



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

JOINT LEGISLATIVE REPORT

**Fraud, Abuse, and Waste,
Payment and Eligibility Errors
for FY 17**

November 2017

**ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES
ALASKA DEPARTMENT OF LAW
JOINT LEGISLATIVE REPORT
Fraud, Abuse, and Waste, Payment and Eligibility Errors for FY17**

Below is a joint report from the Department of Law (DOL) and Department of Health and Social Services (DHSS) as required by Senate Bill 74 (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. This report is for activity that occurred in FY17 and does not repeat information from the report filed on November 15, 2016.

For additional 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 additional 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)**

DEPARTMENT OF LAW:

Criminal Division/Medicaid Fraud Control Unit (MFCU) (funding: 75% federal/25% state general fund):

- Attorneys – 3
- Accountants – 1
- Investigators – 6
- Law Office Assistant – 1
- Paralegal – 1

Civil Division (funding: 50% federal/50% state general fund):

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

DHSS (funding: 50% federal/50% state general fund):

- Commissioner's Office (Program Integrity)¹
 - Six staff in Anchorage. There is one vacant PCN.
 - The state FY 17 component budget was approximately \$1,132,900.

- The Division of Public Assistance (Fraud Control Unit)²
 - The fraud control unit currently consists of 13 staff (9 in Anchorage, 2 in Fairbanks, 1 in Kenai, and 1 in Wasilla).
 - The state FY 17 fraud Investigation component budget was approximately \$2,714,700.³
 - The Division of Public Assistance also has claims collection staff located in Juneau to pursue debt collection.

¹ The Program Integrity Office has statewide responsibility of management and oversight of independent contract audits required by AS 47.05.200, coordination for Medicaid Integrity Program audits, contact and referral process for Department of Law, Medicaid Fraud Control Unit, management of the payment suspension process as a result of credible allegations of fraud, conducting medical assistance claims reviews and audits and supporting provider appeals, providing technical assistance and collaboration with other department's internal reviews of programs and processes, compliance officer contact for Centers for Medicare/Medicaid services, assistance and coordination efforts of divisional quality assurance units, coordination with department audit committee, Payment Error Rate Measurement coordination, provider overpayment recovery and reporting, and coordination of provider sanctions and maintenance of the Alaska excluded provider list.

² The Division of Public Assistance Fraud Control Unit (FCU) has statewide responsibility for the welfare fraud deterrent effort. Fraud case referrals often involve benefits received from one or more programs. Most commonly, these include Alaska Temporary Assistance, Food Stamps, Medicaid, Adult Public Assistance, Child Care and Senior Benefits.

³ This amount includes funds for the Department of Law, Office of Special Prosecutions, Medicaid Fraud Control Unit.

- Division of Senior and Disabilities Services (Quality Assurance)⁴
 - The Quality Assurance unit consists of 16 staff (all in Anchorage). There are currently 3 vacant PCNs.
 - The state FY 17 component budget was approximately \$1,695,530.
- Division of Health Care Services (Quality Assurance)⁵
 - The Quality Assurance Unit currently consists of 10 staff (all in Anchorage). There is currently 1 vacant PCN.
 - The state FY 17 component budget was approximately \$ 1.1 million.

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

DEPARTMENT OF LAW:

Criminal Division/MFCU:

- 79 referrals that resulted in opening new criminal or civil investigations.
- 24 individuals were criminally charged.
- 8 criminal convictions.⁶
- One case with a civil resolution.⁷

⁴ The Division of Senior and Disabilities Services Quality Assurance Unit (QA) has statewide responsibility to ensure the health and welfare of recipients through the monitoring and oversight of service to participants and their families. QA collaborates with stakeholder and other DHSS agencies to investigate fraud. Quality Assurance Unit activities include critical incident report review, investigations, remediation reporting, and mortality review.

⁵ The Quality Assurance Unit houses Provider Enrollment, Surveillance and Utilization Review, Care Management Program (lock-in), Alaska Medicaid Coordinated Care Initiative (AMCCI), Fair Hearings, and the ARM Project. Overall the unit is responsible to ensure that state and federal enrollment guidelines are followed on the front end of the Medicaid spectrum, and that similarly, both providers and members are exhibiting appropriate behaviors on the backside of the Medicaid spectrum. For providers, this means post-payment claims review. For members, this means pattern analysis to ensure medical necessity and continuity of care. QA generally takes an educational/informational approach to correcting provider behaviors, but we certainly collaborate with Program Integrity and MFCU for cases that warrant escalation.

