Report Highlights

Why DLA Performed This Audit

The audit was requested to identify total Medicaid and CHIP travel costs from FY 14 through December 2019, and ways to reduce costs. Audit objectives include identifying the most significant travel vendors and whether the State leveraged its purchasing power to reduce costs; reviewing the prior authorization process and system edits to ascertain whether the controls were operating effectively; testing a sample of travel transactions for reasonableness and proper support; and determining whether telehealth was used to reduce travel when possible.

What DLA Recommends

1. Division of Health Care Services' (DHCS) director should adopt regulations and implement written procedures to encourage the advance purchase of airfare.
2. DHCS's director should consider alternatives to the taxi voucher system.
3. DHCS's director should improve controls over ground ambulance claims.

Continued on next page

A Special Review of the Department of Health and Social Services, Medicaid and Children's Health Insurance Program (CHIP) Transportation Costs

October 28, 2020

Audit Control Number 06-30089-20

REPORT CONCLUSIONS

The audit noted that a 2016 change in federal guidance allowed 100 percent federal reimbursement for services received by Alaska Native recipients through facilities operated by federal Indian Health Services or Tribes under specific circumstances. Prior to the change, the cost of Medicaid and CHIP transportation was shared equally between the state and federal governments. After the State implemented changes per the new federal guidance, the federal share of transportation expenditures grew to 92 percent during FY 17.

The audit concluded that Medicaid reforms were not implemented to expand the use of telehealth as required by statutes. Regardless, use of telehealth did increase; however, the increase was not significant. Regulations to expand the use of telehealth were considered, but not published.

The most significant State-funded transportation vendor was Corporate Travel Management North America Inc. (CTM), the State's travel contractor. Most of the payments to CTM were for airfares. Other than a contract with Alaska Airlines, which included certain discounts, no procurement efforts to reduce Medicaid and CHIP transportation costs were identified.

A total of 145 State-funded Medicaid and CHIP transportation claims were tested by auditors covering airfare, lodging, ground transportation, air ambulance, and ground ambulance. Testing found claims were generally supported, the prior authorization process was followed, and existing system edits appeared to be adequately designed to prevent improper transportation payments.

Report Highlights (Continued)

4. DHCS's director should consider restructuring air and ground ambulance rates.

5. DHCS's director should adopt regulations and implement controls to evaluate the availability of medical services in a recipient's home community prior to authorizing travel.

6. DHCS's director should consider specific opportunities to decrease transportation costs.

7. DHCS's director should implement regulations to expand the use of telehealth for primary care, behavioral health, and urgent care.

REPORT CONCLUSIONS (Continued)

However, the following unallowable or unreasonable costs were detected.

- A Medicaid State Plan amendment approved in July 2016 authorized government-operated facilities to be reimbursed at federal per diem rates. This change was not federally required and allowed tribal owned lodging to be paid significantly higher rates than non-tribal owned lodging.
- Ten percent of taxi claims tested were overbilled.
- Three percent of ground ambulance claims tested were paid an incorrect rate. In addition, analysis of all ground ambulance claims during the audit period found 52 claims billed mileage in addition to an all-inclusive rate.
- Eleven percent of airfare claims tested found medical services may have been available in the home community. DHCS's prior authorization process did not document an evaluation of whether services were available in a recipient's home community.

The audit identified the following potential opportunities to reduce transportation costs:

- establishing fixed rates for certain taxi routes/areas;
- expanding access to transportation through ride sharing companies and/or through contracting for bus or shuttle services;
- allowing and promoting the use of public transportation;
- restructuring air and ground ambulance fees;
- reconsidering higher rates paid to lodging facilities owned by tribal organizations; and
- incentivizing the advance scheduling of non-urgent appointments to allow for the advance purchase of airfare.

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit

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October 30, 2020

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24, we have reviewed Medicaid and Children's Health Insurance Program transportation costs, and the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM TRANSPORTATION COSTS

October 28, 2020

Audit Control Number
06-30089-20

The audit reported Medicaid and Children's Health Insurance Program's transportation costs from FY 14 through December 2019 and the top 15 State-funded transportation vendors. The audit also identified procurement efforts taken by the State to reduce transportation costs. Further, the audit determined whether the prior authorization process and system edit controls were adequately designed to prevent improper transportation payments and tested a sample of transportation claims for reasonableness and proper support. Lastly, the audit determined whether telehealth was used effectively and identified potential opportunities to reduce transportation costs.

The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork procedures utilized in the course of developing the findings and recommendations presented in this report are discussed in the Objectives, Scope, and Methodology.

Kris Curtis, CPA, CISA
Legislative Auditor

ABBREVIATIONS

AAC	Alaska Administrative Code
ACN	Audit Control Number
AS	Alaska Statute
CHIP	Children's Health Insurance Program
CISA	Certified Information Systems Auditor
CPA	Certified Public Accountant
CTM	Corporate Travel Management North America Inc.
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DLA	Division of Legislative Audit
FFY	Federal Fiscal Year
FY	Fiscal Year
MMIS	Medicaid Management Information System
SB	Senate Bill
STO	State Travel Office

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CONTENTS (Continued)

ORGANIZATION AND FUNCTION

Department of Health and Social Services (DHSS)

DHSS's purpose is to promote and protect the health and well-being of Alaskans. The department is separated into 10 divisions that administer programs such as medical assistance, public assistance, children's services, youth corrections, substance misuse and addiction services, behavioral health, senior and disabilities services, and public health.

DHSS's Division of Health Care Services (DHCS) is primarily responsible for the oversight, operation, and support of the Medicaid program and Children's Health Insurance Program (CHIP), which includes ensuring compliance with program requirements by recipients, providers, and contractors; developing policies and procedures governing the programs; and preparing and submitting the Alaska Medicaid State Plan.

Medicaid and CHIP expenditures during FFY 20 were approximately $2.3 billion. DHSS's FY 20 operating budget was approximately $3.1 billion with 3,298 authorized positions.

Conduent State Healthcare, LLC (Conduent)

DHCS contracts with Conduent to serve as its Medicaid fiscal agent. As fiscal agent, Conduent authorizes Medicaid and CHIP travel, and is responsible for operating and maintaining the Medicaid Management Information System (MMIS), also referred to as the Alaska Health Enterprise system. MMIS processes Medicaid and CHIP claim payments to providers.

State Travel Office (STO)

The STO, organizationally located within the Department of Administration, Division of Finance, manages the travel program serving the State's Executive Branch and other individuals that travel on official State business. The STO manages the State's travel contractor, Corporate Travel Management North America Inc. (CTM). CTM provides travel management services, including arranging and billing commercial and charter air, ferry, and train transportation for Medicaid and CHIP recipients.

The STO's FY 20 operating budget was approximately $2.3 million with one authorized position.

BACKGROUND INFORMATION

Medicaid Covers Transportation Services

In Alaska, Medicaid covers travel costs determined necessary to secure medical examinations and treatment for a recipient, as codified under federal regulation Title 42 CFR 440.170(a). Travel is defined as the cost of transportation by ambulance, taxicab, or common carrier; the cost of meals and lodging en route to and from medical care and while receiving medical care; and the cost of an attendant (also referred to as an escort) to accompany a recipient, if necessary, including the cost of the attendant's transportation and meals.

