



**ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES
ALASKA DEPARTMENT OF LAW**

JOINT LEGISLATIVE REPORT

**Fraud, Abuse, and Waste,
Payment and Eligibility Errors
for FY16**

November 2016

**ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES
ALASKA DEPARTMENT OF LAW
JOINT LEGISLATIVE REPORT
Fraud, Abuse, and Waste, Payment and Eligibility Errors for FY16**

Below is a joint report from the Department of Law (DOL) and Department of Health and Social Services (DHSS) as required by Senate Bill (SB 74). This report provides a high level review of the efforts of both departments to combat fraud, abuse and waste in the Medicaid program. Additional details or information is available upon request.

For information from the Department of Law, contact Assistant Attorney General Cori Mills at cori.mills@alaska.gov or Assistant Attorney General Kaci Schroeder at kaci.schroeder@alaska.gov. For information from the Department of Health and Social Services, contact Deputy Commissioner Jon Sherwood at jon.sherwood@alaska.gov.

**I. POSITIONS/PROGRAMS DEDICATED TO FRAUD, ABUSE, WASTE
(NUMBER OF POSITIONS AND FUNDING SOURCE)**

DOL Criminal Division/Medicaid Fraud Control Unit (MFCU):

10¹ FTE funded (75% federally-funded, 25% state general fund):

- Attorneys – 2¹
- Accountants – 1
- Investigators – 6
- Other (Law Office Assistant) – 1

DOL Civil Division:

- Attorneys – 1.25 attorneys
- Paralegals – .5
- Other (Law Office Assistant) – .25

¹ There is the possibility of adding one additional attorney and one paralegal in response to an increase in Alaska Medicaid False Claims Act (AMFCA) cases in January 2017. These positions will be 50% federally-funded, 50% state general fund funded, once the AMFCA is approved by the federal government.

DHSS:

31 FTE in four divisions: Public Assistance, Behavioral Health, Health Care Services, Senior and Disabilities Services, and the Medicaid Program Integrity Office (50% federally-funded, 50% state general fund)

- Clinicians – 1
- Investigators – 13
- Audit & Recovery Analysis - 3
- Medical Assistance Administrators- 10
- Claims Collection staff -3

II. ACTIONS TAKEN TO PREVENT FRAUD, ABUSE, AND WASTE

DOL Criminal Division/MFCU:

- 124 referrals with an additional 58 cases pending from prior years
- 16 cases where charges filed
- 28 convictions²
- 3 cases with civil resolution³
- 178 cases reviewed and/or actively investigating or litigating

DOL Civil Division:

- 20 Myers and Stauffer Audit appeals⁴
- 2 sanction matters referred

DHSS:

- 16,682 referrals (total)
- 11,298 intakes
- 1,841 investigations
- 53 audits (contract audits under AS 47.05.200)
- 149 reviews (targeted/limited audit conducted by DHSS)

² Convictions relate to convictions received in FY16 but the cases may have originally been brought in prior years as well as FY16.

³ These were cases where prosecution was deferred in exchange for an agreement to pay back money and restrict defendant's ability to provide Medicaid services. These agreements were in lieu of criminal prosecution.

⁴ These are the audits required by AS 47.05.200.

III. INITIATIVES TAKEN TO PREVENT FRAUD AND ABUSE

- 2016: Supported the passage of SB 74, including passage of the Alaska State Medicaid False Claims and Reporting Act.
- March 2014: DHSS received permission from the federal government to implement a moratorium on enrolling and certifying new personal care agencies in the Alaska Medicaid program.
- October 2012: Start to develop a new active working relationship between the DOL/MFCU, Civil Division and DHSS, including monthly meetings to discuss all facets of program integrity to prevent waste, fraud, and abuse in the Medicaid program.
- October 2012: Start to developed new active working relationships with federal partners (*e.g.* the FBI, OIG, Immigration, and Social Security).
- 2010: Amended regulation requiring all personal care assistants to individually enroll as Medicaid providers.
- April 2006/July 2012: Revised personal care program regulations resulting in a reduction in the PCS program budget by \$51 million.⁵
- DPA FCU's Annual Accomplishments Report is at:
<http://dhss.alaska.gov/dpa/Pages/features/org/fraud.aspx>⁶

