ALASKA STATE LEGISLATURE
LEGISLATIVE BUDGET AND AUDIT COMMITTEE
Division of Legislative Audit

P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@legis.state.ak.us

SUMMARY OF: A Special Report on the Department of Health and Social Services, Division of Medical Assistance, Internal Control Over Medicaid Payments, January 31, 2003.

PURPOSE OF THE REPORT

The primary objective of our review was to evaluate the controls over the payments made under the State's Medicaid program. The program is administered by the Division of Medical Assistance (DMA) and involves numerous payments made to a variety of service providers involved with meeting the medical needs of citizens that meet the program's eligibility requirements. Additionally, our review addressed specific concerns related to Medicaid's home and community-based (HCB) waiver programs. The issues in this part of the review involved primarily the billing and budgeting practices of private nonprofit community services agencies.

REPORT CONCLUSIONS

Internal controls over Medicaid program need to be improved

Our central conclusion is that the internal controls related to a significant segment of the payments made under State's Medicaid program are weak. There are weaknesses in both phases of the payment process: (1) the system involved in processing claims; and (2) the practices used to monitor the activities of recipient and providers involved in Medicaid. This second phase, we refer to as program integrity function, includes activities both at DMA and the Department of Law's Medicaid Fraud Control Unit (MFCU).

While the control weaknesses in the Medicaid system involve circumvention or neglect of established controls, the findings related to HCB waiver programs primarily stem from the lack of well-designed controls. In this instance, the primary control involves state regulations which permit reimbursement for expenditures in a manner inconsistent with good financial practices.

The weaknesses in the internal controls over the review and electronic processing of payment claims include:

1. Poor controls over provider enrollment. DMA's procedures for enrolling eligible service providers in the State Medicaid program are not consistent with federal regulations. Additionally, DMA fails to inactivate providers with extended lapses of participation in the Medicaid program.

2. Administrative data processing controls being ignored. The data processing system that generates payments uses an elaborate structure of edits to evaluate claims. The objective of these evaluative edits is to provide assurance the claim is legitimate and consistent with state and federal regulations, as well as established healthcare standards. DMA, through practice and policy, has weakened the effectiveness of some of these edit checks.

3. Insufficient controls over nonemergency transportation. Many of the controls in this area are designed to contain transportation costs. There are a number of problems involving the application of controls over nonemergency transportation. There were many transportation claims paid without a related medical claim involved. Some travel costs appear to be unreasonable, while an established control procedure such as prior authorization, is applied in such a way as to be of limited value.

The weaknesses in internal controls relating to program integrity involve:

1. An ineffective provider and recipient review system within DMA. The section within DMA responsible for reviewing providers and recipients for possible abuse and fraud has not been adequately supported. This lack of support compromises DMA's capacity to effectively manage program integrity information. Accordingly, known problem providers are not effectively monitored on an ongoing basis.

2. Lack of effective coordination between DMA and MFCU. In recent years, two DMA policy decisions adversely affected MFCU investigations. Additionally, vague DMA policies and regulations hamper MFCU investigatory efforts.

Weaknesses in the manner in which controls are designed for HCB services allow providers to be paid for levels of service higher than they actually provide. This is due to the way service costs are developed and billed, consistent with the requirements of state regulations.

FINDINGS AND RECOMMENDATIONS

To address the weaknesses in internal control outlined in the Conclusions section we make 13 recommendations. Recommendation numbers 1 through 4 address the data processing involved with payment of claims through the Medicaid management information system (MMIS). Recommendation numbers 5 through 9 address the internal monitoring and review of activities at DMA. Recommendation numbers 10 and 11 address the controls stemming from activities of other agencies such as the Division of Mental Health and Developmental Disabilities involvement with HCB waiver costs. Recommendation numbers 12 and 13 address actions the legislature should possibly take to improve the operations and controls related to administration of the State's Medicaid program.

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

Januarv 31. 2003

06-30018-03

February 18, 2003

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

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

January 31, 2003

Audit Control Number

06-30018-03

This report summarizes our review of internal control over Medicaid payments processed by the Department of Health and Social Services, Division of Medical Assistance. This audit evaluates specific segments of the State's Medicaid payment controls. In the report we discuss certain internal control procedures inherent to the Medicaid management information system, program integrity function performed outside the system, and specific issues related to the Medicaid home and community-based waiver program.

The audit was conducted in accordance with generally accepted government audit standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology.

Pat Davidson, CPA
Legislative Auditor

TABLE OF CONTENTS

.

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we conducted an evaluation of selected internal control procedures related to Medicaid claim payments. These payments are processed by the Department of Health and Social Services (DHSS), Division of Medical Assistance (DMA).

Objectives

The first objective of our audit was to evaluate select internal control procedures over Medicaid payments processed at DMA. Internal control practices occur in two primary phases: (1) the system involved in processing claims for payment; and (2) the activities used to monitor the actions of both the recipients and providers involved with the Medicaid program.

A second objective of our review was to address concerns related to the home and community-based (HCB) waiver programs. These issues involved the billing, cost estimation, and waiver costs approval involved with DMA, the Division of Mental Health and Developmental Disabilities (DMHDD), and the private nonprofit community service agencies.

Scope

Our scope primarily involved control procedures over payments made to Medicaid providers for services rendered on behalf of eligible recipients. In identifying where to focus our assessment we initially inventoried internal control procedures related to claim payments. Included in this inventory were both prepayment and postpayment control procedures.

We then conducted a risk analysis to identify high risk claim categories. Circumstances included in the risk assessment were things such as the nature of the claims involved and changes in policy, personnel, and information systems related to the claim category. An additional risk factor we considered were claim categories that had increased substantially in recent years. We then focused our review on the internal control procedures related to these riskier types of Medicaid claims.

The scope of this audit was not intended to determine if the Medicaid Management Information System (MMIS) was in compliance with system certification standards of the Center for Medicare and Medicaid Services (CMS).

Methodology

We reviewed, and used as resources, the following laws, regulations, and policies relevant to Alaska's medical assistance:

- Code of federal regulations.

- Alaska statutes.
- State regulations.
- Alaska state Medicaid plan.
- HCB waiver applications for Alaska's four waiver programs.
- Fair hearing decisions.
- Policy memorandums.
- Provider manuals.
- Medicaid service provider manuals.

We reviewed the following information that addressed the delivery of Medicaid in Alaska:

- Annual Medicaid reports prepared by DMA.
- Organizational structure of DMA.
- Budget documents related to DMA, DMHDD, and Medicaid Fraud Control Unit (MFCU).

We discussed the following topics with government officials:

- Medicaid cost containment actions, taken over the past few years, were discussed with state officials in Idaho, Montana, and North Dakota.
- MFCU staffing and procedures were discussed with staff in Wyoming, Washington, Oregon, Illinois, Maine, New Mexico, Hawaii, South Dakota, Montana, and Vermont.
- Provider/recipient review procedures were discussed with staff in South Dakota, North Dakota, and Wyoming.
- Federal provisions were discussed with the Office of the Inspector General (OIG), Health and Human Services.
- Alaska's MFCU was discussed with OIG, Office of Investigations, Medicaid Oversight staff.

We attended the following hearings, conferences, meetings, and training related to Medicaid:

- Medicaid Managed Care Conference. This conference allowed us to gain an understanding of processes applied by organizations to ensure adequacy of controls or payment of Medicaid claims. Speakers at the conference included: CMS staff, state Medicaid directors and staff, managed care providers, and Medicaid researchers.
- Medical assistance provider training in Anchorage, Alaska.
- Public hearings, in both Anchorage and Juneau, which addressed proposed HCB waiver regulation changes and cost containment regulation changes.
- A monthly MFCU/DMA provider relations/First Health Services Corporation (FHSC) surveillance and utilization review unit meeting.

Throughout our review we used MMIS system documentation including:

- System user manuals for the following subsystems: point of sale, provider, recipient, reference, prior authorization, and claims processing.
- Data element dictionaries.
- Detailed system designs.
- Edit/audit manual.
- Electronic file formats.
- DMA procedure manuals for data entry, file maintenance, input/output control, medical review, prior authorization, provider relations, surveillance and utilization review subsystem, claims resolution, remote job entry, financial, contract monitoring, adjustment processing, and attachment coding.
- Alaska Medicaid pricing manual.

We interviewed DMA officials, and reviewed information in the following DMA sections:

- Systems and analysis.
- Health and program policy.
- Provider review and rate setting.
- Provider and benefits services.
- Financial services and recovery.
- Hearings and appeals.
- DMA administration.
- State program financing.

We also interviewed Alaska's executive branch staff in the following agencies outside DMA:

- DMHDD, DHSS.
- Medicaid Fraud Control Unit, Department of Law.
- Division of Senior Services, Department of Administration.
- Office of the Commissioner, Department of Public Safety.

We analyzed FY 02 Medicaid claim payment information from the Juneau claim and eligibility database for payments made in the following categories:

- Pharmacy expenditures for the last three months of FY 02 (April, May, June).

- Durable medical equipment expenditures for the last three months of FY 02.
- Outpatient nonemergency hospital service expenditures.
- Transportation expenditures for the last three months of FY 02.
- HCB waivers expenditures for the mentally retarded/developmental disabilities (MRDD) waiver.

We reviewed information of First Health Services Corporation, including:

- *Service Auditor Report, Alaska Operations,* July 8, 2002, performed by the accounting firm of Eggleston Smith PC.
- Professional services agreement between FHSC and the State of Alaska.

We evaluated support for payment of Medicaid claims at four service agencies. These agencies provide services to individuals participating under HCB waiver programs.

We interviewed families of HCB waiver recipients.

We reviewed the following materials at MFCU:

- Intake database and files.
- Reading files.
- Investigation case database.
- Memorandum of understanding between MFCU and DMA.
- Annual reports to the OIG for FY 00, FY 01, and FY 02.
- 2002 annual on-site review by OIG.

We reviewed and scheduled information presented in working papers and reports of Medicaid provider audits performed by the Deloitte Touche Consulting Group.

We reviewed:

- Referrals of DMA's drug utilization review committee.
- Audit reports from the following states relating to internal controls over payments of Medical claims: Idaho, Kansas, Michigan, Nebraska, New Jersey, New York, Washington, Texas, Wisconsin, and Florida.
- Information on Medicaid maintained or authorized by:
    - Kaiser Commission on Medicaid and the Uninsured.
    - National Association of State Budget Officers.
    - Center on Budget and Policy Priorities.
    - US General Accounting Office.

- National Association of MFCUs.
- Malcom Sparrow, Professional Practice at the JFK School of Government, Harvard University.
- CMS.

We interviewed private medical insurance carriers and Alaska's Retirement and Benefits staff. We also analyzed information provided by private insurance carriers with respect to Medicaid third-party billing practices and use of standardized medical codes.

We reviewed and analyzed Medicaid provider information including:

- Applications and certifications.
- Claims information filed both electronically and manually.
- Listing of all "active" Medicaid providers.

(Intentionally left blank)

ORGANIZATION AND FUNCTION

Several agencies and organizations impact the direction and delivery of healthcare benefits to eligible low-income Alaskans. These agencies provide guidance, policy, funding, and eligibility determinations.

Department of Health and Social Services

Created under AS 18, the Department of Health and Social Services (DHSS) was established to administer the laws and regulations relating to the promotion and protection of public health. The department is responsible for a wide variety of health and social service programs. These programs have an impact on virtually every Alaskan. Health programs include medical assistance for Alaska's poor, and public health programs such as nursing services, vital statistics, emergency medical services, infectious disease control, and maternal and child health programs. Social services include programs for children and families, including temporary cash assistance, food stamps, child protection services, foster care, child residential care, preventative services, and youth corrections.

Division of Medical Assistance

The Division of Medical Assistance (DMA) exists within DHSS to ensure eligible low-income Alaskans have access to needed healthcare. DMA accomplishes this by operating the federal and state-funded Medicaid program and the state-funded chronic and acute medical assistance program (also known as CAMA).

The Medicaid program provides medical benefits to qualifying low-income individuals. The federal government and state legislature determines the eligibility standards, which medical services are available, and which individuals are eligible for coverage. To qualify for federal funds, state programs must provide a "core" group of services. Services that must be covered within Medicaid are those considered "mandatory" under federal law. Those that the legislature chooses to cover are "optional" services determined under Alaska law and approved in Alaska's "State Plan" submitted to the federal government.

Goals established by DMA for FY 03 are summarized in DMA's budget documents as follows:

> *To enable Alaskans in need access to the same broad range of medical care through the same network of medical care providers who provide services to the general population, and to conduct medical surveillance that assures provided medical services are appropriate and of the proper amount, duration, and scope.*

Division of Public Assistance

The Division of Public Assistance (DPA) exists within DHSS to provide cash, food, energy assistance, and work-related services for Alaskans in need. Additionally, DPA determines

which individuals are eligible for medical services. The eligibility categories are children, pregnant women, families with dependent children, disabled adults, or persons age 65 or older. Additionally, these individuals must meet financial rules for counting income and assets. DPA determines if the rules for Medicaid eligibility are met.

Division of Mental Health and Developmental Disabilities

The Division of Mental Health and Developmental Disabilities (DMHDD) exists within DHSS to provide services to individuals who experience developmental disabilities and/or mental illnesses. The role of the state developmental disabilities program is to: (1) maintain and promote the program in public policy making; (2) make best use of and account for public funds; (3) develop provider capacity to include people with developmental disabilities in their communities; and (4) set and monitor standards for individualized community-based services.

DMHDD's developmental disabilities staff administers programmatic aspects of Medicaid home and community-based waivers for: (1) persons with mental retardation and developmental disabilities; and (2) children with complex medical conditions. DMHDD's responsibilities in the administration of these waivers include determining whether applications meet the required level of care, approving plans of care, and approving services.

Department of Administration - Division of Senior Services

The Division of Senior Services (DSS) was organized under a 1994 Department of Administration's administrative order, signed by Governor Hickel. This order brought many of the State's senior programs under the administration of one agency. The mission of DSS is to advance the health and well-being of Alaskans who need assistance.

DSS administers certain program aspects of the Medicaid home and community-based waivers for: (1) adults with physical disabilities; and (2) older Alaskans. DSS' responsibilities in the administration of these waivers include: determining whether applicants meet the required level of care, approving plans of care, and approving services. More specifically, clients who do not wish to live in a nursing home, even though they need that level of care, can qualify for a nursing home waiver and receive these services elsewhere. This allows clients to remain in their own homes or communities.

Department of Law – Medicaid Fraud Control Unit

In accordance with federal Medicaid law the State operates a Medicaid Fraud Control Unit (MFCU). The MFCU exists within the Department of Law (DOLaw) and is responsible for investigating and prosecuting instances of Medicaid provider fraud. DHSS provides information and other assistance as requested by DOLaw.

BACKGROUND INFORMATION

The Division of Medical Assistance (DMA) administers the Medicaid program. Medicaid is a large and complex program with expenditures of over $702 million in FY 02.[1]

The primary portion of Medicaid is funded by the federal government under Title XIX. Alaska implemented the Medicaid Program in 1972. A secondary portion of Medicaid is the State Children's Health Insurance Program (also know as Denali Kid Care or SCHIP) funded by the federal government under Title XXI. Denali Kid Care was created, during the 1998 Legislative session, in response to the federal Balanced Budget Act of 1997 which created SCHIP. House Bill 369 authorized the State to participate in the SCHIP program by expanding its Medicaid coverage for children.

The Chronic and Acute Medical Assistance program, or CAMA, is a state-funded medical assistance program that pays for a very limited amount of healthcare services for the low income adults who do not qualify for Medicaid. CAMA expenditures totaled approximately $4 million for FY 02.

Medical Assistance provides payments for medical and related services, generally on behalf of:

- low-income persons who are over age 65,
- disabled adults who meet income eligibility requirements,
- members of families with dependent children that meet income eligibility requirements,
- children and pregnant women who meet income eligibility requirements.

For FY 01 there were 118,000 eligible Medicaid beneficiaries which represents almost one in every five Alaskans.

Each state participating in Medicaid submits a plan which is essentially a contract with the federal government. The plan sets out what a state is required to do and reflects that state's choice of payments, coverage, and administrative processes that will be followed. Each state is required to designate an agency to administer this plan. For Alaska, the designated agency is the Department of Health and Social Services (DHSS). Within DHSS, DMA has the responsibility to analyze, coordinate, and evaluate the Medicaid program. Eligibility for Medicaid is determined by the Division of Public Assistance (DPA).

[1]The expenditure total is taken from DMA reports made to federal funding authorities. The totals in these reports are developed on a cash basis.

Every state must cover a mandatory set of medical benefits. However, most states also elect to participate in optional items and services. Examples of mandatory and optional services are shown below:

Mandatory Services

Inpatient hospital services
Outpatient hospital services
Prenatal care
Vaccines for children
Physician services
Nursing facility services
Family planning services and supplies
Rural health clinic services
Health home care for persons eligible for skilled nursing services
Laboratory and radiological services
Pediatric and family nurse practitioner services
Nurse midwife services
Early and periodic screenings, diagnostics, and treatment

Optional Services Selected by Alaska

Ambulatory surgery center services
Case management services
Dental (adults limited to emergency treatment for pain and infection)
Durable medical equipment
Prosthetic devices
Long-term home and community support services
Hospice services
Medical supplies
Personal care services
Physical and occupational therapy
Prescription drugs
Rehabilitation services (mental health and substance abuse).
Speech and vision services

Administration of Medicaid puts the states in the position of a health insurance company. DMA is involved in receiving claims for payment from a variety of service providers who have delivered goods and services eligible for reimbursement to the program's beneficiaries – more typically referred to as recipients.

Much of the administration and day-to-day claim processing related to the Medicaid program is carried out by the contractor, First Health Services Corporation (FHSC). The contractor, referred to as the state's fiscal agent, is primarily responsible for receiving and reviewing claims for payment. FHSC processes claims through a data-processing system referred to as the Medicaid Management Information System (MMIS).

Medicaid accountability is addressed in a number of ways, both by DMA and FHSC. Some of the primary methods used for program accountability are as follows:

- Provider/Recipient Review (P/RR) – This unit reviews service-utilization of recipients and claim patterns of providers. Patterns of over-utilization or unusual billing are investigated and actions are taken to end the behavior. Additionally, this section sends random letters to recipients to determine if services billed to the division were actually received. P/RR also investigates, processes, and refers on to appropriate entities, complaints from a variety of sources, including recipients, providers, branches of government, and the general public.

- ClaimCheck – Claims-auditing software package that evaluates billing information and coding accuracy. This software applies healthcare industry standards in evaluating claims.
- Audits and On-Site Reviews – Program staff and auditors, on contract with the division, may perform reviews of provider records to determine that services were provided according to program requirements and records adequately documented the level of services billed. The audits were performed from FY 98 – FY 00.
- Primary Care Program – Healthcare services are managed by a designated provider for recipients who over-utilize services or prescription drugs. There are currently 30 recipients on this "lock-in" program.
- Prior Authorization – Some medical services must have reimbursement approval before that service is provided to the recipient. Certain inpatient admissions, mental health rehabilitation, medical equipment, medical procedures, and drugs require prior authorization. All waiver services and nonemergency transportation require prior authorization.
- Medicaid Fraud Control Unit (MFCU) – As required under the Federal law, the Department of Law houses MFCU. DMA forwards any suspected fraud cases detected through P/RR, audits, or tips from the public to the MFCU for investigation and possible prosecution. MFCU also investigates, and takes appropriate action, in identified situations of patient abuse.
- Case Management – Services are provided by nurses under state contract with Qualis Health to seriously ill, medically complex persons in Anchorage.
- MMIS Edits – System edits within MMIS are designed to verify eligibility of recipients and providers, prevent duplicate payments, and otherwise ensure that claims are paid with Medicaid regulations and coverage guidelines.

Medicaid is funded through a combination of appropriations from the State general fund and Federal dollars. Although the level of federal dollars varies based on the nature of the activity and service involved, in FY 02 nearly two-thirds of the $702 million in Medicaid claims (Title XIX and Title XXI) were made up of federal dollars (64.9% or $456.1 million).

Home and Community-Based Waiver Programs

The Home and Community-Based (HCB) services are requested under section 1915(c) of the Social Security Act (the Act) by states to waive certain Federal requirements allowing states to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities (NF), or intermediate care facilities for the mentally retarded (ICF/MR).

There are specific services written in the Act which may be provided as HCB waiver services: case management (known as care coordination in Alaska); homemaker/home health aide services; personal care services; adult day health; habilitation; and, respite care. The State may request additional services be provided to waiver recipients in order to avoid having to place these individuals in a medical facility. Such services may include things as

nonmedical transportation, in-home support services, special communication devices, minor home modifications, and adult day care.

Federal regulations[2] permit HCB waiver programs to serve the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. States may also utilize 1915(c) waiver programs by specific illness or condition, such as technology-dependent children or individuals with acquired immune deficiency syndrome. States can make HCB services available to individuals who would otherwise qualify for Medicaid only if they were in an institutional setting.

Since FY 93, the State of Alaska received approval from the Center for Medicare and Medicaid Services (CMS), [formerly the Health Care Financing Administration (HCFA)], to provide HCB waiver services[3] to the elderly known as Older Alaskan waiver (OA), adults with physical disabilities (APD), mentally retarded/developmentally disabled (MRDD), and children with complex medical conditions (CCMC) (under the Act known as technology-dependent children).

The OA and the APD waiver programs, also known as Choice programs, are administered through the Division of Senior Services (DSS). In FY 02 these Choice programs had expenditures of just over $19.5 million for OA, and almost $11 million for APD. The MRDD and CCMC waiver programs are administered by the Division of Mental Health and Developmental Disabilities (DMHDD). These programs had FY 02 expenditures of just over $50 million under the MRDD waiver and almost $7.5 million for the CCMC waiver program.

The MRDD waiver program began in FY 93 with only a handful of recipients and minimal cost. In FY 94 there were 21 recipients and the program has grown to 867 recipients for FY 02.

Prior to the MRDD waiver program, recipients were able to seek assistance through Developmental Disabled (DD) programs, which provided specific categorical grants for services[4] to local nonprofit DD providers. Although the MRDD waiver program began in 1993, there was an established waitlist of recipients requesting waiver services.

In November 1997 the State of Alaska closed Harborview Developmental Center, the only state-operated ICF/MR, which caused an influx of MRDD recipients in the program and

---

[2] Federal regulation 42 CFR 441.301(b)(1) provides that services are furnished *"only to recipients who are not inpatients of a hospital, nursing facility, or intermediate care facility for the mentally retarded;"* and *"only to recipients who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in – (A) A hospital (B) A Nursing Facility (C) An Intermediate Care Facility for the Mentally Retarded."*

[3] OA, APD, MRDD, and CCMC applications requested care coordination, transportation, day habilitation, chore services, respite, specialized private duty nursing, environmental modifications, specialized equipment and supplies, and meals. APD, MRDD, and CCMC's applications additionally requested residential habilitation, intensive active therapy, and supported employment habilitation. OA and APD's applications also requested residential supported living, and adult day care. MRDD and CCMC's applications also had educational habilitation as a requested service.

[4] Limited services include such things as respite care or supported employment.

community. In addition, Hope Community Resources closed two and converted three ICF/MR facilities into group homes during a three-year period, 1996 to 1998. Hope's ICF/MR residents were transferred to HCB waivers and placed in other facilities.

Due to the number of individuals requesting DD services, including services under the MRDD and CCMC waivers, DMHDD maintains the waitlist. Individuals requesting services have to initially apply for Medicaid services, where their financial and Medicaid eligibility is determined by DPA. They are then enrolled with DMA. Additionally, the individuals complete documents requesting services and a waitlist criteria assessment.

The waitlist criteria assessment form requests information about an individual's current living situation, need for services, and desired services. The form is forwarded to DMHDD central office for processing, where it is scored, and a notification letter is sent to the individual informing them of their ranking. Individuals are selected from the waitlist based on the highest need and longest on the list; however, while on the waitlist, limited grant supports may be available on a case-by-case basis.

Once selected, the individuals are evaluated to determine if they meet the ICF/MR level of care for the MRDD waiver and the NF level of care for the CCMC waiver. DMHDD contracted with Arbitre Consulting, Inc. to perform the inventory for client and agency planning (ICAP)[5] to determine the level of care assessments and scoring. This care assessment is reviewed by a program specialist at DMHDD who will sign off on the level of care as a qualified mental retardation professional (QMRP).[6] For CCMC waivers, the individuals are evaluated by a DD community nurse through the Alaska long-term care assessment (ALTCA), which is forwarded to DSS for review and approval.

For individuals applying for the OA and APD waivers, Medicaid eligibility is performed also through DPA; however, no waitlist is utilized for these waivers. OA and APD individuals also require an assessment to determine if they meet nursing facility level of care.

Once the appropriate level of care is determined and approved, a plan of care[7] is formulated by a team[8] to reflect the needs of the individual outlined in the level of care assessment. As written in state plan and state regulations,[9] the recipient has the freedom of choice of qualified providers for each service included in their written plan of care.

---

[5] The ICAP is a standardized tool that addresses four adaptive behavior areas, (motor, social and communication, personal living, and community living skills) and will ask respondents to identify and quantify any problematic behaviors.

[6] Federal regulation 42 CFR 483.430 specifies minimum qualifications for a QMRP are: Master's degree or the equivalent from an accredited college in mental retardation, developmental disabilities, psychology, social work, rehabilitation, nursing or a closely related field, and one year of entry level professional experience monitoring and planning client assessments, treatment or training services for persons experiencing developmental disabilities. Or a bachelor's degree and one additional professional level in the above master's degree education fields.

[7] State regulations at 7 AAC 43.1030(c) address the location of the applicant, the types of services to be provided by specific providers, and the frequency, amount, projected duration, and projected cost of each service.

