dollars for construction. As we initiated DOC at Spring Branch ISD, we started tracking design cost savings and advertising the costs we saved by not having to advertise every delivery order. These costs were based on reduced design costs since DOC eliminates the need for 100 percent design and usually only requires 35 to 50 percent design (depending on the project). During the course of our project, we awarded over $35 million of work in three-and-a-half years and experienced almost $2 million in savings. These savings were then expended in actual construction instead of administration and advertising costs.

Finally, DOC can produce a win-win contract relationship. Since the contract value is based on performance, the contractor has an incentive to perform at the highest level. This means not only improved quality, response, and timeliness, but also, since the contractor is in it for the long haul, there is a real incentive to value engineer and look out for the best interests of the customer. Where traditional contracts can result in acrimonious contract relationships at best, DOC engenders a true "team" approach. One example of where DOC truly excels is during emergencies. Since costs are fixed in the UPB, and the contract is there to serve and perform, you can react quickly without fear of "being taken to the cleaners" later when you finalize costs.

How Do I Get a DOC?

Now that you are convinced that DOC has something to offer and can help improve your facilities operation, the next question is how to get a Delivery Order Contract. DOC can be procured using an IFB, "low bid" approach, or an RFP, "best value" approach. An RFP selection is the best method, but if you are not allowed to use that approach, you can procure a DOC in the traditional bid method.

In all cases, you need to establish what your guaranteed minimum volume will be and also determine a realistic maximum. It does not make sense to say you will have a maximum of $10 million per year, if you have funding only to do $3 million. So be up front and realistic. As a rule of thumb, 75 percent of your usual minor construction, repair, renovation, and alteration dollars could be considered as a potential maximum. You also need to determine what the contract term will be. Typically, it is a base plus two to four option years with the right to exercise the option

years being the owner's choice.

You also need to determine what you will use for your unit price book. The R.S. Means Facilities Construction Cost Data is the most common UPB used, but there are also price books available from other vendors. Along with the price book, it is important to determine what specifications you will use. There are commercial as well as "public domain" versions that can be used and then tailored to include specific "owner" requirements/specifications. There are also software solutions that automate your UPB and will allow linking of specifications to the line items in the UPB. Using a software package speeds the DOC operation and provides a method to track all activity.

In addition, if you select a software package that integrates DOC estimating and management with Computerized Maintenance Management System (CMMS) and Facility Condition Assessment (FCA), you can develop a system that links all parts of your on-demand and deferred maintenance problem. This allows you to pull items from your FCA into your CMMS, estimate them and execute them as a DOC delivery order, track the progress and costs, and then flow these costs back to your FCA database to update your deferred maintenance backlog. Incidentally, if you do not have a system that can do this and you have the funding to award a large enough DOC contract, you can get the contractor to pay for the software and hardware for such a system.

Finally, you need to determine what criteria are important to you and will be used to evaluate the qualifications of your prospective contractor. A good source of information on this topic is Arizona State University's Performance Based Studies Research Group. Their website is www.eas.asu.edu/pbsrg.

With the upfront issues out of the way, let's discuss the Invitation for Bid, or bid approach, first. If you use an IFB, it is critical that you clearly state the qualifications and capabilities that you require. If possible, use a two-step method where you first take all solicitation submittals, create a short-list, and then ask for a "bid" from those that are qualified. You then award based on the "lowest" bid. The qualifications you need to consider are discussed in the RFP selection process, but it is essential that you spell out what experience and capability the contractor needs to have to perform a DOC.

Also, it will be necessary to have a mandatory pre-bid conference where you explain in detail the concept of DOC and the types of work the contractor will be required to perform. All questions and responses should be provided to all bidders. Also, when developing the "short-list" or making selection, make sure that you rigidly stick to your qualification

requirements. The IFB approach is more difficult and not the best way to procure a DOC, but it can be successful.

If your contracting regulations allow the use of an RFP, then you should definitely do so. Your goal is to get a contractor who will perform and provide you with the best value. If you use an RFP, you must decide what stages you wish to use. The usual stages are a technical proposal submission (containing information on the contractors technical and performance capability), followed by a short-list and then a cost proposal submission (containing the required cost coefficients that will be applied to the UPB pricing). The technical and cost proposals can be requested at the same time, but the costs proposals should be sealed and should not be reviewed until after the technical review and ranking is complete. Also, you can ask for best and final costs from the top contractors. If you do, you should not make costs from vendors public until after best and final is complete and a final selection is made.

As you can imagine, it is best to set up an evaluation committee, composed of interested parties. The committee should jointly establish the scoring criteria for use in evaluation of the technical proposals. It is also valuable to establish weighting for your criteria, including cost. After you have completed the technical evaluation, all you have to do is "plug" the costs into the equation and you have your top vendors.

The criteria used often include the number and dollar volume of DOC or similar contracts, past performance, ability to manage multiple contracts and multiple subcontractors, financial capability, plus other issues you may consider critical. Using the RFP methodology helps ensure you truly get the "best value and performance," including both technical ability as well as price; not just lowest price, which, as you know, is "not always the best deal in town" and often brings lots of headaches.

How Do I Make a DOC Succeed?

Once you have your DOC contractor on board, how do you make it a success? Use best practices in the operation of your contract. First, within the limits of your contracting constraints, try to make a "best value, performance-based" selection. This will ensure that you select a contractor who can handle a large number of diverse projects in a quality manner.

Next, you need to develop a "team" environment. DOC works best in an open partnered environment. This means you need not only have a contractor that knows what DOC is supposed to be, but you also need to teach your staff what DOC is, what it can do for them, and how it should work.

Once you start to give the contractor delivery orders, i.e., orders against the base DOC contract, get the contractor involved up front. Walk the job site and involve the contractor in scope development. That provides an opportunity for the contractor to perform "value engineering"—looking at approaches and construction methods and making suggestions that will reduce costs and improve delivery.

Finally, and probably the most important, communicate! Communicate with the contractor, communicate with your staff, and communicate with your customer. Let the DOC contractor know what jobs you have coming and the timeframes they will need to be performed in. If asked, most DOC contractors are more than willing to provide cost estimates in advance for potential end-of-budget-year funding. Take advantage of this; it will really improve contract execution. Make sure the DOC contractor really knows what your goals are and that he is matching up to them. Have regular status meetings and review all delivery order statuses: those under construction, those being estimated, and those coming down the pike. Equally important to your relationship with the contractor is your communication with your customer. DOC contractors are superb at doing this. The results of the 1998 survey of DOC contracts performed by the Center for Job Order Contracting Excellence (CJE) at Arizona State University, www.eas.asu.edu/joc, found that on a scale of 1-10, DOC contractors customer service and public relations rated an 8.54!

The Bottom Line

The bottom line is that DOC is a superb tool in today's facility manager's toolkit. It has been used successfully in the government, Department of Defense, U.S. Postal Service, National Institutes of Health, and others. Its use is growing in education; currently DOC is being used at over a dozen K-12 and university sites and is under procurement at several others. It is a contracting method that can increase your ability to meet rising maintenance backlogs, respond to critical customer needs and wants, improve quality and responsiveness, reduce change orders, and put more dollars into "hard construction" instead of soft upfront costs.

In case you are not sure about DOC yet, consider this final example from the 1998 CJE survey:
How would you rate the efficiency of your JOC/DOC contract compared to other methods of project delivery?

- Better than 82%
- Same as 16%
- Worse than 2%

With results like this, can you be without Delivery Order

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AIR FORCE CONTRACTING
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PART 1 — GENERAL

1.1 Scope

This guide provides suggestions and procedures designed to assist contracting officers and civil engineers in the award and contract administration of Simplified Acquisition of Base Engineer Requirements (SABER) contracts. The intent is not to describe the entire acquisition process from requirements definition to contract award, but rather to focus on those features specific to SABER acquisitions. The guidance contained herein is not mandatory. Contracting officers and civil engineers are encouraged to adapt their SABER-like acquisitions and processes to meet their local needs and the local environment.

1.2 Definitions

(a) "SABER contract" generally means a fixed-price, indefinite-delivery/indefinite-quantity (IDIQ) contract. A SABER contract includes a collection of detailed task specifications that encompass most types of real property maintenance, repair, and construction work. SABER contracts normally include options for work in years beyond the initial performance period. The significant features of a SABER contract are:

(1) "Unit Price Guides (UPG)." UPGs include commercial pricing tools such as computer cost databases and libraries of hard copy books. Although rare, they might also include government-developed unit price books. UPGs consist of detailed task specifications along with a standard unit of measure and a unit price for each. Because the task specifications and prices apply to a general area or industry, it is necessary to tailor the UPG to the costs and practices of a specific location. This step, which is called "localization," is critical to the success of a SABER Program. Government and commercial software alternatives are available for the localization process and for compiling the basic task listings and standard unit prices. Examples of commercially available UPGs are those published by WinEstimator Inc., Timberline Software, and R.S. MEANS, Inc.

