STATE OF ALASKA
Department of Health And Social Services
Medicaid Fraud and Abuse Prevention

Acronym Soup

- ACA
- CMS
- MIP/MIG/MIC
- OIG
- MFCU
- SURS
- RAC
- PERM
- CHIP
- REOM
- ICE

Objectives

- Understand Medical Assistance Provider Fraud and the difference from waste and abuse
- Understand the Organizational structure in Alaska
- Understand current fraud and abuse prevention efforts
  - Including pre-payment and post-payment controls
- Understand some of the impact of the Affordable Care Act on fraud and abuse prevention efforts
- Understand the current status and focus of some of the audit programs currently in place:
  - Audits conducted under AS 47.05.200
  - Audits conducted by the Medicaid Integrity Contractor
  - Audits conducted by the Recover Audit Contractor
  - Payment Error Rate Measurement program
- Where do we go from here
  - How to improve results

Fraud vs. Waste and Abuse

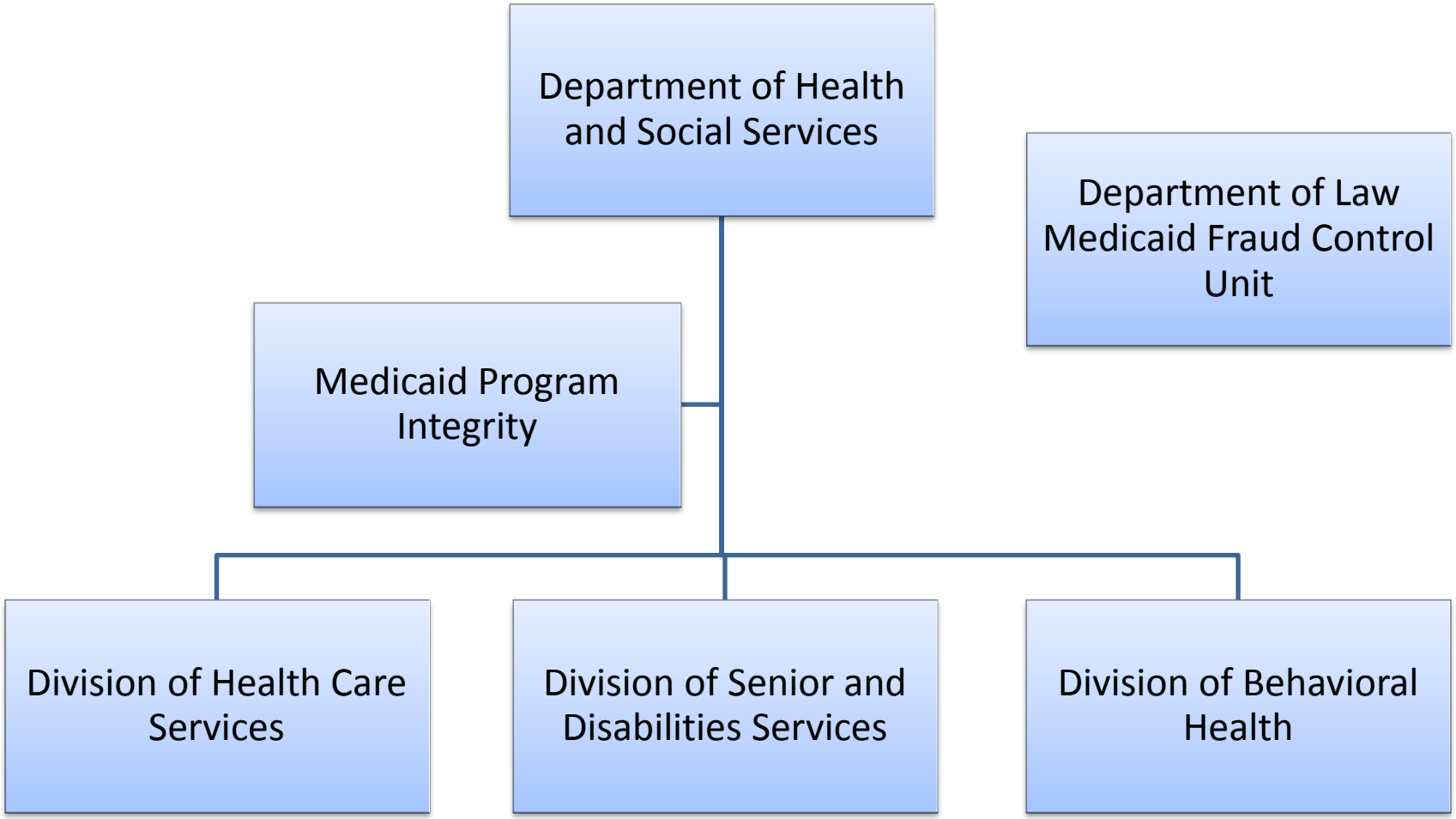
Fraud

- Alaska Statue 47.05.210 Defines Medical Assistance Fraud in Alaska
  - Knowingly submits a claim to a medical assistance agency for property, services or a benefit with ***reckless disregard*** that the claimant is not entitled to the property, service or benefit
  - State has the burden to prove beyond a reasonable doubt
- ACA requires payment suspension in cases of “credible allegation of fraud”