[8] The team usually consists of the parents or guardian, individual, care coordinator, teacher, nurse, doctor, care providers, and the care providing agency. CMS requires the plan of care to be formulated by a team.

[9] Section 1915(c) of the federal law and state regulations at 7 AAC 43.1020.

The regional program specialist and program administrator for DMHDD waivers, the Medicaid waiver nurse, and social workers at DSS, review and approve the plans of care. Once the plan of care is approved, prior authorization is required for certain HCB services,[10] such as: chore, adult day care, residential supported living, habilitation, respite, specialized private duty nurse, transportation, meals, environmental modifications, and specialized equipment and supplies.[11]

[10] State regulations at 7 AAC 43.1040

[11] Under State regulations at 7 AAC 43.1990(62) "prior authorization" means approval by a managing state agency, as defined in 7 AAC 43.1110(17), or the division of a certain type and number of units of Medicaid-covered services before those services are provided.

REPORT CONCLUSIONS

The primary objective of our review was to evaluate the controls over the payments made under the State's Medicaid program. The program is administered by the Division of Medical Assistance (DMA) and involves numerous payments made to a variety of service providers involved with meeting the medical needs of citizens that meet the program's eligibility requirements. Additionally, our review addressed specific concerns related to Medicaid's home and community-based (HCB) waiver programs. The issues in this part of the review involved primarily the billing and budgeting practices of private nonprofit community services agencies.

Internal controls over Medicaid program need to be improved

Our central conclusion is that the internal controls related to a significant segment of the payments made under State's Medicaid program are weak. There are weaknesses in both phases of the payment process: (1) the system involved in processing claims; and (2) the practices used to monitor the activities of recipient and providers involved in Medicaid. This second phase, we refer to as program integrity function, includes activities both at DMA and the Department of Law's Medicaid Fraud Control Unit (MFCU).

While the control weaknesses in the Medicaid system involve circumvention or neglect of established controls, the findings related to HCB waiver programs primarily stem from the lack of well-designed controls. In this instance, the primary control involves state regulations which permit reimbursement for expenditures in a manner inconsistent with good financial practices.

Internal control refers to a system of checks and balances designed to protect the integrity of a financial payment process. Internal controls consist of a system of policies, procedures, and physical security measures designed to ensure funds are spent in accordance with the programs' intent.

The primary objective of a well-designed system is to foster an internal control environment to promote and ensure:

1. reliability and integrity of information;
2. compliance with state and federal policies, plans, procedures, and laws and regulations;
3. safeguarding of state assets;
4. economical and efficient use of state resources;
5. meeting established objectives and goals of the organization's operations and programs.

Annual Medicaid expenditures projected to exceed $850 million in FY 03, with over $600 million being processed through the program's payment system, suggests the deficiencies discussed in this report could be addressed in a cost-effective manner.

A critical part of internal controls involves what is termed the control environment. Auditing standards define this term as follows:

> *Control environment is an interrelated component of any internal control system. The control environment sets the tone of the organization, influences the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure.*[12]

The control environment over the Medicaid program is weak. Most of the individual control weaknesses discussed in this report, in large part, have occurred with the concurrence or, at least, the knowledge of the program management. Oftentimes controls intended to ensure the payment of only valid Medicaid claims were systematically circumvented or ignored in order to expedite payment to providers.

The weaknesses in the internal controls over the review and electronic processing of payment claims include:

1. Poor controls over provider enrollment. DMA's procedures for enrolling eligible service providers in the State Medicaid program are not consistent with federal regulations. Additionally, DMA fails to inactivate providers with extended lapses of participation in the Medicaid program.

2. Administrative data processing controls being ignored. The data processing system that generates payments uses an elaborate structure of edits to evaluate claims. The objective of these evaluative edits is to provide assurance the claim is legitimate and consistent with state and federal regulations, as well as established healthcare standards. DMA through practice and policy has weakened the effectiveness of some of these edit checks.

3. Insufficient controls over nonemergency transportation. Many of the controls in this area are designed to contain transportation costs. There are a number of problems involving the application of controls over nonemergency transportation. There were many transportation claims paid without a related medical claim involved. Some travel costs appear to be unreasonable, while an established control procedure such as prior authorization, is applied in such a way as to be of limited value.

The weaknesses in internal controls relating to program integrity involve:

1. An ineffective provider and recipient review system within DMA. The section within DMA responsible for reviewing providers and recipients for possible abuse and fraud has not been adequately supported. This lack of support compromises DMA's capacity to effectively manage program integrity information. Accordingly, known problem providers are not effectively monitored on an ongoing basis.

[12] Statement on Auditing Standards issued by the American Institute of Certified Public Accountants

2. Lack of effective coordination between DMA and MFCU. In recent years, two DMA policy decisions adversely affected MFCU investigations. Additionally, vague DMA policies and regulations hamper MFCU investigatory efforts.

Weaknesses in the manner in which controls are designed for HCB services allow providers to be paid for levels of service higher than they actually provide. This is due to the way service costs are developed and billed, consistent with the requirements of state regulations. These conclusions, in addition to other specific issues, related to the HCB waiver program are discussed in more detail in Conclusions Section 3 beginning on page 35.

The detailed discussion of our report conclusions are structured into three categories:

1. Review and processing of Medicaid claims by DMA and First Health Services Corporation (FHSC);

2. Postpayment review and control procedures involving the Provider/Recipient Review (P/RR) section within DMA and the activities of the MFCU; and,

3. Home and community-based waiver billing and payment issues involving DMA and the Division of Mental Health and Developmental Disabilities (DMHDD).

CONCLUSIONS SECTION 1 – REVIEW AND PROCESSING OF CLAIMS BY DMA & FHSC

DMA controls over provider enrollment are weak and/or inconsistent with federal regulations

In order to receive payment from Medicaid, individuals and businesses that provide services to eligible recipients must be formally enrolled in the program. Enrollment involves completing the necessary application forms and meeting various qualification requirements. We reviewed administrative controls over provider enrollment and identified the following deficiencies:

1. Provider enrollment procedures are not in compliance with federal regulation. The federal Office of Inspector General (OIG), with the U.S. Department of Health and Human Services (USDHHS), identifies the provider enrollment process as the first safeguard in preventing unqualified applicants from obtaining Medicaid provider numbers – a basis for submitting bills for reimbursement.[13]

[13] USDHHS-OIG report issued in July 2000, entitled *Medicaid Proactive Safeguards* (report OEI-05-99-00070).

For corporate entities, disclosure of ownership and control,[14] along with disclosure of criminal convictions of individuals[15] is important. Such disclosures play an integral part in identifying individuals who have been excluded, by federal regulation, from participation in federally-funded programs. Exhibit 1 discusses specific disclosure requirements.

Our review of 20 provider agreements and files indicate that DMA does not require, or obtain, any of the above disclosures prior to enrollment of Medicaid providers. Of the files reviewed, only one contained evidence of DMA confirming that the provider was not on the OIG exclusion list[16] at the time of enrollment.

Failure to obtain complete disclosure of ownership and control interests diminished DMA's ability to verify that individuals and entities are qualified to participate in the Medicaid program. As a result, DMA's provider enrollment process is not in compliance with federal regulations.

Providers background checks are particularly critical with consumer-directed personal care agencies. These agencies provide personal care attendants (PCA) to the elderly and disabled who require assistance with health maintenance tasks, respite care, and shopping. Currently there is no requirement that the PCAs be subject to a background check. However, DMA is in the process of developing regulations that would require background checks of all consumer directed PCAs.

Exhibit 1

Medicaid Providers are Required to Make Certain Disclosures

To aid in the identification of individuals who have been barred from participating in Medicaid, federal regulations require prospective service providers make the following disclosures:

- The state Medicaid agency must require each enrolling entity to disclose the name and address of each person with an ownership or control interest in the enrolling entity of 5% or more, prior to enrollment.

  Federal financial participation is not available for payments made to a provider that fails to disclose ownership or control information as required by federal regulation.

- The applicant must disclose the identity of any person associated with the enrolling provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid.

2. Ineligible providers are enrolled in the Medicaid program. State regulation[17] permits only licensed or certified providers to enroll with DMA and bill for services rendered. Weaknesses in DMA's controls over the enrollment process are as follows:

[14] Federal regulation 42 CFR 455.104 sets out this requirement. Noncompliance may result in the disallowance of all federal Medicaid expenditures.

[15] Federal regulations at 42 CFR 455.106(a)(1) and (2) specifically requires disclosures at time of original or renewed provider agreement that disclosures include any person who *"has ownership or control interest in the provider, or is an agent or managing employee of the provider"* and *"has been convicted of criminal offense related to that person's involvement in any program under Medicare, Medicaid, …since the inception of those programs.*"

[16] The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.

[17] State regulations at 7 AAC 43.035 address Eligible Providers.

- Medicaid Management Information System (MMIS) data regarding license status of providers is not kept current. MMIS extracts data from the Department of Community and Economic Development, Division of Occupational Licensing (OccLic) database regarding licensure status of various healthcare professionals. OccLic, however, does not revise the license expiration date in its database to reflect the license suspension date of a Medicaid provider. The suspension date is recorded in a data field not used by the MMIS update process, which results in the provider remaining enrolled in Medicaid for the remainder of their licensing period.

  Five individuals, whose licenses had been suspended in the last year by their respective professional licensing boards, were enrolled Medicaid providers. This made them eligible for reimbursement.[18]

- Lack of a formal protocol with OccLic regarding updating of licensing file. No formal Memorandum of Understanding (MOU) exists between DMA and OccLic that sets out a protocol regarding how OccLic should communicate with DMA or FHSC staff when a professional's license is suspended. Additionally there is no formal schedule established for regularly updating and cross-checking the MMIS file of approved licensed providers and OccLic's database.

  The electronic licensing update is not being received from OccLic in a consistent and timely manner. In a seven month period only three updates were received by FHSC from OccLic.[19] Additionally, there is no formal agreement for OccLic administrators to communicate with DMA or FHSC when a professional, who may be a Medicaid provider, has their license suspended by the licensing board. One DMA staffer commented that he did not find out about a physician's suspension by the State Medical Board until he read it in the newspaper.

- No signature is required from a principal care provider(s) at time of enrollment. DMA does not require providers, who either may be operating as sole proprietors, a limited liability professional corporation or as a partnership, to sign the enrollment form. Often the clerical or administrative staff signs the form on behalf of the professionally licensed providers. The form documents that providers have read and are attesting to a basic understanding of enrollment requirements.

3. Nonparticipating providers are not regularly inactivated in MMIS. From our review of DMA's controls to safeguard Medicaid provider numbers from inappropriate or fraudulent use, we identified the following weaknesses:

   - Provider numbers are not inactivated after extended periods of nonuse,
   - DMA policy does not require providers to reenroll on a regular basis.

   As of October 23, 2002 MMIS has almost 10,000 providers currently enrolled in the Medicaid program. Of those providers:

[18]Only one of the five providers was paid after the date of their suspension.

[19]The updates had been done November 1, 2001; January 31, 2002; and May 29, 2002.

- 40%, or just over 4,000 had not submitted a claim in one year or more,
- 25%, or almost 2,500 had not submitted a claim in two years or more,
- 17%, or 1,701 had not submitted a claim in three years or more.

Almost half of the providers, currently active in MMIS, have had no claim activity for more than year. Many of these numbers represent providers who are retired from practice, have left the state, are no longer in business, or are billing under a Medicaid group number (such as a clinic or group medical practice).

These numerous active numbers increase MMIS's susceptibility to fraudulent claim submission by persons who may be aware of their vulnerability. DMA should regularly inactivate unused provider numbers.

DMA plans to have all providers reenroll during the implementation of the new payment processing and review system in the Fall of 2003. Our inquiries with DMA staff indicate that the agency does not anticipate requiring regular reenrollment after the implementation process is completed. Regular reenrollment of providers can be an effective means of ensuring their legitimacy and confirming they are still active.

These weaknesses, regarding controls over the enrollment and ongoing monitoring of providers, represent a control risk to DMA. The multiplicity of provider numbers increase the likelihood of making payments to individuals who could pass themselves off as providers and submit fraudulent billings. Given the control weaknesses resulting from the practices discussed in the next section of this report, this lack of control over provider enrollment makes MMIS vulnerable to abuse. (See Recommendation No. 2.)

Some administrative controls in MMIS and payment subsystems are circumvented or ignored

MMIS is the claims processing systems used by DMA's fiscal agent FHSC to process all Medicaid claims for payment. DMA has established a weekly goal of having no more than 30% of claims "pend" or be rejected for payment through what is termed the adjudication cycle. Accordingly, the agency strives to pay 70% of claims each week. DMA staff and management told us that such ratios were necessary to maintain good provider relations and to encourage new providers to participate in the Medicaid program.

Part of DMA's strategy to achieve this payment processing objective appears to involve ignoring many claims flagged by MMIS edits for possible review. Additionally, DMA has modified or circumvented MMIS edits to ignore possible problem claims. As a result, DMA has adopted informal policies and procedures that improperly dispose of flagged claims generated by edits – thus circumventing the utility of the edit. The agency ignored, or disengaged, edit checks that were originally established to provide some assurance that submitted claims were consistent with requirements set out in state and federal regulations.

Edits are assigned a "disposition" by DMA's program and policy group. The determination of an edit disposition is an administrative control over the proper evaluation of claims submitted for

payment. If claim data meets the criteria of the evaluating edit, or if the edit is "turned off", the claim will be approved for payment. In some situations, the claim data might fail the evaluating edit criteria, but the disposition will be set to "test" which also allows the claim to be paid. If the claim data fails the criteria of the evaluating edit, and the assigned disposition is set to pend, deny, or reject, the claim will be held for further review or returned to the provider.[20]

We reviewed 25 Medicaid claims that were: 1) pended by MMIS edits; and, 2) subsequently manually-reviewed and approved for payment by the FHSC claims resolution department. We verified the appropriateness of the edit dispositions that evaluated the claims, along with the manual review and approval for payment by the FHSC. We also reviewed seven claims that DMA approved for payment in the second level claims appeal process. From our review of MMIS editing, claims resolution, and second level claims appeal processes we identified the following control weaknesses:

1. MMIS edits have been assigned an inappropriate disposition action inconsistent with proper evaluation of claims. State Medicaid regulations,[21] require DMA to pay only for prescribed medical supplies. A valid prescription assures that supplies being purchased are medically necessary for the recipient, as required by Federal regulation. In our claims review we identified two MMIS edits with dispositions that are inconsistent with this regulatory requirement:

    - Prescriber Missing (edit 121) – This edit looks for data that would indicate supplies for the recipient are being prescribed by a physician. By policy, this edit has never been utilized for durable medical equipment (DME) claims and is not being used to provide some assurance that supplies are medically necessary.

    - Prescriber Invalid (edit 122) – This edit evaluates the validity of the prescriber number listed on the claim. By policy, this edit has not been utilized in evaluating DME claims and has been set to "test" for pharmacy claims. As a result the edit is not effectively being used to provide assurance that supplies are prescribed by a valid, presumably licensed prescriber.

    From our analysis of detail data from the fourth quarter of FY 02, DMA paid almost $1.9 million in DME claims without a prescribing physician's provider number. DMA's policy of how to set or handle these edit controls prevents the agency from consistently assuring if there is some evidence that DME claims are medically necessary.
2. MMIS and Point-of-Sale (POS) pharmaceutical edits have been assigned a disposition action inconsistent with proper evaluation of claims. Recipients who have been identified as

[20] To review the adequacy of claims evaluation, we focused on the FHSC claims resolution department and DMA's second level claims appeal process. The FHSC claims resolution department manually reviews all claims pended by the MMIS editing process. The second level claims appeal process reevaluates claims that were denied for payment by MMIS, and FHSC's first level claims appeal process. By limiting our claims review to these areas, we were able to evaluate the appropriateness of MMIS editing and the manual review process of both DMA and FHSC.

[21] State regulations at 7 AAC 43.598 provides that DMA will pay only for prescribed medical supplies that have been assigned a current specific billing code number by the division. DMA can, in its discretion, grant an exception based on written information submitted on the appropriate request for authorization form.

abusing or over-utilizing the Medicaid program can be placed in "lock-in" status. In cases where the abuse includes prescription medication, the recipient is limited to use of one primary care prescriber and pharmacy. Ostensibly, this allows the prescriber and pharmacist to monitor the drug usage of the recipient, and help reduce abusive behavior. One example of this involves the following MMIS and POS edit:

- Invalid prescriber for primary recipient (edit 389) – This edit is used to evaluate claims for recipients who have been placed in lock-in status. Edit 389 has a "test" disposition in both MMIS and POS. The "test" disposition allows lock-in recipients to receive services from any prescriber, rather than limiting them to their primary care prescriber. This weakens the control objective of the "lock-in" procedure.

3. MMIS and POS edits are not using the appropriate criteria for evaluation of claims. We identified an edit in POS that did not properly evaluate claims and deny payment as it was presumably designed to do. The edit identified was:

   - Prescriber invalid (edit 122) – This edit does not properly evaluate the prescriber number for pharmacy claims submitted through POS. The edit recognizes that a number exists in the MMIS provider files, but does not limit approval to only those prescribers with active numbers. Edit 122 is allowing payment of claims for prescriptions from inactive and unlicensed prescribers.

     From our detailed analysis of claim payments made during the fourth quarter of FY 02, we identified payments of more than $117,000 in pharmacy claims that had prescriber numbers of providers that are not only inactive but unlicensed in Alaska.

4. MMIS edits are being overridden inappropriately during the manual claims review process. In other instances when edits flag a claim for manual review, DMA staff, or FHSC staff at DMA's direction, are ignoring the edit exception and manually override the edit to expedite payment of the claim. For example:

   - Medical justification/medical records required (edit 289) – The DME provider manual lists certain supplies for which "medical justification" must be submitted with the claim in order to receive payment. To ensure that medical justification has been submitted, edit 289 pends these claims for manual review by FHSC staff. However, if proof of medical justification is not attached to claims for certain supplies, the FHSC staff does not request documentation from DME providers.

At DMA's direction, the FHSC staff ignores the requirement and inappropriately overrides edit 289, approving payment of DME claims. FHSC is not obtaining evidence suggesting medical justification prior to payment for certain DME supplies. Lack of medical justification may mean that many DME supply claims are not medically necessary.

- Procedure being billed is incidental[22] to primary procedure (edit 434) – This edit is designed to preclude the payment of two separate medical procedures that by healthcare standards are typically provided in conjunction with each other. For example, providers who bill the primary procedure 99213, Evaluation & Management (E&M), along with incidental procedure 69210 (removal of impacted earwax as a separate procedure) would be paid for only the E&M. The removal of impacted earwax is necessary in order to allow proper vision of the area, and is considered to be a component of E&M services. Additionally, the description provided by ClaimCheck of an earwax removal that would be included in the E&M was consistent with the information in the billing providers chart notes.

  Claims submitted by providers for payment of procedure code 69210 were denied for payment by this edit. These claims were denied payment a second time by the FHSC first level claims appeal process. DMA overrode the MMIS edit and FHSC denials and approved claims for payment, citing that additional procedure is medically necessary.

  As a result, DMA paid for two procedures when industry standards suggest that the primary procedure included all services that qualified for billing. DMA inappropriately overrode controls designed to ensure proper payment of Medicaid claims.

5. MMIS procedure formulary files do not contain the necessary or correct criteria to properly evaluate claims for allowability of services billed. The procedure formulary file on MMIS stores information for three record types: medical procedures, dental procedures and drug codes. The file is designed to contain information that would limit fees for procedures, supplies, and drugs. Additionally, criteria can be included in the file that would restrict or limit the services available to recipients. Our review indicates that DMA is entering only minimal, or incorrect, data to the file and is not maximizing the potential of the file's ability to aid in the evaluation of claims. For example:

   - Personal care services (procedure code 0761P) – This code file does not contain the correct maximum units allowed for services in a 30-day period. State regulations[23] limit

[22]The degree of complexity entailed in the procedure identified as incidental is minimal when compared to the more intensive primary procedure. Industry guidelines suggest that certain incidental procedures should not be billed separately, when procedure must be performed as part of, or to accomplish, the primary procedure.

[23] State regulations at 7 AAC 43.790 (b) state in full:

The division will base its reimbursement upon the tasks specified in the approved service plan and the time allowed by the service plan for each task, to the extent that the tasks and times are consistent with the recipient's condition. ***Except as provided in (d) of this section****, the division will reimburse at an hourly rate for personal care services that do not exceed a total time of eight hours in a day and 56 hours in a week.* [Emphasis added.]

services to approximately 247 hours per month. However, the formulary file indicates a maximum unit limit of 279, permitting payment of claims that are over-billed by 32 hours. The formulary file maximum is not set to the standard, instead is set to the exception identified under subsection (d) of the regulation (see footnote 23 on the previous page) which states :

> *If the division approved a service plan that requires more than eight hours in a day or 56 hours in a week, the division will reimburse the agency at the hourly rate provided in this section or $200 a day, whichever is less.*

This control would be more effective if test level was set at the lower standard amount rather than at the higher exception amount. The code would then flag claims that may be valid under the subsection (d) exception. DMA could then manually review the claim involved and confirm it was approved for the exception standard of care.

- Unlisted specialized equipment (procedure code 7799M) – This code is used to bill for a wide variety of specialized items. The miscellaneous description prevents identification of duplicate items and does not permit proper assessment of allowability of items being purchased.

Overall, the procedure formulary file can be better utilized to evaluate Medicaid claims. DMA should enter complete criteria data in all the procedure code files to realize maximum claims evaluation prior to payment.

6. DMA has used its authority to change regulations in a manner which have often resulted in greater costs to the Medicaid program. Under state regulations,[24] DMA has the authority to issue policy changes to regulation. This authority allows DMA to make changes to regulation *"where undue hardship may result to an individual"* if medical care services are denied by *"strict"* application of regulations.

   DMA policy changes have been made that have resulted in greater reimbursement to providers, with little or no discernable "undue hardship" on a specific recipient. For example:

   - State regulation provides that pharmacists should be paid only one dispensing fee per 30-day supply[25] of prescription drugs. A March 21, 2000 DMA policy letter gave

---

[24] State regulations at 7 AAC 43.080(a) state in full:

> *The need for medical care is not subject to inflexible determination which can be described completely in policy or regulations. Professional judgment must be exercised in each case and exceptions granted in those instances where unusual circumstances exist. Where undue hardship may result to an individual if medical services are denied by strict application of regulations, exceptions to policy may be made when considered appropriate by the division.*

[25] State regulation at 7 AAC 43.950 (22) states: *"dispensing a lesser quantity of a drug than that prescribed in order to receive multiple dispensing fees for one prescription, unless the drug provider is reducing the prescribed amount in order to dispense no more than a 30-day supply."* Regulations also state that violation of this provision is grounds for sanctioning a provider.

pharmacists permission to dispense 30-day prescriptions in 7-day increments. This policy also allows pharmacists to bill a dispensing fee, in addition to a Medipak filling labor fee, for each 7-day supply.

Weekly or bi-weekly Medipaks are necessary for recipients in assisted living situations or with severe medical conditions. However, since the pharmacist is being allowed to bill a labor fee for each prescription, in each Medipak, for each week, DMA could adhere to the regulation requiring only one dispensing fee per 30-day supply while still reimbursing providers for additional costs. Allowing pharmacies to bill a dispensing fee for each weekly Medipak results in a substantial increase in these types of payments, as illustrated in Exhibit 2 at right.

Pharmacists that would typically bill for only one dispensing fee are now billing up to four dispensing fees per prescription per month. From our analysis of quarterly data provided by DMA, this policy change resulted in Medicaid being charged over $500,000 more for dispensing fees related to prescriptions prepackaged for periods of less than one month. We project that this Medipak dispensing fee policy increased pharmacy expenditures over $2 million on an annual basis.

Exhibit 2

Change in Dispensing Fee Policy Involving Medipaks Can Result in Much Higher Costs

To illustrate the fiscal impact of DMA's change in dispensing fees for Medipaks, consider the following example.

A recipient has prescriptions for 10 different medications. Under the previous policy a pharmacy was paid a dispensing fee of $11.46 for each 30 day prescription for each medication. For a quarter that would represent a reimbursement of $343.80 to the pharmacy (10 prescriptions x 3 months x $11.46).

If the recipient was determined to need his medicine packaged in daily and weekly packs DMA's reimbursement would have been an additional 50¢ per prescription per pack or an additional $65 (10 prescriptions x 13 weekly packs x 50¢) for a total of $408.80

Under the change in policy, pharmacies are paid both the 50¢ labor fee and a dispensing fee for each week's medipak. This results in a total service reimbursement of $1,554.80 (10 prescriptions x $11.46 x 13 weeks in addition to the $65 labor charge).

- DMA policy, as set out in the agency's DME provider manual, and state regulation[26] requires certain durable medical equipment, supplies, and services be authorized by the division before being provided to recipients. This prior authorization process is a valuable control in ensuring that only claims for valid, medically necessary, services are paid.

  DMA, however, on a limited basis does allow providers to obtain retroactive authorization. This is to be done when medical necessity does not allow time for prior authorization – suggesting the intent of the policy is that retroactive approval is to be the exception, not the rule.

[26] State regulation at 7 AAC 43.925 (a) (2) states: *"According to the provisions of this section, the division will, in its discretion, reimburse an enrolled provider for certain durable medical equipment, supplies, and respiratory services furnished to Medicaid recipients, if the equipment, supplies or services are (2) authorized by the division before being provided."*

We tested ten DME claims involving equipment rentals and found that all received retroactive authorization rather than prior approval. DMA is regularly circumventing the prior authorization process and weakening controls over payment of DME claims. Additionally, DMA is paying DME claims in a manner that is inconsistent with agency policy and state regulation.