(2) "Coefficients." Coefficients are factors that are multiplied against the standard unit prices in the UPG to calculate delivery order (DO) prices. Offerors propose coefficients to cover cost elements such as overhead, profit, minimum design costs, G&A expenses, bond premiums, and gross receipts taxes. The number of coefficients in a SABER contract depends on the installation's requirements. Coefficients may include bands or ranges based on dollar levels, standard and non-standard hours, range or isolated site work, or work in secured areas. Coefficients also reflect the offeror's perception of the accuracy of the UPG. UPGs that are consistently lower than prices found in the local economy will cause the contractor to offer higher coefficients. Inconsistent or unbalanced UPGs increase the uncertainty in preparing proposals. This can lead to high coefficients or inequitable pricing of SABER contracts.

(b) "SABER minimum design" means a design effort that is incidental to accomplishing the required task. The extent of the design will depend upon the complexity of each task. Generally, however, if the contractor needs to hire the services of a registered architect or engineer to

accomplish the design effort, it is outside the parameters of minimum design. The contractor will have to provide sufficient design documentation to substantiate the proposed approach for the task. This documentation may include any or all of the following:

- Statement of Work (technical description of the task)
- Work flow chart similar to a PERT diagram
- Detailed cost estimate
- Justification for any non-prepriced items
- Material Approval Submittals
- Verified As-Built Drawings
- Shop drawings showing basic layout and planning of the work
- Manufacturer's or technical drawings/schematics for fabrication and assembly of structural elements
- Form, fit, and attachment details for installation of materials/equipment
- Design calculations to substantiate proposed layout and sizing of utilities and structural elements (i.e., HVAC loads, lighting, platform supports, etc.)

(c) "SABER delivery order." Prices for individual SABER delivery orders are a result of applying the contractor's coefficients to items covered by the UPG and negotiating prices for items that are not included in the UPG. These non-prepriced items (NPI) must be within the basic intent and general scope of the contract and be negotiated separately from UPG items prior to issuance of the delivery order.

1.3 Purpose of the SABER Program

(a) The purpose of the Air Force SABER program is to expedite contract award of civil engineer requirements by reducing civil engineer design work and acquisition lead-time. SABER is best suited for non-complex, minor construction and maintenance and repair projects that require minimum design.

(b) Benefits of a successful SABER program include:

(1) Improved customer service and responsiveness. After contract award, the time required to estimate, propose, negotiate, and issue delivery orders for individual projects is usually three to four weeks, or less; and

(2) An incentive for a highly motivated contractor to produce high quality work in a timely manner. While an IDIQ contract must guarantee a minimum dollar value of work, award of additional work is dependent on the quality and timeliness of the contractor's prior performance under the contract.

1.4 Limitations

(a) General. SABER is not appropriate for large, complex construction projects that require extensive design effort or for predominately single skill/material projects for which competitively awarded contracts or single trade IDIQ contracts would be more cost effective.

(b) Architect-engineer (A-E) services.

(1) SABER is not an appropriate acquisition approach for A-E services as defined in FAR 36.601-4(a). The Brooks Act (40 U.S.C. 541-544) requires use of specific procedures (see FAR Subpart 36.6) to acquire engineer services.

(2) Task specifications in SABER UPGs and corresponding coefficients include: minor design efforts needed to complete a project, such as basic layout and planning of work; fabrication and assembly of structural elements; form fit and attachment details for installation of materials and/or equipment; production of shop and/or record drawings; and other similar activities which do not require the services of a registered architect or engineer.

(3) A SABER contract is not the proper vehicle to execute a project that was designed using A-E services except when:

(i) an A-E designed project requires validation/updating due to age of the design; or

(ii) the A-E design did not proceed beyond 35 percent completion and the remaining design effort will not require a significant amount of A-E services.

(c) Non-personal services. Non-personal services subject to the provisions of the Service Contract Act (e.g., a delivery order solely to install carpet when the labor involved exceeds $2,500) are not SABER requirements. The Department of Labor (DOL) has jurisdiction over whether a particular requirement is classified as construction work subject to Davis Bacon Act or services to which the Service Contract Act applies. DOL guidance provides that services such as carpet installation, landscaping, asbestos removal, and building demolition may be performed as construction when the work is incidental to a larger construction project. If the preponderance of the work is non-personal services, even though there may be some incidental related construction work, the project falls under the Services Contract Act and is not a candidate for SABER.

PART 2 — ACQUISITION PLANNING

2.1 SABER Working Group

(a) Successful SABER programs require a team effort. A working group of all SABER players from CE and Contracting should convene at the beginning of the planning process. The BCE or SABER Chief should chair the group, assisted by the contracting officer, and meet regularly until issuance of the solicitation.

(b) The SABER working group should concentrate on:

(1) Estimating the expected scope of the SABER Program for the installation or civil engineer organization and determining the guaranteed minimum amount to be included in the contract.

(2) Investigating the feasibility of establishing a joint effort with other nearby bases (including Army, Navy, Air Force Reserve, and National Guard installations) as possible sources for funding the initial and any subsequent contract minimums.

(3) Determining the most efficient organizational structure for the SABER unit, identifying the types of personnel needed.

2.2 SABER Specifications and the UPG

Based on the SABER requirements and budget as established, the BCE prepares the SABER program specifications. These include the master specification and the technical or guide specifications. The master specification describes the overall scope of the SABER Program and is part of Section C in the RFP. The technical specifications define specific construction standards for tasks to be ordered under the contract and form the basis for developing line item work tasks in the UPG. After developing the specifications, the BCE chooses the UPG.

2.3 Request for Proposal (RFP)

The SABER RFP should closely mirror the format and content of a large construction solicitation. Unique features of a SABER RFP generally include the following:

(1) A description of the coefficient(s) that the offeror must propose;

(i) The factors that generally make up the coefficient(s);

(ii) Individual coefficients for standard hours, non-standard hours, geographically separated ranges or sites, secured areas, and/or varying project magnitudes, as appropriate;

(2) The applicable UPG and any related software, hard copies, and computer support requirements;

(3) A sample SABER project (using a project that will actually be awarded later under the resulting SABER contract);

(4) The level of architectural/drafting support to be performed by the contractor; and

(5) A mechanism for (and frequency of) adding non-prepriced items (NPIs) to the contract.

PART 3 — SABER PROGRAM EXECUTION AND CONTRACT ADMINISTRATION

3.1 Processing Civil Engineer Project Orders After Contract Award

(a) Issuance of project order. The SABER project manager:

(1) provides the statement of work, including concepts, sketches, and drawings;

(2) identifies any statutory cost limitations;

(3) furnishes any special instructions or requirements; and

(4) includes required cost comparisons, justifications, and approvals.

(b) Site visit. The SABER project manager/inspector, contracting officer representative, using organization, and contractor should conduct a scope validation/site visit for each project order to discuss:

(1) site access;

(2) methods and alternatives for accomplishing work;

(3) definition and refinement of requirements;

(4) requirements for plans, sketches, drawings, etc;

(5) detailed scope of work; and

(6) time requirements for completion, phasing requirements, and liquidated damages.

(c) Contractor's proposal. The contractor develops a detailed price proposal by identifying necessary tasks in the UPG, verifying as-built drawings, refining quantities, pricing NPIs, preparing working drawings, and developing performance times. The SABER program manager may need to answer questions from the contractor and clarify technical aspects of the project.

(d) Delivery order negotiation.

(1) The contract administrator and contracting officer review the contractor's proposal for scope, compliance, completeness, and reasonableness. The contract administrator then forwards the technical proposal to the SABER program manager for a technical review. The contracting officer evaluates the proposed method of construction, tasks, quantities, performance schedules, and any contractor drawings.

(2) After receiving the technical evaluation from the SABER program, the contracting officer reviews the proposal with the contractor. The contracting officer, with assistance from the SABER program manager, establishes the government's negotiation objective, including any variations involving tasks, methodology, quantities, NPIs, and timelines.

(3) After completing negotiations, the contracting officer prepares a price negotiation memorandum (PNM) in accordance with FAR Subpart 15.406-3.

3.2 Adding non-prepriced items (NPIs) to the Contract

(a) Negotiating prices for NPIs and incorporating them in a DO does not incorporate the items in the contract for subsequent use as a priced item. To permit subsequent use, the contracting officer must incorporate prices for NPIs by supplemental agreement into the SABER contract itself, in which case they become pre-priced items under the contract. This may occur with an annual update to the UPG or separately at another time during the year.

(b) When negotiating prices for NPIs, ensure the prices include only direct costs. If the contract incorporates a static coefficient for the life of the contract, an economic price adjustment clause (see Attachment 1) will adjust the prices for these items in subsequent contract periods.