⁶ Convictions relate to convictions received in FY 17 but the cases may have originally been brought in prior years.

- Including prior fiscal year cases, the Unit began with 141 open cases, added 79 new cases and closed 113 cases by the end of FY 17, leaving 107 active cases.
- 50 cases reviewed and declined based on a lack of sufficient evidence.
- The Division of Public Assistance is implementing an Asset Verification System. The Asset Verification System will check for financial accounts on a national level.
- Initial phases of the RFP process for an eligibility verification system.

Civil Division:

- 9 audit appeals referred to the Office of Administrative Hearings.
- 5 sanction appeals referred to the Office of Administrative Hearings.

DHSS:

- Commissioner's Office (Program Integrity)
 - Number of referrals to the DOL/MFCU (Credible Allegations of Fraud): 15
 - Number of incoming referrals from incoming complaints: 57
 - Number of audits issued under AS 47.05.200: 38
 - Number of focused reviews: 65
- Division of Public Assistance (Fraud Control Unit)
 - The FCU received 276 fraud referrals for the Medicaid program:
 - Applicant or Early Fraud Detection Investigations: 11
 - Categorically Ineligible Investigations: 209
 - Recipient or Post Certification Investigations: 56
 - The FCU completed 345 investigations involving the Medicaid program:
 - Applicant or Early Fraud Detection Investigations: 1
 - Categorically Ineligible Investigations: 185
 - Recipient or Post Certification Investigations: 2
 - Closed cases for reasons other than fraud pertaining to the Medicaid program: 157

⁷ This was a case where prosecution was deferred in exchange for an agreement to pay back money and pay an additional civil penalty.

- Senior and Disability Services (Quality Assurance)⁸
 - 11,992 intakes to SDS Quality Assurance.
 - 1,009 intakes screened into Investigation.
 - 17 investigations referred to Program Integrity Unit and/or Medicaid Fraud Control Unit.
 - 283 Investigations were conducted.
 - 75 allegations were substantiated.
 - 157 compliance reviews by SDS Provider Certification and Compliance.
 - 6 Providers were required to submit a Corrective Action Plan.

- Division of Health Care Services (Quality Assurance)
 - 30 Unitization Review Cases opened.
 - Worked with numerous providers related to repayments associated with the go live of the Medicaid Management Information System (MMIS) in 2013.

III. INITIATIVES TAKEN TO PREVENT FRAUD AND ABUSE

- See DPA Fraud Control Unit's Annual Accomplishments Report for all fraud initiatives taken.⁹
- Enrolling direct care provider in the home and community based waiver system (respite and chore); will do the same for behavioral health providers once the 1115 Waiver is in place.
- Put Conduent on a corrective action plan to improve the process for manually processing claims.
- Entered into a third party contract to improve our capabilities related to 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 and Social Services. This would allow real-time information sharing, leading to a more coordinated department fraud, waste, and abuse prevention effort.

⁸ Due to the conversion to a new database/case management system, some FY 17 data is not currently available.

⁹ This report can be found at <http://dpaweb.hss.state.ak.us/node/29>.

- Amended regulations to:
 - Increase clarity in dental regulations regarding service limits and better define emergent and enhanced dental services.
 - Implement new SDS regulations related to PCA and Waiver to provide more detailed requirements around eligibility and service levels.
- In the process of amending regulations to:
 - Follow Medicare guidelines regarding rounding of time-based procedures codes, to clarify what is allowable for a time-based code. Reduce confusion about how to bill for a partial code (how to bill for 5 minutes of a 15 minute unit).
 - Increase the use of functioning service authorizations and benefit/service limits in order to create a more thorough prepayment review process.
 - Provide a definition of “contemporaneous” to clarify what is meant related to records to support a submitted claim.
 - Implement provision from SB74 allowing for civil fines and self-audits.
- The Medicaid Program Integrity section publishes the Alaska excluded provider list. This published list helps prevent fraud and abuse by helping to ensure providers who may have been convicted of medical assistance fraud or other barring conditions are not allowed back in to the program unless they have been reinstated. The list may be found at : <http://dhss.alaska.gov/Commissioner/Documents/PDF/AlaskaExcludedProviderList.pdf>.

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

- Need to address gap in background check process to assure that all billers have valid background checks as a condition of enrollment. We propose using SB 81 or HB 162 to address the identified gaps.