7. DMA does not utilize software designed to determine if procedures are consistent with generally-accepted professional billing practices for dental claims. DMA utilizes software suggested by the CMS, called ClaimCheck. The ClaimCheck[27] software is designed to identify procedures that would typically be considered mutually exclusive, incidental or bundled. Use of ClaimCheck is an accepted and proven method to prevent overpayment of Medicaid claims. DMA, however, has modified MMIS controls to allow all dental procedure codes to bypass the ClaimCheck audit.

These deficiencies are further discussed in Recommendation No. 1.

DMA controls over nonemergency transportation are ineffective at containing costs

In FY 02 the Alaska Medicaid program spent over $29 million on transportation for recipients. This amount represents a 37% increase over FY 01 and a 165% increase since FY 97. We reviewed nonemergency transportation claims for the 4th quarter FY 02. Our detailed analysis[28] indicated areas of possible abuse and excessive expenditures that could seemingly be cost-effectively curtailed by DMA through better claims management, an emphasis on cost containment, and more effective prior authorization. Results and analysis of our review involved:

1. Transportation claims without associated medical claims. State regulations require all reimbursed travel under Medicaid to be medically necessary. Additionally travel is to be scheduled to correspond with medical appointments and is not to include weekend travel. During our review we noted the following:

   - 15% of transportation claims reviewed had no corresponding claim for medical services during the period of travel. This raises the question whether the travel was medically necessary.
   - 8% of transportation claims reviewed in detail included weekend accommodations.

[27] The ClaimCheck audit software is developed based on current healthcare trends, medical and technological advances, CMS guidelines and American Medical Association guidelines.

[28] From 4th quarter FY02 MMIS claims data, we selected 40 recipients and tested all transportation claims paid during the quarter to determine if corresponding medical services claims were submitted during the period of travel, if excessive utilization occurred, if transportation policies were followed, and if transportation costs were reasonable. We also selected 15 high-dollar, nonemergency, airfare claims and 10 recipients who received high-dollar ground taxi services to determine if costs associated with these claims were reasonable and for medically necessary purposes.

2. Some travel costs appear unreasonable. DMA's state Medicaid plan says:

> *When necessary medically-related transportation service is not available from a voluntary source without cost, then a commercial carrier or private provider of transportation will be reimbursed on the basis of reasonable cost.*

During our review of travel costs, we evaluated transportation claims for reasonableness. We identified various instances where excessive costs where incurred for transportation claims. For example:

- Excessive airfare rates paid for out-of-state travel. Claims involving three round trips from Juneau to Wisconsin for nonemergency transportation cost just over $9,000. Based on our research, with some preplanning and advance purchase, this cost of the fares could have been obtained for less than $3,000.
- No discounts for ground transportation of multiple recipients. One reimbursement was made to a provider for transporting four individuals from the Matanuska Valley into Anchorage for medical treatment. Medicaid was charged $800 for this ground transportation, being billed $100 each way for each of the four covered recipients. The individual providing transportation was paid a total of $36,000 in the 4th quarter of FY 02 and paid over $110,000 in FY 02. Given these reimbursement levels, it seems DMA has leverage, along with regulatory authority,[29] to negotiate bulk discounts.
- Local air charters charging unreasonable fares. One individual in our analysis took 25 flights over a 9-month period. The flights originated from Portage Bay just outside of Petersburg to other southeast Alaska communities. In 14 of the nonemergency flights that fell within our 3 months of detailed reviews, Medicaid was charged more than $8,600. In one instance, the air charter service charged $1,300 for a round-trip flight between Portage Bay and Juneau.

Contributing to this lack of "reasonableness" in nonemergency airfare transportation is the resolution of edits involving some of these claims. We reviewed seven air transportation claims that were pended in MMIS by edit 343 (MMIS payment amount exceeds established limit). In each instance, per DMA instructions, the FHSC claims resolution manager approved the claim for payment without verifying that the amount billed was reasonable.

[29] State regulations at 7 AAC 43.510(f)

3. Lack of effective prior authorization. State regulations[30] require that all nonemergency medical transportation in-state receive prior authorization. We questioned DMA and FHSC management regarding prior authorizations for transportation. They reported that cost information is not considered and, despite references in state regulations to medical practice review (see footnote below), it is also not a factor in the review.

   All requests for transportation are subject to approval by FHSC's prior authorization unit. This unit receives phone calls from local providers and public health nurses requesting travel on behalf of recipients.

   FHSC requests information regarding the recipients' diagnosis, the procedure to be performed, the requested destination of travel, and the dates of travel. FHSC and DMA managers also stated that out-of-state travel requires written medical justification often in the form of chart notes or written letters of need. We see written justification as a good internal control practice.

   From our review, we identified the following weakness in the prior authorization process:

   - Eight out of fifteen out-of state claims tested were authorized without written justification.

   - Three of ten prior authorizations tested were changed in order to accommodate an increase in the number of trips billed by the transportation provider.

   - One provider was paid $2,300 for a $230 fare, due to an apparent clerical error (an extra zero added by "mistake"). This error went undetected because the airfare cost was not noted at the time of prior authorization and nonemergency airfare claims do not "pend" unless the fare exceeds $5,000.

   Inconsistent application of prior authorization requirements undercut the effectiveness of this prepayment control procedure.

We discuss concerns regarding controls over transportation costs in Recommendations Nos. 3 and 4. Recommendation No. 3 addresses actions DMA should consider in the short term to better manage travel costs. Recommendation No. 4 discusses a possible long-term approach to better managing transportation costs.

CONCLUSIONS SECTION 2 – POST PAYMENT REVIEW AND CONTROL BY DMA AND MFCU

[30] State regulations at 7 AAC 43.500 (a) and (c) provide:

(a) All nonemergency, in-state medical transportation under $250 per person one-way must have prior authorization by the division's regional office manger or his or her designee. All nonemergency, in-state medical transportation exceeding $250 per person one-way and all nonemergency, out-of-state medical transportation must be authorized in advance by the medical practice review section of the division.

(c) The division will not authorize payment to a provider of medical transportation for nonemergency medical transportation without first verifying medical need for those services.

DMA's provider and recipient review section is not adequately supported by management

DMA's operating philosophy has resulted in deemphasizing the program integrity function. Division management has repeatedly stated that they are primarily concerned with the recruitment, retention, and satisfaction of Medicaid providers. Management stated they rely on the integrity of the providers to ensure that Medicaid claims are valid and accurate.

DMA's provider review section is understaffed and ill-equipped to carry out its responsibilities. Accordingly, DMA is not effectively safeguarding against unnecessary or inappropriate payment for Medicaid services. Between October 2000 and November 2001, there was only one full-time individual and one split-duty manager monitoring providers within DMA. From that time on, there have been only one full-time staff member, one split-duty supervisor, and one split-duty manager assigned to provider reviews. Additionally, FHSC staff does some provider monitoring, although as discussed below, this activity is primarily limited to extracting necessary information and performing preliminary claims analysis for the P/RR unit.

DMA does not effectively manage program integrity information

The federal government requires that the State make every effort to eliminate waste and abuse in program expenditures and develop payment safeguards designed to protect Medicaid funds from unscrupulous and fraudulent providers. Due to the importance of these internal control elements, the federal government encourages states to maintain an effective utilization review function. This is done by providing a federal participating rate of 75% for staff engaged in data retrieval and analysis of provider and recipient utilization data.

Federal regulations require that the State verify whether services reimbursed by Medicaid were actually furnished to recipients. Given these requirements, it is important DMA determine whether payments were made to enrolled providers for appropriate and covered services to eligible recipients.

Administratively, this responsibility is carried out by the provider/recipient review (P/RR) section of DMA. Due to a variety of circumstances, this section does not operate in an efficient and effective manner.

This operational deficiency is reflected by the section's inability to collect, analyze, and act on information received from various sources. Medicaid program integrity information is tracked on several databases, none of which is comprehensive or adequate to accurately track provider and recipient activity.

Specifically, the P/RR section does not effectively utilize, act on, or respond to:

1. Computer-generated program integrity information. As of late October 2002, DMA had 352 case referrals from FHSC in various levels of development. The cases were open and awaiting further action or resolution. An additional 32 were awaiting a second review and action by DMA personnel. We noted that in most instances, these backlogged cases from FHSC are nothing more than three pages of statistical data pulled from SURS and minimal, if any, critical claims analysis by FHSC personnel (See Exhibit 3). A substantial amount of time is likely required to resolve these cases. Because the P/RR section does not have a comprehensive case tracking mechanism, it is impossible to determine the extent or status of their investigation on any given case. (See Recommendations Nos. 5 and 6.)

Exhibit 3

FHSC Analyzes Claims Processed by the State's Payment System and Makes Referrals to DMA for Follow-up

DMA's automated claims processing system (MMIS) contains a surveillance and utilization review subsystem (SURS), a computerized post-payment review system. This system compares each provider's claims against those of other similar providers. Based on this comparison, reports are generated that identify providers with aberrant billing patterns.

SURS is maintained by FHSC. FHSC generates various reports on a weekly, monthly, and quarterly basis using SURS, and submits these reports to DMA. Based on these reports and other incoming program integrity information, specific provider cases are assigned by DMA to FHSC personnel. FHSC personnel then perform a comprehensive internal claims analysis on each case.

The cases are then referred back to DMA to complete the review. Due to a lack of personnel, problems with the quality of claims analysis by FHSC, and other conflicting priorities, DMA's provider review section has not fully investigated these referrals in a consistent and timely manner.

2. Complaints from external sources. Both DMA's P/RR section and FHSC's SUR section (named after the computer processing subsystem) receive program integrity information from external sources. The information received may be in the form of phone calls from recipients, providers, or the general public. Referrals may be received from other State agencies such as DFYS, DSS, DMHDD, or MFCU. Referrals are also received from other units within DMA, such as the DUR Committee. Program integrity information is also obtained from the media, including newspaper articles or internet sources. National Alerts are also received from federal agencies.

   As of late October 2002, DMA had 353 open complaints related to either providers or recipients. This is a significant amount given that DMA had received a total of 173 complaints in FY 01, 298 in FY 02, and is projected to receive more than 400 in FY 03. While these complaints may offer a significant opportunity for DMA to identify and limit possible fraud or abuse under the program, the provider review section has not had the resources to effectively resolve these items. With their current resources, the P/RR section is relegated to trying to stay abreast of the information flowing in and pursuing only the most egregious allegations that are relatively simple to prove and sustain on appeal.

   FHSC's SUR section is also responsible for tracking information as a condition of their contract. However, their obligation to track information appears to be confined to tracking the work they do and does not include tracking work performed by DMA or

other contractors. This results in P/RR's case tracking database being inadequate and incomplete. (See Recommendations Nos. 5 and 6.)

3. Confirmation of service provision. Federal regulations require that DMA have a method for verifying that recipients have received the services for which Medicaid is being billed.[31] These confirmations, referred to as Recipient Explanations of Medical Benefits (REOMBs), are sent out each month by FHSC.

   Currently, FHSC sends approximately 400 REOMBs to a randomly selected group of recipients each month. Returned REOMBs may provide indications where there may be fraud or abuse of the program, although the way they are currently being utilized has proven of limited value.

   FHSC reports that of the 400 REOMBs sent out each month, they typically receive 15 recipient responses, many of which are returned in error and do not necessarily indicate if the service was not provided. With such a low return/response rate, DMA's P/RR section has minimal incentive to spend time evaluating or following up on such small return rates. The lack of follow-through on REOMB information, and more importantly, the inability to strategically focus the use of these confirmations further limits the section's effective use of this program integrity control. (See Recommendation No. 9.)

4. Provider Audits. During FY 98 through FY 00, DMA received funding to contract for audits of selected service providers. These audits were conducted by the Deloitte and Touche Consulting Group (D&T) for a total cost of approximately $1.5 million. In all, there were 173 audits conducted identifying just over $8 million in questioned costs. DMA is still in the process of resolving these audit findings. As of early November 2002 DMA, with MFCU's assistance, had resolved 42 audits – only one fourth the total – and had recovered approximately $2.2 million (including fines and penalties recovered by MFCU).

   Fifty of the 173 D&T audits were a basis for formal referral from MFCU to DMA for action. That is, MFCU reviewed the audits, and considered if the findings could serve as a basis for possible criminal prosecution. After deciding that criminal prosecution was not supported, the MFCU Director formally referred these audits, involving over $2.4 million in questioned costs, back to DMA.

   This referral fell under specific federal regulations[32] which requires DMA to *"initiate any available administrative or judicial action to recover improper payments to a provider."* These referrals were made between July 1999 and December 2001. As of November 2002, DMA had completed investigations on only four of these referrals, resulting in recoveries of less than $6,000.

---

[31] Federal regulations at 42 CFR 455.1 (2) requires each state to *"have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients."*

[32] Federal regulations at 42 CFR 455.21(a)(3) require that the state Medicaid agency, must on referral from MFCU, initiate any available administrative or judicial action to recover improper payments to a provider.

Resolution of these provider audits are further complicated by the fact that the audits are now two to five years old. In some instances, the provider is no longer in business, or has sold the business, filed bankruptcy, is deceased, or has left the State. Resolution of these more complicated cases will require the services of a civil attorney, which to date, have not been available to the provider review unit due to other priorities.

While DMA is working to resolve these audits, no new provider audits have been initiated since FY 00. Current actions have been limited to claims analysis and record reviews of selected providers as the staff has been occupied with the administrative resolution of the D&T audits. (See Recommendation No. 7.)

Known problem providers are not effectively monitored on an ongoing basis

DMA does not effectively monitor known problem providers. The agency rarely uses various administrative remedies to limit abuse. In addition to accurately identifying providers that have over-billed Medicaid, an effective program integrity system should include implementing disincentives, such as sanctions, against such providers. When sanctions are rarely applied, providers may consider having to repay funds to Medicaid simply "the cost of doing business" and not be dissuaded from fraudulent or abusive billings.

Despite the previously discussed data management problems, DMA's P/RR section does identify some providers who merit further investigation and possible administrative action. Most of the administrative actions available are sanctions and require approval of the DMA director. The only action that the P/RR unit can take on its own is to request the provider voluntarily repay the amount overpaid to them or conduct a voluntary "self-audit" and report the results, including any overpayment identified, to DMA. Typically, it appears that problem providers are sent education or warning letters but no further administrative action is taken. No follow-up reviews are conducted on providers who have received education letters or repaid money to Medicaid.

Until recently, when the P/RR section did identify a problem provider, the staff would seek approval for appropriate sanctions from the DMA management and not receive the necessary approval. In one instance, the P/RR section recommended sanctioning a provider indicted for healthcare fraud. No approval to sanction was ever received. Subsequently, the provider was convicted and the P/RR section again sought approval for sanctions. Even though the provider is currently serving five years in a federal prison, he still has an active provider number.

The first administrative review and sanction since 1996 was imposed against a provider in July 2002. The penalty to the provider was the requirement to complete a mere five hours of provider training. Another sanction was imposed in November 2002. This provider has been the subject of numerous and continuing complaints received by both DMA and MFCU. Additionally, the provider continued to appear on FHSC's SURS claims analysis and MFCU investigations. The 1998 D&T audit findings related to the provider were egregious, but not

resolved and finalized until September 2002. Despite this history, DMA took an additional eight weeks to initiate the sanction.

The delay in finalizing the audit and imposing sanctions allowed this provider to continue his billing and prescribing practices for four more years which are not covered by the audit or recoupment. This provider received over $275,000 in Medicaid payments from July 2001 through December 2002. Aside from recoupment, the sanctions involved:

1. Review of all claims submitted prior to payment for one year.
2. Referral to the State Medical Board.
3. Mandatory attendance at provider-education related to billing procedures.

P/RR section personnel and management stated they believe sanctions cause conflict between providers and DMA and providers are more likely to contest a sanction than a recoupment for overpayments, because sanctions are reported to the federal OIG as well as state licensing boards. However, for exactly this reason, the threat of and actual imposition of sanctions should serve as a strong incentive for providers to ensure they appropriately spend Medicaid dollars and adhere to Medicaid policies.

Even in situations where investigations indicated a provider may be continually submitting improper billings, aside from one instance during our audit, DMA has not implemented monitoring techniques such as prior authorization or prepayment review. Such review is considered in all cases a sanction by management, rather than a tool to safeguard Medicaid funds and ensure that billings are supported.

Many examples of providers, who should be monitored, came to our attention during the audit. One provider was still enrolled and receiving thousands of dollars of Medicaid funds even though he received a 1995 criminal conviction by MFCU. Other providers were involved in MFCU prosecutions and settled in civil court, but continue to receive Medicaid reimbursements without any monitoring of billings submitted. These providers received Medicaid reimbursements totaling $3.6 million dollars in the previous fiscal year.

Another provider has been the subject of numerous complaints and referrals to DMA in the past ten years, and has been the subject of an unresolved D&T audit with multiple findings and evidence of improper payments. This provider has also had an on-going open MFCU investigation for several years. Despite these and other red flags, DMA has not implemented any monitoring techniques, such as manual review of all or even a random selection of claims prior to payment. This provider received over $7 million dollars in Medicaid funds during the past fiscal year.

While we agree that Medicaid providers should not be unnecessarily limited or controlled, it is the responsibility of DMA to safeguard Medicaid funds. It is incumbent upon DMA to implement more effective monitoring techniques, when indicated, in order to prevent the abuse of Medicaid funds. Prudent internal controls over improper payments should not be discarded in the name of provider satisfaction and retention. (See Recommendation No. 8.)

Two DMA actions adversely affected MFCU investigations

DMA has taken administrative action in the midst of MFCU investigations that adversely affected the unit's efforts. DMA did not consult with MFCU on how these actions might impact the agency's investigations or impair possible prosecution. We also saw no evidence that DMA considered the financial impact these policy changes may have had on the Medicaid program. Specifically, DMA administrative actions compromised investigations and resulted in higher program costs as follows:

1. Pharmacy dispensing fees. Multiple pharmacy providers were being actively investigated by MFCU for charging the Medicaid program for excessive prescription dispensing fees, in addition to other issues. The practices of one particular pharmacy were addressed in a contractors audit which identified more than 18,000 prescriptions where the pharmacy had charged excessive dispensing fees resulting in an overpayment of more than $150,000.

   The audit findings eventually prompted a MFCU investigation, but the investigation was suspended when DMA, exercising discretion granted by state regulation, issued a policy change letter. The letter permitted the previously prohibited dispensing practice. The effect of retroactively approving the procedure resulted in Medicaid paying excessive dispensing fees.

   Previously, providers were required to bill no more than once a month for dispensing fees. Pharmacy providers would now be allowed to bill Medicaid for dispensing fees up to four times per month for a prescription for 30 days of medication. As a result of DMA's retroactive endorsement of these billing practices, MFCU terminated their investigations.

2. The "unbundling" of dental services. In 1999, an audit was conducted on dental providers. Among the initial audit findings were instances where the provider "unbundled" certain multiple dental procedures, involving eligible recipients, that were done on the same day. By doing this, the dental practitioner received increased Medicaid reimbursement, even though the DMA provider manual specified a "global" bundled code for these services.

   After the contract auditor issued their initial findings, MFCU expanded the unit's investigation of the provider. However, during this time, DMA issued a "policy clarification" to the Alaska Dental Association, distributed to all dental providers, which made it permissible to bill for the procedures involved on either a separate or "bundled" basis.

   DMA did not consult MFCU to determine how such a change in policy may impact that agency's ongoing civil and/or criminal investigation. DMA's policy decision (or "clarification") impaired MFCU's ability to prosecute this provider. In "clarifying" this

policy so dental providers are allowed to bill in such a manner, DMA has also increased the costs to the Medicaid program.

Vague policies and regulations hamper MFCU investigatory efforts

In many instances, MFCU has been unable to continue investigations of suspected Medicaid fraud due to vague or unclear policies and regulations. MFCU's ability to investigate and prosecute providers is compromised when regulations are subject to broad interpretation. These policies and regulations have resulted in the following questionable billing practices by providers which MFCU is unable to pursue for prosecution or recoupment:

- Questionable billing of "activity therapy" by mental health providers;
- Inadequate levels of physician and psychologist supervision at mental health providers;
- Billing individually for each recipient when multiple recipients are served at the same time by the same person;
- Billing for unsubstantiated time spent on various types of mental health therapy given to recipients;
- Billing for services by personal care attendants at full pay for work contracted regardless of whether or not the full contracted hours are worked;
- Air transportation providers charge DMA the highest current fares for tickets rather than honoring discount fares.

These situations demonstrate the need for better coordination between DMA policy makers and MFCU investigators. Having investigations being developed and then "defined" away by DMA policy changes, contributes to an inefficient, counter-productive relationship.

CONCLUSIONS SECTION 3 – HOME AND COMMUNITY-BASED WAIVER BILLING AND PAYMENT ISSUES

Rate setting method for waiver services promote payment for service levels greater than actually provided

We were directed to evaluate the level of services provided to HCB waiver recipients compared to those outlined in the approved plan of care. As discussed in Exhibit 4, shown on the next page, there were numerous instances identified where the community service agencies provided a level of service less than that set out in the plan of care – when measured strictly by service hours involved.

Despite these discrepancies the essential service involved was provided, if not to the extent projected in the plan of care.

In our view, this difference between actual service hours and those used in the daily billing rate is primarily attributable to a flawed rate-setting process used to establish the daily rate billed to Medicaid.

Significant costs to the HCB waivers are billed to Medicaid through what is termed a "bundled" basis. Bundled services are typically billed as a daily rate which is designed to capture reimbursement for day-to-day operating costs of the community service agencies.

The community agency builds the bundled daily rate by developing and allocating estimated direct and indirect costs involved in maintaining a waiver-covered individual in a particular living situation.

Additionally, the budgetary estimate process involved in arriving at the bundled daily billing rate is not reconciled to the actual service provided, and adjustments made accordingly. (See Recommendation No. 10.)

HCB waiver billings, involving state employees' insurance, do not affect coverage costs

When applicable, DMA's third-party liability unit uses a "pay and chase" procedure in seeking reimbursement to the Medicaid program from an individual's or family's personal insurance coverage.

This means the Medicaid program pays service providers for HCB services and if the individual or family involved has other insurance, private coverage that may cover some of the costs, DMA's third-party liability unit will submit claims to these primary and secondary insurers for reimbursement. Since most HCB do not involve medical treatment the costs are generally not eligible for reimbursement.

Concerns have been expressed, particularly by state employees with dependents participating in the HCB waiver program, that DMA's pay and chase procedure may have an adverse impact on the cost of the State's coverage.

Exhibit 4

Plan of Care Service Costs Based on Projected Work Hours, Actual Work Hours Often Less

The nature and extent of services for MRDD waiver recipients are set out in what is termed a plan of care. Plans of care are based on an assessment of the individual's needs and level of functioning. The plan of care sets out in detail the frequency and duration of a service, and the associated costs related to each service component are outlined on an attached cost sheet.

Plans of care are typically developed by care coordinators who either are affiliated with a private-nonprofit (PNP) community service agency or, in a few instances, work as independent contractors. (See Recommendation No. 11.) Plans of care must be approved by DMHDD staff.

The PNP community service agencies often coordinate and provide many of the services set out in an individual's plan of care. We compared the payments to four PNP service agencies with the agency's supporting documentation.

We identified billings paid at service levels greater than that provided. For two of the four providers reviewed, almost 75% of the payments we reviewed involved services not provided up to the service levels represented by the rate.

The other two providers had error rates of 45% and 30%, where errors represented a level of service less than that calculated in the daily rate calculation. Generally, the unsupported billings stemmed from the PNP agency billing for daily services, using a service level as specified in the plan of care rather than for actual services provided.

The State of Alaska is a self-insured entity and the rates/premiums are only affected by paid claims. Thus the number of claims submitted for reimbursement, whether paid, pended, or denied, do not affect individual employees' insurance costs or the overall cost of coverage.

DMA does not engage in recoding of costs

The State of Alaska utilizes unique procedure codes for the HCB services where insurance companies pay for procedures identified by a Current Procedural Terminology (CPT) code, a universally recognized code. Of the claims we reviewed and traced through MMIS that were submitted to the insurance companies, we noted no instances of recoding of the State's unique procedure codes to CPT codes by state employees.

However, in our contacting Aetna, they acknowledged their claim processors will recode Alaska's unique procedure code to a recognized CPT code and pay accordingly. DMA has sent a memorandum to insurance carriers informing the companies of which standard industry billing codes are equivalent to unique procedure codes.

DMHDD is not manipulating MRDD waiver waitlist or available openings

We were asked to review whether DMHDD is allowing waitlists to grow by decreasing the number of waivers available and keeping remaining openings unfilled. Some states have reportedly used these strategies as a way to help contain Medicaid costs in the HCB waiver programs.

DMHDD has not been manipulating either the waivers available or the remaining openings. The development of the large and apparently static waitlist is related more to factors such as: (1) the lack of a necessary administrative infrastructure in the communities; (2) increasing need for services; (3) inadequate regulations; and, (4) paperwork delays on the part of prospective participants. Many of these items have been discussed in the preceding conclusions. Additionally, "total remaining" waivers are relatively high over the past five years, due to other delays involved in getting eligible recipients evaluated and fully eligible to participate in the waiver program.

Except in FY 02, as shown in Exhibit 5 on the next page, the number of spaces available has increased each year for the MRDD waiver program. In FY 02, when seeking renewal of the waiver from the federal funding authorities, the division revaluated the number of slots for which it sought approval. The division realigned the number "slots," slightly reducing the number from FY 01, to better match the service capacity within the state.

Exhibit 5

FY 98 – FY 02 (*unaudited*)

Waivers	**FY 98**	**FY 99**	**FY 00**	**FY 01**	**FY 02**
Total available	546	692	838	984	960
Participating recipients	472	505	694	797	867
Total remaining spaces	74	187	144	187	93
Individuals waitlisted	805	628	974	1,250	1,340

Source: State of Alaska, Department of Health and Social Service records.