3.3 Funding

(a) In order to expedite year-end or emergency requirements, the contracting officer may process SABER projects up to the point of award in advance of full project funding. Prior to requesting the contractor's proposal, the contracting officer should either obtain from the contractor a no-cost agreement (in case the order does not materialize) with acknowledgment that funds are not available, or utilize a line item for project estimating. The latter compensates the contractor for the level of effort expended in estimating, designing, and negotiating the project order in advance of full funding. Any payment the contractor receives under this line item will be offset by a reduction from the negotiated price of the delivery order if the project results in an award.

(b) The contracting officer normally establishes milestones for actions in support of end-of-year actions to ensure sufficient lead time for SABER review, approval requirements, receipt of preliminary SABER project cost estimates, technical analyses, and negotiations.

PART 4 — OPTIONS

4.1 Option Price Adjustments

There are several ways to structure SABER contracts to allow for option price adjustments. One strategy is to incorporate a static UPG for the duration of the contract and allow offerors the opportunity to propose different coefficients for each of the contract periods. Another approach is to incorporate a static coefficient, or coefficients, and update the UPG each period. A third strategy, and probably the most cumbersome and least desirable, is to incorporate a static coefficient and a static UPG. This last approach requires use of an economic price adjustment (EPA) clause to adjust option prices. Attachment 1 contains a sample clause.

APPENDIX A

SAMPLE CLAUSE FOR SABER ECONOMIC PRICE ADJUSTMENT (EPA)

(a) Coefficient(s) for SABER options under this contract will be adjusted annually to recognize variations in labor, equipment, and material costs as stated below.

(b) The Market Trends Construction Cost Index (CCI) for the city of [*insert where the work is to be performed*] as published in the McGraw Hill publication "Engineering News Record (ENR)" will be used to determine adjustments to the contract coefficients for options under this contract. To determine the amount of adjustment, the contracting officer calculates the change in the index appearing in the issue of ENR published during the month prior to the effective date of the option from [*the contracting officer enters the most recently published index at the time of initial contract award*]. Eighty percent of this variation will be applied to [*the contracting officer enters the coefficient for the initial period of the contract*]. If the publication of the index should be discontinued, the parties to the contract will negotiate a replacement index or new contract provision. If a replacement index or contract provision cannot be agreed upon, the contracting officer may unilaterally determine the contract adjustment method, and the contractor may dispute the determination under the Disputes Clause. Adjustments to option year contract coefficients must be determined in accordance with the following formulae:

(1) To calculate the new coefficient use:

$$C = C_i * f$$

Where:

C = New Coefficient;
f = Adjustment Factor; and
C_i = Contract pricing coefficient at contract award.

(2) To calculate the Adjustment Factor use:

$$f = ((CCI_c - CCI_l) / CCI_l) * 80\% + 1$$

Where:

CCI_c = the ENR index for the option; and
CCI_l = the ENR index for the initial contract award.

(c) Adjustment calculations for second and subsequent option years will each be based on the contract coefficient for the initial contract period.

EPA Coefficient-Index Matrix

Action	ENR Index	Adjustment Factor	Coefficient
Contract Award	110.0	NA	1.03
Option 1	115.4	1.039	1.07
Option 2	130.2	1.147	1.18
Option 3	125.1	1.110	1.14
Option 4	100.0	.927	.96

NOTE: Round calculation results as done in this example.

EPA Calculations

Column 2 - ENR Indices for the options are taken from the issue of the McGraw Hill publication ENR published during the month prior to the effective date of the option. The ENR Index for the Contract Award is the most recent ENR index published during the month prior to initial contract award.

APPENDIX B

DELIVERY ORDER FILE CHECKLIST

CONTRACT NO: _____ DELIVERY ORDER NO: _____

DATE ORDER AWARDED: _____

CONTRACTOR/SUBCONTRACTOR: _____

AMOUNT OF THIS ORDER: _____

Checklist Item	Yes	No
1. Does file contain properly approved and classified work request (AF Form 332)?		
2. Are sufficient funds available and documentation contained within the file?		
3. Is the memorandum for record of site visit adequate?		
4. Does the file contain statement of work revisions for changes as a result of the site visit or negotiations?		
5. Does the contractor's proposal contain:		
(a) Proposal for the scope as stated in the request for proposal?		
(b) Pricing by line item in accordance with the SABER UPG?		
(c) Non-prepriced items?		
(d) Method of construction?		
(e) Other items as stated in the request for proposal?		
6. Does the file contain an adequate technical evaluation?		
7. Does the Record of Negotiations provide sufficient detail of the negotiated variances in price, period of performance, quantities, statement of work changes, negotiated methodology, etc.?		
8. Is DD Form 1155 complete and does it contain:		
(a) Accounting and appropriation data?		
(b) Scope of work?		
(c) Period of performance?		
(d) Any mandatory methodologies?		
(e) Negotiated NPIs?		

DOT&PF FORCE ACCOUNT REPORT

By Calendar Year - Dollar Amounts are in Thousands

Labor = The "**Labor** "column includes State owned equipment charges. And, where applicable, it includes small contracts let to entities that supplemented State Force Account work.

Other = Material, rental equipment, etc. costs are shown in the "**Other**" column. Where only an estimated overall cost was available, the cost was placed solely in the "Labor" column. This results in an inflated estimate of the Labor costs associated with Force Account projects.

1998

Number	Name	M&O	Local Agency	Village Safe Water	Labor $	Other $
001	NR NHS Road Pave & Bridge Refurb	X			1,764.0	1,386.0
002	CE NHS Crack Sealing & Bridge Repair	X			670.0	249.3
003	KTN-Cent Bus Dist Sidewalk Imp.		X		134.5	70.3
004	NR Surface Maintenance & Bridge Rehab.	X			1,064.0	
005	Selawik Boardwalk Improvements		X		75.0	310.0
006	Rural Ak. Sanitation Rds.-Chignik Lagoon			X	350.0	450.0
007	SE Gold Rush Centennial Enhancements	X			20.2	7.0
008	SE NHS/Non Pave & Bridge Refurb.	X			500.0	
009	Kongiginak Sanitation Boardwalk			X	250.0	450.0
010	SE Jnu-Hazard Elimination	X			48.7	
011	KTN-Waterfront Promenade		X		82.2	17.5
				Totals	$ 4,958.6	$ 2,940.1

Total dollars committed to surface transportation funding for 1998 was $ 406.3 million.
1998 FA work performed = 1.94 % of the total surface transportation program **$ 7,898.7**

1999

001	NR FFY 99 NHS Prev. Maint. & Repairs	X			2,000.0	1,850.0
002	CE Bridge Maint/Repair FY 99	X			284.3	74.8
003	NR FFY 99 Non-NHS Maint. & Repairs	X			836.0	1,064.0
004	CE Crack Seal Program FY 99	X			643.4	224.3
005	SE NHS Pavement Rehab.	X			147.0	653.0
006	CE Asphalt Pave. Surface Refurb. FY 99	X			383.9	399.6
007	Force Account (AMHS) Wireless Com.	X			33.4	135.6
008	SE Non-NHS Pave. Rehab. FY 99	X			600.0	
009	NR Dalton Hwy. Erosion Control	X			15.3	102.7
010	NR Surface Treatment, Brenwick/Craig	X			73.6	129.4
011	CE FY 99, Non-NHS Fed. Crack Seal Pro.	X			200.4	69.3
				Totals	$ 5,217.3	$ 4,702.7

Total dollars committed to surface transportation funding for 1999 was $ 524.0 million.
1999 FA work performed = 1.89 % of the total surface transportation program **$ 9,920.0**

2000

001	NR FFY 00 NHS M&O Prev. Maint.	X			2,215.6	1,604.4
002	NR FFY 00 CTP M&O Prev. Maint.	X			1,725.5	1,249.5
003	CE: FY 00 Central Region Crack Seal Crew	X			704.3	189.4
004	SE Non-NHS Pavement Rehab. (FFY00)	X			256.7	576.1
005	SE Road Surface Treatment (FFY00)	X			253.6	552.4
006	CE: Interstate Maint. & Bridge Repair FY00	X			260.4	139.3
007	Proj. #66740, Russian Mission AWOS Pad		X		47.2	
008	Proj. #66740, Russian Mission Airport Clearing		X		122.0	
009	CE: Bridge Maint./Repair Non-NHS FY 00	X			278.0	121.5
010	CE: Cascade Shop Reconstruction	X			82.0	230.0
011	SE Haines-Lutak Rd. Storm Drain	X			207.0	
012	Chefornak Sanitation Boardwalk			X	262.2	1,117.8
013	CE: FY00 Non-NHS Fed. Crack Seal Pro.	X			580.6	227.8
014	SE Haines-Chilkat Lake Rd.	X			310.0	190.0
015	SE Skagway-Taiya River Erosion Control	X			90.0	
016	Married Man's Trail Lighting		X		40.6	22.1
017	St. Mary's Airport Rd. Rehab.	X			1,205.6	1,793.9
018	SE Wrangell Airport Control Reg. Shelter	X			11.9	
019	Nunapitchuk Sanitation Boardwalk			X	399.0	1,701.0
				Totals	$ 9,052.2	$ 9,715.2