IV. EXAMPLES OF ISSUES UNCOVERED, *i.e.* VULNERABILITIES IN THE MEDICAID PROGRAM (INCLUDING SUGGESTIONS MADE BY MEYERS AND STAUFFER, IF ANY)

Amend Regulations to:

- Address interplay between enrollment and certification and clearance from the background check unit.
- Require all direct service providers (respite and chore providers) to enroll in the Medicaid program, as required for personal care assistants.
 - Require any recipient caught committing fraud to receive all PCA services through an agency-based provider rather than consumer directed.

⁵ Personal Care Program expenditures in FY13 of \$126 million, FY16 expenditures were \$75 million.

⁶ MFCU produces a report to the federal government each year on or about December 1. That report is available upon request.

- Provide Senior and Disabilities Services (SDS) the authority to require agency-based services if there is a suspicion of fraud or abuse.
- Require all PCA agencies use a single standardized timesheet format.
- Require Medicaid beneficiaries to bill Medicaid first for all provided services, to prevent beneficiaries from paying cash for prescription drugs in order to avoid triggering a notice of overutilization. Additionally, the ability to pay a large quantity of cash for prescription drugs suggests that the recipient may be over-income and does not qualify for Medicaid.
- Provide clear guidance on the use of Recipient Support Services (RSS).⁷
- Create verification system so that personal care assistants cannot submit timesheets for more than 40 hours per week without advance authorization.
- Evaluate the efficacy and impact of daily limits for recipients' behavioral health services.
- Evaluate alternative payment models for behavioral health services (*e.g.*, 1115 waiver)

V. RECOMMENDATIONS TO INCREASE EFFECTIVENESS OF FRAUD AND ABUSE MEASURES/INITIATIVES

- Implement a case tracking system that can be used by Medicaid Program Integrity and the Quality Assurance and Surveillance and Utilization Review units within the Department of Health & Social Services. This would allow real-time information sharing leading to a more coordinated fraud, waste and abuse prevention effort. State law enforcement uses a program called ARMS – and this program is available for DHSS –which allows for storage of evidence and lockdown with respect to viewing privileges.
- Enroll all direct service providers such as home and community based (chore, respite, habilitation) and behavioral health rehabilitation providers. The successes we have achieved with the Personal Care Program are largely due to the enrollment of the direct service providers.

⁷ Recipient support services are currently defined in regulation as a face-to-face encounter to provide structure, supervision, and monitoring necessary to maintain a child experiencing a severe emotional disturbance, or an adult experiencing a severe mental illness within the recipient's home, workplace, school, or community, and to prevent harm to the recipient or others.

- Require background checks as a condition of enrollment of direct service providers and prohibit the billing for any service prior to the receipt of a provisional background check clearance.
- Follow Medicare guidelines regarding rounding of time based on procedure codes.
- Increase use of functioning service authorization and benefit/service limits.
- Better definitions of certain terms (*e.g.*, “contemporaneous duplicative services”). Waiver regulations should mirror PCA regulations with regard to documentation requirements.
- Increase clarity in dental regulations regarding service limits and better define emergent and enhanced dental services.
- Require provider attestation of training and education.
- Implement use of corporate integrity agreements requiring providers to sign a stipulation that conduct is in violation of Medicaid regulations as part of agreement.
- Decreased lag time between the audit issuance and appeal decision.
- Division of Public Assistance Fraud to resume Medicaid beneficiary fraud cases.
- Establish a telemedicine program manager. With the increased emphasis on telemedicine, ensuring adequate program oversight is more important than ever.
- Review and amend the language in 7 AAC 100.910 (Recovery of Medicaid Expenditures) to give the State the ability to pursue and collect identified Medicaid overpayment amounts for all individuals related to the Medicaid case.