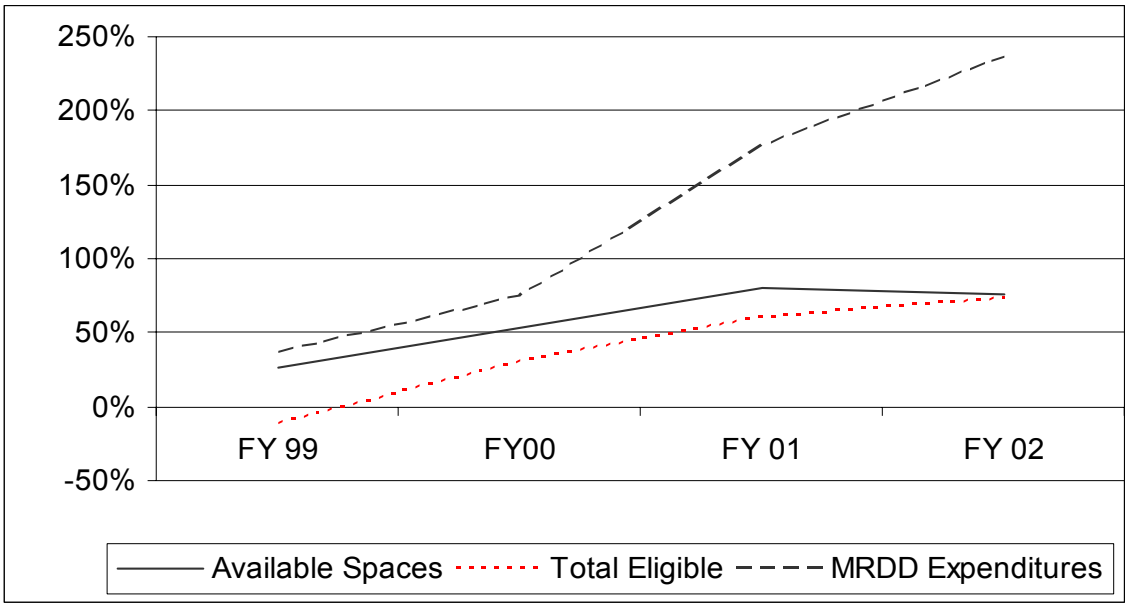
The number of available waivers are filled by HCB recipients as they complete the necessary assessments and plan of care. However, individuals are selected from the waitlist each year that have yet to complete the necessary assessment and paperwork to receive services. For example, on June 30, 2002 – 867 recipients had plans of care and were participating in the program.

In order to fill the remaining waiver spaces, 107 eligible individuals were selected from the waitlist to receive services. These 107 are still included in the "individual's waitlisted" figure as the necessary assessment and paperwork to receive services had not been completed by the individuals' care team, or approved by MHDD by the end of June 2002.

In summary, we evaluated the cumulative change between the total available waivers over the past five years, the total universe of individuals either participating or waiting to participate in the waiver program, and the expenditure increase. As can be seen in Exhibit 6, to the right, both the available waivers and universe have increased proportionally. We also included the total increase of expenditures for the waiver program to show MRDD waiver expenditures have increased by a much greater proportion. Currently, each MRDD waiver recipient's plan of care costs an annual average of almost $62,000.

Exhibit 6

MRDD Medicaid Waivers
Comparison of Growth
Available Spaces, Eligible Individuals, and Program Expenditures
FY 99 – FY 02



(Intentionally left blank)

FINDINGS AND RECOMMENDATIONS

The following findings and recommendations address various issues raised in the conclusions section of this report. As discussed previously, our review considered controls and the administration of the Medicaid program at various levels.

Our findings and recommendations address controls at those various levels of review and monitoring related to Medicaid. Generally, the recommendations are structured to address the first level of review involving the controls involved with day-to-day claim processing. From there we expand our discussion until we address actions the legislature should consider taking to improve overall program integrity of the Medicaid program. Specifically:

1. Recommendation numbers 1-4 address the data processing involved with payment of claims through the Medicaid Management Information System (MMIS).
2. Recommendation numbers 5-9 address the internal monitoring and review of activities at the Division of Medical Assistance (DMA).
3. Recommendation numbers 10-11 address the controls stemming from activities of other agencies such as the Division of Mental Health and Developmental Disabilities (DMHDD) involvement with waiver costs.
4. Recommendation numbers 12-13 address the actions the legislature should possibly take to improve the operations and controls related to administration of the State's Medicaid program.

Recommendation No. 1

DMA's health and programs manager should review MMIS administrative controls and edits, and the related disposition policy, in order to better utilize the payment system's capacity to evaluate claims.

As discussed in the conclusions section, there are multiple edits and other administrative controls available in MMIS not being effectively utilized to evaluate claims. Edits designed to provide some assurance that goods and services involved, with various claims, are consistent with state or federal regulations are not appropriately set, or when set, the related disposition policy is inconsistent with regulatory requirements.

Specifically, we recommend:

1. All MMIS and Point of Sale edits (POS) edits with a disposition of "off" or "test," for all claim types, should be reevaluated for the appropriateness of assigned disposition. Specifically, DMA should change the disposition of the following edits:

    - Edit 121, Prescriber Missing, claim type 10, disposition "off," should be changed to "RTD,"

- Edit 122, Prescriber Invalid, claim type 10, disposition "off," claim type 9, disposition "test" should be changed to "pend," then manually reviewed,

- Edit 389, Invalid prescriber for primary recipient, claim type 9, disposition "test" should be changed to "deny."

These edits are critical to the proper evaluation of durable medical equipment (DME), pharmacy medical supplies, and pharmacy prescription claims. Edits search for evidence of medical necessity, as indicated by valid prescriber numbers and pay claims in a manner consistent with federal regulations.

2. DMA should make certain that edit 122, prescriber invalid, is using the correct data elements to determine the validity of prescribers issuing prescriptions to Medicaid recipients. DMA should discontinue paying pharmacy claims that contain inactive prescriber numbers.

3. DMA's manual claims review process should be consistent with written DMA claim payment policy as set out in the provider billing manuals. Medical justification for certain medical supplies should be required to be submitted with claims as specified in the relevant provider billing manuals. DMA should stop overriding MMIS and FHSC first-level claim denials for payment requests. This should be done especially if the claim was appropriately denied in accordance with professional practice or industry standards.

4. DMA should require that DME providers obtain prior authorization before providing equipment, supplies, or services to recipients. Retroactive authorization should only be allowed in emergency situations when medical necessity will not allow time for prior authorization.

5. DMA should enter complete data for procedure codes in the procedure formulary file. Improved utilization of this file will ensure that Medicaid claims are properly reviewed prior to payment.

6. DMA should discontinue paying pharmacists multiple dispensing fees for a 30-day prescription. Additionally, DMA should reactivate use of ClaimCheck auditing for dental procedure codes.

DMA can better ensure that payments are meeting the requirements of state and federal regulations. For the most part, these regulations involve safeguards to promote the payment of valid, supported, and medically necessary claims. Failure to consistently require providers to submit billings in accordance with such safeguards diminishes the system's quality control and may promote improper and unsupported billing practices on the part of some providers.

Recommendation No. 2

DMA's provider and beneficiary services manager should develop and implement stronger Medicaid provider enrollment controls consistent with Federal regulations and to prevent enrollment of inappropriate service providers.

As discussed in the conclusions section, we identified weaknesses in control over the provider enrollment process. Three of the identified control weaknesses are a result of noncompliance with state and federal regulations. In order to comply with state and federal regulations, strengthen controls, and prevent payment to unqualified providers, we recommend the following improvements be made to the provider enrollment process:

1. DMA should develop provider enrollment policies that require complete disclosure by Medicaid providers prior to enrollment.

   DMA should obtain complete disclosure information from current and enrolling Medicaid providers. Disclosures should include names and addresses of all owners and control interest of 5% or more, including information on subcontractors as required by federal regulation 42 CFR 455.104.

   Additionally, DMA should obtain positive certification from current and enrolling providers that no persons, convicted of crimes against federally-funded health programs, are associated with the Medicaid provider as mandated by federal regulation 42 CFR 455.106. This information should be added to the provider history file and used to:

   - Verify legitimacy of the enrolling entity,
   - Identify inappropriate relationships among providers, subcontractors, and recipients,
   - Assist in identifying individuals who have been excluded by OIG from participation in the Medicaid program,
   - Update the OIG list and make periodic comparisons to identify convictions that have not been voluntarily disclosed by the provider,
   - Aid in the efforts of DMA's Surveillance and Utilization Review (SUR) and the Medicaid Fraud Control Unit (MFCU) to prosecute identified fraudulent practices.

2. DMA should develop a Memorandum of Understanding (MOU) with OccLic that allows DMA to receive immediate notice, from OccLic, of licensure suspension of healthcare professionals who may be enrolled as Medicaid providers. The MOU should require OccLic to furnish a monthly, electronic, occupational-licensing update containing license expiration date or suspension date in a data field used by MMIS, to update the provider license file. An MOU between DMA and OccLic will improve the communications and exchanges of vital information and protect the integrity of the provider enrollment process. The benefits achieved by implementation of an MOU are:

- Improved maintenance of the Provider License File to aid in verification of the validity of provider licenses,
- Reduce any misrepresentation of licensure status by current or enrolling providers,
- Remove from active status any providers whose occupational license has been suspended by authorized licensing boards.

3. DMA should routinely inactivate provider numbers having no claim activity for an extended period of time. This will prevent provider numbers from being inappropriately used to bill for services not rendered. DMA should implement a policy of regular reenrollment of all Medicaid providers. Specifically, DMA should:

   - Place providers into an inactive status after 24 months of billing inactivity,
   - Reenroll providers after they have been placed on inactive status,
   - Educate the providers on their obligation to protect their provider number from unauthorized use,
   - Update disclosure information,
   - Ensure that provider numbers are only assigned to active providers,
   - Monitor providers subject to periodic license renewal.

DMA managers stated they were not aware of the need to obtain disclosures prior to enrollment. Providing disclosures as required by state and federal regulations will safeguard the integrity of the service provider listing and provide greater assurance that all providers are legitimate, valid, ongoing, operating entities who are providing services to eligible recipients.

Recommendation No. 3

DMA's health program and policy manager should strengthen controls over transportation claims.

As discussed in the conclusions section, in our detail review of reimbursement on transportation claims, we identified various instances of possible abuse and excessive Medicaid expenditures for nonemergency medical transportation. These instances grew out of circumstances where there were weak controls over provider and recipient practices. The lack of having in place effective controls stem in large part from DMA's management perspective that, because recipients have a "freedom of choice"[33] for healthcare-related services and there is a general prohibition against prepayment of services, there is little or no cost-effective action the agency can take to limit these abuses.

[33] Freedom of Choice is a federal requirement for Medicaid program administration.

There are actions that DMA could take to limit the types of problems identified in the conclusions sections. Specifically, we recommend the following:

1. Verification of services. DMA should verify that recipients actually receive medical services at their travel destination and their appointments correspond with the dates of travel. Two methods of appointment verification have been successfully utilized in other states. These include:

   - Request that medical/dental providers fax a confirmation when the recipient attends their appointment(s).
   - Contact medical/dental service providers on a random basis to inquire if the recipient kept their appointment(s).

2. Pursuit of volume discounts. DMA should negotiate bulk discounts with specialized ground transportation providers who provide simultaneous transportation of multiple recipients. As discussed in the conclusions, we identified a provider who was paid the same per-recipient-rate, regardless of the number of recipients transported. State regulation requires that DMA make every effort to negotiate a "bulk rate" discount in such circumstances.

3. Establishment of standards for reasonable costs. DMA should survey and document statewide and common out-of-state destination airfare rates to identify reasonable costs. DMA should use this information to conduct periodic postpayment reviews of nonemergency airfare claims in order to identify unreasonable billed charges. Medicaid policy precludes providers from charging Medicaid recipients more than the general public. Providers whose rates substantially exceed the identified reasonable cost should be referred to the DMA SURS unit for investigation.

4. Confirmation of medical necessity for transportation with excessive estimated costs. DMA should require written medical justification for all out-of-state as well as in-state travel requests with exceptional circumstance or costs. Per DMA policy, all out-of-state travel should have written justification prior to being authorized. Yet, we found numerous instances where out-of-state transportation was authorized without written justification.

5. Increasing scrutiny of changes to transportation "units" made by providers. DMA should require medical provider confirmation of changes to the number of transportation units authorized. As discussed in the conclusion, we noted multiple instances where FHSC altered prior authorizations in order to accommodate a change in billing by the provider. We recommend that only servicing medical providers be allowed to initiate changes to prior authorizations. Without this control, transportation claims are more susceptible to provider and recipient fraud, waste, and abuse.

Strengthening controls over transportation claims will be beneficial in containing transportation costs through limiting unnecessary travel, limiting unreasonable payments to

providers, and limiting fraud, waste, and abuse associated with Medicaid transportation. The above suggestions are actions we think DMA could take in the short-term to better monitor transportation costs. Recommendation No. 4 addresses a possible long-term strategy for better managing nonemergency transportation costs.

Recommendation No. 4

The Director of DMA should evaluate the costs and possible savings that may be involved in various administrative alternatives to managing nonemergency transportation costs.

As discussed in the conclusion section, we identified multiple examples of unreasonable travel costs involved in the provision of nonemergency travel. Much of the increase in these costs and the unreasonableness of many charges can be attributed to DMA's inability to aggressively manage these costs.

DMA managers cited that two factors prevented the agency from better managing travel expenditures. Both of the following factors are related to the classification of transportation as an "optional medical service:"

1. Prohibition against prepayment of services. Federal regulations prohibit state Medicaid agencies from paying for medical services before these services are provided to the recipient (see footnote 32). Accordingly, DMA reports that the agency cannot take advantage of the discount pricing typically available from many large commercial airlines which involve purchase of tickets in advance of travel. Rather, the agency consistently pays day-of-travel fares to transport Medicaid recipients for treatment.

2. Freedom of choice on the part of the recipient. Unless a state seeks approval, referred to as a waiver, from CMS it is required to allow Medicaid eligible recipients to patronize the enrolled medical service provider of their choice.

Federal regulation[34] requires states to ensure recipients have access to medical services through the provision of nonemergency transportation. States have the option to pay for such costs, as discussed above, as an optional medical service or as what is termed as "administrative services." Based on how a state chooses to provide transportation services, different federal requirements and funding are required. Specifically:

1. Optional Medical Service. Medicaid costs under this method are reimbursed at each state's federal medical assistance percentage (FMAP). The average in recent years for FMAP nonemergency travel has been around 58%. Additionally, transportation services must conform to all other Medicaid regulations including the recipient's freedom of

[34] Federal regulations at 42 CFR 431.53 require: *"A State plan must: (a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement."*

choice of providers and a limitation to only pay for services after they have been provided.

2. Administrative Service. As an administrative service, transportation expenditures may include the use of vendors, reimbursements to recipients, direct payments to providers or other arrangements. Medicaid costs under this method have a FMAP of 50% allowing for more flexibility, due to not being subject to the freedom of choice or prepayment constraints.

Because of the lower FMAP involved with administrative services classification, there is an incentive for states to classify nonemergency transportation as another medical service rather than an administrative service. With the high and increasing costs involved with nonemergency transportation an alternative classification may be preferred. Given the greater administrative flexibility, even with a reduced FMAP, it may be cost effective to pay for nonemergency travel as an administrative expense. Specifically, reclassification of transportation as an administrative service would allow DMA to:

- Purchase discount airfares from major carriers using advance purchase options,
- Encourage provider participation through prepayment of services,
- Negotiate rates with transportation providers,
- Utilize the least costly providers within each geographical area and category.

Cost savings may be realized by using the services of a contract travel broker or additional staff to aggressively manage nonemergency transportation on a day-to-day basis. Even if state funds involved in Medicaid are slightly higher, the agency may be able to utilize the same broker or staff to realize savings in other departmental programs with extensive travel costs such as the Division of Family and Youth Services and the Division of Juvenile Justice.

We recommend that the Director of DMA research the available, federally-supported alternatives to transportation management. Specifically, we recommend that DMA conduct a cost-benefit analysis of administrative services option for nonemergency transportation to determine if state funds could be saved through utilizing the flexibility and cost-saving benefits this option provides.

Recommendation No. 5

DMA's director should direct resources to assist the Provider/Recipient Review (P/RR) section to develop a comprehensive case management system to better manage the operations of this important internal review function.

As discussed previously in the conclusions section of this report, the P/RR unit of DMA is overwhelmed by a backlog of both computer-generated program integrity information and

complaint referrals from internal and external sources. The unit lacks the capability to link information on complaints, cases, other investigations, and policy research. This impairs their effectiveness in investigating and monitoring abusive providers.

Because P/RR investigations are not captured on a comprehensive case tracking system, it is impossible to determine the extent or status of their investigation on any given case. While the SURS section at First Health is responsible for tracking information as a condition of their contract, their obligation is confined to tracking the work they do and does not include tracking work performed by DMA or other contractors. Therefore, their case tracking database is inadequate and incomplete.

The P/RR personnel lack the expertise to develop an effective database or case management system on their own. They have reportedly been unable to secure the necessary services from knowledgeable personnel located in other sections within DMA. The division should either reallocate current personnel resources or pursue an outside contractor to develop an integrated case management system. DMA should also ensure that P/RR personnel are adequately trained to effectively utilize the system for investigatory and monitoring purposes.

Recommendation No. 6

The director of DMA should carry out a comprehensive risk assessment to estimate the level of improper Medicaid payments that may be associated with different types of services and providers.

A strong system of internal controls over a claim payment system like Medicaid would typically involve a risk assessment. Such a risk assessment would be used to determine what payments have the greatest likelihood of being made improperly. The results of the risk assessment would serve as a basis to design appropriate, cost-effective safeguards and controls. Such safeguards and controls would be incorporated into the payment processing system, involving both electronic data and manual processing procedures to better ensure payments are supported, as well as being consistent with state and federal regulatory requirements.

In recent years, several states have attempted to estimate the percentage of Medicaid dollars lost to improper payments through innovative payment accuracy studies. Illinois conducted a payment accuracy study in 1998 and estimated a payment error rate of about 5%. In 1998 and again in 2000, Texas conducted payment accuracy studies and estimated overpayments of about 7%. In 1999, Kansas found an overall payment error rate of 9% to 24% (depending upon whether a claim for which the provider might have complete documentation but failed to mail it in was counted as an error). At the federal level, the Medicare program has been performing annual estimates of erroneous payments since 1996, and has estimated improper Medicare fee-for-service payments of about 7% in FY 00.[35]

[35] It is essential to stress that these measurements are of payments errors, not measurements of fraud. Certain kinds of fraud, such as falsification of medical records, probably would not be detected through current methodology.

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

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

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

Recommendation No. 7

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

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

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

---

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

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

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

Recommendation No. 8

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

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

Prepayment Review

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

State regulations list prepayment review as one of a number of sanctions that DMA could impose, either separately or in combination, on a given provider. This does not limit DMA's authority in conducting prepayment review only as part of a formal sanction action. Provider policy 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.

---

[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. …

When DMA did do prepayment review of claims, the action was done in conjunction with what is termed a Resubmission Turnaround Document (RTD) used by FHSC to request supporting claim documentation. This is no longer being done ─ resulting in the loss of both a valuable quality assurance check and cost-effective control procedure.

Other administrative remedies

In addition to lack of prepayment review, DMA rarely uses other administrative remedies in addressing problem providers. It appears that, typically, such providers may be sent an education or warning letter and may be asked to voluntarily remit overpayments and/or conduct a "self-audit."

Such actions, along with the reluctance to carry out prepayment review, create an atmosphere of tolerance for providers' abusive and potentially fraudulent billing practices. This situation increases the risk that the Medicaid program is inadvertently paying providers who are engaging in abusive billing and/or medical practices. For instance, if DMA is paying for narcotics knowingly prescribed to recipients who do not legitimately need them, but who are either addicted or illegally distributing the narcotics, the recipients as well as the community at large is put at risk.

DMA management has made it clear that they are primarily concerned with encouraging provider participation, satisfaction, and retention. While we agree that this is important, it should by no means prevent DMA from appropriately safeguarding Medicaid funds. It is not the unscrupulous provider that DMA should strive to satisfy or retain. In situations where recipient-access to medical services is an issue, such as in remote communities, DMA could allow problematic providers to continue to participate in the Medicaid program by utilizing compliance agreements and closely monitoring performance.

When providers abuse[39] the Medicaid program, DMA should judiciously apply appropriate sanctions with due notice. However, DMA should not hesitate to implement prepayment review to ensure that all elements such as medical necessity, prior authorization, and appropriate prescriber numbers are consistently evident for claims involving suspicious or randomly selected providers. Alternatively, as discussed previous, such reviews can be done on "high risk" procedures or claim types on a rotating basis. DMA management should support these critical program integrity functions, and make it clear throughout the Medicaid program that the submission of inaccurate and invalid or unsupported claims will not be accepted.

Recommendation No. 9

[39] Federal Regulations at CFR 455.2 define "abuse" as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare."

DMA's manager of the provider and recipient review unit should improve the confirmation of service provision process and utilize the process to monitor providers in a risk-based manner.

Currently, as required by federal regulation, each month DMA attempts to verify, with selected recipients, that these individuals have received the services for which Medicaid is being billed. The agency uses what is termed a recipient explanations of medical benefits form, or REOMBs, to carry out this verification process.

As discussed in the conclusions section of this report, the way in which REOMBs are being used is of limited value. Few REOMBs are returned by recipients, and those returned are usually done so in error. Recipients find the current format difficult to read and confusing, and they are given no contact phone number on the form. When recipients have questions regarding their REOMB, they tend to call their service provider which renders the process ineffective for monitoring purposes. Due to these various problems REOMBs contribute little to program integrity efforts and DMA's Provider/Recipient Review unit considers returned REOMBs a low priority.

DMA should utilize the REOMB process in a more strategic manner. DMA should improve the readability and format of the REOMB. DMA should also include a telephone number for recipients to contact the division if they have any questions and, when called, encourage recipients to return the forms confirming (or not) whether they did indeed receive the service. DMA should develop a more targeted, risk-based approach to selecting recipients that are to receive REOMBs. DMA could target recipients of specific services (e.g., lab tests, x-rays) or who received services from a particular type of provider (e.g., dentist, taxi cab) that has been identified as high-risk. These improvements to the REOMB process could greatly enhance its effectiveness in promoting overall program integrity.

Recommendation No. 10

DMA Medicaid policy administrator and DMHDD's program administrator should address home and community-based (HCB) agency payment rate issues to ensure costs paid are reasonable and contained.

As discussed in the background information section, the MRDD waiver is the largest of the four HCB waivers. With 867 covered developmentally disabled individuals, the MRDD waiver represented 57%[40] of the Medicaid program's FY 02 HCB waiver expenditures. As shown in Exhibit 6 on page 39, costs for the MRDD waiver are increasing at a much greater rate than the number of waiver recipients.

Our review of HCB expenditures for habilitation services indicated that service providers are paid at levels of service higher than provided. As discussed in the report conclusions, this is

[40] The four home and community-based waivers expenditures exceed $89 million for FY02. The MRDD waiver represents over $51 million of the $89 million (over 57%).

because the service providers are being paid at a daily rate which is based on projected work hours anticipated to be involved with a given service.[41]

This billing practice is consistent with state regulations for HCB services. The level of service is calculated on a daily basis, using a projected number of work hours involved. This is translated into a daily charge and billed at what is called a "bundled" rate. The bundled daily rates represent varying service configurations which include direct service costs and indirect costs anticipated to be provided to each recipient each day.[42] If fewer hours in a day are spent with a recipient than those projected, the provider has the option to bill for one day unit, or nothing.

Federal guidelines require that reimbursed expenditures be reasonable.[43] These same guidelines, in discussing wages, specifies that budget estimates or distribution percentages, determined before the services are performed, do not qualify as support for charges to federal awards but may be used for interim accounting purposes. Additionally, federal financial participation is available for medical care or services provided.[44]

DMHDD is aware of concerns about how waiver rates are calculated and services delivered in context of federal guidelines. The agency has contracted for a cost study to identify the major cost element involved in various types of waiver program services. After completion of the study, the intent is to compare the costs of services across service categories, providers, regions, living arrangements, and other data elements. DMHDD and DMA should use these results to reform the rate setting mechanism for MRDD waivers.

---

[41] The recipient's plan of care establishes the authorized number of units (days) of service to be provided over the year. For reimbursement, the HCB provider calculates the amount of reimbursement in a waiver year for each unit of a particular waiver service, which is based upon the total number of units of services authorized for that waiver year.

[42] 7 AAC 43.050(f) . . . *The amount of reimbursement for a unit of a particular service is determined by multiplying the **projected** total allowable direct service costs of providing that service to the recipient during the waiver year by the sum of one plus the provider's approved administrative and general cost rate under 7 AAC 43.1060 and dividing the product by the total number of units and services authorized for the recipient for the year.* [Emphasis added.]

The direct rates may include: salaries, annualized hourly wages, contract labor payments and stipends for direct care staff; travel costs for recipients and providers; and the costs of items or services purchased for recipients necessary to carry out their approved plans of care.

[43] A cost is reasonable if it does not exceed that which would be incurred by a prudent person under the circumstance prevailing at the time the decision was made to incur the cost.

[44] 42 CFR 435.1002

While considering rate setting reforms, we recommend DMA and DMHDD address issues identified with the HCB bundled daily rates paid to providers as follows:

1. Charging an hourly, bundled rate for direct service provided on behalf of a recipient for residential habilitation services such as supported living, in-home support, and shared care; for day habilitation; and for supported employment.
2. Requiring a reconciliation between services projected and services provided (also know as "true-up") for daily "home" costs such as group home and foster care or placing a daily upper limit in regulations.
3. Any daily costs' underage or overage, involved in the services funded by rates, should be adjusted in the subsequent period's rate.
4. Requiring standardized service configurations.