Total dollars committed to surface transportation funding for 2000 was $ 463.8 million.
2000 FA work performed = 4.05 % of the total surface transportation program **$ 18,767.4**

Provided by Sen Cowdery

Updated Feb. 12, 2003

2001

001	NR FFY 01 M&O Preventive Maintenance	X			7,150.0	
002	CE: FY 01 Non-NHS Fed. Crack Sealing Prog.	X			339.4	86.5
003	NR FFY 01 CTP Pavement Markings	X			7.3	43.3
004	South Naknek Airport Repairs		X		30.0	15.0
005	CE: Bridge Maint./Repair NHS FY 01	X			325.5	35.6
006	Kwigillingok Sanitation Road		X		764.2	2,235.8
007	Cordova Sidewalks Asbestos Removal	X			14.2	2.7
008	CE: Bridge Maint./Repair Non-NHS FY 01	X			373.6	74.0
009	CE: FY 02 NHS Crackseal IPM	X			701.1	210.6
010	CE: FY 02 Non-NHS Crackseal Program	X			670.6	185.6
				Totals	$ 10,375.9	$ 2,889.1

Total dollars committed to surface transportation funding for 2001 was $ 380.0 million.
2001 FA work performed = 3.49 % of the total surface transportation program $ 13,265.0

2002

001	NR FFY 02 M&O Preventative Maintenance	X			8,860.0	
002	SE Region Road Surface Treatment	X			527.0	
003	Dalton Hwy. Painted Traffic Markings	X			113.6	61.4
004	CR Bridge M& R, NHS FY '02	X			118.5	200.0
005	Soldotna: East Redoubt Ave., Improvements		X		633.0	
006	Statewide Emergency Sign & Traffic Signals	X	X		430.0	
007	Northern Region Winter Trail Marking		X		182.8	111.0
008	King Cove Lagoon Bridge		X			5.0
				Totals	$ 10,864.9	$ 377.4

Total dollars committed to surface transportation funding for 2002 was $ 505.0 million.
2002 FA work performed = 2.23 % of the total surface transportation program $ 11,242.3

The average of all FA work performed (1998 - 2002) = 2.68 %

Subject: SB 40
Date: Mon, 29 Mar 2004 19:50:43 -0900
From: "Walton Smith" <waltonksm@yahoo.com>
To: <Representative_Mary_Kapsner@legis.state.ak.us>, <Senator_Georgianna_Lincoln@legis.state.ak.us>, <Senator_Donny_Olson@legis.state.ak.us>, <Senator_Lyman_Hoffman@legis.state.ak.us>, <Representative_Richard_Foster@legis.state.ak.us>

March 29, 2004

To our legislators:

I apologize for sending a "group email", rather than a personalized letter. I am due to travel in the morning, and will be unable personally to testify on SB 40. Most of you who know me realize I am very much opposed to this bill. However, I still want to make the following points:

1. The imposition of a $250,000 limit on force account projects will dramatically increase the costs for small projects. Advertising, bidding, mobilization and demobilization all add to the costs of a project. At a time when the State is looking for maximum returns on minimal investments, such a requirement is totally out of line.

2. Local project management and construction lead to local pride and ownership of the project. This results in better long-term maintenance.

3. At a time when the Bush economy is in serious trouble, such a requirement will take money from the families that really do need "self-help." We have been encouraged to help ourselves in the Bush, but this is increasingly difficult when local projects only generate wealth for outside contractors.

4. The proposed legislation is a thinly veiled effort by the AGC and its contractor membership to further make DOT funds the exclusive province of their membership. Past reviews of DOT expenditures show that well over 95% of the Federal DOT funds coming into the state currently end up in contractor pockets. This measure is to insure that virtually 100% will end up in contractor pockets.

5. In spite of the public relations campaign by the AGC several years ago in their ALASKA CONTRACTOR magazine, the fact is that outside contractors have historically done very little for the Bush worker. As with all rules, there are a few exceptions, but the exceptions do not make the rule.

6. Also in spite of statements to the contrary, much Bush force account work is done to very high standards. Again, the exceptions do not make the rule. All of us can find examples of good and bad force account work, just as we can find examples of poorly constructed jobs by contractors.

I realize that money equates to power. We in the Bush certainly do not have the power of well organized "professional organizations". But sometimes it behooves us to do what is right, rather than bow to the pressures of moneyed interests.

Thank you for your time and consideration.

Walton Smith
City Manager, St. Mary's.

> *Walton Smith*
> *City Manager, St. Mary's.*

For what it is worth, I completely endorse CM Walton Smith's comments. I only hope that you can bring some levity to the situation. Big Business (AGC & the Unions) can live a while longer (a lot longer) without the few sheckles that trickle to the Bush. Need I point out some fantastic bush projects that were brought to completion ahead of schedule and on or under budget.
LEO B. RASMUSSEN, Mayor Emeritus 1985 & 2003 ACOM

Associated Builders and Contractors, Inc.

Alaska Chapter

SB 40 / An Act Relating to the Construction of Highways

ABC Alaska believes in a system of free enterprise and open competition. This premise is generally embraced by the State of Alaska as evidenced by the language existing in Alaska Statutes AS 19.10.170 and AS 35.15.010 which state it is the general policy of the state to require construction under bid contract in accordance with the state procurement code. Additionally, Alaska Statutes require: *"A contractor or subcontractor who performs work on public construction in the state, as defined by AS 36.95.010 , shall pay not less than the current prevailing rate of wages for work of a similar nature in the region in which the work is done."*

The intent of the Legislature is clear: public works ought regularly to be constructed in compliance with state procurement code and shall be regulated by "Little Davis Bacon" laws establishing prevailing wage rates. Force Account Construction by the state subverts this intent, bypassing the competitive bid process inherent in the state procurement code and hiring its own forces to complete construction work at sub-standard wages.

The two compelling arguments for Force Account Construction are cost savings and local hire. The cost savings are claimed by reduced labor costs and by the fact that the state does not have to make a profit. The payment of lower than prevailing wage has been used as the justification for avoiding federal procurement law by citing reduced project costs. In effect, the state is paying sub-standard construction wages on government work, eliminating opportunities for private sector employers who would be required to conform to federal Davis-Bacon or Little Davis Bacon regulations on that same work. In short, this practice places the state in direct competition with private sector employers, a practice in direct conflict with privatization goals that have been expressed by the legislature over the past several years.

It may be argued that the published prevailing wage does not reflect local conditions. If this is the case, there is a mechanism in place to address the variation. 8 AAC 30.050 states *"A region may be s bdivided into zones if the commissioner determines that the prevailing wage rate has local variations within the region..."* and *"Special prevailing wage rate determinations may be requested for special projects or special worker classifications, if the work to be performed does not conform to traditional public construction for which a prevailing wage rate has been established under (a) of this section."* This would be in keeping with the intent of the Legislature and also protect the rights of the workers.

The contention that the state does not have to make a profit and therefore can operate at a lower cost is also misleading. While the state may not include a risk factor in its estimate, risk is still there. Delays and cost overruns will be borne solely by the state. Under bid contract, these risks and costs are borne by the contractor. The state will have no incentive for cost control and innovation as is routine in the competitive bid process. The notion that the State can compete with private industry on a level playing field is highly questionable and again flies directly in the face of the state privatization goal.

The local hire issue is also compelling and should not be ignored. Again, local residents are best served by a level playing field. Providing an accurate prevailing wage and including "helpers" in the job classifications will allow local residents the best opportunity to compete in the marketplace.

Senate Bill No. 40 and House Bill No. 67 will help limit the State's ability to engage in force account construction. The same language should be added to AS 44.33.300 and we, as a community, should then focus our efforts on improving the implementation of existing prevailing wage regulations to provide opportunities for local hire in a free and open competitive bidding environment.

360 W. Benson Blvd. Suite 200 • Anchorage, AK 99503 • Tel (907) 565-5600 • Fax (907) 565-5645 • Email: info@abcalaska.org

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INFORMATION & TELECONFERENCING
Nome Legislative Information Office
320 East Front Street, P. O. Box 1630
Nome, AK 99762
Phone: (907) 443-5555 Fax: (907) 443-2162
Email: Nome_LIO@legis.state.ak.us

WRITTEN TESTIMONY

Following this page is written testimony submitted by Jimmy Adams, Western District Manager, Maintenance & Operations, DOTPF in Nome for the Senate Finance Committee teleconference hearing, re: SB40, on Tuesday morning, March 30th at 9:00 am.