VI. DOLLAR RETURN FOR EFFORTS, INCLUDING COST AVOIDANCE

DOL Criminal MFCU:⁸

- Restitution ordered from criminal convictions: \$1,999,977
- Restitution recovered: \$1,143,611
- Recoveries from nationwide false claims cases: \$1,529,540
- Return on investment for MFCU: 10.5:1.00
- Fines ordered in criminal cases: \$417,050

DOL Civil:⁹

- Awarded in court orders: \$1,735,573
- Amounts agreed upon in settlements: \$196,596

DHSS:

- Recoveries: \$1,803,989
- Estimate re offsets/avoidance: \$20,750,345
- DPA: \$511,297

VII. EXAMPLES OF FRAUD ABUSE THAT WAS PROSECUTED/PREVENTED

DOL Criminal/MFCU:¹⁰

State v. Good Faith -- Agnes Francisco and Good Faith Services, LLC were convicted for their part in defrauding Medicaid over \$1.5 million. This case resulted in 52 criminal convictions and seven civil resolutions, and providers associated with Good Faith were suspended from program participation. Francisco was sentenced for a Class C felony of medical assistance fraud and ordered to serve three years in prison and to pay a fine of \$50,000. Good Faith was sentenced for a Class B felony of medical assistance fraud and ordered to pay restitution of \$1.5 million to the Alaska Medicaid Program. The restitution will be secured through civil agreements with two corporate owners who were not criminally prosecuted.

⁸ Collections relate to all funds received in FY16 but also include cases which may have originally been brought in prior fiscal years.

⁹ *Id.*

¹⁰ For more information on any of these cases, go to www.law.alaska.gov/department/criminal/mfcu.html or contact Assistant Attorney General Kaci Schroeder at kaci.schroeder@alaska.gov.

State v. De Leon Sober -- Cecelia De Leon Sober, owner of C Care Services, LLC, was sentenced to 12 months incarceration and 10 years' probation, and ordered to pay restitution of \$73,000 and a fine of \$15,000, for her conviction for Medicaid fraud. She had billed the State of Alaska for unnecessary services, submitted fraudulent timesheets, and billed for services that were never provided. A total of 27 individuals associated with C Care were prosecuted for fraudulently billing the Alaska Medicaid Program approximately \$300,000.

State v. Ghosh -- Former physician Ghosh was convicted of evidence tampering and Medicaid fraud for his role in creating false medical records to convince investigators that the alleged services were provided when they were not, and billing Medicaid over \$600,000 for these false services. Ghosh was sentenced to 3.5 years' incarceration and ordered to pay restitution of \$605,000.

State v. MARC -- The owner of a corporation and company was convicted for altering medical records to avoid an overpayment finding during an audit. The auditors noticed a discrepancy and scheduled an on-site review, which revealed that the medical records had been intentionally changed in attempt to avoid repaying Medicaid \$287,000. The owner was sentenced to four months in jail, a \$50,000 fine, and ordered to pay the full amount of all past audit findings over multiple years, which totaled \$1.6 million.

There were multiple convictions against several personal care assistants (PCA) for falsely billing Medicaid for services that were not provided, including six cases jointly investigated with the FBI and referred to the U.S. Attorney's Office for prosecution, with a fraud value of over \$500,000.

DOL Civil Division:

The Civil Division was involved in 24 audit appeals during the fiscal year. That includes 11 settlements finalized during the fiscal year, nine of which were Myers and Stauffer audits and two were DHSS audits. Examples of these audit appeals include the following:

- *ITMO: C Care Services* – This was an appeal of an audit that involved claims for in-home waiver and respite services. The overpayments were predicated on insufficient documentation. The auditors found the provider impermissibly (and likely fraudulently) used the same service notes for multiple dates of service. Recovery: \$146,674.58.