Medicaid Fiscal Agent Authorizes Medicaid and Children's Health Insurance Program (CHIP) Travel

The Division of Health Care Services utilizes a service authorization process to document medical necessity before a Medicaid or CHIP recipient travels. When travel is needed, a recipient's medical provider contacts the fiscal agent, Conduent State Healthcare, LLC. (Conduent) to request a service authorization. A Conduent agent enters the request into the Medicaid Management Information System (MMIS); retrieves recipient eligibility data; documents information, including medical necessity, scheduled appointments/procedures, and needed travel dates; and approves or denies the request based on information given by the provider and a recipient's eligibility. If approved, Conduent provides a service authorization number to the provider and enters the approved number of units for various transportation categories (e.g. air, lodging, taxi, and meals) into the MMIS service authorization. Conduent also electronically sends select service authorization data to the travel contractor.

Once travel is approved by Conduent, a recipient may contact the State's travel contractor, Corporate Travel Management North America Inc. (CTM), to arrange travel. CTM verifies recipient travel information against the service authorization data when arranging travel (which may include air, ferry, or train transportation) and provides additional travel-related assistance when needed.

Senate Bill (SB) 74 Encouraged Use of Telehealth Services

The Alaska State Legislature passed SB 74 in 2016. Senate Bill 74 established the Medical Assistance Reform Program under AS 47.05.270 to improve the effectiveness and efficiency of health care expenditures and improve the quality of care received by recipients, including:

- adopting regulations to expand the use of telehealth for primary care, behavioral health, and urgent care; and identify areas of the state where improvements in access to telehealth would be most effective in reducing the costs of medical assistance;
- allowing for incentives to be created for the use of telehealth services; and
- reducing travel costs by requiring recipients to obtain medical services in the recipient's home community, to the extent appropriate services are available.

Senate Bill 74 also directed the Department of Health and Social Services (DHSS) to fully implement a February 2016 policy issued by the federal Centers for Medicare and Medicaid Services, which authorized 100 percent federal funding for services provided to American Indian and Alaska Native Medicaid recipients under specific conditions.

Emergency Regulations Reduced Certain Transportation Reimbursement Rates by Five Percent

Effective October 2019, DHSS's commissioner adopted emergency regulations to reduce transportation expenditures over the following categories:

- lodging and meals;
- wheelchair van services;
- air ambulance; and
- ground ambulance.

The regulations reduced reimbursements to providers by five percent through the end of June 2020. According to the public notice, the emergency regulations were necessary due to insufficient Medicaid funding.

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REPORT CONCLUSIONS

An audit of Medicaid and Children's Health Insurance Program (CHIP) transportation was performed to identify total Medicaid and CHIP transportation costs from FY 14 through December 2019, and ways to reduce costs. Audit objectives include identifying the most significant travel vendors and whether the State leveraged its purchasing power to reduce costs; reviewing the authorization process and system edits to ascertain whether the controls were operating effectively; testing a sample of travel transactions for reasonableness and proper support; and determining whether telehealth was used to reduce travel when possible.

The audit noted that a 2016 change in federal guidance allowed 100 percent federal reimbursement for services received by Alaska Native recipients through facilities operated by federal Indian Health Services or Tribes under specific circumstances. Prior to the change, the cost of Medicaid and CHIP transportation was shared equally between the state and federal governments. After the State implemented changes per the new federal guidance, the federal share of transportation expenditures grew to 92 percent during FY 17.

The audit concluded that Medicaid reforms were not implemented to expand the use of telehealth as required by statutes. Regardless, use of telehealth did increase; however, the increase was not significant. Regulations to expand the use of telehealth were considered, but not published.

The most significant State-funded transportation vendor was Corporate Travel Management North America Inc. (CTM), the State's travel contractor. Most of the payments to CTM were for airfares. Other than a contract with Alaska Airlines, which included certain discounts, no procurement efforts to reduce Medicaid and CHIP transportation costs were identified.

A total of 145 State-funded Medicaid and CHIP transportation claims were tested by auditors covering airfare, lodging, ground transportation, air ambulance, and ground ambulance. Testing

found claims were generally supported, the prior authorization process was followed, and existing system edits appeared to be adequately designed to prevent improper transportation payments. However, the following unallowable or unreasonable costs were detected:

- A Medicaid State Plan amendment approved in July 2016 authorized government-operated facilities to be reimbursed at federal per diem rates. This change was not federally required and allowed tribal owned lodging to be paid significantly higher rates than non-tribal owned lodging.

- Ten percent of taxi claims tested were overbilled based on recalculations.

- Three percent of ground ambulance claims tested were paid an incorrect rate. In addition, analysis of all ground ambulance claims during the audit period found 52 claims billed mileage in addition to an all-inclusive rate.

- Eleven percent of airfare claims tested found medical services may have been available in the home community. Division of Health Care Services' (DHCS) prior authorization process did not document an evaluation of whether services were available in a recipient's home community.

The audit identified the following potential opportunities to reduce transportation costs:

- establishing fixed rates for certain taxi routes/areas;

- expanding access to transportation through ride sharing companies and/or through contracting for bus or shuttle services;

- allowing and promoting the use of public transportation;

- restructuring air and ground ambulance fees;

- reconsidering higher rates paid to lodging facilities owned by tribal organizations; and

- incentivizing the advance scheduling of non-urgent appointments to allow for the advance purchase of airfare.

Detailed conclusions are as follows:

Change in federal guidance allowed 100 percent federal reimbursement for certain transportation expenditures.

Prior to FY 16, the cost of Medicaid transportation was generally shared equally between the state and federal governments. During FY 16, the Centers for Medicare and Medicaid Services issued guidance that clarified how services received by Alaska Native recipients through facilities operated by Indian Health Services or Tribes may qualify for 100 percent federal reimbursement. In response, DHCS made changes to take advantage of increased federal contributions. These changes included establishing care coordination agreements with tribal health providers and encouraging Alaska Native recipients to obtain care through those tribal health providers. As a result, a larger percentage of Medicaid transportation expenditures was paid by the federal government.

Exhibit 1 on the following page shows the payment of Medicaid and CHIP transportation expenditures for FY 14 through December 2019 by the federal and state governments. Appendix A further breaks down the expenditures between Medicaid and CHIP.

Exhibit 1

Medicaid and CHIP Transportation Expenditures FY 14 through December 2019

Year	Federal	State	Total
FY 14	$35,501,187	$33,167,830	$68,669,017
FY 15	36,843,968	35,219,296	72,063,264
FY 16	45,419,510	32,880,431	78,299,941
FY 17	84,833,117	7,763,009	92,596,126
FY 18	73,769,932	12,013,804	85,783,736
FY 19	91,322,426	12,547,613	103,870,039
July 2019 – December 2019	51,598,812	5,977,293	57,576,105

Source: State Accounting System data.

As shown above, prior to FY 16, the federal and state governments' shares of expenditures were generally 50/50 plus or minus one or two percent. After the State implemented changes, the federal share of transportation expenditures grew to 92 percent in FY 17, then decreased to 86 percent in FY 18 and 88 percent in FY 19.