This will require DMA and DMHDD to modify and expand regulations to better address service costs and federal requirements of Medicaid, and more specifically, HCB waivers.

Recommendation No. 11

DMHDD program managers should adopt regulations requiring the business relationship between the care coordinators and home care community service agency providers are maintained at arm's length.

During FY 02, for the MRDD waivers, 138 of the 140 care coordinators[45] involved in developing the recipients' plans of care were employed by one of the 20 homes and community-based service providers[46] (HC providers). The care coordinators (CC) have many responsibilities, such as assisting applicants in completing an application for services, assisting with level of care assessment, establishing and coordinating the case planning team, developing a comprehensive plan of care, providing ongoing care coordination, and annually reassessing the level of care and plan of cares.

Part of the care coordinator's duties in developing the plan of care is set out in state regulations.[47] CCs must determine the types of services to be provided by specific providers, and the frequency, amount, projected duration, and projected cost for each service. Based on

[45] 7 AAC 43.1110(3) "care coordination services provider" means a provider that is certified by a managing state agency under 7 AAC 43.1090(e) to provide care coordination services as stated in 43.1110(4) "care coordination services" means services that assist recipients to gain access to needed medical, social, educational, and other services and includes screening, assessment, care plan development, care plan implementation, including routine monitoring and support, care plan revision, and case termination, and reassessment.

[46] 7 AAC 43.1110(14) "home and community-based services provider" means a provider that is certified by a managing state agency under 7 AAC 43.1090(e) to provide one or more of the following home and community-based waiver services: chore, adult day care, habilitation, respite, waiver transportation, meals, and environmental modifications.

[47] See 7 AAC 43.1030(c)

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.

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

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

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

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

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

Recommendation No. 12

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

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

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

[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.

in the undermining of fraud investigation efforts, circumventing of payment edit controls, and deemphasizing internal quality assurance efforts also threaten accessibility.

DMA staff are motivated by the desire to expedite payments to providers and keep a positive working relationship with the provider community. We were reminded of measures set out in legislation also speaking towards this motivation and desire. The missions and measures for the Division of Medical Assistance states, in part, that *"the legislature intends to measure the success of the division in achieving its mission by considering*

> *(1) the average time the division takes from receiving a claim to paying it;*[51]
>
> *(2) the percentage of claims with no errors categorized by type of provider;*[52]
>
> *(3) the percentage of total funds that are used to pay claims compared to the percentage used for administration of the division;*
>
> *(4) the percentage of providers who are participating in the medical assistance program by region.*[53]

Each of these measures contributes to an agency culture that: (1) focuses on paying providers as soon as possible and avoiding edits or reviews that might slow payments; (2) keeping the administrative costs involved in reviewing claims aggressively to a minimum; and, (3) reluctance to purge any provider from MMIS, even though they may not have submitted a claim in over year.

Maintaining a balance between healthcare services and control over the payments for such services is vital to ensure the continued effectiveness of a program. Between FY 99 and FY 02, program costs increased annually by 16%, 24%, and 21% respectively. Although we realize that some of these costs are related to cost shifting from general to federal funds, there has also been a significant increase in the cost for services.

We suggest the legislature could contribute to a change in "culture" of DMA. By amending the agency's mission statement, and adding additional measures evaluating the effectiveness of various control procedures, the legislature could bring more balance to the agency's perspective. We suggest that reasonable access could be maintained while at the same time improving the controls over Medicaid payments. By amending the mission and measures for the agency, that are consistent with this objective, the legislature could play an important role in maintaining the balance between accountability and accessibility.

---

[51] Current budget documents report DMA pays claims, on average, in just over 11 days. If management is concerned that this figure would be adversely affected by improving controls and edits related to claims, it should be noted that for general "goods and services" AS 37.05.285(a)(2) allows the state to make payment "*within 30 days after receipt of a* ***proper*** *billing*…[emphasis added]*"*

[52] From a review of DMA's underlying budget reports, it seems the agency views this measure a way to quantify its provider outreach and education efforts.

[53] See part (b) of both Section 82, Chapter 126, SLA 00 and Section 78, Chapter 90, SLA 01.

(Intentionally left blank)

AUDITOR'S COMMENTS

The Medicaid Fraud Control Unit (MFCU) can be a powerful control over minimizing fraud and abuse of Medicaid funds. As discussed in this report in recent years certain actions, or in some cases inactions, by the Division of Medical Assistance (DMA) has compromised some of the unit's efforts. Additionally, in recent years the unit has not been fully staffed.[54]

USDHHS Office of Inspector General (OIG), in addition to the State Attorney General, have some oversight responsibilities for the State's MFCU function. The OIG has expressed concern about the operations of MFCU and the understaffing of the unit. The Director of the OIG Medicaid Oversight Staff stated he felt it would be very difficult for Alaska's MFCU to pursue additional patient abuse and neglect cases because the unit was currently *"operating at a bare-bones minimum of staff and resources."*

As the Department of Health and Social Services, Department of Law, and the Legislature considers the role MFCU should play in the Medicaid program, we suggest the items listed below be addressed in the following order of priority:

1. Provide stronger statutes and regulations related to prosecution of Medicaid fraud (See Recommendation No. 12),

2. Improved communications between DMA and MFCU regarding the development of DMA regulations and results of DMA's program integrity efforts, and

3. Conduct an analysis of the cost/benefit and workload to determine if additional funding of MFCU is warranted.[55]

Other areas that can improve the effectiveness of the unit include MFCU's participation in DMA meetings of the drug-utilization review committee.

Currently, the MFCU function is not being fully utilized. The discussion here is intended to summarize and offer our perspective on the priorities regarding the changes necessary to improve the unit's effectiveness. In the short-term, improved statutes, better collaboration with DMA, and a commitment to complete staffing, are necessary steps to enhance MFCU's operations. Such enhancements are critical for effective management of the State's Medicaid program.

[54] Only 71% of MFCU's original allocation was spent on Medicaid fraud areas. The remaining general fund portion of MFCU's budget was reallocated and spent by other sections within the Criminal Division.

[55] At the current funding levels the State has not maximized the Medicaid funds available for MFCU activities. This category of Medicaid funds requires only a 25% match in state funds.

(Intentionally left blank)

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Office of the Commissioner

Frank H. Murkowski, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX (907) 465-3068

March 26, 2003

Ms. Pat Davidson
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 11330
Juneau, AK 99811-3300

Dear Ms. Davidson:

RE: Department of Health and Social Services
Division of Medical Assistance
Internal Control Over Medicaid Payments
Audit Control Number 06-30018-02

Thank you for the opportunity to respond to the findings and recommendations developed by your division during the conduct of a special audit as requested by the Legislative Budget and Audit Committee.

The department's written reply to the findings and recommendations follow.

Sincerely,

Bob Labbe
Deputy Commissioner

ORGANIZATION AND FUNCTION

The audit report on pages seven and eight notes the agencies and organizations that impact the direction and delivery of healthcare benefits to eligible low income Alaskans by providing guidance, policy, funding, and eligibility determinations.

All fifty states are grappling with budget deficits and the toughest financial challenges in decades, driven in nearly every state by increasing Medicaid costs. A goal of this Department is to find ways to continue to deliver vital health and social services to Alaskans in a time of declining state revenues. This challenge is also an opportunity to rethink how the Department conducts its business, and to find new ways to finance its operations and ensure delivery of effective customer service. The task before DHSS is to bring financial stability to the Department's operations.

DHSS will be reorganized to maximize alignment of program and budget responsibilities with the entities whose customers are the major users of the services. The reorganization will:

- Reduce general fund expenditures
- Focus on access to services within the community
- Be responsive to customers; and
- Assure a balance of quality and cost effectiveness of services

Within the Commissioner's Office, a new Office of Program Review is being established to:

- Coordinate and manage DHSS efforts to enhance services for Alaska Natives;
- Assure that each division contains a program integrity function aligned with DHSS priorities
- Balance quality and cost effectiveness in service delivery
- Coordinate and streamline functions of the department to integrate services and provide a seamless delivery system

The major themes of the DHSS restructuring are:

Financing

Key to cost containment and streamlining is the restructuring of Medicaid financing and programmatic responsibility in the Department. To achieve this goal, the following actions are necessary.

- Move senior services to the department to allow refinancing under Medicaid and combine long term care programmatic and financial responsibility for the elderly and disabled. This will provide:

  - A single point of entry to promote a cost effective continuum of care for the most vulnerable populations, from application for assistance to authorization of services.
  - Management of service delivery from community care to institutional placement that emphasizes customer choice.
  - Allow the Department of Administration to focus on core government support services.

- Consolidate mental health and substance abuse services within one administrative section that will control the program policy and financing of those services. This will create:

  - Integration of services at the community and service level to increase partnerships of the state and communities.
  - A seamless delivery system with a more comprehensive array of services and better treatment outcomes.
  - A combined infrastructure to simplify administrative activities and better serve the many Alaskans will co-occurring disorders.

- Combine state services for children and the promotion of well being of families into a single administrative entity. This will result in:

  - Consolidation of child protection, foster care, adoption and an array of services focused on family support and the well being of children to solidify the commitment to building for the future.
  - Transfer of management of behavioral rehabilitation services to support effective treatment for troubled children at the community level.

Streamlining

- Focus Public Health on core functions, homeland security and capacity development of the health care infrastructure. Supporting arguments include:

  - Disease control and prevention and the protection of public health, including biological, chemical and radiological attack are essential to prepare Alaska for any eventuality.
  - Consolidation of health planning, Certificate of Need (CON) and health care infrastructure development will promote development of a well integrated system of appropriate levels of care in Alaskan communities.
  - Licensing, quality assurance monitoring and investigative functions for all institutional and community services will be integrated into a single unit to promote effective use of trained staff in ensuring safety.

- Manage health care policy and payments for services provided to individuals with programs aimed at clinical effectiveness, quality and program integrity:

  - Efficient management of health care funding is promoted by balancing outcomes with quality assurance.
  - Provider relations focus on outcomes and quality care while promoting sound financial management of limited resources.

- Enhance family self sufficiency by consolidating outreach and enrollment efforts, and child care funding with eligibility for assistance to support individuals entering or remaining in the workforce.

  - Streamline efficiency by reducing the number of applications and offices a busy family need deal with and give caseworkers access to all resources a family needs.

- Combine rate setting oversight for all department services within one unit with the experience to assure that adequate payment is available for efficiently operated services.

BACKGROUND INFORMATION

1. On page ten of the audit report you note: "Administration of Medicaid puts the State in the position of a health insurance company. DMA is involved in receiving claims for payment from a variety of service providers who have ostensibly delivered goods and services eligible for reimbursement to the program's beneficiaries – more typically referred to as recipients."

The Department questions whether insurance companies typically perform the level of program integrity activity suggested by Legislative Audit. Since the Department's competitors for the supply of health care providers are insurance companies, a comparison of the integrity activity required under the state's contract for state employee health insurance, for example, or an insurance provider like Aetna, would be most informative.

Home and Community-Based Waiver Programs

1. On page thirteen of the audit report you note: "Due to the number of individuals requesting HCB waiver services under the MRDD and CCMC waivers, DMHDD maintains the waitlist. Individuals requesting services have to initially apply for Medicaid services, where their financial and Medicaid eligibility is determined by DPA. They are then enrolled with the DMA. Additionally, the individuals complete documents requesting services and a waitlist criteria assessment."

The Department wishes to advise the auditor that, under DMHDD policy, waitlist individuals do not have to apply for Medicaid until their names are selected from the waitlist. They may be encouraged to apply for Medicaid prior to selection, as it can pay for regular medical services they may need.

REPORT CONCLUSIONS

1. On page fifteen of the audit you state: "Our central conclusion is that the internal controls related to a significant segment of the payments made under State's Medicaid program are weak."

The Department believes internal controls within the Medicaid system protect the integrity of the financial payment process and support the policies and procedures of the Division of Medical Assistance.

The data processing system that evaluates claims presently conducts 561 unique evaluations for validity and integrity that are performed on up to twenty-four different types of claims. The combination of these claim edits, types of claims, and media (paper, electronic or adjustment) results in thousands of individual active prepayment evaluations within the claims processing system.

Of this, every type of claim processed is subject to at least 130 unique edit checks. These checks include the evaluation to verify:

- eligibility of the beneficiary
- eligibility of the provider
- dates of service
- timely filing
- covered benefits
- claim billing requirements

While the evaluations described above exist for every claim processed, there are an additional 431 unique checks within types of claims to evaluate for specific program rules. These include service limits, authorization requirements, pricing standards, health industry standards (Claim Check), and duplicate relationships.

In FY 02, five service categories[1] represented 70% of the Medicaid program expenditures. In addition to the 130 checks applied to all claims, up to 150 unique checks actively evaluated claims for these five service categories. Each item billed in these five categories had a minimum of 205 evaluations performed by the data processing system. The combination of these unique edits, types of claims, and media resulted in thousands of individual evaluations within these service categories.

There is no other more cost effective method of ensuring appropriate payment than the automated validation and integrity evaluations performed by the data processing system. Though other methods such as post payment review are used to identify inappropriate payment, this is the most cost effective method. Even though existing post payment review

[1] Five service categories: Inpatient Hospital, Nursing homes, pharmacy, physician services, waivers.

activities in place in the program provide additional controls, the prepayment processes described herein provide a solid foundation of controls and protect the integrity of the financial payment process.

While the Department concurs with the concept that there is opportunity in any organization to improve efficiencies and cost effectiveness, it would also ask that this finding be put in perspective. The scope of this audit was on control procedures over payments made. This is only part of program operation. The Department is constantly challenged to balance its resources to administer all components of its operation effectively, and acknowledges some weaknesses could be found in almost any area of operations. Improvements in one area need to be evaluated relative to the benefits of improvements made in other areas of the program. Over the last decade, the Department has administered the Medicaid program with almost no per capita growth in state general fund spending. Given its mission, this outcome suggests that its priorities, while perhaps not perfect, have been reasonable.

A number of comprehensive, rigorous, and far-reaching administrative data processing controls and analyses are also missing from this audit conclusion. Such controls and analyses include updates and security measures resulting from Y2K, ongoing implementation of the federally mandated Health Insurance Portability and Accountability Act (HIPAA), and the Department's recently concluded efforts to reprocure a new and more technologically advanced MMIS system.

The department's philosophy and operating style remain focused on striking an efficient balance between accessibility to health coverage for Alaskans in need, and timely and accurate reimbursements to those who provide those services while being financially and fiscally responsible. The Department wishes to further point out that the performance measures for the Division of Medical Assistance, as set in statute by the legislature (Ch 90 SLA 2001, sec. 78(b)(1)), conflict with and appear to conspire against the Department's efforts to further strengthen the Medicaid program's control environment. These include:

- Measuring the average time the division takes from receiving a claim to paying it
- Measuring the percentage of claims with no error categorized by the type of provider
- Measuring the percentage of total funds that are used to pay claims compared to the percent used for administration of the division
- Measuring the percentage of providers who are participating in the medical assistance program by region

Legislative Audit's recommendations to maximize system edits and controls wherever and whenever possible would assure the Department's inability to comply with these legislatively mandated performance measures.

2. On page sixteen, number two of the audit you state: "Administrative data processing controls are being ignored. The data processing system that generates payments uses an elaborate structure of edits to evaluate claims. The objective of these evaluative edits is to provide assurance the claim is legitimate and consistent with state and federal regulations, as

well as established healthcare standards. DMA through practice and policy has weakened the effectiveness of many of these edit checks."

As noted above in the Department's response #1, the data processing system that evaluates claims presently conducts 561 unique evaluations for validity and integrity that are performed on up to twenty-four different types of claims. The combination of these claim edits, types of claims, and media (paper, electronic or adjustment) results in thousands of individual active prepayment evaluations within the claims processing system.

The Department strongly believes the cost/benefit of additional internal controls must be compared to the cost/benefit of other program activities and improvements. DMA has new statutory obligations to meet (HIPAA, the addition of breast and cervical cancer coverage), competing program improvements (new MMIS), and budget considerations (IHS claiming, Pro-Share, etc.). To fail to consider the benefits of internal controls in relation to the benefits of other items would be to operate a medical assistance program to support a program integrity program, not the other way around. The Department also believes Legislative Audit, in its findings and recommendations, has not consistently applied a cost effectiveness test to all of its criticisms of edits later on. The Department notes that not all of the problems identified have been evaluated to see if improvements to internal controls are in fact cost effective.

The Department also strongly disagrees with the statement that DMA policy and practice have weakened the effectiveness of edits. While the system is configured with a standard that lists each edit for every claim type, the edit flags or edit dispositions are only set for those claim types or services for which the particular edit is intended. The division is not failing to apply these edits to certain claims. The division applies the edits only to claims for which the policy is applicable. In some cases the system logic has been programmed only for certain providers or services. While it may appear that the edit would be applied if it was turned on, this is not the case. Subjecting some claims to additional edits would require programming logic changes and in many cases a change in policy or regulation to support this action. The resulting cost benefit of many of these changes may be negligible.

3. On page sixteen, number three of the audit you state: "Insufficient controls over nonemergency transportation. Many of the controls in this area are designed to contain transportation costs. There are a number of problems involving the application of controls over non-emergency transportation. There were many transportation claims paid without a related medical claim involved. Some travel costs appear to be unreasonable, while an established control procedure such as prior authorization, is applied in such a way **as to be of limited value.**" [Emphasis added.]

The Department notes it is not a requirement that every transportation service have a related medical claim. For example, the service may not have been billed yet, another insurance may have paid for the medical service but not the transportation; the transportation was for follow-up or post-operative care which was included in the treatment cost; the servicing provider may not be enrolled in the program; the service itself may have no charge to the

program (e.g., Shriners Hospital); the medical service may not have been provided yet, as in the case of a patient awaiting delivery. DMA defines "reasonable transportation cost" as the cost for the same service to the general public.

All non-emergency transportation services require prior authorization. The process requires the medical practitioner requesting the service call FHSC and certify the medical need for the travel. Authorization is given only to the extent justified by the client's medical need. This includes destination, mode of transportation, need for overnight accommodations, number of service units authorized, and approval for escort services. The Department believes this process is a valuable control procedure.

The Department thus disagrees with the general statement that prior authorization is applied in such a way as to be of limited value.

4. On page seventeen, number two in the audit you state: "Lack of effective coordination between DMA and Medicaid Fraud Control Unit (MFCU). In recent years, two DMA policy decisions have adversely affected MFCU investigations. Additionally, vague DMA policies and regulations impede MFCU investigatory efforts."

The Department does not agree there is a lack of effective coordination between the Department and MFCU. The MFCU and the Department have executed a detailed cooperative written agreement to describe coordination activities, and staff from both agencies interact very frequently and share information. Preliminary audit reports from the Deloitte and Touche contract were shared with the MFCU staff even before the reports were reviewed internally or shared with the audited provider. The units have formal monthly meetings where current cases are discussed, and FHSC and SURS staff is invited to share reports and concerns. The units have cooperated on settlements with Department staff testifying in support of findings adopted by MFCU. Most recently the MFCU and Department staff have agreed to work together to facilitate collections, even in instances where fraud does not exist.

CONCLUSIONS SECTION 1 – REVIEW AND PROCESSING OF CLAIMS BY DMA & FHSC

DMA controls over provider enrollment are weak and/or inconsistent with federal regulations

1. On page seventeen, number one of the audit you state: "Provider enrollment procedures are not in compliance with federal regulation."

The Department is complying with disclosure requirements at 42 CFR 455 relating to ownership interests, business transactions over $25,000 per year, and criminal convictions. These regulations specify that certain providers are required to comply with requests about ownership and control and all providers agree to comply when they sign the Medical Assistance enrollment agreement. Penalties are imposed if providers fail to comply with a request for information.

A "disclosing entity" is a Medicaid provider or fiscal agent. Individual practitioners or groups of practitioners, whether they are organized as partnerships or corporations, are not regarded as disclosing entities and are not subject to the requirements of this section. (FR V. 44 No. 148, 41638). For "disclosing entities" that are "subject to periodic survey", DMA requests and receives this information during each survey and renewal before certification is finalized. Facilities are surveyed according to a timeline specified by Congress in the Budget Call Letter for Survey and Certification. In addition, JCAHO-certified facilities send disclosure information directly to CMS as a condition of certification.

The Department will seek further legal review to clarify the federal requirements, remediate activities as necessary, and take any actions necessary to assure full compliance with federal requirements.

2. On page eighteen, Exhibit 1 in the audit you state: "The applicant must disclose the identity of any person associated with the enrolling provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid.[2]"

The Department is in the process of updating the Medical Assistance Enrollment Application. A section will be added requesting providers to disclose owners, individuals with controlling interests, agents, or employees having any criminal convictions relating to Medical Assistance, Medicare, any health related business, or federally funded health or social program. Additionally, the Department will update its enrollment procedures to comply with reporting requirements to any applicant answering positively to this section. Lastly, the Department will insure a provision is included in the new fiscal agent contract to add any individuals disclosed here be listed on the MMIS under the providers on-line file in order to accommodate automated matching against the OIG exclusion list.

3. On page eighteen in the audit you state: "Our review of 20 provider agreements and files indicate that DMA does not require, or obtain, any of the above disclosures prior to enrollment of Medicaid providers. Of the files reviewed, only one contained evidence of DMA confirming that the provider was not on the OIG exclusion list[3] at the time of enrollment…Failure to obtain complete disclosure of ownership and control interests diminished DMA's ability to verify that individuals and entities are qualified to participate in the Medicaid program. As a result, DMA's provider enrollment process is not in compliance with federal regulations."

The Department notes that prior to this audit, it had revised its procedures relating to providers excluded by the Office of the Inspector General. FHSC verifies that any provider

---

[2] Federal regulations at 42 CFR 455.106 specifically requires disclosures at time of original or renewed provider agreement that disclosures include any person *"who has ownership or control interest in the provider, or is an agent or managing employee of the provider"* who has been *"convicted of criminal offense related to that person's involvement in any program under Medicare, Medicaid, … since the inception of these programs."*

[3] The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.

requesting enrollment is not listed on the OIG exclusion list. This list is available via the OIG website. Additionally, the OIG list is reviewed and matched monthly against the complete active provider enrollment file. Any provider found on the OIG exclusion list is inactivated immediately. Additionally, the Department identifies any claims paid after the date of exclusion, and initiates recovery. Lastly, the Department notifies the OIG of any funds paid by the Alaska Medical Assistance Program after the date of exclusion. Under the new fiscal agent contract, portions of this process are to be automated to minimize the chance for manual error.

4. On page eighteen, number two in the audit you note: "Ineligible providers are enrolled in the Medicaid program."

The Department has its fiscal agent (FHSC) provide monthly updates to the provider occupational licensing fields. Additionally, the Department has requested a report be produced monthly that will enable the Department to identify providers who licenses have been suspended or temporarily inactivated. Upon receipt of this information, the Department will manually inactivate the providers from participation as indicated. Suspended licenses found during the legislative audit process will be updated in the MMIS appropriately.

It is important to note that the new MMIS system, currently under contract negotiations, includes the appropriate functionality to update the data fields and will read these fields as a part of the adjudication process.

5. On page nineteen in the audit you note a lack of a formal protocol with the Department of Community and Economic Development, Division of Occupational Licensing (OccLic) regarding updating of licensing file: "No formal Memorandum of Understanding (MOU) exists between the Department and OccLic that sets out a protocol regarding how OccLic should communicate with the Department or FHSC staff when a professional's license is suspended. Additionally there is no formal schedule established for regularly updating and cross-checking the MMIS file of approved licensed providers and OccLic's database."

The Department initiated discussions with the Division of Occupational Licensing over four years ago to improve the automated interface used to update the on-line MMIS provider file. A Memorandum of Understanding (MOU) was drafted and sent to OccLic for their review and approval. The Department understands that MOU has subsequently been referred by OccLic to the Department of Law for review.

6. On page nineteen of the audit you note: "No signature is required from a principal care provider(s) at time of enrollment."

The Department is working to clarify policy and procedure regarding "authorized representative" signatures. The Department plans to re-enroll all providers during the new procurement of the fiscal agent contract. New signatures will be obtained from all providers at that time.

7. On page nineteen, number three in the audit you note that non-participating providers are not regularly inactivated in MMIS.

The Department must maintain provider on-line files in order to maintain claims history, thus on-line files are not purged. However, the Department agrees that providers could be placed in an "inactive" status after twenty-four months, not twelve months as recommended by Legislative Audit. Many providers, especially specialists, may only see Medicaid clients occasionally, sometimes only once per year. A significant number of providers, primarily specialists critically important for the adequate delivery of specialty services to Alaskans, who are enrolled in Alaska's Medicaid program do not in fact practice in Alaska. Their practices are based in out-of-state hospitals and health facilities. The Department finds no merit in requiring such providers to enroll each time they see a Medicaid client, supporting the recommendation for the twenty-four month inactivation policy.

The Department will also request its fiscal agent FHSC to perform annual verification of the provider file information. In addition, the Department will include in its regular provider training program information regarding the provider's obligation to protect their provider number from unauthorized use.

The Department agrees a control weakness would exist if enrolled providers did not act responsibly and exercise appropriate controls over their assigned provider numbers. The Department also asks the auditor to share with the Department any information it may have regarding specific cases of such abuse.

8. On page twenty in the audit you state: "Some administrative controls in MMIS and payment subsystems are circumvented or ignored." You also state that the Department has established a weekly goal of having no more than 30% of claims "pend" or be rejected for payment through what is termed the adjudication cycle.

The Department disagrees with the statement that it strives to pay 70% of the claims each week. This information was obtained from the Department's systems staff that uses the 70 % as a benchmark to identify system claims processing errors or programming errors. This is not used by department policy staff responsible for determining the edit dispositions. Department policy staff does not intentionally ignore valid edits in order to expedite claims payment. The application and use of edits and edit dispositions is subject to ongoing review and revision. They may be revised due to a change in policy, a change in processing, a change in service delivery etc. There has never been an intention to continually subject all claims to all of the original edits and edit dispositions that were established 15 years ago.