Please call our office if you have any questions.

Thank you,

Angelique Horton

Angelique Horton,
Information Officer

cc: Representative Richard Foster
Senator Donny Olson

Comment for Senate Bill No. 40

Due to high mobilization costs for shipping construction equipment and project related supplies to Western Alaska the proposal under Senate Bill 40 to limit the costs to $250,000 is not realistic.

Costs for mobilization of Department work (not to mention private bid construction projects) will shoot that boat right out of the water.

Passing that bill will only increase costs of road improvement projects out this way.

Thank you for the opportunity to comment.

Jim Adams
Western District Manager
Maintenance and Operations

ASSOCIATED BUILDERS AND CONTRACTORS, INC.
Alaska Chapter

Position Paper on

Force Account Construction

ABC Alaska believes in a system of free enterprise and open competition. This premise is generally embraced by the State of Alaska as evidenced by the language existing in Alaska Statutes AS 19.10.170 and AS 35.15.010 which state it is the general policy of the state to require construction under bid contract in accordance with the state procurement code. Additionally, Alaska Statutes require: *"A contractor or subcontractor who performs work on public construction in the state, as defined by AS 36.95.010 , shall pay not less than the current prevailing rate of wages for work of a similar nature in the region in which the work is done."*

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Senate Bill No. 40 and House Bill No. 67 will help limit the State's ability to engage in force account construction. The same language should be added to AS 44.33.300 and we, as a community, should then focus our efforts on improving the implementation of existing prevailing wage regulations to provide opportunities for local hire in a free and open competitive bidding environment.

ALASKA MUNICIPAL LEAGUE
Alaska Conference of Mayors

217 Second Street, Suite 200 • Juneau, Alaska 99801
Tel (907) 586-1325 • Fax (907) 463-5480 • www.akml.org

February 18, 2003

Senator Cowdery, Chair
Transportation Committee
State Capitol, Room 101
Juneau, AK 99801

Re: SB 40

Dear Senator Cowdery,

The AML Public Works and Infrastructure Subcommittee reviewed SB 40 and recommends against its adoption.

This summer a number of public and private organizations worked on a compromise that took into consideration all of the aspects of this complex issue. The result is Administrative Order 199. I believe that all of the public and private groups involved in the discussions support working with new procedures.

Sincerely

Kevin Ritchie
Executive Director

NATIVE VILLAGE OF TUNUNAK
TUNUNAK IRA COUNCIL
PO BOX 77;TUNUNAK, ALASKA 99681
PHONE:(907)652-6527 FAX:(907)652-6011

TO: ALASKA STATE LEGISLATORS Date: March 12, 2003

FROM: James G. James, Tribal Administrator

Re: Senate Bill 40 and House Bill 67

MESSAGE:

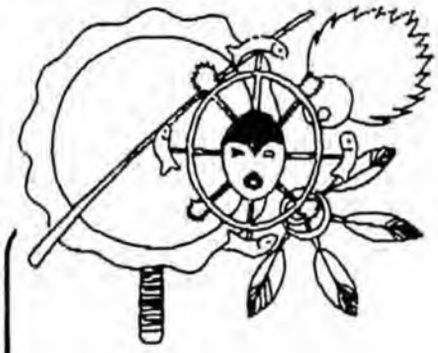
Once again the construction of capital projects by force account within the State of Alaska has been put into place in question.

The Bill which has been sponsored by Senator John Cowdery and Representative Jim Holm would limit the construction of state funded capital projects by force account to those projects under $250,000.00.

It will have a big impact especially to rural areas in which the majority of village members are in dire need of jobs and economic opportunities because of high costs of living.

I have seen many of our people that are in need to feed their baby and to clothe them with proper clothings during harsh winter months.
A can of evaporated milk costs $1.55 per can and the baby formula can costs nearly $20.00 or more depending on the price market up. The clothings price are devastating compare to Anchorage prices.
Although, people that are on welfare or on any assistance through State and Federal Assistance programs are just a quarter worth.

We urge you not to pass those two bills because it won't help the real Alaskans who needs it the most.
Thank You.



Nunakauyak Traditional Council

TO ALL ALASKA STATE LEGISLATURES

Senator John Cowdery under Senate Bill 40 and Representative Jim Holm under House Bill 67 have introduced the bills which will affect the capital projects by "Force Account" in which we know will have devastating impact in our region and local economy.
With limitation on State-funded projects to no more than $250,000 will not support local economy whatsoever. This limitation and phasing out construction jobs under force account will not help high unemployment rate in rural communities. Big construction companies and non-residents will only benefit from construction jobs instead..

Villages do not even have economic base in which to support their own projects whether they are funded by the State or Federal government. The tribes or Tribal organizations have exercised their right to govern themselves by handling projects under force account thereby guaranteeing jobs to local residents who are jobless and have families to support. Big construction firms from outside of or even those based in Alaska do not always have that guarantee and instead bring in crews with them. This type of construction project do not support local economy.

The Alaska State Legislatures would be more lenient to its constituent's needs and well-being by helping them to protect their interest and allow them to continue to handle their own projects under force account. As a long time Tribal Council employee, I see many benefits that local force account projects provides to those who took part in construction projects which also help provide local economy little by little.

On the behalf of Nunakauyak Traditional Council (NTC) and many tribal governments and tribal organizations within AVCP/Calista region, I would like to humbly ask Senator Cowdery and Representative Holm to listen and reconsider or withdraw their bills immediately.
Last but not least, I would like to ask all Alaska State Legislatures to vote these bills down if the bills are not withdrawn by its original authors.

ON THE BEHALF OF NUNAKAUYAK TRADITIONAL COUNCIL

James Charlie, Sr.. Director
Tribal Support Services

cc: Mr. David B. Tim, NTC Chairman
Editor, The Delta Discovery
Editor, The Tundra Drums

P.O. Box 37048, Toksook Bay, Alaska 99637-0048 • (907) 427-7114 • Fax (907) 427-7714

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/29/03

FURTHER: Finance

Date of 5-Day Notice: 1/29/03
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/18/03

Transportation Committee considered SENATE BILL NO. 40

SB 40 CONSTRUCTION OF HIGHWAYS BY DOTPF

"An Act relating to construction of highways by the Department of Transportation and Public Facilities."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] 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#
DOTPF	2/18		✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

	SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Olson			✓		
Therriault				X	
Wagoner				✓	
Lincoln			✓		
Cowdery	CHAIR:	✓			

SENATE FINANCE COMMITTEE

S I G N - I N

SB 40-CONSTRUCTION OF HIGHWAYS BY DOTPF

NAME: Frank Richards / Nona Wilson Subject/Bill No: SB40

Co./Dept./Title: DOT+PF Phone: 465-3900

Address: _____ Zip: _____

Do you wish to testify? X Yes ___No X 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

SITE: ANCHORAGE	SUBJECT OF MEETING or BILL #
COMMITTEE: SFIN	SB 40
DATE: 3-30-04	UPDATE #:

PRINT YOUR NAME	COMMUNITY	REPRESENTING/AFFILIATION	DO YOU WANT TESTIFY Y or N
Don Valeske	Anchorage	Public Employees Local 71	Y-SB 40

SITE: Offnets

COMMITTEE: SFIN

DATE: 3/30/04

SUBJECT OF MEETING:

BILL # SB40

UPDATE #:

PRINT YOUR NAME	COMMUNITY	REPRESENTING/AFFILIATION	DO YOU WANT TESTIFY Y or N
Eden Larsen		ABC	Y
Jeff Alling		Alcan Builders	Ans. ?'s

SENATE FINANCE COMMITTEE

S I G N - I N

SB 40-CONSTRUCTION OF HIGHWAYS BY DOTPF

NAME: George Levasseur Subject/Bill No: SB40

Co./Dept./Title: DOT/PF - State Mtce. Engr. Phone: 465-3940

Address: 3132 Channel Drive Zip:

Do you wish to testify? X 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

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:

Senate Bill:
[x] same title
[ ] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #_____

[X] 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

NEW FISCAL NOTE(S):

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

* recd this forthcoming FN 3/18

[ ] **APPROPRIATION - no fiscal note**

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

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

SENATE FINANCE COMMITTEE

S I G N - I N

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, Juneau Zip: 99811

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

SITE: **OFFNETS** *COMMITTEE:* *DATE:*	*SUBJECT OF MEETING:* *UPDATE #:*

PLEASE SIGN IN

P R I N T *YOUR NAME*	*ADDRESS (MAILING & ZIP)*	*REPRESENTING*	*DO YOU WANT TO TESTIFY? Y or N*
Steve Branchflower & Randall Schlapia			
Jack Neilson		**AG**	
Don Kitchen		**Victim's Rights**	

REPORTED OUT
APR 15 2003
SENATE FINANCE COMMITEE

SENATE FINANCE COMMITTEE REPORT

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#
H455	3/19/03	66.5		#1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
	✓			
			—	
			✓	
	✓			
COCHAIR:	✓			
COCHAIR:	✓			

REPORTED OUT
APR 15 2003
SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSSSB 41(HES)
(S) Publish Date: 3/18/03
Revision Date/Time (Note if correction): Dept. Affected: Health & Social Services
Title MEDICAL CARE AND MEDICAID FRAUD
BRU Medical Assistance Admin
Component Health Purchasing Group
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

COMMITTEE COPY

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CSSSSB 41(HES)

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%.