Use of telehealth did not significantly reduce transportation costs.

An objective of the audit was to determine whether use of telehealth effectively reduced transportation costs. Auditors found that, although the telehealth utilization rate increased during the period FY 17 through FY 19, the impact on transportation costs was negligible given FY 19 telehealth claims were only $6.9 million, or .3 percent of total FFY 19 Medicaid and CHIP costs (see Exhibit 2). Telehealth was predominantly used for mental health services. Appendix B lists telehealth claims by diagnosis description.

As noted in the background information section of this report, SB 74 required the Department of Health and Social Services (DHSS) to adopt regulations to expand the use of telehealth for primary care, behavioral health, and urgent care; and identify

Exhibit 2

Medicaid and CHIP
Telehealth Expenditures and Utilization Rates
FY 17 through FY 19

Year	No. of Claims	Expenditures	No. of Eligible Recipients*	Utilization Rate (claims/ recipients)
FY 17	17,007	$5,580,694	198,742	.086
FY 18	19,141	$5,440,578	210,368	.091
FY 19	23,904	$6,853,929	221,587	.108

Source: Medicaid Management Information System (MMIS) data.
* Based on FFY (October 1st through September 31st).

areas of the state where improvements in access to telehealth services would be most effective in reducing transportation costs. A telehealth workgroup was formed and began meeting in November 2016. The workgroup submitted a final report with recommendations for expanding telehealth in August 2017. After reviewing the report, DHCS management decided to amend telehealth regulations in two phases. Phase one would define the allowability of telehealth services (covered services, allowable delivery methods, and rates) and phase two would expand the use of telehealth.

Phase one regulations were released for public comment in August 2019. Based on feedback, DHCS management determined that additional review was needed to ensure the project's success. In December 2019, DHCS management decided to combine both phases into one regulatory package. As of March 2020, the telehealth regulations had not been finalized or rereleased for public comment. However, as a result of the COVID-19 pandemic, emergency regulations were adopted that established a telehealth fee schedule under a temporary expansion of telehealth services. According to DHCS management, the continued operation of expanded

telehealth services, once the emergency regulations expire, was being discussed at the time of the audit. (See Recommendation 7)

This audit's analysis of transportation claims focused on State-funded transportation.

This audit limited its review of Medicaid and CHIP transportation claims to those with State funding. Claims that were 100 percent funded by the federal government were reviewed as part of the State single audit and excluded from this audit's detailed review of claims.

Limited procurement efforts were made to reduce Medicaid and CHIP transportation costs.

Exhibit 3 lists the top 15 transportation providers, which accounted for 68 percent of the FY 19 transportation claims that were funded, in part, by State general funds.[1] CTM, the State's travel contractor, was the top vendor, accounting for 24 percent. CTM was paid over $7.5 million during FY 19, most of which was used to pay airfares.

Exhibit 4 shows the same transportation expenditures by activity type. Commercial and charter air services were approximately 33 percent of the total. Air ambulance and lodging were the second and third highest cost activities.

The audit evaluated the State of Alaska's efforts to leverage its purchasing power to reduce costs and found that the State continued to have an agreement with Alaska Airlines to provide flight discounts. The audit did not identify other significant procurement efforts related to Medicaid and CHIP transportation.

Transportation claims were generally supported; however, unallowable or unreasonable costs were detected.

The audit tested a sample of transportation transactions for reasonableness and proper support. A total of 145 transportation claims were tested covering airfare, lodging, ground transportation, air ambulance, and ground ambulance.[2] Testing found that, for non-emergency services, billed units did not exceed the units

[1] Exhibit 3 and Exhibit 4 exclude claims 100 percent reimbursed by the federal government.
[2] Testing consisted of 35 airfare claims, 25 lodging claims, 30 ground transportation claims, 25 air ambulance, and 30 ground ambulance claims.

Exhibit 3

Medicaid and CHIP
Top 15 FY 19 Transportation Providers*

Provider	Amount
Corporate Travel Management North America Inc.	$ 7,531,495
LifeMed Alaska LLC	2,192,136
Anchorage Fire Department Area Wide EMS	1,676,053
Best Western Golden Lion Hotel	1,511,859
Alaska Yellow Dispatch LLC	1,470,824
Guardian Flight LLC	1,096,104
Northgate Inns Inc, dba Hotel Nexus, Seattle	903,472
Plaza Inn, dba GuestHouse Anchorage Inn	869,966
University of Washington, dba Airlift Northwest	754,741
AAA Alaska Cab Inc.	708,700
Dale Street Hotel Operations Inc., dba Alpine Lodge	570,875
AKHappytime LLC, dba Alex Hotel & Suites	557,649
Providence Health & Services Washington, dba Walter J & Ermalee Hickel House	550,393
Corky A. Hedrick, dba Mat Valley Tranz	497,330
Matanuska Susitna Borough EMS	496,373
Total	$21,387,970

Source: MMIS data.
* Excludes claims 100 percent reimbursed by the federal government.

Exhibit 4

Medicaid and CHIP
Top 15 FY 19 Transportation Providers
Expenditures by Activity Type*

Type	Amount	Percent
Commercial/Charter Air	$ 7,150,007	33.4%
Air Ambulance	3,846,441	18.0%
Lodging	3,771,676	17.6%
Taxi	2,676,854	12.5%
Ground Ambulance	2,368,965	11.1%
Meals	1,192,539	5.6%
Travel Contractor Booking Fees	324,288	1.5%
Train/Ferry	57,200	0.3%
Total	$21,387,970	100.0%

Source: MMIS data.
* Excludes claims 100 percent reimbursed by the federal government.

authorized, billed dates of service were within authorized dates, and medical necessity was documented. Testing for emergency services found billings were generally supported. Additional results of testing are as follows:

- **Lodging and meal claims**

Per State regulations, lodging and meals are authorized when an overnight stay away from a home community is required when seeking medical care and meals are only authorized when provided by an approved Medicaid lodging provider. During the audit period, there were 57 approved lodging providers, 29 of which billed for meals. Regulations establish reimbursement rates of $110 per night for lodging and $36 per day for meals.

Testing of 25 lodging transactions found all were adequately supported. However, auditors noted several lodging claims paid at a rate of $229 per night and several meal claims paid at a rate of $42 per day. The higher rates were paid to tribal organizations. DHCS management stated the higher rates for tribal organizations were allowable per a Medicaid State Plan amendment approved in July 2016 which authorized government-operated facilities to be reimbursed at federal per diem rates. Auditors found no federal requirement for the higher fees. (See Recommendation 6)

- **Taxi claims**

Medicaid recipients presented vouchers to taxi providers when services were provided. In turn, taxi providers billed Medicaid for services; however, no details, such as pick-up and drop-off locations or mileage, were submitted with billings. Testing of 30 ground transportation claims found three[3] (10 percent) were overbilled. According to DHCS management, the transactions were identified as overbillings by post-payment review subsequent to payment to the provider. (See Recommendation 2)

[3] Testing found three of 25 (12 percent) randomly selected claims and zero of five judgmentally selected claims were overbilled.