- *ITMO: Eben-Ezer Home Health Care*-- was an appeal of audit that involved claims for in-home Personal Care services. The overpayments were predicated on incomplete and insufficient timesheets. Recovery: \$252,364.73
- *ITMO: Last Frontier Assisted Living, LLC*-- was an appeal of an audit that involved two separate Myers and Stauffer audit appeals that were consolidated along with a DHSS audit. The overpayments for the two Myers and Stauffer audits were predicated largely on discrepancies between the units billed and amount of time reflected in the timesheets. There were also overpayments due to a lack of prior authorization to establish medical necessity for the billed services. The overpayments for the DHSS audit were due to services being provided by an individual PCA who was disqualified due to a barring condition. Recovery: \$1,337,533.25.
- *ITMO: Family Centered Services of Alaska* -- was an appeal of an audit that involved overpayments related to lack of documentation to support behavioral health services, particularly residential supported services (“RSS”). Recovery: \$92,764.
- *ITMO: Transplant House* -- was an appeal of an audit that identified improper billing for recipients and their escorts, billing Medicaid more than the public, and billing while recipient was receiving inpatient care. Recovery: \$51,255.23.

DHSS:

Substantiated allegations that M.C. Smith failed to declare multiple bank accounts, associated account balances, and a monthly structured annuity payment in the amount of \$4,657.12 as part of multiple applications for public assistance benefits, resulting in his receiving \$98,846.64 worth of benefits to which he was not entitled. Smith pled guilty to unsworn falsification and was sentenced to 360 hours of community service and 360 days of suspended jail time. Smith made restitution in full.

Also, it was substantiated that Emotion Lynd gave her minor child’s Medicaid card to Jabriel Johnson-Byrd so that he could procure dental services of \$10,705 to which he was not entitled. Johnson-Byrd pled guilty to attempted theft in the second degree. Johnson-Byrd was also convicted of intentional program violation and was sentenced to 160 hours of community service and 60 days of jail time, and he was ordered to make restitution.

Medicaid Program Integrity in conjunction with the Department of Law suspended payments to 15 providers during FY16 due to credible allegations of fraud.

Case management and recipient Surveillance and Utilization Review (SUR) efforts have resulted in waste prevention through continuity of care, improved medication compliance, and completion of treatment plans for chronic illnesses, as well as various other efforts. Estimated Cost Savings of \$50,000.

Health Care Services implemented the Super Utilizer Program, which means expensive emergency room care has been diverted to treatment-appropriate primary care providers. Estimated costs savings of \$2.5 million.

VIII. MOST RECENT PAYMENT ERROR RATE (EXPLAIN THE REASON FOR THE RATE)

The Medicaid program rate is 16.8%. Alaska has no managed care, so this rate should be compared with the national fee-for-service error rate, which is 18.6%. Alaska's Medicaid program had 81 errors:

- 22 for insufficient documentation,
- 31 for non-covered services,
- 18 for claims pricing errors, and
- 10 for other.

The Children's Health Insurance Program (CHIP) had an overall error rate of 8.4%, compared with the national CHIP FFS error rate of 13.1%. CHIP had 53 errors:

- 15 for insufficient documentation,
- 21 for non-covered services,
- 14 for claims pricing errors, and
- 3 for other.

IX. RESULTS, IF ANY, FROM THE MEDICAID ELIGIBILITY QUALITY CONTROL PROGRAM

The Centers for Medicare and Medicaid Services issued an official state health letter on August 15, 2013, directing states to implement Medicaid and CHIP Eligibility Review Pilots in place of the Payment Error Rate Measurement and the Medicaid Eligibility Quality Control (MEQC) eligibility reviews for fiscal years 2014 – 2016. The eligibility pilot replaces the MEQC pilot and traditional reviews that began in federal FY14.