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

- Revisit and address gaps in the background check process under AS 47.05.300. Re-introduce legislation to re-classify Unsworn Falsification as part of welfare applications from Class A Misdemeanors to Class C felonies.
- Waiver regulations should mirror PCA regulations with regard to documentation requirements.
- Make amendments to the language in 7 AAC 100.910 (recovery of Medicaid expenditures) in order to give the State the ability to pursue/collect identified Medicaid overpayment amounts for all “individuals” related to the Medicaid case.
- Improve the lag time between the audit issuance and appeal decision.

VI. DOLLAR RETURN FOR EFFORTS, INCLUDING COST AVOIDANCE

DEPARTMENT OF LAW:

Criminal Division/MFCU:

- Restitution ordered from criminal convictions resolved during FY 17: \$93,502
- Restitution recovered from all outstanding matters: \$315,942
- Recoveries from nationwide false claims cases: \$33,260
- Return on investment for MFCU: approximately \$1.30 dollars for every \$1 dollar spent
- Fines ordered in criminal cases: \$7,500

Civil Division:

- Awarded in court orders: unidentified/unknown¹⁰
- Amounts agreed upon in settlements: \$23, 500

¹⁰ There are seven pending decisions with the OAH, which may result in recoveries to the State, but those amounts have not been established as of the date of this report.

DHSS:

Program Integrity:

Recoveries:	\$2,279,338
Cost Avoidance:	\$5,216,082
Total Program Integrity Return to State:	\$7,495,420

Fraud Recovery Unit:

Recoveries:	\$29,172.00
Cost Avoidance:	\$513,448.54

Quality Assurance (SDS)

Recoveries:	\$14,538.66
Cost Avoidance: ¹¹	

<u>Quality Assurance (DHCS):</u>	\$80,222.71 ¹²
----------------------------------	---------------------------

VI. EXAMPLES OF FRAUD AND ABUSE THAT WAS PROSECUTED/PREVENTED

DEPARTMENT OF LAW:

Criminal Division/MFCU:¹³

1. Flamingo Eye, LLC Assisted Living Home:

In March 2017, the Alaska MFCU received a grand jury indictment on Margaret Williams, the owner of Flamingo Eye, LLC assisted living home on three felony counts of Medical Assistance Fraud, one count of Scheme to Defraud and one count of

¹¹ Due to the database conversation, this number is not available as of the date of this report.

¹² This number is low because the unit developed the majority of its recourse to collecting overpayments from the MMIS go live issues in 2013 and 2014. That project has coordinated the reprocess of claims and recovery of \$17,680,723.68 since October of 2016 when the project began.

¹³ 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.

evidence tampering. Since 2012, Williams billed the Alaska Medicaid program over \$8 million dollars for Home and Community Based Waiver services.

Williams is alleged to have billed Medicaid approximately \$1,159,962.45 for services not rendered in the manner required under the recipient's plan of care. Currently the case is set for trial sometime at the beginning of 2018, and the MFCU was able to freeze approximately \$60,000 in her bank accounts, plus suspended some of her claims that had yet to be paid.

2. Lookhart Dental, LLC:

In April 2017, 31-year-old Dr. Seth Lookhart was charged with 10 felony offenses consisting of Medical Assistance Fraud, Theft in the Second Degree, and Scheme to Defraud. Dr. Lookhart's 32-year-old office manager, Shauna Cranford was also charged with the same felony offenses and six of the seven misdemeanor offenses. Dr. Lookhart started working in Alaska in 2014 under an established practice called Alaska Dental Arts. Dr. Lookhart allegedly devised a scheme to cut out his then partners by billing Medicaid under a different provider ID and sending the money directly to his home. The estimated value of the fraud towards his partners is approximately \$250,000 to \$350,000. Dr. Lookhart was paid by Medicaid approximately \$1.9 million for IV sedation services; he billed Medicaid approximately \$2.5 million. The MFCU anticipates the trial sometime in 2018, and the MFCU was able to freeze approximately \$680,000 in his bank accounts, plus suspended some of his claims that had yet to be paid. Since Dr. Lookhart was charged, Medicaid payments for IV Sedation (D9243) has been reduced by about 20%.

3. Five people charged with Medicaid Fraud:

In August of 2017, five people were charged with nearly two dozen counts of Medicaid fraud totaling about \$365,000. The group pretended Regino Aldeza suffered from serious disabilities, and the DHSS approved his siblings to provide around-the-clock care. However, through the MFCU investigation it was established that Regino Aldeza was not currently suffering from a debilitating disability, nor had he been suffering from a debilitating disability since at least January 2009.