- **Air and ground ambulance claims**

Testing of 55 air and ground ambulance claims found one ground ambulance claim was paid an incorrect rate. In addition, analysis of all ground ambulance claims during the audit period showed 52 instances that mileage was billed in addition to an all-inclusive rate. Mileage was part of all-inclusive rates and should not have been separately billed by providers. DHCS had no system edit or other control to prevent the payment of mileage in addition to the payment of an all-inclusive rate. (See Recommendation 3)

- **Multiple passengers transported in one ambulance**

Regulation 7 AAC 145.440 states that air ambulance providers are prohibited from billing mileage for each recipient when more than one passenger is transported. There is no comparable exclusion for ground ambulance claims in regulations or the Medicaid billing manual. Testing of 30 ground ambulance claims found one instance where two recipients involved in a traffic accident were transported in the same ground ambulance. The provider billed the fixed pick-up fee plus mileage for both recipients. (See Recommendation 3)

- **Airfare claims**

Testing of 35 airfare claims found all were adequately supported.

The prior authorization process was followed for transportation claims.

An objective of the audit was to determine whether the prior authorization process could be improved to ensure the lowest travel costs are obtained, with an emphasis on booking travel in advance when possible. Auditors verified all transportation claims for the period July 2018 through December 2019 that required a service authorization had a corresponding service authorization number in MMIS. In addition, detailed testing of 90 claims[4] showed the authorization process was generally followed, service authorizations were approved prior to travel, and information regarding medical necessity was documented.

[4] Service authorizations are not required for air and ground ambulance claims.

As part of the prior authorization testing, auditors noted that AS 47.05.270(a)(10) directs DHSS to adopt regulations that require recipients to obtain medical services in the recipient's home community when available. As of March 2020, regulations had not been developed and there were no written procedures to evaluate the availability of medical services in a recipient's home community prior to authorizing travel. DHCS's lack of procedures to document consideration of local providers raises concerns that availability of services in a home community was not routinely considered during the prior authorization process. (See Recommendation 5)

Advance purchase of airfares may reduce travel costs.

At the time the audit was requested, DHCS had a long-standing policy to purchase fully refundable tickets for Medicaid and CHIP travel to accommodate frequent change requests and cancelations. An audit objective was to determine whether purchasing non-refundable tickets would reduce travel costs. According to DHCS management, the division directed CTM to purchase non-refundable Alaska Airlines tickets starting July 2016 for intra-state travel when possible.

Auditors reviewed CTM's booking data for the period July 2018 through November 2019[5] and confirmed non-refundable discount tickets were purchased. Thirty-five percent of Alaska Airlines tickets purchased during this time period were non-refundable. Auditors noted that DHCS staff did not evaluate whether purchasing non-refundable tickets reduced travel costs, taking into consideration change fees and canceled/rebooked tickets. Further, information was not available to enable auditors to determine the fiscal impact of the change.

Advance purchase of tickets is another way to discount airfare. Given that seven days is a typical cutoff for an advance purchase discount, scheduling travel at least seven days prior to departure would likely reduce transportation costs. Auditors noted that there

[5] CTM data contained federal and State funded airfare, including claims paid at 100 percent by the federal government.

were no regulations in place to encourage, incentivize, or require providers to schedule non-urgent appointments in advance to allow for the purchase of discounted airfare.

As shown in Exhibit 5, a review of Medicaid and CHIP airfare over an 18 month period found that 35 percent of costs were for tickets purchased less than three days before travel and 68 percent were for tickets purchased less than seven days before travel.

Exhibit 5

Medicaid and CHIP
Airfare Cost by Days Purchased in Advance of Travel
July 1, 2018 through December 31, 2019

Days	Cost	Percentage
0–2	$13,142,962	35%
3–6	12,643,827	33%
7–13	8,921,526	23%
Over 13	3,386,941	9%
Total	$38,095,256	100%

Source: Travel Contractor Booking Data.

Detailed testing found similar results. Testing of 35 airfare claims found 21[6] (60 percent) were booked less than seven days prior to departure. Additionally, service authorizations for 26 of the 35 claims[7] (74 percent) were approved 10 days or less prior to departure.

[6] 15 of 25 randomly selected and six of 10 judgmentally selected airfare claims were booked less than seven days prior to departure.
[7] 18 of 25 randomly selected and eight of 10 judgmentally selected airfare claims service authorizations were approved ten days or less prior to departure.

Existing system edits were adequately designed to prevent improper payments.

The Medicaid billing system contains numerous edits designed to detect improper billings and prevent payments. An objective of the audit was to determine whether edit controls over travel transactions were adequately designed and operating effectively. Existing travel-related edits identify claims that may have an unauthorized number of units submitted, a mismatch between recipient data submitted and information in the system, invalid procedure codes, duplicate claims, and unauthorized dates of service. Testing of claims found that the edits appeared to be functioning as intended.

Although existing edits appeared to be adequately designed and operating effectively, auditors found no edit that matched transportation claims against the medical service dates to verify travel was justified or necessary.

The audit identified potential opportunities to reduce transportation costs.

One of the audit's objectives was to identify procurement efforts that could be made to leverage the State's purchasing power to reduce travel costs for the most significant providers or types of purchases. The audit identified the following opportunities to reduce transportation costs:

- **Establishing fixed rates for certain taxi routes/areas**

The State's taxi voucher system does not require providers to report mileage or the pick-up and drop-off locations when billing. The lack of support increases the risk of erroneous or fraudulent billings.

Alternatives, such as fixed rate vouchers for specific routes or fixed rates within specific areas, may help reduce the likelihood of fraudulent or unreasonable taxi billings. (See Recommendation 2)

- **Expanding access to transportation through ride sharing companies and/or contracting for bus or shuttle services**

Arizona, Texas, and Florida have passed legislation which allows for ride sharing companies, such as Uber and Lyft, to become approved Medicaid providers. Allowing ride sharing companies to provide non-emergency transportation may increase access to transportation and grow the supply of providers which, in turn, may reduce costs.

Analysis of taxi claims during the audit period showed that trips of $50 or more each way accounted for approximately $1.5 million of total taxi costs during an 18 month period. Contracting for bus or shuttle services may reduce or control costs for select routes or areas. (See Recommendation 6)

- **Allowing and promoting the use of public transportation**

Public transportation provides a low cost alternative to taxis. Anchorage serves the largest number of Medicaid recipients and has a public transportation system, yet Anchorage was not an approved Medicaid provider. DHCS stated that public transportation had been considered; however, challenges to administering the program kept the division from implementing a program. Difficulties administering a program include limited service routes, purchasing bus tickets in advance, maintaining an inventory of bus tickets purchased and issued, and providing tickets to recipients in a timely manner. Per DHCS management, the limited use of public transportation was being tested in DHSS's Early and Periodic Screening, Diagnostic, and Treatment program at the time of the audit. (See Recommendation 6)

- **Restructuring air and ground ambulance fees**

The fee structure for air and ground ambulance services was based on whether services were provided in an urban setting or a non-urban setting. Ground ambulance rates were further defined by mileage and level of care administered to a recipient during transport. Air ambulance rates were further defined by type of aircraft and mileage flown. Exhibit 6 displays the rates for air and ground ambulance services.