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 1S of the cost of an audit we recovered S2.

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
S0	S1,567.5	S1,630.2	S1,695.4	S1,763.2	S1,833.8

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

SENATE FINANCE COMMITTEE
Amendment Number: #1 amended
Bill Number: SB 41 23-LS0204\U.1
Sponsor: Green Date: 4/15 Lauterbach 4/15/03
Logged In By: Mindy

AMENDMENT

OFFERED IN THE SENATE BY SENATOR GREEN

TO: CSSSSB 41(JUD)

Page 6, lines 4 - 8:

Delete all material.

Insert

"(2) "claim" includes a request for payment for medical assistance services under applicable state or federal law or regulations, whether the request is in an electronic format or paper format, or both;"

Page 7, line 6. following "services":

Insert "or "medical services""

assistance

Page 7, lines 6 - 7:

Delete "available to a medical assistance recipient"

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			
Motion by	Green			
Objection by	no			
Removed				
Second Objection by				
Committee Member	**Y**	***Vote***	**N**	
Senator Taylor				
Senator Bunde				
Senator Hoffman				
Senator Olson				
Senator Stevens				
Co-Chair Green				
Co-Chair Wilken				
Tally				
Yea				
Nay				
Absent				
MOTION	Pass			

SENATE FINANCE COMMITTEE

4/15 **2003 COMMITTEE ACTION**

Bill Number	SB 41			
Amendment	#1			
Motion	adopt			
Motion by	Green			
Objection by	Wilken			
Removed	✓			
Second Objection by				
Committee Member	**Y**	***Vote***	**N**	
Senator Stevens				
Senator Taylor				
Senator Bunde				
Senator Hoffman				
Senator Olson				
Co-Chair Green				
Co-Chair Wilken				
Tally				
Yea				
Nay				
Absent				
MOTION	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 laws 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:
500 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-3707
1-877-465-3707
Fax (907) 465-3809

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).

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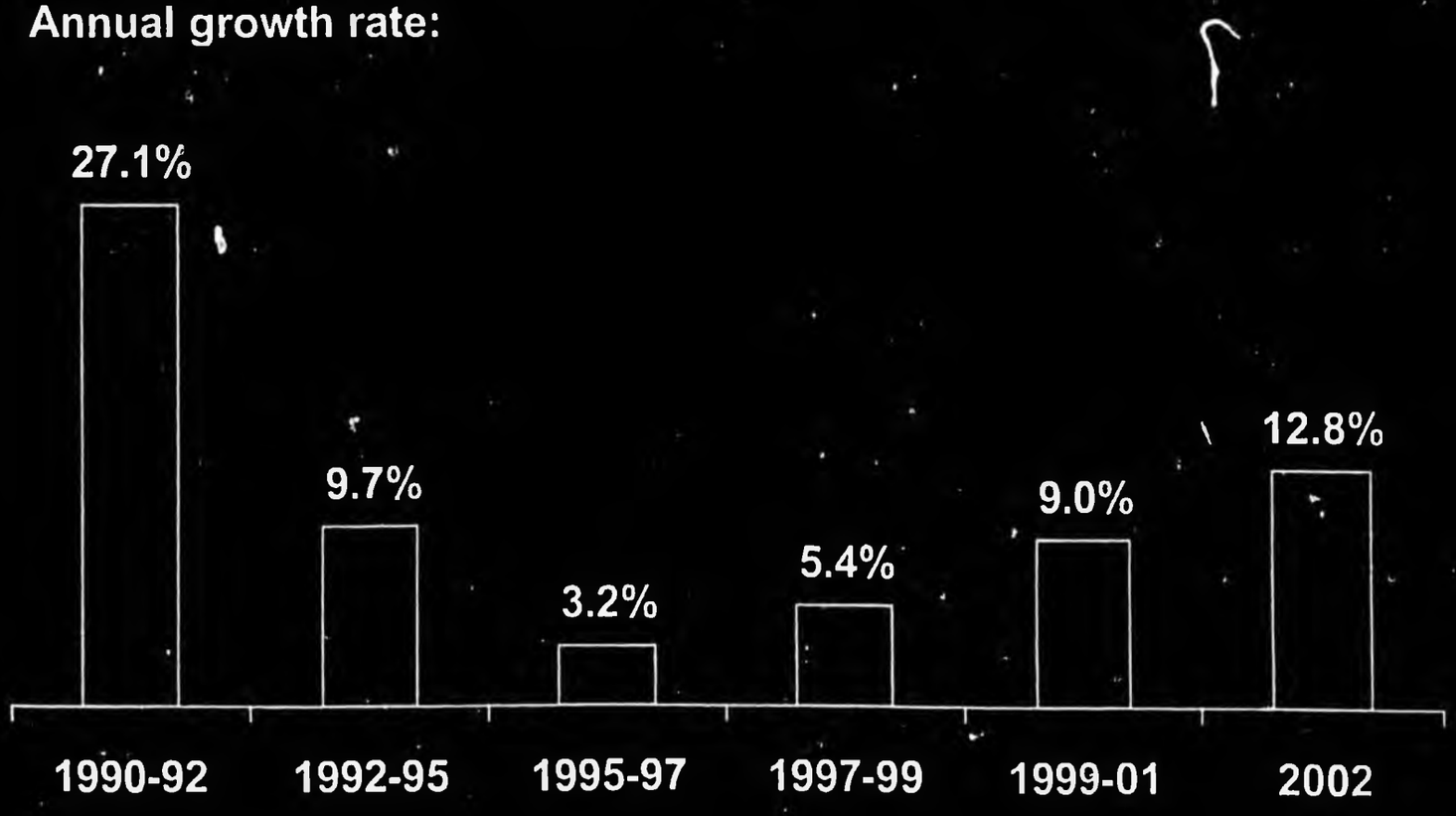
The legislation establishes three specific crimes of misconduct involving Medicaid services, defines the actions constituting those crimes, and classifies the type of crime committed as either a felony or a misdemeanor. It clarifies the circumstances under which controlled substances may be prescribed. 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.

It is vital that the State of Alaska administer its Medicaid program in a manner that ensures effective, long-term cost containment while providing medically necessary services 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.

Provided by Sen. Green

Figure 13

Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 20012002: Health Management Associates surveys for the Kaiser Commission on Medicaid and the Uninsured.