9. On page twenty-one, number one in the audit you state: "MMIS edits have been assigned an inappropriate disposition action inconsistent with proper evaluation of claims." You also state the Department's policy of how to set or handle these edit controls prevents the agency from effectively assuring if the DME billed and paid is medically necessary.

The Department offers the following comments on edit 121 (Prescriber Missing) and edit 122 (Prescriber Invalid).

These edits were established specifically for claim type 9 and not claim type 10 (Durable Medical Equipment). The Department disagrees that requiring the prescribing physician number on the claim is the only effective way to insure medical necessity for DME. While system edits are used to insure compliance with program guidelines, other methods are utilized effectively. All DME claims are subject to post-payment review activities. Some DME services require authorization before payment is made; some services are reviewed for medical justification before the claim is paid. Additionally, the Department is already in the process of revising the provider billing manual to include more specific coverage guidelines for DME and medical supplies.

10. On page twenty-two, number two in the audit you state: "MMIS and Point-of-Sale (POS) pharmaceutical edits have been assigned a disposition action inconsistent with proper evaluation of claims."

The Department offers the following comment on edit 389 (Invalid Prescriber for Primary Recipient).

The Department turned edit 389 to deny right after the edit was designed. However, there were too many false denials with claims denied for the edit. The false denials were the result of patients appropriately visiting specialists while under the care of a primary care giver. There needed to be an override capability. The Department only recently developed an override capability that would allow appropriate referrals, while appropriately denying prescription claims from non-referred prescribers. The Department plans to turn this edit to deny and have an appropriate override procedure in place within the next few months.

11. On page twenty-two in the audit you state that edit 122 (Prescriber Invalid) does not properly evaluate the prescriber number for pharmacy claims submitted through POS.

The Department disagrees with the statement regarding edit 122 for Pharmacy. [Reference Table 1.] The disposition of the edit shows the edit is fully applied for Pharmacy POS claims. When the pharmacy bills in an online environment there is an opportunity for the pharmacy to change the prescriber ID if the edit denies the claim.

The disposition of this edit was changed to deny in April 2000 to require those submitting non-POS Claim Type 9. However, the Department found this disposition of the edit improperly impacted Medical Supply billers and required them to obtain additional information that held up claims payment. When the Department noted how many billers were being adversely impacted, the Department re-set the edit for Non-POS billers to Test.

TABLE 1

```
AK31 I 122                      ERROR TEXT FILE                          PAGE 1
ERROR CODE: 122          REJ: N   DENY: Y   RES. OVERRIDE: N   PA OVERRIDE: N
S. DESC.: PRESCRIBER INVALID                  LOC.: A  LAST UPDATE:  04/11/00
L. DESC: PRESCRIBER INVALID
POS DSP: D   NCPDP: 56 PRN ERR: 094 DRG PA OVR:   PA#:   PROV#:   RX#:
QTY:   NDC:   DAYS:   THERP:   XREF:   MAX UNITS:   MAX $ AMT:   PA PHY:
  CLAIM     SERVICE      EFFECTIVE     PAPER  TAPE        CODED BY  FINC.   LAST
  TYPE      PAYMENT        DATE        ORIG   ORIG   ADJ   TVCC    CLAIM  UPDATE
   06         S       01 / 01 / 80      O      O      O     O       O     12/02/87
                                        O      O      O     O       O     12/02/87

   07         S       01 / 01 / 80      O      O      O     O       O     12/02/87
                                        O      O      O     O       O     12/02/87

   08         S       01 / 01 / 80      O      O      O     O       O     12/02/87
                                        O      O      O     O       O     12/02/87

   09         S       06 / 28 / 95      T      T      T     T       T     04/11/00
                                        O      O      O     O       O     12/02/87

   10         S       01 / 01 / 80      O      O      O     O       O     12/02/87
                                        O      O      O     O       O     12/02/87
PRESS ENTER FOR NEXT SET OF CLAIMS DATA
PRESS PF1 TO RETURN TO MENU
```

POS DSP = D for deny; the **T = test is set for Claim Type 9 other than POS claims.**

The Department is aware the edit does not evaluate whether the prescriber is currently enrolled in Medicaid. Previous to turning this edit to deny and requiring pharmacies to obtain an identifiable number, the pharmacy program experienced many unknown prescribers. Turning the edit to deny and allowing a changing non-specific prescriber ID substantially improved prescriber identification. Since the Department allows non-enrolled prescribers to prescribe to recipients, the Department needs a non-specific prescriber ID to allow those claims to process.

Other states and Pharmacy Benefit Managers also have issues with Prescriber Identification. There is no perfect solution to this dilemma. Some states use the prescriber's Drug Enforcement Agency (DEA) number for the prescriber ID, however the DEA does not support using this ID for prescription billing, as the DEA number is to be used for prescribing Controlled Substances only.

The Department looks forward to acquiring the new Pharmacy Claims Processing System that will assign a proprietary prescriber identification to identify every licensed prescriber in Alaska, including those practicing in other states whether they are enrolled in Medicaid or not. The prescriber number will also identify physician assistants licensed to prescribe; this group is currently not recognized in our current MMIS system.

The audit identified claims that had prescribers they termed as unlicensed. The correct terminology would state the prescribers did not have current Medicaid enrollment. When additional information on this issue was sought from the auditor, the particular provider

identified to the Department was MD9332. The Department believes the correct choice should have been MD9250.

12. One page twenty-two, number four in the audit you state: "MMIS edits are being overridden inappropriately during the manual claims review process…DMA staff, or FHSC staff at DMA's direction, are ignoring the edit exception and manually override the edit to expedite payment of the claim." Reference edit 289.

The Department disagrees with the statement that Department staff is directing FHSC to ignore edit requirements and override edits to expedite payment. Several issues are involved with this issue. If durable medical equipment (DME) has already been authorized by FHSC or Department staff before the claim was submitted, and the claim pends for medical justification, the medical justification edit would be overridden because the need for the medical equipment was reviewed and approved in the authorization process. The example cited in the audit as having been paid inappropriately was a wheelchair repair. The attachment which was reviewed and approved by FHSC was an invoice for the cost of the wheelchair parts and documentation from the DME provider that they were replacing the wheelchair assembly for the safe mobility of the patient. FHSC reviewed the invoice, verified the claim charges and overrode the edit to pay the claim. In this case the invoice and documentation of the repair is the necessary justification for payment of the claim. Because the original purchase of the wheelchair was prescribed by a physician, there is clearly no requirement for a physician consult to justify the repair of a wheel. FHSC staff is never directed by the Department to ignore necessary requirements to pay claims.

13. On page twenty-three in the audit you state: "Procedure being billed is incidental[4] to primary procedure (edit 434) – This edit is designed to preclude the payment of two separate medical procedures that by healthcare standards are typically provided in conjunction with each other."

The Department uses the industry standard ClaimCheck software which includes edits disallowing payment of procedures considered incidental to other primary procedures. The example given was a claim which was reviewed by Department medical professional staff. The denial was overturned and the claim paid because it is Department policy to pay for services normally considered incidental when the patient was seen for two separately identifiable services. In this case the patient was in fact seen for two separately identifiable services (this is noted by the use of the modifier 25 and verified by the chart notes) and the services were performed by the treating physician. Since the time of this appeal ClaimCheck software has been programmed to pay claims in accordance with Department policy when modifier 25 is present.

[4]The degree of complexity entailed in the procedure identified as incidental is minimal when compared to the more intensive primary procedure. Industry guidelines suggest that certain incidental procedures should not be billed separately, when procedure must be performed as part of, or to accomplish, the primary procedure.

14. On page twenty-three, number five in the audit you state: "MMIS procedure formulary files do not contain the necessary or correct criteria to properly evaluate claims for allowability of services billed."

The audit referred to procedure code 0761P (personal care services). The audit is correct that the existing edit does not edit against the 8 hours/day or 56/hour per week limit in 7 AAC 43.790(b). However, the limit cited in 7 AAC 43.790(d) is the absolute limit on personal care services, not the limit in 7 AAC 43.790(b). The Department believes it would be more effective to edit against both limits; a new edit to require prior authorization over the limit in 7 AAC 43.790(b) and the existing edit to enforce the absolute limit.

15. On page twenty-four, number six in the audit you state: "DMA has used its authority to change regulations in a manner which have often resulted in greater costs to the Medicaid program. Under state regulations,[5] DMA has the authority to issue policy changes to regulation. This authority allows DMA to make changes to regulation *"where undue hardship may result to an individual"* if medical care services are denied by *"strict"* application of regulations."

The Department believes that this reference to the hardship exception is inappropriate. The Department's authority under 7 AAC 43.080 is to make exceptions to policy based upon unusual circumstances. Legislative Audit implies the Department uses this as justification to reinterpret regulations. The actions cited are ones of policy interpretation, not exception to regulation. There is a difference between making an exception to regulations and interpreting regulations.

Also, the footnote does not cite the Department's prescription drug regulations, it cites its sanction regulations. It is a sanctionable offense to dispense "a lesser quantity of drug than that prescribed **in order to receive multiple dispensing fees for one prescription**…." [Emphasis added]. The reason for dispensing a lesser quantity of drug is relevant. If pharmacists have legitimate reasons of practice to dispense lesser quantities of drugs that are not related to receiving multiple dispensing fees, the Department does not interpret this as subject to sanction. There is no absolute bar to multiple dispensing fees in the drug reimbursement regulations. While the Department's decision may have been somewhat more costly, it neither involves using the exception policy at 7 AAC 43.080 or clearly contradicting a state regulation.

The Department thanks the auditor for bringing this ambiguity or potential conflict of interpretation to our attention. It will be clarified in future regulations.

---

[5] State regulations at 7 AAC 43.080(a) state in full:

> *The need for medical care is not subject to inflexible determination which can be described completely in policy or regulations. Professional judgment must be exercised in each case and exceptions granted in those instances where unusual circumstances exist. Where undue hardship may result to an individual if medical services are denied by strict application of regulations, exceptions to policy may be made when considered appropriate by the division.*

16. On page twenty-four, number six in the audit you state: "DMA has used its authority to change regulations in a manner which have often resulted in greater costs to the Medicaid program."

The auditor cites DMA policy regarding "[s]tate regulation [that] provides that pharmacists should be paid only one dispensing fee per 30-day supply of prescription drugs." However, the footnote attached to that example does not cite the Department's prescription drug regulations, it cites its sanction regulations. It is a sanctionable offense to dispense "a lesser quantity of drug than that prescribed **in order to receive multiple dispensing fees for one prescription**,…" [Emphasis added]. There is no absolute bar to multiple dispensing fees in the drug reimbursement regulations. The reason for dispensing a lesser quantity of drug is relevant. If pharmacists have legitimate reasons of practice to dispense lesser quantities of drugs that are not related to receiving multiple dispensing fees, the Department does not interpret this as subject to sanction

The Department established the Mediset guidelines in March 2000 to assist pharmacies provide compliance packaging and to prevent abuse to the program while assisting those who needed the service. This policy was developed to address the need for dispensing medications in specialized containers called medisets to residents of assisted living homes. This service was provided by several pharmacies who served this population. While the Department was gathering information to formulate the mediset policy, the MCFU was investigating an issue related to pharmacy dispensing fees.

The division issued a policy letter on March 21, 2000 stating that, effective April 1, 2000, a pharmacy would be allowed to bill for filling a mediset no more than every seven days if certain conditions were met: the patient had to live in an assisted living home or group home; the patient had one of the specified conditions; and the need for the mediset was documented.

The resident in an Assisted Living Home may self administer their medications if it is mentioned in the patient's care plan. The home may provide assistance by reminding the resident, opening a medication container or prepackaged medication for a resident, reading a medication label to a resident, observing a resident while the resident takes the medication, checking a resident's self administered dosage against the label of the container, reassuring a resident that the resident is taking the dosage as prescribed (AS 47.33.020).

Medication assistance is difficult when there are few trained assistants in the assisted living home. These homes are generally more cost-effective than nursing facilities; more important, they are the residents' preferred home. Medisets help make this choice possible. The clearly labeled package assists the patients self-medicate, or to have the attendants assist the patient to be properly medicated in an environment that does not have the high degree of professionals to administer meds that are present in the more expensive long term care facility.

Proper medication management provides other costs savings. For example, for some residents, critical problems associated with missing one dose of medications can send them into relapse and cause a hospital admission. Medisets are desirable for patients with difficult

regimes or with medications such as warfarin (a blood thinner) that require rigid compliance. Non-compliance may result in the consequence of heart valves that may have to be replaced as the valves clot over, requiring an expensive surgery or causing a stroke with astronomical costs.

Another way in which the cost-effectiveness of the mediset filling is demonstrated is by considering the number of medications that are destroyed at a local nursing home when the patient receives a complete month's supply and dies, or experiences a medication or dose change. The drugs presented in the attached spreadsheet were actually dispensed to a nursing home and became unusable due to patients dying before using up the supply or due to medication changes.

The Department developed a spreadsheet identifying 50 medications. [Reference Exhibit A, page 33.] This spreadsheet hypothetically indicates the number of lost units as a 27 day supply. In the example the prescription is filled for a thirty day supply and the prescription becomes unusable on the 3rd day. This leaves 27 days worth of medication unusable. This example is valid since the sample of patients using medisets are brittle patients whose needs for medication change on a daily or weekly basis. Their medications are changed to increase or decrease doses.

The results of the study contained on the spreadsheet show that prescriptions filled with a 7 day supply have a cost of $ 3,798.90 for fifty prescriptions for these fifty drug entities. If the fifty prescriptions were filled for thirty days the cost is $ 14,585.30. If the prescriptions filled for thirty days became unusable after three days the Medicaid program would have wasted $13,534.87. The seven day prescription is the product of multiplying the seven day supply times EAC plus the dispensing fee. The thirty day prescription is the product of multiplying the thirty day supply times EAC plus the dispensing fee.

The Department is cognizant of the fact a pharmacist will spend more time to dispense the drugs in the compliance packaging. There is an initial set up of approximately one hour to obtain all prescriptions from the prescribers and determine optimal dosing times. The initial setup also entails developing a label that addresses each drug and dosing requirement. The medisets labeling requirement is set in the pharmacy regulations at 12 AAC 52.520. It is a challenge to develop all the requirements into a label that fits on the medisets.

It is not Department policy to make wholesale policy changes to benefit clients or providers. In the example cited in the audit, the Department simply interpreted regulations to clarify how to apply them in circumstances that are not anticipated when the regulations were initially developed. The Department had a compelling reason to provide adequate reimbursement to ensure medisets were available to assisted living residents. The Department will address this policy more directly in future regulations.

Also, the Department would like to point out that in those few instances when it might make a hardship exception due to unusual circumstances, one would expect it to cost more, as the auditor so states. Unusual circumstances that result in undue hardship are likely to be exactly those cases where the Department would be expected to appropriately spend more money.

17. On page twenty-five in the audit you state: "DMA policy, as set out in the agency's DME provider manual, and state regulation[6] requires certain durable medical equipment, supplies, and services be authorized by the division before being provided to recipients. This prior authorization process is a valuable control in assuring that only claims for valid, medically necessary, services are paid."

Current Department policy does accept retroactive authorizations for DME services. The Department determined this is necessary to insure that patients' medical needs are met. Patients often require DME or medical supplies directly after discharge from a facility. The discharge from a high-cost facility is dependent upon the patient receiving these necessary services. Also, some recipients are determined eligible for benefits retroactively. The Department did not intend to suggest that these retroactive authorizations were an exception. The Department's primary interest is to insure that patients have an ability to receive the services necessary to treat their medical needs. The Department plans to clarify this policy in 7 AAC 43.925 when revised regulations are proposed for public comment.

18. On page twenty-six, number seven in the audit you state: "DMA does not utilize software designed to determine if procedures are consistent with generally-accepted professional billing practices for dental claims."

The Department does indeed utilize software suggested by the CMS, called ClaimCheck. The ClaimCheck[7] software is designed to identify procedures that would typically be considered mutually exclusive, incidental or bundled.

The Department disagrees with the statement that it modified the system to bypass ClaimCheck software for dental services. The ClaimCheck software does include a component for examining dental procedures. The Department has never examined the ClaimCheck dental software to determine whether or not it is applicable or beneficial to the program. This component has never been programmed into the MMIS system. The Department is confident that the MMIS programming is currently paying for dental services in accordance with program guidelines.

19. On page twenty-six in the audit you also state: "DMA controls over nonemergency transportation are ineffective at containing costs."

As the Department noted earlier, it is not a requirement that every transportation service have a related medical claim. For example, the service may not have been billed yet; another insurance may have paid for the medical service but not the transportation; the transportation

---

[6] State regulation at 7 AAC 43.925 (a) (2) states: *"According to the provisions of this section, the division will, in its discretion, reimburse an enrolled provider for certain durable medical equipment, supplies, and respiratory services furnished to Medicaid recipients, if the equipment, supplies or services are (2) authorized by the division before being provided."*

[7] The ClaimCheck audit software is developed based on current healthcare trends, medical and technological advances, CMS guidelines and American Medical Association guidelines.

was for follow-up or post-operative care which was included in the treatment cost; the servicing provider may not be enrolled in the program; the service itself may have no charge to the program (e.g. Shriners Hospital); the medical service may not have been provided yet, as in the case of a patient awaiting delivery. In truth, even nonemergency travel may be relatively urgent, and scheduled travel must frequently be changed as the recipient's needs change or the provider's schedule changes. Also, in many instances competition for travel is extremely limited, and the Department cannot guarantee a predictable stream of business. Accordingly, the Department defines "reasonable transportation cost" as the cost for the same service to the general public.

The Department also disagrees with the general statement that prior authorization is applied in such a way as to be of no value. The Department does not authorize weekend transportation and accommodation services which would result in additional units or days authorized simply for the patients' convenience. There are, however, instances where travel on a weekend may be necessary due to appointment scheduling or to meet another requirement of the treating provider. Additionally, long-term stays at prematernal homes or required for treatment of chronic conditions may extend over several weekends.

20. On page twenty-seven, number two in the audit you state: "Some travel costs appear unreasonable."

The Department agrees that the cost of some specified airfares appear to be excessive. However, it is difficult to absolutely determine if the providers charged more than their rates to the general public without a thorough review of all of the details related to the cases. As noted above, there are instances where travel costs are directly linked to accommodate specific types of treatment authorized by a physician; to accommodate the negative impacts of Alaska's unpredictable weather; to unanticipated and unpredictable changes in airline fees, etc.

21. On page twenty-seven, number two in the audit you also state: "No discounts for ground transportation of multiple recipients."

The Department agrees that while the rates may seem unreasonable, the rates charged to the program should be comparable to those charged to the general public for the same service. The Department is also encouraged by the interest being shown by the Murkowski administration and the Legislature to possibly reopen discussions with the airlines to address bulk advance purchase tickets and similar cost saving measures for the state.

22. On page twenty-eight, number three in the audit you state further there appears to be a lack of effective prior authorization for all nonemergency medical transportation.

The Department's current practice is to have FHSC review transportation claims which pend. In certain instances FHSC does alter the original number of units after a review of the claims. The division agrees that in a few instances FHSC staff erroneously added units. In those cases it is the responsibility of FHSC to initiate the appropriate procedures to recoup any overpayments or unwarranted claims paid, and to verify to the Department the successful

adjudication of those claims.

The Department concurs that a clerical data entry error resulted in an overpayment because the clerk keyed an extra zero. Again, in that instance FHSC initiated the appropriate procedures to recoup the overpayment and verified to the Department the successful adjudication of that claim.

The Department does not agree that the prior authorization process (PA) could have prevented this error. The cost of the ticket or the air carrier is not known at the time the service is approved. The PA is requested by medical professionals documenting the medical need, and not airline staff.

The Department also disagrees that the prior authorization process is not effective. All non-emergency travel is prior authorized and approved when determined necessary based on the patients' medical needs. Out-of-state travel does NOT require written justification. Most travel requests are telephonic and First Health staff documents the need in the system.

CONCLUSIONS SECTION 2 – POST PAYMENT REVIEW AND CONTROL BY DMA AND MFCU

1. On page twenty-nine in the audit you state: "DMA's provider and recipient review section is not adequately supported by management… Between October 2000 and November 2001, there was only one full-time individual and one split-duty manager monitoring providers within DMA."

The Department strongly disagrees with the statement the recipient review section is not adequately supported by management. Following an extensive internal restructuring during that same time, the Division of Medical Assistance sought and received legislative approval to bring several new full time positions division-wide. The provider and recipient review section received the equivalent of an additional half-time professional level position. All program units were not able to hire new staff (and were subsequently short staffed) until the new positions were created and approved through the state's personnel hiring and classification process. Prior to November 2001 there were two full time positions and one split duty manager in the Department's post payment review. Also overlooked was the contract with the Department's fiscal agent FHSC, with three full time positions; a full-time recipient review position, even though it reported to a different unit within the Division of Medical Assistance; and the Memorandum of Agreement with DMHDD for limited audit responsibilities.

2. On page twenty-nine in the audit you also state: "DMA does not effectively manage program integrity information."

As noted by the auditor, Medicaid program integrity information is tracked on several databases. The current case tracking system includes a system operated under contract with FHSC. The provider review and rate setting unit (PRR) also has multiple spreadsheet

database tracking systems supporting the MMIS. While not state-of-the-art, the current system has not dropped or lost any audits to date. Information needed by management for oversight is developed through coordination of the various tracking mechanisms.

Department staff also reviews and evaluates providers without conducting a full on-site audit. When a complaint is received about a provider or the provider is identified by computer analysis as having an unusual billing pattern, the division can conduct a desk review on the provider or provide specific information to the provider and request that they "self audit". The self audit concept has been demonstrated to be very successful in other states in dealing with programmatic billing errors or a misunderstanding of proper billing procedures. The providers corrected billings can be tracked by the claims payment system and reviewed by division staff.

The Department also notes that Alaska has a relatively small population of providers which allows for easier identification of problem providers. The top 200 providers constitute 74% of total payments. Use of the current provider ranking system, recipient complaints, and communications with various personnel within the Department has been capable of identifying individual providers, service areas, or provider types where audit activities are needed.

The Department has discussed with legislative auditors the various controls currently in place which are intended to add assurance that a claim presented for payment is appropriate. In order for a claim to process there must be an eligible recipient and an enrolled provider. During processing the claim is subject to hundreds of edits which must be met or the claim is rejected for review. Many services must also be preauthorized.

With regard to the auditor's comments on complaints from external sources, the provider and recipient review unit also performs preliminary investigations on complaints related to patient abuse, forwards appropriate information regarding complaints as necessary in the Department, makes referrals to MFCU, and incorporates information about complaints into whatever review activity may be underway with a provider.

3. On page thirty-two in the audit you state: "…no new provider audits have been initiated since FY00."

As mentioned in the Department's response to #2 above, the Department performs ongoing audit activity under contract with FHSC, and as appropriate with Department staff when information regarding a potential problematic situation becomes available.

In addition, the Department notes substantial progress has been made on processing the Deloitte and Touche audits. The number of closed (issued final) audits has risen from 42 in early November 2002 to 60 to date. From August 2002 to the present, the number of audits which are not at least in the hands of providers for comment has decreased from 79 to 15. The Department anticipates the final 15 will be out to providers for comment by mid-April. In addition, the Department successfully issued a sanction notice in July 2002.

4. On page thirty-two in the audit you state: "Known problem providers are not effectively monitored on an ongoing basis."

The Department recognizes a need for a more efficient case tracking system, and is currently in the process of procuring one with the new MMIS. Included in that system is a decision support system with the capabilities necessary to better manage specific data associated with the audit and case load review. As noted above the Department has discussed with Legislative Audit the various controls currently in place to add assurances that a claim presented for payment is appropriate.

The audit also states "...the staff would seek approval for appropriate sanctions from the DMA management and not receive the necessary approval."

The audit identifies a single instance where staff sought the sanction in relationship to a provider who was indicted for of healthcare fraud. Other than the knowledge of the indictment, management had no significant information on which to exercise its discretion. At that time staff believed, and informed management, that the federal exclusion from Medicare and Medicaid of this provider would "take another few months". With federal exclusion, the provider would have no appeal right with its Medicaid exclusion.

The auditor identified four other providers to support its statement. One provider was considered in a work group for possible sanction. The work group concluded that prepayment review would not correct the perceived misconduct and the providers actions were not clearly in violation of any program requirement. Another provider was sanctioned and he has left the Medicaid program. Yet another provider is no longer licensed to practice and is in jail. The last provider has voluntarily left the Medicaid program and she remains the object of future sanction by the Department.

The audit also references a penalty levied in July 2002 as a "mere five hours of provider training." Provider training is one of the possible sanctions under 7 AAC 43.955; the nature of the service does not lend itself to some of the other possible sanctions. The determination of which sanctions to use is governed by 7 AAC 43.960. If the auditor does not believe the sanction is adequate for the offense it should be so stated rather than imply through innuendo the Department is being soft on providers.

5. On page thirty-four in the audit you state: "DMA policy decisions have adversely affected MFCU investigations…DMA has changed their policies for the benefit of Medicaid providers in the midst of MFCU investigations of those very same providers. These changes have adversely affected MFCU's ability to effectively investigate and possibly prosecute the providers."

Pharmacy Dispensing Fees: As noted earlier in this response, in March 2000 the Department established the Mediset guidelines to assist pharmacies provide compliance packaging and to prevent abuse to the program while assisting those who needed the service. This policy was developed to address the need for dispensing medications in specialized containers called medisets to residents of assisted living homes. This service was provided by

several pharmacies who served this population. While the Department was gathering information to formulate the mediset policy, the MCFU was investigating an issue related to pharmacy dispensing fees.