While the fee structure recognized the lower cost of providing services in an urban area (only Anchorage and Fairbanks qualified as urban), it did not recognize the lower costs of providing services in communities on the road system compared to communities not on the road system. As a result, services provided in a road system community, such as Palmer, were compensated at the same level as services provided in a remote community, such as Fort Yukon. Redesigning the rate structure to recognize the costs of servicing communities on the road system may reduce transportation costs. (See Recommendation 4)

- **Reconsidering higher rates paid to lodging facilities owned by tribal organizations**

A Medicaid State Plan amendment approved in July 2016 allowed government-operated facilities to be compensated at the federal per diem rate, which, during the summer months, was over twice the regulatory rate. Per DHCS management, tribal organizations are considered government entities. There was no federal requirement to pay the higher fees. Eliminating the higher fee for government-operated facilities would reduce State-funded transportation costs. (See Recommendation 6)

Exhibit 6

Medicaid and CHIP
Air and Ground Ambulance Fees
FY 19 and FY 20*

Service	Urban	Rural
Ground Ambulance		
Mileage, per patient loaded mile	$6.42	$9.63
Mileage, per patient loaded mile, over 50 miles	-	$8.03
Non-emergency, advance life support 1	$280.76	$344.21
Emergency, advance life support 1	$444.54	$545.01
Non-emergency, basic life support**	$233.97	$286.85
Emergency, basic life support	$374.35	$458.95
Advance life support 2**	$629.80	$635.98
Air Ambulance		
Fixed wing transport	$2,842.43	$4,263.65
Fixed wing, per statute mile	$9.20	$13.80
Rotary wing transport	$3,304.74	$4,957.11
Rotary wing, per statute mile	$20.50	$30.75

Source: State Adopted Medicaid and CHIP Transportation Fee Schedule.
* Emergency regulations reduced rates by five percent during FY 20. The reduction is not shown in this exhibit.
** All-inclusive rate.

- **Incentivizing the advance scheduling of non-urgent appointments to allow for the advance purchase of airfare**

Auditor review of Medicaid and CHIP air travel indicated that 68 percent of tickets were purchased less than seven days before travel (see Exhibit 5 on page 17). Detailed testing of 35 airfare claims found only nine (26 percent) had a service authorization approved more than 10 days prior to the required travel date. During September 2019, DHCS issued a directive to providers requiring travel requests be made at least 10 days prior to a non-urgent

appointment. However, auditors noted that DHCS did not have a mechanism for monitoring or enforcing the directive. (See Recommendation 1)

FINDINGS AND RECOMMENDATIONS

Recommendation 1

Division of Health Care Services' (DHCS) director should adopt regulations and implement written procedures to encourage the advance purchase of airfare.

Discounted airfare is usually available if a ticket is purchased at least seven days in advance of departure and additional discounts are usually available if a ticket is purchased at least 14 days in advance. Analysis of airfare data from July 2018 through December 2019 showed that 68 percent of airfares were purchased less than seven days prior to departure. The high rate of airfare purchased less than seven days in advance of travel strongly suggests the State is missing opportunities to reduce airfare costs.

There were no regulations that required non-urgent Medicaid or Children's Health Insurance Program (CHIP) appointments be scheduled sufficiently in advance of travel to allow for airfare discounts. Further, there was no written guidance directing recipients to reserve travel as soon as the service authorization is approved.

Per 7 AAC 120.410, the department must consider the least expensive means of transportation and accommodation for a recipient and authorized escort when reviewing a service authorization request.

We recommend DHCS's director adopt regulations and implement written procedures that encourage the advance purchase of airfares. Regulations and procedures should require non-urgent medical appointments be scheduled at least 10 days in advance and encourage recipients to book travel immediately after a service authorization is approved.

Recommendation 2

DHCS's director should consider alternatives to the taxi voucher system.

DHCS lacks effective internal controls over Medicaid taxi voucher claims. Taxi providers are required to enter mileage and pick-up/drop-off data on a voucher after services are provided. However, mileage and pick-up/drop-off location data are not required to be submitted with taxi billings and accuracy cannot be confirmed at the time of payment. Completed vouchers are required to be retained by providers for potential post-payment review by DHCS staff. According to DHCS management, post-payment review is generally restricted to the most egregious potential violators due

to limited resources. The audit found three of 25 randomly selected Medicaid ground transportation claims tested were overbilled.

Title 45 CFR 75.303(a) requires the State to establish and maintain effective internal controls over federal awards that provide reasonable assurance that the State is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the grant awards. The lack of effective internal controls designed to prevent unallowable taxi claims increases the risk of fraud and improper payments.

We recommend DHCS's director consider alternatives to the taxi voucher system, including fixed rates for high cost or frequent routes, or within specific areas.

Recommendation 3

DHCS's director should improve controls over ground ambulance claims.

Of the 30 ground ambulance claims tested, one was paid at an incorrect rate. Further, auditors found one instance where mileage was billed for each recipient when two recipients were transported in the same ground ambulance. Ground ambulance claims were manually reviewed by the fiscal agent for medical justification, but there were no edits or controls in place to review the allowability or accuracy of the mileage. Auditors also noted that regulations did not prohibit ground ambulance providers from double-claiming mileage when more than one passenger was transported in an ambulance.

Additionally, an analysis of ground ambulance claims for the period July 1, 2018, through December 31, 2019, found 52 instances of mileage billed when an all-inclusive rate was charged for services. An all-inclusive rate includes mileage, therefore mileage was not permitted to be billed in addition to the rate. There was no information system edit to prevent providers from submitting mileage with all-inclusive claims or to prevent payment of the claims.

Title 45 CFR 75.303(a) requires the State to establish and maintain effective internal controls over federal awards that provide reasonable assurance that the State is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the grant awards. Per 7 AAC 120.405(c), Department of Health and Social Services (DHSS) will not pay for transportation or accommodations that the department determines to be excessive or inappropriate for the distance traveled, or inconsistent with the medical needs of the recipient. Inadequate controls over ground ambulance claims increase the risk of inaccurate or unallowable costs.

We recommend DHCS's director improve controls over ground ambulance claims.

Recommendation 4

DHCS's director should consider restructuring air and ground ambulance rates.

The fee structure for air and ground ambulance services was based on whether services were provided in an urban or non-urban setting. Only Anchorage and Fairbanks were designated as urban, and the fee structure did not recognize the varying costs of providing services to communities on the road system. As a result, services provided in a community on the road system, such as Palmer, were compensated at the same level as services provided in a remote community, such as Fort Yukon. DHCS management had not considered establishing different fees for communities on the road system.

Title 42 CFR 447.201(b) allows the State to establish its fee schedule for each type of service included in the State's Medicaid program as long as the State plan describes the policy and methods used in setting payment rates. Classifying all communities on the road system as non-urban may inflate Medicaid transportation costs.

We recommend DHCS's director consider restructuring air and ground ambulance fees to help reduce transportation costs.

Recommendation 5

DHCS's director should adopt regulations and implement controls to ensure the availability of medical services in a recipient's home community is evaluated prior to authorizing travel.