KAISER COMMISSION ON
Medicaid and the Uninsured

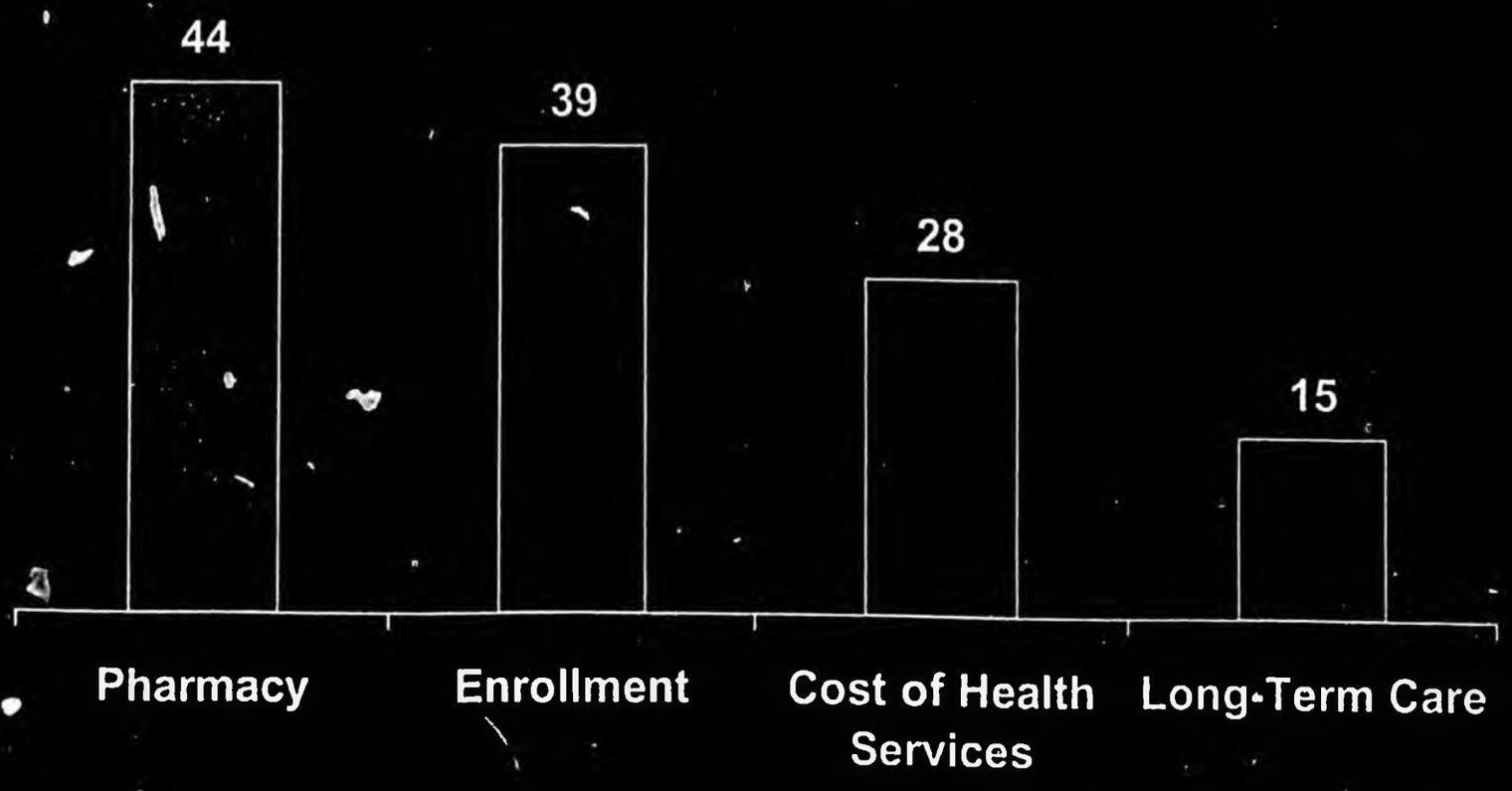
ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language	Actuals FY98	Actuals FY99	Actuals FY00	Actuals FY01	Actuals FY02	Enacted FY03	Projected FY04
Medical Assistance							20% increase
Medicaid	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**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

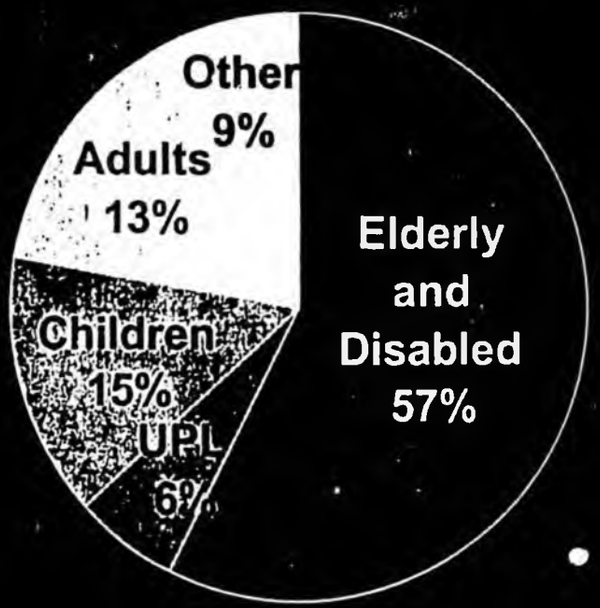


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

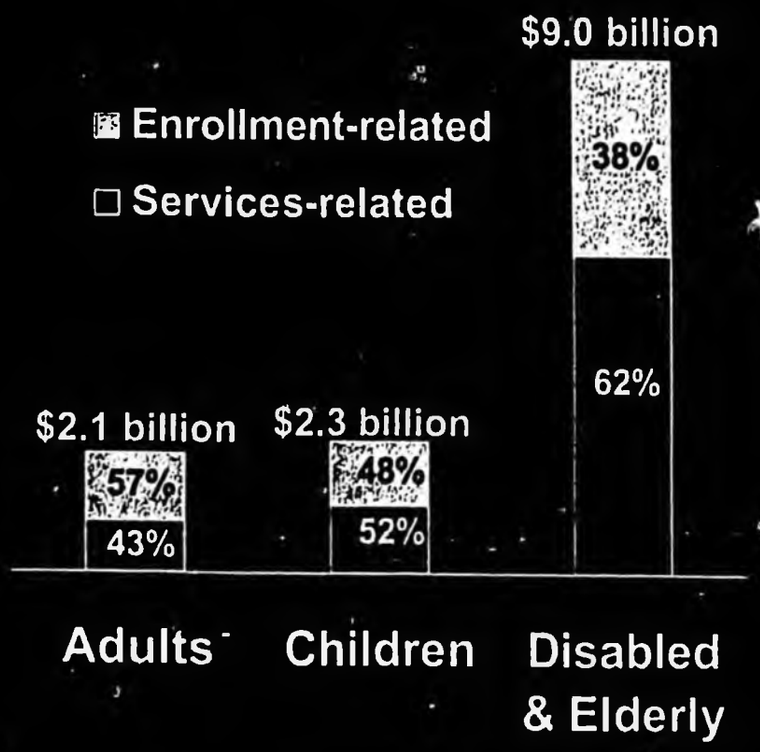
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002