The Department notes that the MFCU investigation on pharmacy fees was occurring when there was no clear policy to address instances where specially filled and dispensed Medipaks were needed in the community to address issues of non-compliance and medication use in Assisted Living Homes.

The Medipak policy was established to ensure proper compliance with difficult dosing regimes of those patients who are visually impaired, living in an Assisted Living Home, or have chronic illness requiring proper maintenance medications. The policy was developed according to the Medicaid pharmacy reimbursement, The State Pharmacy Practice Act regarding filling of Med-Paks, and the Nursing Board Regulations Sec 47.33.020. The policy was requested by the Division of Senior Services as they did not have a procedure or methodology to reimburse for the Medipaks.

While providing for the reimbursement of Medipaks was the main concern for DMA, the policy did address cost efficiencies in Assisted Living Homes and safety concerns in the Assisted Living facilities. Many patients take drug regimes which frequently change. Therefore, weekly filling is more efficient and cost effective for the Medicaid Program and the provider.

The Medipak policy allows providing pharmacies to bill for the service. The policy allows a pharmacy to bill once every seven days for prescriptions dispensed into Medipaks. The new policy allows a pharmacy to receive reimbursement for the drugs at EAC or the FUL, dispensing service or dispensing fee and the Med-Pak filling labor each week. Alaska is following the policy previously set by Washington State Medicaid.

The Department notes that the use of Medipaks, and dispensing no more frequently than every seven days, is allowable under Medicaid. The Washington State Medicaid Pharmacy Program uses a similar payment methodology, and established precedence for the Alaska Medicaid Program.

The "unbundling" of dental services:
The Department does not agree with the statement that DMA policy prohibited the use of certain dental procedure codes. Nor does it agree that this was a change in policy. It is Department policy in general that if policy guidelines do not specify a coverage guideline, a requirement for billing or coding , or a requirement for service provision, the providers should provide and bill for those services using the accepted professional or industry standards. In this case Department policy did not prohibit the use of the codes. It is an accepted practice in the dental industry and therefore an acceptable policy. In this case MFCU did not consult with Department policy staff until they had initiated their investigation.

The Department also notes it continues to work directly and cooperatively with attorneys in the Department of Law's Civil Division and Human Services Section on these and other issues.

6. On page thirty five in the audit you state: "DMA did not consult MFCU to determine how such a change in policy may impact that agency's ongoing civil and/or criminal investigation."

It is important to distinguish between a policy change and a policy clarification. In many areas of policy, the question of which way to interpret statute and regulation, with regard to a specific issue, does not come up until someone raises it. It might be raised by a provider or client inquiry or complaint, or by an audit or investigation. When questions about how to interpret policy arise, the question is answered by clarifying the policy. This is different from changing a policy, when it was clearly one way, and now will be another.

In addition, Department policy clarifications are almost never done in consultation with the MFCU. If health or eligibility policy staff have questions about how a policy would effect the ability to ensure program integrity, they would seek guidance from the Provider and Recipient Review section or from the DPA Fraud unit (for eligibility), not the MFCU. As to how a change would effect a particular investigation, that consideration would likely be irrelevant. The Department would not want to reject a desirable policy simply to allow the MCFU to prosecute providers in a way that we want them to behave, yet that appears to be the logic of this finding.

7. On page thirty-five in the audit you also state: "Vague policies and regulations impede MFCU investigatory efforts."

Further clarification of and reference to specifics regarding "vague policies and regulations" is required before the Department can responsibly and coherently respond to this statement.

CONCLUSIONS SECTION 3 – HOME AND COMMUNITY-BASED WAIVER BILLING AND PAYMENT ISSUES

1. On pages thirty-five through thirty-nine in the audit several issues were raised relating to HCB providers billing for services not delivered.

The Department concurs that the rate methodology used for some home and community-based services is flawed and may promote payments for services greater than actually provided, although the method can also have the opposite effect. The unit rate is calculated by dividing total anticipated costs by total anticipated units of service. If total costs are overestimated, but total units of service are accurate, the unit rate will be too high. However, in other cases, if overestimating the amount of services results in overestimated the units to be provided, while total costs are accurate, then the unit rate will be too low. The Department has received informal complaints from providers about the financial hardships

imposed when they have overestimated the number of units to be provided. Reference also the Department's response to Recommendation 10.

Individual instance of miscalculation may in fact be less of an issue if differences between the rate assumptions and actual amounts of service are randomly distributed in both directions. If the audit did not review claims and records to determine if there were other individuals for whom more service was provided than went into the rate calculation, or whether the same individuals received extra services on other days, this should be acknowledged, and the conclusion qualified.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

DMA's health and programs manager should review MMIS administrative controls and edits, and the related disposition policy, in order to better utilize the payment system's capacity to evaluate claims.

The Department concurs. Department Management is continuously revising and strengthening administrative controls to improve program effectiveness. While there is always the opportunity for further improvement, the division does not agree that administrative controls are not effectively utilized. The Department's comments on the specifics identified by Legislative Audit to support Recommendation 1 follow.

1. The Department does not agree that edit 121 and 122 should be set for DME claims. These edits were specifically programmed for pharmacy claims. Simply changing the disposition would not be sufficient. Other areas requiring revisions include: development of a process to notify DME providers of the applicable identification numbers, provider education, system changes to make this field a required data element, and other data entry changes. The Department does not agree that requiring the prescribing number on the claim is the only effective way to insure that program guidelines are followed. All claims are subject to post-payment review, some DME services require prior authorization or a review for medical justification. Additionally, the Department is currently revising the program guidelines for coverage of DME and medical supplies.

   The Department turned edit 389 to "test" due to programming inefficiencies which resulted in many false denials related to prescriptions provided by specialists. The Department has recently developed edit "override" capabilities to allow the appropriate referrals and deny prescriptions from non-referred prescribers. The edit will be changed to "deny" within the next few months when the system changes are in place.

2. The Department does not agree that edit 122 should be changed to "pend" and claims manually reviewed. Current policy does not require all prescribers to be enrolled in the program. (Note: The disposition of "pend" is generally not an option for point-of-sale claims as providers are notified instantaneously as to the disposition of their claim.) The

Department recognizes that there are problems with presciber identification. This problem is not unique to our state. The Department anticipates the implementation of our new Pharmacy Claim Processing System will help resolve the problem. The Department will be maintaining a proprietary prescriber identification list that will identify all licensed prescribers in Alaska.

3. The Department does not agree that it is directing FHSC to ignore edit requirements. Some DME claims require medical justification. In these cases FHSC staff is instructed to review the relevant documentation submitted in support of the service. In some cases this is submitted as an authorization. When the service is "equipment repair", justification for the service (parts and labor) is required but the "medical justification" had previously been supplied when the equipment was provided. An additional physician consult is not necessary for the repairs.

   The Department does not agree that it is inappropriately overriding claims denied in accordance with professional standards. Department policy allows for a review of all services which may be exceptions to industry standards or which may have been paid according to Department policy but were denied due to ClaimCheck programming specifications. These reviews are conducted by medical personnel.

4. The Department agrees that the current regulations specify the word "prior" as a requirement for payment, and in that context, service authorization is required prior to payment of the claim. Currently Department policy does accept retroactive authorizations for DME services. The Department determined that this is necessary to insure patients' medical needs are met. Patients often require DME or medical supplies directly after discharge from a facility. The discharge from a high-cost facility is dependent upon the patient receiving these necessary services. Also, some recipients are determined eligible for benefits retroactively. The Department did not intend to suggest that these retroactive authorizations were an exception. The Department's primary interest is to insure that patients have an ability to receive the services necessary to treat their medical needs. The Department plans to clarify the word "prior" in 7 AAC 43.925 when revised regulations are proposed for public comment.

5. The Department disagrees with the statement that the procedure formulary file could be better utilized. The Department currently uses the procedure formulary file to insure claims are paid for covered services to the allowed providers in accordance with the coverage guidelines.

6. The Department disagrees with the statement that it modified the system to bypass ClaimCheck software for dental services. The ClaimCheck software does include a component for examining dental procedures. The Department has never examined the ClaimCheck dental software to determine whether or not it is applicable or beneficial to the program. This component has never been programmed into the MMIS system. The Department is confident that the MMIS programming is currently paying for dental services in accordance with program guidelines.

Recommendation No. 2

DMA's provider and beneficiary services manager should develop and implement stronger Medicaid provider enrollment controls consistent with Federal regulations and to prevent enrollment of unqualified service providers.

The Department concurs. Department Management is continuously revising and strengthening administrative controls to improve program effectiveness. The Department's comments on the specifics identified by the auditor to support Recommendation 2 follow.

1. As noted earlier (page 7, CONCLUSIONS SECTION 1), the Department is complying with disclosure requirements at 42 CFR 455 relating to ownership interests, business transactions over $25,000 per year, and criminal convictions. These regulations specify that certain providers are required to comply with requests about ownership and control and all providers agree to comply when they sign the Medical Assistance enrollment agreement. Penalties are imposed if providers fail to comply with a request for information.

   A "disclosing entity" is a Medicaid provider or fiscal agent. Individual practitioners or groups of practitioners, whether they are organized as partnerships or corporations, are not regarded as disclosing entities and are not subject to the requirements of this section. (FR V. 44 No. 148, 41638). For "disclosing entities" that are "subject to periodic survey", DMA requests and receives this information during each survey and renewal before certification is finalized. Facilities are surveyed according to a timeline specified by Congress in the Budget Call Letter for Survey and Certification. In addition, JCAHO-certified facilities send disclosure information directly to CMS as a condition of certification.

   The Department will seek further legal review to clarify the federal requirements, remediate activities as necessary, and take any actions necessary to assure full compliance with federal requirements.

2. Discussions with the Division of Occupational Licensing were initiated by our staff over four years ago to improve the automated interface used to update the on-line MMIS provider file. A Memorandum of Understanding (MOU) was drafted and sent to OccLic for their review and approval. The Department understands that MOU has subsequently been referred by OccLic to the Department of Law for review.

3. As noted earlier, the Department must maintain provider on-line files to maintain claims history, thus on-line files are not purged. However, the Department agrees that providers could be placed in an "inactive" status after twenty-four months, not twelve months as recommended by Legislative Audit. Many providers, especially specialists, may only see Medicaid clients occasionally, sometimes only once per year. A significant number of providers, primarily specialists critically important for the adequate delivery of specialty services to Alaskans, who are enrolled in Alaska's Medicaid program do not in fact practice in Alaska. Their practices are based in out-of-state hospitals and health facilities.

The Department finds no merit in requiring such providers to enroll each time they see a Medicaid client, supporting the recommendation for the twenty-four month inactivation policy.

The Department will also request its fiscal agent FHSC to perform annual verification of the provider file information. In addition, the Department will include in its regular provider training program information regarding the provider's obligation to protect their provider number from unauthorized use.

The Department agrees a control weakness would exist if enrolled providers did not act responsibly and exercise appropriate controls over their assigned provider numbers. The Department also asks the auditor to share with the Department any information it may have regarding specific cases of such abuse.

Recommendation No. 3

DMA's health program and policy manager should strengthen controls over transportation claims.

While the Department concurs there is need to improve the transportation program, the Department does not agree that implementation of the specific recommendations from the auditor would be cost effective. Additionally the recommendations are not possible without additional resources. The Department's planned approach is to review the program and possibly contract with a travel broker or implement measures appropriate to the region.

1. Verification of services. The Department does not agree that verifying all travel would result in program savings. As noted previously there are many instances where there would be no accompanying medical claim. The Department does agree that additional recipient education should be initiated.

2. Volume discounts may result in some cost savings in some instances. However, because there are usually a limited number of available providers, these may be difficult and time-consuming to negotiate.

3. The Department does agree that providers who charge more than they do the general public should be referred to SURS. However, maintaining reasonable charges for the wide variety of transportation services, various aircraft and specialized services would be administratively burdensome. A review of random services is feasible.

4. The Department notes it is not a requirement that every transportation service have a related medical claim. For example, the service may not have been billed yet, another insurance may have paid for the medical service but not the transportation; the transportation was for follow-up or post-operative care which was included in the treatment cost; the servicing provider may not be enrolled in the program; the service itself may have no charge to the program (e.g., Shriners Hospital); the medical service

may not have been provided yet, as in the case of a patient awaiting delivery. DMA defines "reasonable" as the cost for the same service to the general public.

All non-emergency transportation services require prior authorization. The process requires the medical practitioner requesting the service call FHSC and certify the medical need for the travel. Authorization is given only to the extent justified by the client's medical need. This includes destination, mode of transportation, need for overnight accommodations, number of service units authorized, and approval for escort services. The Department believes this process is a valuable control procedure.

5. The Department agrees that in several instances First Health staff inappropriately revised PA's. First Health has been notified of this and a revised process has been initiated.

Recommendation No. 4

The Director of DMA should evaluate the costs and possible savings that may be involved in various administrative alternatives to managing nonemergency transportation costs.

The Department concurs that non-emergency travel services should be reviewed. However the Department does not agree with the specific recommendations, as other alternatives should also be reviewed for consideration.

Recommendation No. 5

DMA's director should direct resources to assist the Program/Recipient Review (P/RR) section to develop a comprehensive case management system to better manage the operations of this important internal review function.

The Department concurs. Department Management is continuously revising and strengthening administrative controls to improve program effectiveness. As noted in the Department's comments on the Organization and Function section of the audit, a new Office of Program Review is being established in the Commissioner's Office to coordinate and manage DHSS efforts to enhance services for Alaska Natives; assure that each division contains a program integrity function aligned with DHSS priorities; balance quality and cost effectiveness in service delivery; and coordinate and streamline functions of the department to integrate services and provide a seamless delivery system. The new unit will provide oversight to the following department functions:

- Reduction of general fund expenditures
- Program integrity
- Government relations
- Interdepartmental coordination
- Customer service

The Department also recognizes the need for an improved case tracking system. Department efforts to procure a new MMIS are anticipated to conclude this fiscal year. It includes a new case tracking system. Contract negotiations have been completed and the approval process is underway. Included in the procurement effort is a decision support system with the capabilities necessary to better manage specific data associated with the audit and review case load.

Recommendation No. 6

The director of DMA should carry out a comprehensive risk assessment to estimate the level of improper Medicaid payments that may be associated with different types of services and providers.

The Department concurs that, while a comprehensive risk assessment may provide some insight into where the divisions audit and inspection efforts should be focused, such an assessment is not likely to provide any significant change in identified areas of potential audit activity.

Alaska has a relatively small population of providers which allows for easier identification of problem providers. The top 200 providers constitute 74% of total payments. The Department also maintains open communication with various divisions, groups and individuals to enhance the awareness of potential problem areas. Procurement of a new decision support system as part of the new MMIS will assist the Department better manage specific data associated with the audit and review case load.

Recommendation No. 7

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

The Department concurs. The Department is in the process of preparing for another contract for audit services. Future audit contracts will require a more complete audit product, reducing the significant time division staff must participate and speeding up the results.

The Department notes that the on-site audits are additional, optional internal controls which are not required by state or federal law. This additional optional control was implemented for the first time in the Deloitte and Touche contract by the Director of the Division of Medical Assistance.

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.

While the Department concurs with the commitment to aggressive monitoring and the effective utilization of administrative remedies, the Department notes that controls are currently in place to assure that a claim presented for payment is in fact appropriate. In order for a claim to process there must be an eligible recipient and an enrolled provider. During processing the claim is subject to hundreds of edits which must be met or the claim is rejected for review. Many services must also be preauthorized.

Prepayment review is a valuable and effective tool when used correctly. It is not a tool that should be used in every instance where the department suspects a provider may or could be billing inappropriately. Prepayment review is ineffective, however, in stopping claims payments if the provider chooses to provide bogus backup, or when all services were accommodations or travel are preauthorized and then billed. In situations where medical services are at issue the medical provider can be required to provide financial billing records and medical records. In these situations the amount of work at the provider and with the division's prepayment operations can be substantial depending upon the size of the claim load. Some audited providers have many thousands of claims per month.

A review of the medical necessity requires the expert analysis of a physician or similar medical expert to question the practice or prescribing habits of a medical professional. This step should be taken with great care and should not be expected to occur often.

Recommendation No. 9

DMA's manager of the provider and recipient review unit should improve the confirmation of service provision process and utilize the process to monitor providers in a risk-based manner.

The Department concurs. Approximately 400 Recipient Explanation Of Medicaid Benefits (REOMBs) are currently mailed on a monthly basis. The current REOMB software within the MMIS is incapable of incorporating the recommended changes without significant reprogramming. This system does not allow for focusing on suspect areas. Due to the imminent MMIS reprocurement, along with mandatory HIPAA changes, the Department is not seeking this work effort at this time. The Department has long recognized the benefit to having an REOMB process that could focus on a specific geographic area, provider type, or specific provider in a risk based manner.

The Department has been and is currently in the process of procuring a new claims payment system and a new decision support system. This new system will allow for significant capabilities which the current system does not have. With these new capabilities the Department will be able to monitor providers in a risk-based manner.

Recommendation No. 10

DMA Medicaid policy administrator and DMHDD's program administrator should address home and community-based (HCB) agency payment rate issues to ensure costs paid are reasonable and contained.

The Department concurs with the recommendation to reform the rate setting mechanism at the completion of its cost study. The Department intends to pursue this recommendation.

The Department will evaluate whether it is feasible to implement the four immediate action steps included in the recommendation. Moving to an hourly rate for services that are now billed daily could require extensive MMIS modifications at a time when MMIS resources are directed at complying with the federal HIPAA requirements and with implementing MMIS reprocurement. Reconciliation and subsequent adjustment is labor intensive. One concern of the Department is that without adequate staff to evaluate expenses, the process would not be effective. While the Department will consider standardized service configurations, it must remains concerned that any reimbursement methodology accommodates the individualized service planning process that consumer and their families value highly.

Recommendation No. 11

DMHDD program managers should adopt regulations requiring the business relationship between the care coordinators and home care community service agency providers are maintained at arm's length.

The Department recognizes there is a potential conflict of interest when care coordinators work for agencies that provide other HCB services. When the MRDD waiver was developed, this was less of an issue, as few communities were served by more than one provider. While the Department acknowledges the potential conflict of interest in the current care coordination system, it is also important to point out that some consumers prefer to get all of their services from a single provider, because of the convenience of dealing with a single agency for planning, scheduling, and accountability.

To address the quality of care coordination, DMHDD has sought and obtained funding for incremental improvements. These include the DD Systems Reform Initiative and the Real Choice Systems Change grant. The former included a component to improve care coordination training; the latter will look at moving toward more client direction and altering the present system of care coordination

Both DMHDD and DSS are considering whether to move some components of care coordination, specifically the assessment and plan of care development process, to an administrative function of waivers. This would enable the state to contract for independent assessment/plan of care providers (under federal law, clients are entitled to freedom of choice of service providers). However, there is not currently a large enough network of independent

care coordinators to assume the responsibilities for MRDD waiver recipients. Any transition away from the current system of care coordination—whether it be a shift to administrative assessment and care planning or simply a switch to independent care coordination--will have to be planned thoughtfully, in cooperation with consumers and providers, to ensure that waiver consumers are not placed at risk of harm by the transition.

Recommendation No. 12

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

The Department is currently reviewing a number of legislatively proposed strategies to address Medicaid fraud.

Recommendation No. 13

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

The Department concurs with the recommendation to include the full array of "missions and measures" statements and performances objectives for DMA.

ID	MEDICATIONS	7 day supply	30 day supply	mac	AWP	Disp Fee	EAC	usual 7 day cost	usual 30 day cost	lost cost	lost number
1	Neupogen 300mcg/ml	7	30		207.500	$11.46	$197.13	$1,463.96	$6,236.46	$5,613.96	27
2	Lovenox 80mg	7	30		51.44	$11.46	$48.87	$371.54	$1,554.66	$1,400.34	27
3	Duragesic 100mcg/hr	2	10		50.282	$11.46	$47.77	$112.02	$514.28	$614.84	12
4	Duragesic 75mcg/hr	2	10		38.862	$11.46	$36.92	$89.18	$400.08	$477.80	12
5	Lovenox 40mg	7	30		25.688	$11.46	$24.40	$191.28	$782.10	$705.04	27
6	Duragesic 50mcg/hr	2	10		24.722	$11.46	$23.49	$60.90	$258.68	$308.12	12
7	Lovenox 30mg	7	30		19.26	$11.46	$18.30	$146.28	$589.26	$531.48	27
8	Fosamax 70mg	1	4		17.14375	$11.46	$16.29	$28.60	$80.04	$131.47	7
9	Duragesic 25mcg	2	10		14.5480	$11.46	$13.82	$40.56	$156.94	$186.04	12
10	Duragesic 25mcg/hr	2	10		14.5480	$11.46	$13.82	$40.56	$156.94	$186.04	12
11	Zyprexa 7.5mg	7	30		7.2620	$11.46	$6.90	$62.29	$229.32	$207.53	27
12	Zyprexa 5mg	7	30		6.34066	$11.46	$6.02	$55.84	$201.68	$182.66	27
13	Cipro 500mg	14	60		5.632	$11.46	$5.35	$90.31	$349.38	$293.06	50
14	Augmentin 875mg	14	60		5.61312	$11.46	$5.33	$90.04	$348.25	$292.12	50
15	Cipro 250mg	14	60		4.81150	$11.46	$4.57	$78.82	$300.15	$252.04	50
16	Nexium 40mg	7	30		4.42076	$11.46	$4.20	$42.41	$144.08	$130.82	27
17	Remeron 15mg	7	30		3.0168	$11.46	$2.87	$32.58	$101.96	$92.91	27
18	Detrol LA 4mg	7	30		2.9645	$11.46	$2.82	$32.21	$100.40	$91.50	27
19	Celebrex 200mg	7	30		2.87948	$11.46	$2.74	$31.62	$97.84	$89.21	27
20	Vioxx 25mg	7	30		2.87563	$11.46	$2.73	$31.59	$97.73	$89.10	27
21	Inapsine 2.5mg/ml	7	30		2.8655	$11.46	$2.72	$31.52	$97.43	$88.83	27
22	Zoloft 50mg	7	30		2.6488	$11.46	$2.52	$30.00	$90.92	$82.98	27
23	Zoloft 25mg	7	30		2.6468	$11.46	$2.51	$29.99	$90.86	$82.92	27
24	Zoloft 100mg	7	30		2.64676	$11.46	$2.51	$29.99	$90.86	$82.92	27
25	Remeron Soltab 15mg	7	30		2.511	$11.46	$2.39	$29.04	$86.79	$79.26	27
26	Celexa 20mg	7	30		2.41090	$11.46	$2.29	$28.34	$83.79	$76.55	27
27	Lipitor 10mg	7	30		2.38555	$11.46	$2.27	$28.16	$83.03	$75.87	27
28	Ambien 5mg	7	30		2.281	$11.46	$2.17	$27.43	$79.89	$73.05	27
29	Celebrex 100mg	14	60		1.75552	$11.46	$1.67	$36.04	$116.79	$99.24	50
30	Detrol 2mg	14	60		1.72702	$11.46	$1.64	$35.64	$115.08	$97.81	50
31	Coreg 6.25mg	14	60		1.72	$11.46	$1.63	$35.54	$114.66	$97.46	50
32	Detrol 1mg	14	60		1.6832	$11.46	$1.60	$35.02	$112.45	$95.62	50
33	Atacand 16mg	7	30		1.44666	$11.46	$1.37	$21.59	$54.86	$50.52	27
34	Altace 5mg	14	60		1.375	$11.46	$1.31	$30.71	$93.96	$80.21	50
35	Albuterol MDI	17	34		1.25941	$11.46	$1.20	$32.87	$54.28	$37.91	21
36	Amaryl 4mg	14	60		1.0234	$11.46	$0.97	$25.79	$72.86	$62.63	50
37	Amoxicillin 875mg	14	60		0.969	$11.46	$0.92	$25.03	$69.60	$59.91	50
38	Versed 1mg/ml	7	30		0.82475	$11.46	$0.78	$17.23	$36.20	$33.73	27
39	Amaryl 2mg	14	60		0.5426	$11.46	$0.52	$19.06	$44.02	$38.59	50
40	Acetamenophen/Codeine#3	42	180	0.2137		$11.46		$20.44	$49.93	$41.81	142
41	Acyclovir 400mg	28	120	0.7048		$11.46		$31.19	$96.04	$79.12	96
42	Albuterol Inh. Solution /cc	25	100	0.145		$11.46		$15.09	$25.96	$22.92	79
44	Allopurinol 300mg	7	30	0.1671		$11.46		$12.63	$16.47	$15.97	27
45	Alprazolam 0.25mg	14	60	0.048		$11.46		$12.13	$14.34	$13.86	50
51	Alprazolam 0.5mg	14	60	0.0493		$11.46		$12.15	$14.42	$13.93	50
52	Amoxil 500mg	21	90	0.1272		$11.46		$14.13	$22.91	$20.75	73
53	Anucort HC 25mg	7	30	0.4953		$11.46		$14.93	$26.32	$24.83	27
54	Atenolol 25 mg	7	30	0.1595		$11.46		$12.58	$16.25	$15.77	27
55	Atenolol 50 mg	7	30	0.0885		$11.46		$12.08	$14.12	$13.85	27
								$3,798.90	**$14,585.30**	**$13,534.87**	

March 11, 2003

Ms. Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Dear Ms. Davidson:

Thank you for the opportunity to respond to the Preliminary Audit, Control # 06-30018-03 of the Department of Health and Social Services, Division of Medical Assistance, Internal Control over Medicaid Payments.

Although most of the audit relates to operations outside of the Department of Administration, the Division of Senior Services (DSS) in the Department of Administration administers the Home and Community-Based Waiver programs for the Department of Health and Social Services and will respond to two issues addressed in the audit.

Recommendation No. 7
DMA's director should provide for a full-time, ongoing service provider audit function.