4. Hearts and Hands of Care, Inc. (HHCI):

In 2016, a MFCU investigator contacted HHCI following an alleged incident involving acuity care pertaining to a single client for service period May 2, 2016 to June 17, 2016. HHCI erroneously billed for acuity services at a daily rate of \$350.81

when much of the services were never provided. HHCI self-identified the Medicaid overpayment and began to void the claims resulting in a return to the Medicaid program of \$16,488.07 plus the civil settlement of \$45,000.

5. Intellectual and Developmental Disability Provider:

In 2016, Alaska began an investigation of an intellectual and developmental disabilities provider for billing for services not provided, billing for individual and group at the same time with the same servicing provider, and billing for overlapping services with the same servicing provider. The provider performed an audit of the services and found there to be an overpayment but failed to repay the Alaska Medicaid program for the identified overpayment. As a result, the provider and the MFCU in cooperation with the HHS-OIG are entering into a corporate integrity agreement to settle the case. The agreement will require the provider to repay the identified overpayment of \$1,274,875.37 plus an additional amount due to the False Claims Act.

6. Anchorage Business Owner Charged with \$239,000 Healthcare Fraud:

On June 21, 2016, U.S. Attorney Karen L. Loeffler announced that 40-year-old Mi Ran Yu of Anchorage was charged in a 20-count indictment alleging that she devised a scheme to defraud the State of Alaska Medicaid Program over \$239,000. The indictment alleges that Yu misrepresented the condition of her parents in order for them to receive PCA benefits from the State of Alaska Medicaid Program. Physical surveillance documented that Yu's parents' health conditions had been greatly exaggerated as both were observed riding bicycles, lifting heavy bags of potting soil, and walking significant distances unaided. Surveillance further revealed that Yu billed Medicaid for providing PCA services that were never provided to her parents. This case was jointly investigated by the Alaska MFCU and the FBI, who took the lead in conducting the surveillance.

DHSS:

Division of Public Assistance (Fraud Control Unit):

- Wendy J. Waterman was charged with various crimes after investigation by FCU substantiated the allegations. The crimes include felony-level theft, as well as several counts of Unsworn Falsification 2 (a Class A Misdemeanor).

- On February 22, 2017, the court accepted a guilty plea agreement to one count of Unsworn Falsification and agreed to provide restitution in the amount of \$15,875.65 for repayment of the Medicaid benefits that she fraudulently obtained.
- On February 22, 2017, partial restitution payment, in the amount of \$10,000.00. A restitution judgment was issued ordering the defendant to pay the remaining balance of \$5,875.65.

Senior and Disability Services (Quality Assurance):

- One recipient was criminally charged for colluding with a provider to bill for PCA services which were not needed.
- Worked with MFCU on Eye to Eye investigation for medical assistance fraud.
- One Care Coordinator was terminated for failing to meet timelines on behalf of beneficiaries.
- Three Care Coordinators voluntarily stopped Care Coordination following investigations as they realized through the process that they were unable to complete the work in an organized and timely manner.
- One provider was civilly charged with insurance fraud following a referral from the SDS Certification Unit.
- One Care Coordination agency was terminated for habitually failing to meet timelines on behalf of beneficiaries, thereby jeopardizing their health and safety.
- One PCA provider was terminated from the Medicaid program for failing to complete background checks on PCAs and for billing while recipients were hospitalized.
- Quality Assurance Investigators provided a number of providers (Assisted Living Home providers, Care Coordinators and Waiver providers) with technical assistance and training during the course of investigations.
- Senior and Disabilities Services issued “Notices to Correct” for a variety of reasons. The notices are an effort to correct behavior considered non-compliant with program rules, and offer providers an opportunity to correct.
- Corrective Action Plans were required when provider agencies needed to retrain staff or redesign procedures to meet compliance standards as the result of substantiated allegations.

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

The Payment Error Rate Measurement (PERM) is the same as in last year's report (16.8% for the Medicaid program and 13.1% for the Children's Health Insurance Program). The PERM is a federal program that reviews state Medicaid programs every three years so our rate remains the same until our next review/report which is expected in November of 2018.

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

The State of Alaska continues to participate in the mandated PERM eligibility pilot pursuant to The Centers for Medicare & Medicaid Services (CMS) State Health Official Letter 13-005, dated August 15, 2013, directing states to implement Medicaid and CHIP Eligibility Review Pilots in place of the PERM 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 FY 2014. Alaska is currently in round five of the pilot, which is the last round.