Total Increase = $15.7 billion

Factors Behind Expenditure Growth for Beneficiaries

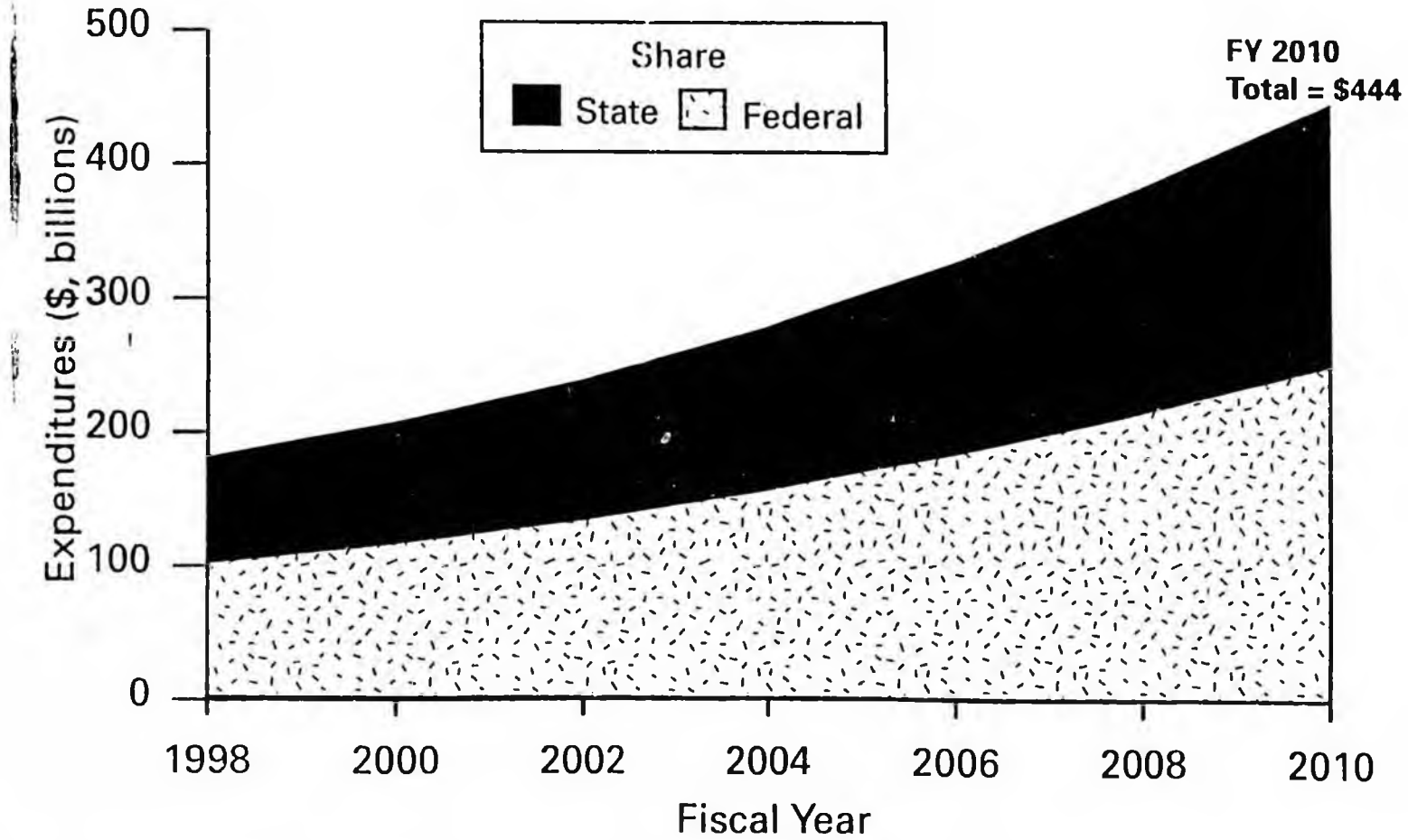


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years1998-2010

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

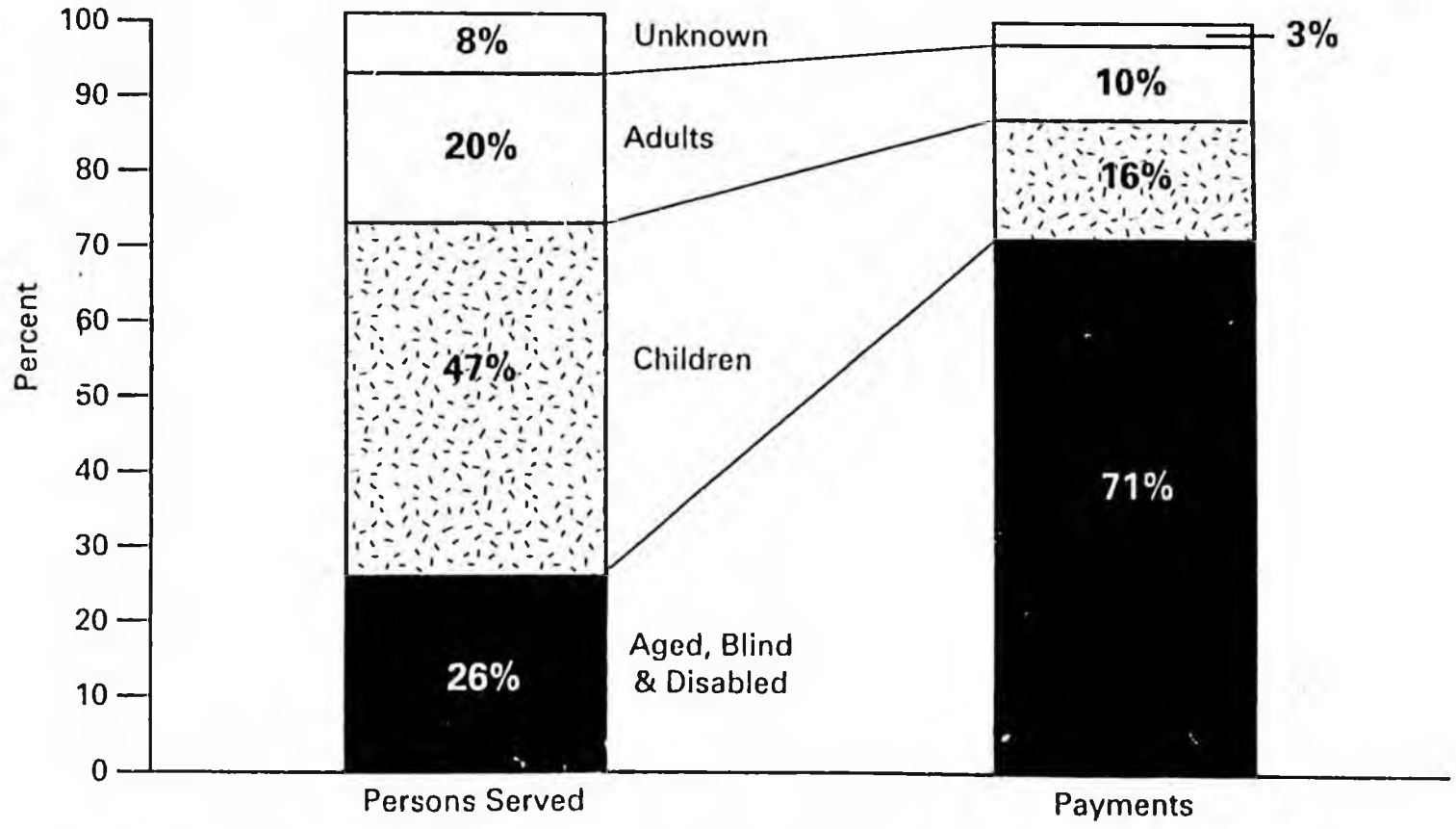


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors -- case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal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

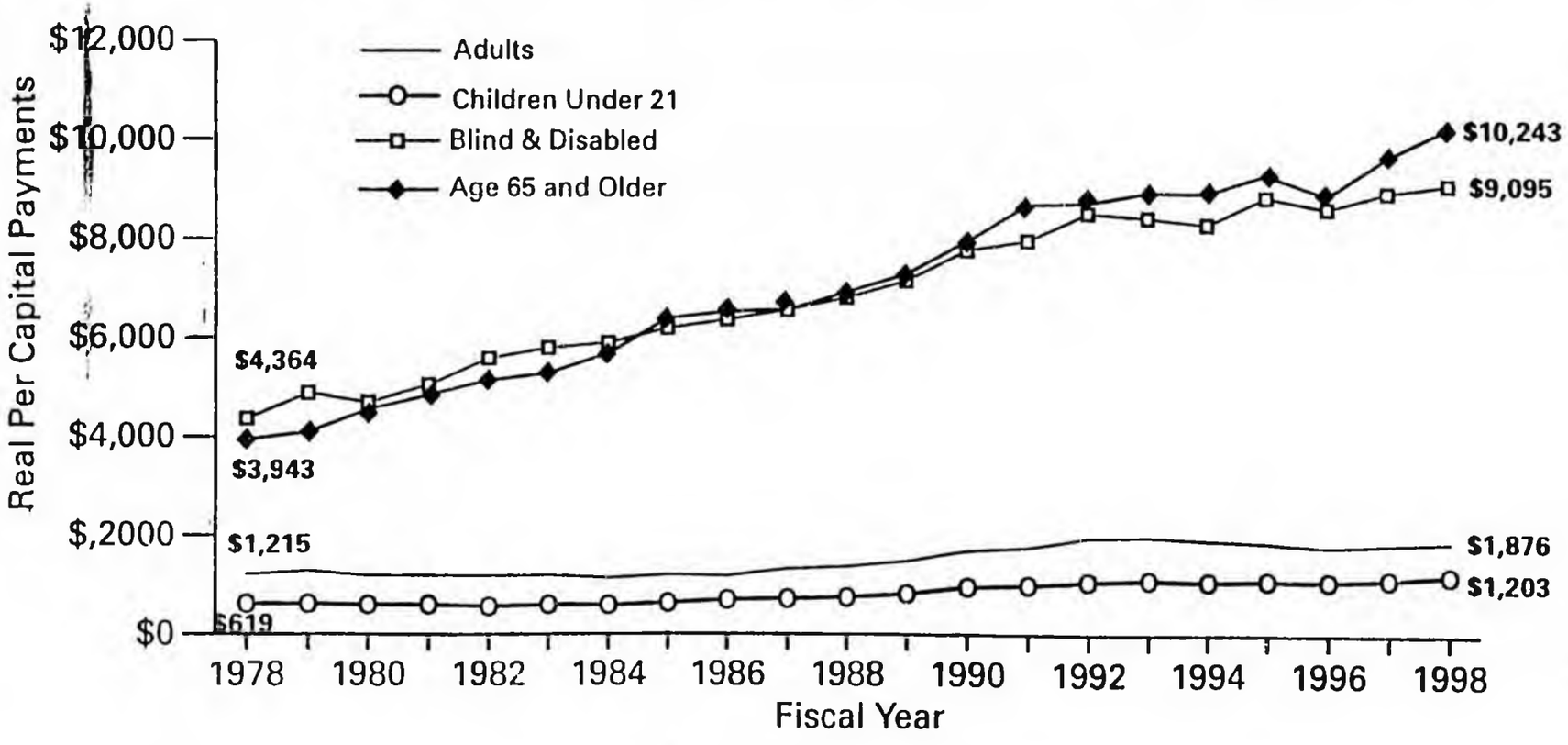


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled 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 DEPARTMENT OF LAW

www.law.state.ak.us

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 centry 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	HCFA News	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

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 inflamation 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 $25,423 for services to an inmate charged with killing his mother.
- In another State, Medicare paid a facility $97,283 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

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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 statements[37] and state regulations[38] 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.

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[36] State regulations at 7 AAC 43.955(8) lists *"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.

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

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,

[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:

Senate Bill:
[✓] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

[✓] be **replaced** with ____ **CS** SSSB41 (JUD)

[ ] adopt **previous** ____ **CS** ____ (____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ____ Committee

[ ] further referral to ____ Committee

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		X			
French		X			
Ogan		X			
Theriault		X			
Seekins	CHAIR:	✓			