DHCS's prior authorization process did not document the evaluation of whether services were available in a recipient's home community. Auditors found medical services may have been available in the local community for four of 35 airfares tested, with no documentation as to why the services were not available in the home community. DHCS management relied on the medical provider's referral and the fiscal agent's knowledge of services available in a community when the agent determined whether to approve travel. DHCS management was confident that staff working for the fiscal agent were knowledgeable and did not see a need to formally document the determination.

Alaska Statute 47.05.270(a)(10) directs DHSS to adopt regulations that require recipients to obtain medical services in the recipient's home community when available. Title 45 CFR 75.303(a) requires the State to establish and maintain effective internal controls over federal awards that provide reasonable assurance that the State is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the grant awards. Per 7 AAC 120.405(b)(1), transportation and accommodations may be approved for a Medicaid or CHIP recipient outside a recipient's home community if medically necessary services are not available in the recipient's community. Lack of adequate and effective internal controls increases the likelihood of unnecessary travel, which inflates transportation costs.

We recommend DHCS's director adopt regulations and implement controls to ensure the availability of medical services in a recipient's home community is evaluated prior to authorizing travel.

Recommendation 6

DHCS's director should consider opportunities to decrease transportation costs.

In addition to Recommendations 1 through 5, the audit identified the following opportunities to reduce transportation costs:

1. Expanding access to transportation through ride sharing companies may increase the supply of transportation providers, which may reduce costs. At the time of the audit,

DHCS management was not considering the use of ride sharing companies because of perceived barriers.

2. Contracting for bus or shuttle services may control or reduce costs. Management was exploring the use of transportation brokers and contractors for bus or shuttle services at the time of the audit.

3. Allowing the use of public transportation systems would provide a low cost alternative to taxi services. DHCS staff had not pursued the use of public transportation because administering such a program was considered too burdensome.

4. Reducing the rates paid to lodging owned by tribal organizations would decrease lodging and meal costs. There was no federal requirement for higher fees established by DHSS in 2016. According to DHCS management, the higher fees were negotiated as part of establishing care coordination agreements with tribal providers and encouraging Alaska Native recipients to obtain care through approved providers.

Per 7 AAC 120.410, DHCS must consider the least expensive means of transportation and accommodation for a recipient when reviewing a travel request. We recommend DHCS's director consider opportunities to decrease transportation costs, analyze the costs versus benefits, and implement fiscally prudent opportunities.

Recommendation 7

DHCS's director should implement regulations to expand the use of telehealth for primary care, behavioral health, and urgent care.

Medical assistance reform,[8] passed in 2016, required DHSS to adopt regulations to expand the use of telehealth for primary care, behavioral health, and urgent care. As of March 2020, DHSS had not adopted the telehealth regulations.

According the DHCS management, the telehealth regulatory project required an extended amount of time to prepare. An actuarial analysis provided to DHSS in 2015 projected telehealth Medicaid

[8] AS 47.05.270(a)(3).

cost savings of approximately $2.6 million in the first year and $13 million by year four. Delayed implementation of telehealth regulations may have resulted in avoidable Medicaid and CHIP service and transportation costs.

We recommend DHCS's director implement regulations to expand the use of telehealth for primary care, behavioral health, and urgent care.

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 a performance audit of the Medicaid and Children's Health Insurance Program (CHIP) transportation costs.

Objectives

The objectives of the audit were to:

- Identify Medicaid and CHIP transportation expenditures from FY 14 through December 2019 and report the top 15 transportation providers with the highest expenditures for FY 19.
- Identify procurement efforts that have been made or could be made to leverage the State's purchasing power to reduce transportation costs for the top 15 transportation providers.
- Determine if the use of telehealth reduced transportation costs.
- Test a sample of travel transactions and determine if transportation claims were reasonable and supported.
- Determine whether the prior authorization process was followed and whether the process could be improved.
- Determine whether changing policy to purchase non-refundable tickets will reduce transportation costs.
- Identify and review ticket cancellations and reissuances.
- Determine whether Medicaid Management Information System (MMIS) edits were adequately designed to prevent improper payments of transportation claims.
- Identify opportunities to reduce transportation costs.

Scope

The audit summarized Medicaid and CHIP transportation expenditures from July 1, 2013, through December 31, 2019. The audit reviewed Medicaid and CHIP transportation claims with State funding from July 1, 2018, through December 31, 2019.

Scope Limitations

The audit was unable to evaluate cancellations and rebookings because the data was not available.

Methodology

To address the objectives, auditors:

- Gained an understanding of transportation and telehealth services by reviewing the following laws, legislation, and documents:
  - Senate Bill 74, effective 2016, which adopted Medicaid and CHIP reform measures.
  - Statutes and regulations (AS 47.05, AS 47.07, 7 AAC 105 through 7 AAC 160) governing Medicaid and CHIP.
  - Alaska State Medicaid Plan and State Plan Amendments.
  - Alaska Medicaid provider billing manuals, remittance advices, recipient handbooks, and fee schedules.
- Reviewed the Division of Legislative Audit report[9] on the State Travel Office (STO) to gain an understanding of potential issues pertaining to Medicaid and CHIP travel.
- Reviewed articles to identify potential issues pertaining to Alaska Medicaid travel or opportunities to reduce transportation costs.
- Reviewed reports and documents issued or provided by Department of Health and Social Services (DHSS), the Government Accountability Office, and other state auditor offices to identify changes in Medicaid and CHIP and to identify potential ways to reduce transportation costs in Alaska.
- Reviewed State travel contracts to gain an understanding of the discounts and travel fees. Also inquired with STO staff regarding the contract details.

[9] ACN 02-30082-16.

- Obtained Medicaid and CHIP federal fiscal year enrollment and expenditure data from the federal medicaid.gov website and DHSS management for reporting purposes.

- Compiled federal and state Medicaid and CHIP travel expenditure data from the State accounting system for the period July 2013 through December 2019 for analysis and reporting purposes.

- Reviewed and analyzed FY 19 transportation expenditure data from the MMIS to identify the top 15 vendors with the highest expenditures.

- Conducted interviews with DHSS and STO staff to gain an understanding of the State's efforts to reduce travel costs.

- Reviewed federally required edits of the National Clear Coding Initiative to gain an understanding of the system edits for transportation claims. Reviewed and analyzed a listing of MMIS system edit controls over transportation claims and tested the edits' operating effectiveness.

- Conducted interviews with DHSS and STO staff and observed the transportation service authorization process to gain an understanding of transportation claims and service authorization policies and procedures.

- Conducted interviews and observations with the travel contractor to gain an understanding of the transportation booking process and available booking data.

- Reviewed and analyzed airfare data from the travel contractor to determine refundable and non-refundable ticket purchases during the period of July 2018 through December 2019 and calculate the days purchased in advance of travel.

- Conducted interviews with DHSS staff to gain an understanding of telehealth claims and progress made in utilizing telehealth services to help reduce transportation costs.

- Compiled telehealth claims data from FY 17 through FY 19 to review the use of telehealth.