The Medicaid program requires a quality assurance program. To comply with this requirement the Mental Health Trust Authority provided three years of matching funding for implementation. Over the three years, the program has proven effective. The Quality Assurance Unit was responsible for more than $220,000 in savings last year.

To continue this program, DSS has requested general funds to replace funds provided by the Mental Health Trust Authority which were scheduled to end inFY03. The Mental Health Trust Authority's FY04 budget includes an additional year's request of $100,000. This request, if approved, will provide the match for FY04. However, to continue to operate at a minimal level after FY04 the Quality Assurance program would still need long term matching funds of $100,000 per year to remain in compliance with program requirements, and to receive the $125,000 matching Medicaid funds from the federal government.

Recommendation No. 10
DMA Medicaid policy administrator and DMHDD's program administrator should address Home and Community-based (HCB) agency payment rate issues to ensure costs paid are reasonable and contained.

The Home and Community Based Waiver programs provide varying levels of assistance to seniors based on need. Care coordinators of the program assess the level of care. These coordinators build caseload from their own assessments.

DSS staff based eligibility determinations on these assessments, however they do not complete the assessment nor see the clients. DSS staff have performed after the fact assessment reviews. These reviews have found that the assessments are not accurate. Plans of Care are often inflated, based on Care Coordinator assessments, to cover services clients do not need. Further, the client may not receive all services prescribed on the Plan of Care.

Current procedures for these assessments have a serious conflict of interest. Those preparing the assessments are the ones gaining, by increasing their caseloads, from the assessments prescribed. Nonscientific surveys show support for a change in this policy, and both clients and long term care nurses have expressed their support.

The DSS would like to change the initial assessment process. We believe that the initial assessment should be performed by someone other than the caregiver. By using a DSS employee to perform the assessments, only appropriate services would be listed on the Plan of Care, and only those meeting federal eligibility standards would be enrolled in the program. Providers of these services will not have their assessments questioned and can perform the services assigned without reservation.

Changes to the process may require a change to State regulation. DSS is currently working with DHSS to change the process for completing assessments of waiver clients. The change will result in the completion of the assessments by professionals without a conflict of interest, rather than the care coordinators responsible for providing the care.

Thank you again for the opportunity to comment on your findings.

Sincerely,

Mike Miller
Commissioner

cc: Ray Matiashowski
Deputy Commissioner

Kevin Jardell
Assistant Commissioner

Dan Spencer, Director
Division of Administrative Services

Steve Ashman, Director
Division of Senior Services

Bob Labbe, Director
Division of Medical Assistance

Frank H. Murkowski, Governor

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

P.O. BOX 110300
JUNEAU, ALASKA 99811-0300
PHONE: (907)465-3600
FAX: (907)465-2075

March 11, 2003

Pat Davidson
Legislative Auditor
Alaska State Legislature
P.O. Box 113300
Juneau, Alaska 99811-3300

Re: Preliminary Audit Report On Department of Health and Social Services, Division of Medical Assistance Control Over Medicaid Payments, January 31, 2003.

Dear Ms. Davidson:

Pursuant to your request in your letter of February 19, 2003 the Department of Law hereby responds to the preliminary audit report on the Division of Medical Assistance and its control over Medicaid payments. We earlier responded to your management letter on the same subject and will not repeat the comments contained therein except as necessary to address a specific recommendation in the preliminary audit. Also, as with our earlier response, we are confining our comments only to specific recommendations, regarding the Medicaid Fraud Control Unit (MFCU) in the Criminal Division of the Department of Law.

Recommendation No. 12. We agree with the recommendation that the legislature should enact Medicaid fraud statutes as discussed in Recommendation 12. We note that a bill containing criminal Medicaid fraud statutes was introduced early in the current legislative session. MFCU and Department of Law staff have been working closely with the bill's sponsors in an effort to provide a comprehensive criminal law package that addresses a multitude of fraud issues. The work is not yet complete but the Department of Law will continue to assist the legislature in the effort to complete this important project.

At the conclusion of the report the auditor also makes several comments. One of the comments refers to Recommendation No. 12. Please see our response above. The other two are at least in part directed at the Department of Law and the MFCU. The following are our responses to those comments:

The MFCU continues to keep lines of communication open so that DMA policy decisions do not negatively impact ongoing investigations. DMA is currently undergoing a significant change in its organizational structure. Once complete, the MFCU intends to make direct contact with the new offices that most impact criminal investigations so that the new policies of those offices have no negative impact on MFCU investigations. The MFCU will encourage any additional suggestions to keep these lines of communication open.

Finally, the Department of Law intends to continue to maximize the effectiveness of the MFCU and will hire an investigator to fill the vacant investigative position when it becomes apparent that the changes noted in the preliminary audit, including the statutory changes, will result in a caseload that fully justifies the additional investigator. Should that come to pass, the additional investigator, coupled with the anticipated new criminal fraud statutes, should increase the effectiveness of the MFCU, and thereby reduce the abuse of Medicaid funds.

Sincerely,

Gregg D. Renkes
Attorney General

March 24, 2003

Members of the Legislative Budget
and Audit Committee:

We have reviewed the Department of Health and Social Services' (DHSS) response to the preliminary audit report. While DHSS extensively comments on, and disputes many of, the points set out in the report, nothing contained in the response leads us to reconsider our overall conclusions, findings, and recommendations.

The federal government, in the audit guidance developed for federally-funded programs (developed by the Office of Management and Budget) consistently designates Medicaid as being at high risk for fraud, waste, and abuse. The federal General Accounting Office similarly ranked Medicaid as a high risk program.[1] Given such concerns, it is important for state agencies responsible for administering Medicaid funds to balance program operating objectives such as access to medical services, with accountability over program expenditures.

DHSS and the Division of Medical Assistance (DMA) challenge or dismiss many of our conclusions, findings, and recommendations although they acknowledge agreement and merit at the same time. The response often comments that implementation of our recommendations are not necessary or would unduly constrain the nature and extent of services provided. The department believes the system of internal controls currently in place is adequate for the size and scope of Alaska's program. DMA's response does not give enough consideration to the "high risk" aspect of the Medicaid program.

DMA's programmatic perspective is demonstrated by comparing the agency's response to Recommendation No. 11 to the one offered by the Department of Administration (DOA).

[1] Every two years, with the start of each new Congress, the federal General Accounting Office (GAO) issues an update of the high risk series, identifying and reporting of federal programs and operations that have greater vulnerabilities to waste, fraud, abuse, and mismanagement or that have major challenges associated with their economy, efficiency, or effectiveness. GAO audit work in recent years found that federal and state oversight efforts of the Medicaid program have often been inadequate to prevent inappropriate spending, thereby increasing federal spending unnecessarily. More specifically, they identified:

- Financial arrangements by some states that improperly leverage federal funds;
- State waiver programs that inappropriately increase the federal government's financial liability; and
- Insufficient federal and state oversight to ensure that payments are accurate and appropriate.

In that recommendation (pages 54-55 of the report) we suggest that regulations be developed to promote more of an "arm's length" relationship between care coordinators and organizations responsible for providing services to Medicaid waiver recipients.

DHSS/DMA in responding to our recommendation stated on page 92 of the report (page 31 of the DHSS response) comments:

> *While the Department acknowledges the potential conflict of interest in the current care coordination system,* ***it is also important to point out that some consumers prefer*** *to get all of their services from a single provider, because of* ***the convenience of dealing with a single agency*** *for planning, scheduling, and accountability. [Emphasis added]*

As the response indicates, DHSS/DMA puts more emphasis on the preference of the recipient involved and is apparently less concerned about possible conflict of interests. Contrast this with DOA's response on page 98 (page 2 of DOA's response) that states:

> ***Plans of care are often inflated****, based on Care Coordinator assessments, to cover services clients do not need. ...*
>
> ***Current procedures for these assessments have a serious conflict of interest****. Those preparing the assessments are the ones gaining, by increasing their caseloads, from the assessments prescribed. Nonscientific surveys show support for a change in the policy, and both clients and long term care nurses have expressed their support. [Emphasis added]*

DOA's response acknowledges the problem and indicates a move toward resolving the problem. DHSS' response indicates some problems might exist but is satisfied with the status quo.

In a high risk program, the cost of controls will likely be higher than those in a low risk program, because the cost of ineffective controls is substantial. In evaluating the cost benefit of internal controls, it is more critical that costs of the controls be compared to the prospective savings or improved compliance with established program standards involved with public funding. Impact on other program objectives should be evaluated after this initial cost benefit assessment is completed.

Clarifications related to certain comments in the DHSS response to the report

From our review of DHSS/DMA response, we offer the following additional clarifications regarding various points:

Unlicensed rather than unenrolled providers. On page 22 of the report we state that *"we identified payments of more than $117,000 in pharmacy claims that had prescriber numbers of providers that are not only inactive but unlicensed in Alaska."*

On pages 72-73 of the report, the agency suggests that it would be more accurate to say the prescribers were not enrolled service providers. The agency points out that a prescriber does not have to be an enrolled provider to write a prescription reimbursed under Medicaid.

Using the database of the Division of Occupational Licensing, we confirmed the individuals involved were not licensed by the State Medical Board at the time the drugs were dispensed. We reaffirm the statements made in the report.

The 70% objective. On page 71 of the report DMA takes exception with our statement that the agency has established a weekly goal of processing 70% of claims through the adjudication cycle without error or exception. DMA insists that the 70% standard refers to a "benchmark" used in identifying claims processing errors or programming errors.

While management may mean to use 70% as a benchmark, the staff has implemented it as a directive. On at least four occasions, we were advised by staff of either DMA's contractor, First Health Services Corporation (FHSC), or DMA of the need to **pay** 70% of all claims on a weekly basis. Staff were concerned that no more than 30% of claims "pend" or be rejected for payment through what is termed the claim adjudication cycle. We reaffirm the statements made in the report.

The use, or modification, of the ClaimCheck claim analysis software. On page 26 of the report we state *"DMA does not utilize software designed to determine if procedures are consistent with generally-accepted professional billing practices for dental claims."* The software referred to is ClaimCheck, a data processing program that is designed to evaluate medical and dental billings for coding accuracy and consistency with established health care standards. We state further in the audit that DMA "modified" claim processing controls to allow all dental claims to bypass the ClaimCheck review.

On page 78 of the report the agency takes exception with our assertion that DMA "modified" the claim payment system. In the response DMA states the agency has never examined the ClaimCheck software to determine if it is applicable or beneficial to the Medicaid program. Accordingly, from DMA's perspective since the agency never evaluated, much less used this analytical software, there has never been any "modifications."

We acknowledge the mischaracterization of the agency's nonuse of this software. However the more important issue is that DMA should utilize appropriate software designed to determine, confirm, and approve for payment dental claims that are consistent with generally-accepted professional billing practices. We reaffirm the overall conclusion made in the report.

Transportation. In responding to our concerns about payment for transportation without a related medical service claim, on page 79 of the report the agency offered several possibilities why this might happen. When we suggested DMA randomly check to make sure services were provided to recipients when travel was reimbursed, the agency responded such confirmation for **all** nonemergency travel was not practical or cost effective (see report page 88).

We did not intend to suggest that DMA should confirm all of the nonemergency travel. Rather we meant to recommend DMA contact medical/dental and other service providers on a random basis to inquire if the recipient kept their appointment(s); or periodically ask providers to fax a confirmation when the recipient attended their appointment(s).

Comments and Analysis of selected issues set out in DMA's response

In addition to these clarifications, we also have more substantial comments regarding various other aspects of the department's response to our report, such as:

Reliance on compensating pre- and post-payment controls. In some instances, such as on page 72 of the report, DMA minimizes our concerns about the lack of certain data processing edits by pointing to compensating controls. The agency cites such procedures as prior authorization and post-payment review as mitigating the need for unused edits. Specifically, in responding to Recommendation No. 1 (on page 41 of the report) DMA again comments that our concerns about use (or nonuse) of edits is somewhat misplaced since all claims are subject to post-payment review.

Besides not being as cost-effective as upfront data processing controls, the cited compensating controls are not operating efficiently and effectively enough to suffice as adequate compensating controls.

Medipak policy change regarding dispensing fees. On pages 76-77 of the report DMA discusses the importance of providing Medipaks (referred to also as medisets in the department's response) to needy and eligible recipients. Certainly Medipaks are critical to a segment of the Medicaid population.

Our primary concern, as expressed in the report, was this policy change resulted in an estimated $2 million increase in annual dispensing fees. DMA suggests that there were significant savings involved that offset some, if not most, of the costs of the policy change. Our review of these offsetting, cost-saving factors indicate that while there may be some merit to them – the impact is limited. Specifically:

- Availability of Medipaks was improved. DMA stated they had a compelling reason to provide adequate reimbursement to ensure Medipaks were available to assisted living residents. The agency comments this population often is more frail and more in need of help in dispensing medication through the use of Medipaks.[2]

[2] Under state regulation, Medipaks are reimbursed for recipients who fall into one of two categories: In responding to this concern, it is important to understand that medisets are allowed for Medicaid recipients meeting one of the two following requirements:

(a) The recipient is a resident of an Assisted Living or Group Home facility

or

(b)The recipient has any of the following conditions: Alzheimer's disease, diabetes, epilepsy, schizophrenia, hypertension, clotting disorders, congestive heart failure, chronic mental illness, AIDS, or had an organ transplant

In our random sample, only three recipients met the eligibility criteria through being in an assisted living home. The remaining recipients had conditions identified in section (b) of the footnote on the prior page. This suggests that the necessity to provide Medipak packaging to brittle recipients, living in a more institutional setting, may be a factor. Most Medipaks are for people in more independent living situations, presumably with fewer needs brought on by frailty.

- Waste would be minimized when recipients die. When a recipient passes away, any remaining medication must be destroyed. As DMA points out, when medications are dispensed on a 30-day basis, it is likely more drugs will be wasted in this manner, than would be if dispensed on a 7-day Medipak basis.

  In the sample of 25 randomly-selected recipients used to develop our estimate, none of the individuals selected passed away during the three month period of our review. Two of the recipients have subsequently died since June 30, 2002 – the end of our review period. This suggests while this factor may have some merit, its impact on costs is minimal.

- Changes in medication or doses of existing medication. DMA suggests the weekly Medipak prescriptions allow greater flexibility and less waste when prescriptions are changed or a prescriber makes a change in a recipient's dosage. Again in our sample of Medipak recipients, we found that prescriptions established in the Medipak were fairly consistent from week to week. Accordingly, this suggests to us this flexibility factor has limited impact on prescription costs.

- Pharmacists need to be compensated for extended work. DMA states that paying pharmacists additional dispensing fees is necessary to offset the additional setup time involved with preparing Medipaks. This seems to be a valid point, but as discussed in the report pharmacists do receive a labor fee, per prescription, for each Medipak package. If the labor fee needs to be adjusted to better reflect the time and effort involved, DMA should explore those options rather than allow pharmacies to quadruple the number of times they can charge a relatively high dispensing fee.

- Cost savings spreadsheet attached to response. DMA attached a spreadsheet that showed "hypothetical" savings and costs that were presumably involved in the change of policy involving Medipaks and dispensing fees (see page 94 of the report).

  The cost of the medications, listed as being wasted, averaged out to more than $140 over a three month period (if each prescription was extended out to a quarter's worth of data). The average cost of each individual drug in our sample of recipients did not exceed $10 for the three months reviewed.

We believe DMA's cost analysis of the policy change does not present an accurate picture of the factors and associated costs involved. The agency made a policy change with an estimated

annual cost of $2 million, with no documented predecisional analysis of the related costs and benefits.

Durable Medical Equipment (DME) claims, prescribers, and medical necessity. Under state Medicaid regulations all DME claims must be confirmed as being medically necessary. This is an important way to prevent fraud and abuse. In the report we take exception to DMA not using computer edits to verify prescribers and its application of prior authorization.

The department acknowledges we are technically correct and the way DMA is using prior authorization is inconsistent with state regulations. On page 86 the department states it *"agrees that the current regulations specify the word 'prior' as a requirement for payment"* but its primary interest is to *"insure that patients have an ability to receive the services to treat medical needs."* The department goes on to say it intends to clarify the meaning of "prior" in future regulatory changes.

DME has been identified in many national studies as being a "high risk" area for Medicaid fraud and abuse.[3] Given this elevated risk, it is critical DMA effectively use data processing edits and comply with existing regulations to give increased assurances that DME claims are medically necessary.

In summary, while the agency's response adds some perspective to the issues discussed, we reaffirm the conclusions, finding, and recommendations in this report.

Pat Davidson
Legislative Auditor

[3] See:
Strategies to Manage Improper Payments, General Accounting Office, October 2001, p.19, 30.
State Efforts to Control Improper Payments, General Accounting Office, June 2001, pp.10-12, pp.17-18.
License to Steal, Why Fraud Plagues America's Healthcare System, Malcom K. Sparrow, pp.4-6.

April 4, 2003

Honorable Ralph Samuels
Chairman
Legislative Budget & Audit Committee
State Capitol; Rm. 428
Juneau, AK 99801-1182

Dear Representative Samuels,

I have received your letter of April 2, 2003 and appreciate the opportunity to meet with the Legislative Budget and Audit Committee regarding the recently completed legislative audit of the Medicaid program.

I have now had the opportunity to read the final audit that includes the department's response to the audit and the legislative auditor's comments on our response. In hindsight I am concerned that our response, while a good faith effort to address the many elements of this extensive and complex audit, might be misconstrued.

As you know, the Medicaid audit spanned many months and consumed significant resources in both the Division of Legislative Audit and the Division of Medical Assistance. Department staff were understandably anxious to provide auditors with all the information they could to fully explain the extremely complicated policies and procedures that govern the state/federal Medicaid partnership. It is now apparent to me that our formal response to the audit provided far too much detailed information while failing to adequately address the fundamental issues that were raised in the audit. Therefore I would like to reiterate several key points.

First and foremost, the Murkowski Administration is wholly committed to running an efficient and effective Medicaid program that provides quality health care to clients while maintaining strict accountability for these public funds. To this end the department has initiated a number of Medicaid related reforms and cost containment strategies.

In mid-March, Executive Order 108, restructuring the Department of Health and Social Services, was presented to the Legislature. One of the primary goals of the reorganization is to improve the accountability for Medicaid funds by establishing clear lines of authority and responsibility for the expenditure of these funds. Over the past several decades, Medicaid has become a primary funding source for many programs and services that were not previously funded by Medicaid. The department's new

organizational structure recognizes that Medicaid funds now permeate the department's operations and eliminates overlapping or unclear lines of authority that I believe are a significant contributor to a number of the deficiencies cited in the legislative audit.

Last month Governor Murkowski introduced a package of legislation designed to give the department additional tools to contain the costs of the Medicaid program. These bills have been generally well received by the legislature, and if enacted into law this session, will cap eligibility for certain elements of the Medicaid program as well as provide the department with greater flexibility to reduce program expenditures in a manner that will least impact services to clients.

Early this session, the department committed to work closely with interested legislators to improve and enhance our fraud and abuse detection activities. Senate Bill 41, introduced by Senator Lyda Green, is currently in the Senate Judiciary Committee, and if enacted, will significantly strengthen the State's ability to detect and prosecute Medicaid fraud and abuse as well as recoup funds associated with these activities.

As Commissioner, I have also initiated the creation of the Office of Program Review which will report directly to the Commissioner's Office and will have as one of it's primary functions the oversight of the department's fraud and abuse activities.

Finally, I must point out that Governor Murkowski's Fiscal Year 2004 operating budget represents an unprecedented commitment to Medicaid cost containment, efficiency and accountability. In numerous hearings in the legislature over the course of the past several months I have consistently and repeatedly expressed my personal belief that we MUST act to control Medicaid cost growth if we are to preserve this critical safety net for those Alaskans who look to the program to provide for basic health care.

In the interest of further clarifying the department's position, I am also attaching an abbreviated response to the major recommendations contained in the audit.

Again, thank you for the opportunity to respond to the Legislative Budget and Audit Committee on this important issue. I look forward to meeting with the committee next week.

Sincerely,

Joel Gilbertson
Commissioner

Attachment

Department of Health and Social Services-Replacement Response
Legislative Audit Number 06-30018-02

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

DMA's health and programs manager should review MMIS administrative controls and edits, and the related disposition policy, in order to better utilize the payment system's capacity to evaluate claims.

The Department concurs. Department Management will direct Division of Medical Assistance staff to: 1) review administrative controls and edits to ensure they are appropriately and set and used in the claims payment process; 2) To ensure that the related policy is consistent; and 3) Ensure that the claims evaluation system promotes the payment of valid and medically necessary claims.

Recommendation No. 2

DMA's provider and beneficiary services manager should develop and implement stronger Medicaid provider enrollment controls consistent with Federal regulations and to prevent enrollment of unqualified service providers.

The Department concurs. Department Management is continuously revising and strengthening administrative controls to improve program effectiveness. The Department's comments on the specifics identified by the auditor to support Recommendation 2 follow.

1. The Department will make every effort to be in compliance with 42 CFR 455.105 (Disclosure related to business transactions over $25,000 per year) and 42 CFR 455.106 (Disclosure related to criminal convictions information from non-surveyed entities. Our plan is to seek further legal review to clarify the federal requirements, remediate activities as necessary, and take any actions necessary to assure full compliance with federal requirements.

2. The Department agrees that an MOU with the Division of Occupational Licensing is critical to our success in this area. A Memorandum of Understanding (MOU) was drafted and sent to Occupational Licensing for their review and approval. The Department will work with Occupational Licensing to finalize this agreement.

3. The Department agrees that providers could be placed in an "inactive" status after a period of time. The Division of Medical Assistance will review claim payment history and trends to determine if twelve months of inactivity is an adequate standard or whether extending the time longer will be more efficient.

Recommendation No. 3

DMA's health program and policy manager should strengthen controls over transportation claims.

The Department concurs with the recommendation and agrees that all of the items listed in the recommendation are worth consideration. In particular, items 2 through 5 could be important tools in strengthening department controls over the Medicaid transportation program.

Recommendation No. 4

The Director of DMA should evaluate the costs and possible savings that may be involved in various administrative alternatives to managing non-emergency transportation costs.

The Department concurs that non-emergency travel services can be better managed. In fact, within the FY04 budget the department documents savings from establishing a transportation brokerage program for non-emergency travel. We believe this is a good first step to managing non-emergency travel for Medicaid recipients.

Recommendation No. 5

DMA's director should direct resources to assist the Program/Recipient Review (P/RR) section to develop a comprehensive case management system to better manage the operations of this important internal review function.

The Department concurs. The Department also recognizes the need for an improved case tracking system. Department efforts to procure a new MMIS are anticipated to conclude this fiscal year. It includes a new case tracking system. Contract negotiations have been completed and the approval process is underway. Included in the procurement effort is a decision support system with the capabilities necessary to better manage specific data associated with the audit and review caseload.

Recommendation No. 6

The director of DMA should carry out a comprehensive risk assessment to estimate the level of improper Medicaid payments that may be associated with different types of services and providers.

The Department concurs that a comprehensive risk assessment may provide some insight into where the division's audit and inspection efforts should be focused. The Division will assess the cost benefit of doing such an assessment. In addition, Procurement of a new decision support system as part of the new MMIS will assist the Department better manage specific data associated with the audit and review caseload.

Recommendation No. 7

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

The Department concurs. The Department is in the process of preparing for another contract for audit services. Future audit contracts are an important part of program integrity and will continue.

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.

The Department concurs that aggressive monitoring of problem providers can be an important and effective method to prevent abusive and unsupported billing practices. The Department notes that controls are currently in place to assure that a claim presented for payment is in fact appropriate. In order for a claim to process there must be an eligible recipient and an enrolled provider. During processing the claim is subject to hundreds of edits, which must be met, or the claim is rejected for review. Many services must also be preauthorized.

Recommendation No. 9

DMA's manager of the provider and recipient review unit should improve the confirmation of service provision process and utilize the process to monitor providers in a risk-based manner.

The Department concurs. Approximately 400 Recipient Explanation Of Medicaid Benefits (REOMBs) are currently mailed on a monthly basis. The current REOMB software within the MMIS is incapable of incorporating the recommended changes without significant reprogramming. This system does not allow for focusing on suspect areas. The Department has long recognized the benefit to having an REOMB process that could focus on a specific geographic area, provider type, or specific provider in a risk based manner.

The Department has been and is currently in the process of procuring a new claims payment system and a new decision support system. This new system will allow for significant capabilities, which the current system does not have. With these new capabilities the Department will be better able to monitor providers in a risk-based manner.

Recommendation No. 10

DMA Medicaid policy administrator and DMHDD's program administrator should address home and community-based (HCB) agency payment rate issues to ensure costs paid are reasonable and contained.

The Department concurs with the recommendation to reform the rate setting mechanism at the completion of its cost study. The Department intends to pursue this recommendation.

Recommendation No. 11

DMHDD program managers should adopt regulations requiring the business relationship between the care coordinators and home care community service agency providers are maintained at arm's length.

The Department recognizes there is a potential conflict of interest when care coordinators work for agencies that provide other HCB services.

To address this and other concerns about the quality of care coordination, DMHDD has sought and obtained funding for incremental improvements. These include the DD Systems Reform Initiative and the Real Choice Systems Change grant. The former included a component to improve care coordination training; the latter will look at moving toward more client direction and altering the present system of care coordination

Both DMHDD and DSS are considering how to move the assessment and plan of care development process to an administrative function of waivers. This would enable the state to contract for independent assessment/plan of care providers (under federal law,

clients are entitled to freedom of choice of service providers). This shift will be addressed in future regulations.

Recommendation No. 12

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

The Department is currently reviewing a number of legislatively proposed strategies to address Medicaid fraud.

Recommendation No. 13

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

The Department concurs with the recommendation to include the full array of "missions and measures" statements and performances objectives for DMA.