Waste and Abuse

- Waste
  - The unintentional, thoughtless, or careless expenditures, consumption, mismanagement, use, or squandering of federal, or state resources
- Abuse
  - Practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program
  - State must prove by a preponderance of the evidence

Organizational structure in Alaska



Components of a Model Fraud Control Strategy

1. Commitment to routine, systematic measurement
2. Resource allocation for controls based seriousness of the problem
3. Clear designation of responsibility for fraud control
4. Adoption of a problem solving approach to fraud control
5. Deliberate focus on early detection of new types of fraud
6. Fraud specific prepayment controls
7. Every claim faces some risk of review

Fraud, Waste and Abuse Prevention

Pre-Payment Controls

- Provider Certification
- Background Check
- Provider Enrollment
- ACA Section 6401. Provider screening and other enrollment requirements
- Claims processing edits
- Pre-payment Review
- Payment suspensions

Post-Payment Controls

- REOMB process
- Audits
- Claims data mining
- Provider technical assistance
- Provider sanctions
- Fraud investigations and charges
- Provider terminations
- OIG list of excluded individuals and entities

ACA Section 6401 Requirements

- Applies to all healthcare providers and suppliers participating in federal healthcare programs including Medicare, Medicaid, and Children's Health Insurance Program (CHIP)
- Requires levels of screening including initial enrollment site visits based on risk of fraud, waste and abuse
- Requires imposition of application fees to be used for provider screening
- Requires periodic revalidation of enrollment
- Provides for possibility of temporary moratorium on new provider enrollment by category of provider
- Requires providers to establish a compliance program that contains the core elements of an effective compliance program as established by CMS

AS 47.05.200 (Myers and Stauffer)

- Required By: Alaska Statute 47.05.200
- Scope: Individual Medicaid Provider for a calendar year , currently 2011
- What is measured: Appropriateness of Medicaid payments
- What is reviewed: Provider claims and corresponding documentation
- Subcontracted to: Myers and Stauffer
- Providers affected: Potentially any provider billing in excess of $30,000
- Extrapolation: Yes. Using the greater of actuals or the lower bound of a one sided 90% confidence Interval

Medicaid Integrity Program (MIP)

- Required By: CMS
- Scope: Nationwide. Individual Medicaid Provider typically covering 2-5 Calendar years
- What is measured: Appropriateness of Medicaid payments
- What is reviewed: Provider claims and supporting documentation
- Subcontracted to: HMS Federal, DBA Integriguard
- Providers affected: Potentially any provider billing Alaska Medicaid. Focus has been Dental, Pharmacy
- Extrapolation: Yes. Lower bound of a one sided 90% confidence interval.

Recovery Audit Contractor (RAC)

- Required By: 42 CFR 455 Subpart F (Affordable Care Act required expansion to Medicaid)
- Scope: Improper payments (both over-and under payments) Claims based, not provider
- What is measured: Appropriateness of Medicaid payments
- What is reviewed: Provider claims and supporting documentation
- Subcontracted to: Health Management Systems (HMS)
- Providers affected: Potentially any provider submitting claims to Medicaid
- Extrapolation: No. Limits on Record requests and Maximum 3 year look back

Surveillance and Utilization Review Subsystem (SURS)

- Required By: 42 CFR 433 Subpart C
- Scope: Potentially all providers submitting claims to Alaska Medicaid
- What is measured: Appropriateness of Medicaid payments
- What is reviewed: Provider claims and supporting documentation
- Subcontracted to: Xerox at the direction of Health Care Services
- Providers affected: 32 per quarter are reviewed but all are not necessarily contacted. SURS reviews typically start with a comparison of one providers bills to other similar providers by specialty
- Extrapolation: No.