- Conducted random and judgmental samples of July 1, 2018, through December 31, 2019, transportation claims from MMIS to assess compliance with federal regulations, state statutes and regulations, and established policies and procedures; verify for proper support; and evaluate for reasonableness. This included verifying applicable authorizations, appropriate claim codes, corresponding medical claims, and billing rates. Sample sizes were selected based on a 90 percent confidence level, with zero expected deviations, and a nine percent tolerable deviation rate. Test results were projected to the population. The samples included the following:

  - A random selection of 25 from 50,340 lodging claims.

  - A random selection of 25 and judgmental selection of five from 391,999 ground transportation claims.

  - A random selection of 25 from 1,607 air ambulance claims.

  - A random selection of 25 and a judgmental selection of five from 27,522 ground ambulance claims.

  - A random selection of 25 and a judgmental selection of 10 from 23,275 airfare claims.

- Analyzed July 1, 2018, through December 31, 2019, transportation claims for unusual activity. Conducted inquiry with DHSS staff regarding high dollar and high usage claims.

Internal controls over transportation claim service authorizations and payments were assessed to determine if controls were properly designed and implemented.

APPENDICES SUMMARY

Appendix A presents FY 14 through December 31, 2019, travel expenditures for Medicaid and CHIP by program and funding source.

Appendix B presents July 2018 through December 2019 telehealth claims by diagnosis code.

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APPENDIX A

Medicaid and CHIP
Transportation Expenditures by Program
FY 14 through December 2019

Fiscal Year	Funding Source	Medicaid Services	CHIP Services	Total
FY 14	Federal	$33,720,556	$1,780,631	$35,501,187
	State	$32,209,029	$958,801	$33,167,830
	Total	**$65,929,585**	**$2,739,432**	**$68,669,017**
FY 15	Federal	$35,682,743	$1,161,225	$36,843,968
	State	$34,594,021	$625,275	$35,219,296
	Total	**$70,276,764**	**$1,786,500**	**$72,063,264**
FY 16	Federal	$44,252,920	$1,166,590	$45,419,510
	State	$32,663,314	$217,117	$32,880,431
	Total	**$76,916,234**	**$1,383,707**	**$78,299,941**
FY 17	Federal	$84,375,121	$457,996	$84,833,117
	State	$7,700,555	$62,454	$7,763,009
	Total	**$92,075,676**	**$520,450**	**$92,596,126**
FY 18	Federal	$73,214,940	$554,992	$73,769,932
	State	$11,938,123	$75,681	$12,013,804
	Total	**$85,153,063**	**$630,673**	**$85,783,736**
FY 19	Federal	$90,668,989	$653,437	$91,322,426
	State	$12,458,508	$89,105	$12,547,613
	Total	**$103,127,497**	**$742,542**	**$103,870,039**
July 2019 – December 2019	Federal	$51,240,031	$358,781	$51,598,812
	State	$5,896,327	$80,966	$5,977,293
	Total	**$57,136,358**	**$439,747**	**$57,576,105**

Source: State Accounting System.

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APPENDIX B

Medicaid and CHIP
Telehealth Claims by Diagnosis Code
July 1, 2018 through December 31, 2019
(unaudited)

Diagnosis	Number of Claims
Mental, Behavioral and Neurodevelopmental Disorders	19,890
Injury, Poisoning, and Certain Other Consequences of External Causes	4,792
Diseases of the Ear and Mastoid Process	4,449
Factors Influencing Health Status and Contact With Health Services	1,536
Diseases of the Musculoskeletal System and Connective Tissue	1,292
Diseases of the Skin and Subcutaneous Tissue	884
Symptoms, Signs, and Abnormal Clinical and Laboratory Findings	879
Diseases of the Circulatory System	722
Diseases of the Respiratory System	425
Diseases of the Nervous System	424
Endocrine, Nutritional and Metabolic Diseases	330
Certain Infections and Parasitic Diseases	234
Congenital Malformations, Deformations, and Chromosomal Abnormalities	165
Neoplasms	159
Diseases of the Digestive System	139
Diseases of the Blood and Blood-Forming Organs	65
Diseases of the Eye and Adnexa	63
Diseases of the Genitourinary System	47
Pregnancy, Childbirth, and Puerperium	42
Certain Conditions Originating in the Perinatal Period	5
Total	36,542

Source: Medicaid Management Information System data.

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Agency Response from the Department of Health and Social Services

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

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November 27, 2020

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Dear Ms. Curtis,

RE: Confidential Preliminary Audit Report, Department of Health and Social Services (DHSS), Medicaid and Children's Health Insurance Program (CHIP) Transportation Costs.

The Department of Health and Social Services (DHSS) appreciates the opportunity to review and provide feedback to the associated findings and recommendations as shared in your management letter.

In response to the Report Organization and Conclusions:

The report conclusions discussed on page 4 fail to note that the state was relieved of the administrative burden associated with the transition to the tribes from the state. So, while the state realized savings in general fund spending for transportation services due to the increase of federal reimbursement to over 90%, the state also was relieved of the administrative burden associated with these operations as the responsibility transitioned completely to the tribal health organizations.

The department has the following comments, regarding the bulleted comments on page 5:

Paragraph (1) Identified Unallowable or Unreasonable Costs:
Bullet 1: The federal per diem rates are higher than those for standard lodging, however, they are reimbursed at 100% by CMS, leading to a significant savings in state general funds. This change was part of tribal state negotiations to have tribal health organizations assist with the tribal reclaiming efforts set forth in SB74. Tribal consultation with CMS views the tribes as a federal entity and are privy to federal reimbursement rates. These costs are both allowable and reasonable.
Bullet 2: Disagree with statement that taxi claims were overbilled.
Bullet 4: Disagree – All claims presented to HCS regarding medical justification for transport out of the members home community were found to be appropriate based on the member's diagnosis.

Potential opportunities to reduce transportation costs:
Bullet 1-3: Agree – These are goals currently being worked on by the department.

Bullet 4: Partially Disagree – Alaska Medicaid rates for ambulance services have remained stagnant since 2012 and reimbursement rates are set lower than Medicare rates. A rate restructure will likely result in higher reimbursement and additional expenditures to providers. One area that could be vetted is restructuring how HCS determines urban vs. rural; currently HCS utilizes the Census, however, the DLA has mentioned other potential sources that could be considered.
Bullet 5: Disagree – The fee structure for tribal lodging has been established in the state plan and approved by CMS. The federal per diem rate is set by the federal government, thus any alteration to the structure of tribal lodging rates would be at their discretion. It should also be noted that the state saves a substantial amount of general funds due to the 100% federal reimbursement at these rates. Were the state to attempt to remove the provision of allowing the federal per diem for tribal lodging from the state plan, general fund expenditures would increase significantly. This change was part of tribal state negotiations to have tribal health organizations assist with the tribal reclaiming efforts set forth in SB74. Tribal consultation with CMS views the tribes as a federal entity and are privy to federal reimbursement rates.
Bullet 6: Partially Agree – The system is set up for the licensed medical providers to establish medical necessity and referral for travel. The state would incur liability if it imposed restrictions on or second guessed licensed medical professionals. As an example, if travel is not done timely it can be the difference between a routine fever potentially being misdiagnosed meningitis and resulting in a medevac vs regular travel cost, thus the need for medical professional referrals. The department is always exploring alternate approaches while prioritizing the safety and well-being of its program recipients.