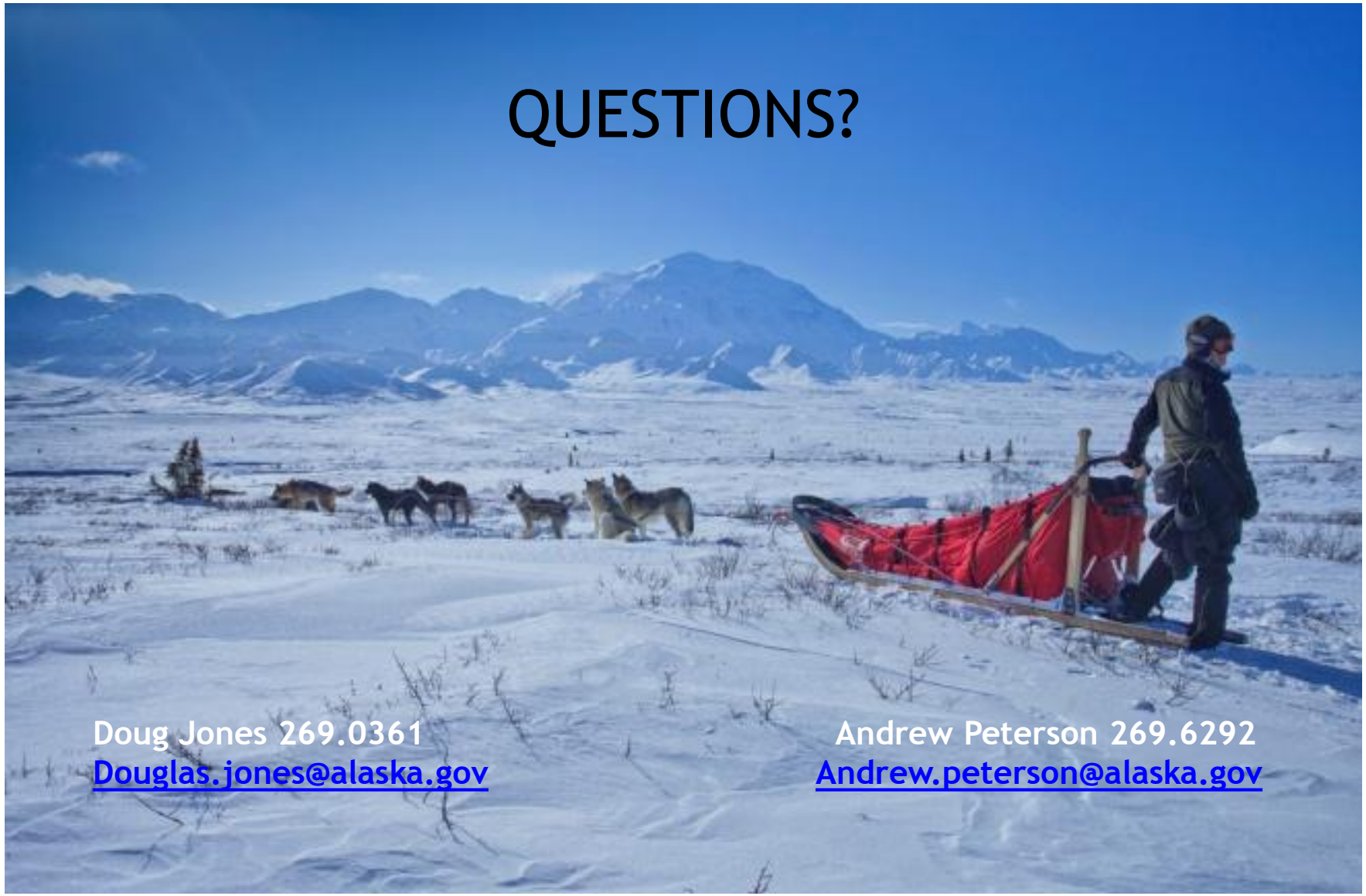
Payment Error Rate Measurement (PERM)

- Required By: CMS; Improper payment information act
- Scope: Nationwide. Each State is reviewed every 3 years, state focused, claims based
- What is measured: rate of Medicaid payment errors; eligibility component and Fee for service component (included Medical records and data processing)
- What is reviewed: Providers Medical and billing records, state data processing and recipient eligibility
- Subcontracted to: A+ Government solutions and Health Data Insights perform Medical reviews
- Providers affected: For FFY 2014, 336 claims for Medicaid and 308 claims for DKC

Where to from Here? How to improve results

- Importance of enrolling rendering providers cannot be over-stated
- Increased attention on data analytics and focus on multiple data sources
  - Opportunities for data sharing with Medicare
  - Opportunities for data sharing with Private insurers (All payer database)
- Continue to collaborate and build partnerships with state, federal and private partners
  - Opportunities for improved processes working with Department of Corrections, ICE
- Continue and increase education and outreach efforts to recipients and providers

QUESTIONS?



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