The department has the following concerns pertaining to statements in the following paragraphs:

Page 14: Lodging and meals claims – last sentence of second paragraph
Disagree – The federal per diem rates were agreed upon during a tribal consultation with both the tribes and Centers for Medicare and Medicaid Services (CMS).
Page 14: Taxi Claims
Disagree – There is a threshold limit in place to monitor providers billing over $125. These claims are manually reviewed to ensure reimbursement is appropriate. Post payment reviews and audits are done for claims billed at a lower rate. Over three hundred thousand ground transportation trips were billed to the Department in SFY2020; HCS does not possess the resources to validate the mileage on each transport prior to payment, this would significantly delay reimbursement to providers.
Page 15: Air and Ground Ambulance Claims
Partially Agree – Agree with the 52 instances where mileage was billed along with all-inclusive rates.
Page 15: Multiple passengers transported in one ambulance
Agree – It would be a benefit to the department to have exclusions in place for multiple passenger ground ambulance transport.

Recommendation #1 – DHCS's director should adopt regulations and implement written procedures to encourage the advance purchase of airfare.
DHSS partially concurs with the recommendation. The system is set up for the licensed medical providers to establish medical necessity and referral for travel. The state would incur liability if it imposed restrictions on or second guessed licensed medical professionals. As an example, if travel is not done timely it can be the difference between a routine fever vs meningitis. The department is always exploring alternate approaches while prioritizing the safety and well-being of its program recipients. An example may include a tiered

approach to scheduling travel which includes services that could be scheduled a month or more in advance such as routine well child exams; a second tier where travel is imminent due to onset of an illness or injury and needs to occur in two weeks or less and a third tier that looks like diverting emergent travel or medevac costs by arranging next day or same day air. Additionally, purchasing advance airfare does not always bring efficiencies, and the savings may be offset if recipients need to change tickets multiple times due to scheduling changes. Non-refundable tickets may become more expensive than refundable.

Recommendation #2 – DHCS's director should consider alternatives to the taxi voucher system.
DHSS concurs with the recommendation. DHCS is actively exploring alternatives to the voucher system.

Recommendation #3 – DHCS's director should improve controls over ground ambulance claims.
DHSS partially concurs with the recommendation. Implementation of system edits to prohibit an all-inclusive base rate from billing mileage may be expensive due to the complexities in ambulance billings. Alternately, in response to DLA findings, HCS has implemented a post payment manual review process to assist in identifying these errors within 120 days of adjudication of the claims.

Recommendation #4 – DHCS's director should consider restructuring air and ground ambulance rates.
DHSS concurs with the recommendation. HCS will research alternate methods for determining urban vs. rural and to determine the feasibility of replacing the Census.

Recommendation #5 – DHCS's director should adopt regulations and implement controls to ensure the availability of medical services in a recipient's home community is evaluated prior to authorizing travel.
DHSS does not concur with the recommendation. Alaska Medicaid's fiscal agent retrieves all of the necessary information to process a service authorization request for each travel to include referral from the member's healthcare provider, member diagnosis, procedure being traveled for, medical appointments that will be attended, and other information to substantiate the travel. This information is documented on the service authorization and provides a picture of why the travel was necessary.

Recommendation #6 – DHCS's director should consider opportunities to decrease transportation costs.
DHSS partially concurs with the recommendation. HCS continues to actively explore opportunities to reduce costs to the state. The Medicaid program is required to provide access to services for recipients. This often requires transportation. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program also requires medically necessary services and travel to locations for these services. In some cases, attempting to decrease transportation for specific cases increases fair hearings and may still result in transportation and additional administrative burdens. DHSS does not concur with item 4 as it relates to a negotiated agreement that occurred during a tribal consultation including CMS.

Recommendation #7 – DLA recommends the DHCS's director implement regulations to expand the use of telemedicine for primary care, behavioral health, and urgent care.
DHSS partially concurs with the recommendation. In alignment with Senate Bill 74 the department has been working toward better defining and operationalizing telemedicine within the Medicaid program. The draft regulations will need to be re-assessed following the public health emergency for COVID-19 due to interim

emergency changes in federal guidance for COVID-19 that have taken priority. Additionally, while telemedicine visits expand access to care for some, they do not reduce the occurrence of other services, such as travel and in-person office visits. There is a liability issue for providers to withhold travel for a telemedicine patient they would otherwise treat or examine in person to determine the extent of a medical issue. While telemedicine is a valuable tool, nationwide data has shown that it does not reduce the need for additional visits or save money.

Lastly, to better achieve the goal of designing a telemedicine program which serves the needs of beneficiaries and reduces expenditures, the Medicaid Program will need to require the full participation and expertise of medical associations and experts who are in a better position to offer insight into any changes to the service delivery model.

Please contact Linnea Osborne at 907-465-6333 if you have any questions or concerns.

Sincerely,

Adam Crum
Commissioner

CC: Sana P. Efird, Assistant Commissioner
Albert Wall, Deputy Commissioner
Renee Gayhart, Director, Division of Health Care Services
Linnea Osborne, Accountant V

Legislative Auditor's Additional Comments

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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November 30, 2020

Members of the Legislative Budget
and Audit Committee:

I have reviewed the Department of Health and Social Services commissioner's response to the audit report. Nothing contained in the response leads me to revise or reconsider the report conclusions or recommendations. However, I offer the following comments:

- Page 1 of the commissioner's response states that the tribal lodging rates are reimbursed at a rate of 100 percent by the federal government. This statement is not accurate. Only Alaska Native recipient travel claims for services obtained through facilities operated by federal Indian Health Services or Tribes qualify for 100 percent reimbursement. As discussed in the report conclusions, this specific universe of claims was excluded from detail testing. All of the lodging claims tested as part of the audit were paid, in part, with State funds.

- The commissioner disagrees with the audit's conclusion that three of the 30 taxi claims tested (10 percent) were overbilled. However, the three taxi claims found by auditors were also identified as overbilled by the Division of Health Care Services (DHCS) post-payment review process. DHCS management agreed with the auditors' finding during fieldwork. The ten percent error rate and the commissioner's statement that over 300,000 ground transportation claims are processed annually demonstrate that inadequate controls over taxi claims is a material issue that should be addressed.

- The commissioner disagrees that medical services may have been available in the home community for four of the 35 airfare claims tested. The commissioner also disagrees with the related recommendation (Recommendation 5) to adopt regulations and implement controls to ensure the availability of medical services in a recipient's home community is evaluated prior to authorizing travel. In rebuttal, I note that Senate Bill 74 included specific language requiring the department to adopt regulations to ensure Medicaid recipients receive medical care in their home community whenever appropriate services are available in the home community. I also note that auditors

found regulations were not adopted and that the service authorizations for the four airfare claims did not include evidence that fiscal agent staff evaluated availability.

In summary, I reaffirm the conclusions and recommendations.

Sincerely,

Kris Curtis, CPA, CISA
Legislative Auditor