STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	**SECTION:** 2 Cross-program Policies	**Number:** 2-4	**Page:** 1
	SUBJECT: Financial Accountability		
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	EFFECTIVE: February 1, 2012		

Purpose

To outline responsibilities for maintaining the financial integrity of Medicaid-funded programs.

To define a process for discovery and remediation of overpayments.

Policy

Senior and Disabilities Services (SDS) is responsible, along with the state Medicaid authority, for the financial integrity of the Home and Community-Based Waiver Services and Personal Care Services programs. Several administrative processes are designed to maintain financial integrity; these processes include eligibility determinations and enrollment to ensure only qualified participants receive services, prior authorization to ensure payment is made only for services approved in the service plan, and certification to ensure providers are qualified to render and receive payment for services. In addition, SDS evaluates the financial activities of providers at various points in the operation of their programs through prepayment and post-payment controls and review. Findings of possible overpayments, as a result of these monitoring activities, are subject to SDS remediation or referral to appropriate state agencies for investigation.

Through the certification and enrollment process, providers accept responsibilities for maintaining the integrity and fiscal viability of the state's Medicaid program. To promote accountability in their own financial systems, providers monitor activities to ensure that claims for payment are accurate and supported by clinical and financial records, and that its personnel cooperate fully with investigations and remediation of possible overpayments.

Definitions

"Financial accountability" means the assurance by a state that payments for services have been rendered to eligible participants, have been authorized in a service plan, and have been billed correctly by qualified providers.

"Overpayment" means a payment for Medicaid services that involve any of the circumstances described in 7 AAC 105.260, or that are not supported by records requested under 7 AAC 105.240.

"Provider" means an individual or agency that is certified by SDS, is enrolled in the Medicaid program, and receives Medicaid program funds in payment for services to participants.

"Quality Improvement Steering Committee" means the committee, appointed by the Commissioner of the Department of Health and Social Services, that provides oversight for SDS continuous quality improvement activities.

Authority

AS 47.07.010 [Provider accountability]. 7 AAC 105.220 Provider responsibilities; 7 AAC 105.230 Requirements for provider records; 7 AAC 105.240 Request for records; 7 AAC 105.260 Recouping an overpayment.

Responsibilities

1. The **provider** is responsible for
   a. implementation of financial accountability systems;
   b. maintaining records that support claims for services;
   c. reporting to the Medicaid fiscal agent, and voiding or adjusting, amounts identified as overpayments; and
   d. cooperating with investigation and remediation activities.

2. **SDS** is responsible for:
   a. monitoring provider claims for services;
   b. identifying and notifying the provider of possible overpayments;
   c. when overpayments are not recovered through SDS efforts, referring possible overpayments to the Medicaid Program Integrity Unit; and
   d. conducting quality improvement activities.

Procedures

A. Prepayment financial accountability processes

1. SDS program management controls.
   a. SDS determines whether applicants/participants are qualified to receive services through eligibility and enrollment determinations.
   b. SDS, to facilitate the prior authorization process,
      i. evaluates the service plan of each participant;
      ii. approves or denies services; and
      iii. transmits to the Medicaid fiscal agent the types, duration, and frequency of services approved, and the appropriate coding for the services.
   c. SDS ensures that only qualified providers may seek payment for services by
      i. certifying providers to render specified services, and
      ii. notifying the Medicaid fiscal agent of the certification period and the services that the provider has been approved to render to participants.

2. Provider management activities. The provider
   a. develops a record-keeping system that supports its claims for services;
   b. institutes and maintains financial controls to avoid inappropriate billing by the provider or its billing agent, and to identify, if received, overpayments for services; and
   c. enrolls as Medicaid provider with the fiscal agent.

B. Post-payment financial accountability processes

1. SDS programs staff reviews.
   a. Review of program processing documents. SDS reviewers evaluate claims for payment for consistency with the following:
      i. prior authorizations,
      ii. payment records,

iii. service plans and case records,
iv. service transfers and service plan amendments,
v. case closures,
vi. complaints regarding provider financial activities, and
vii. critical incident reports.

b. Requests for payment clarification. SDS reviewers
   i. send a courtesy notice of possible payment errors to the provider for clarification;
   ii. follow-up to validate repayment when a payment error is confirmed by the provider;
   iii. refer non-responsive providers to the Medicaid Program Integrity Unit; and
   iv. send payment error and provider response information to the Quality Assurance Unit for the purpose of tracking discovery and remediation activities.

2. Provider activities. The provider
   a. reconciles payments received with claims for services;
   b. discloses receipt of overpayment when identified to the Medicaid fiscal agent; and
   c. cooperates with investigations by SDS and other state agencies, and with any repayment process.

3. Quality Assurance Unit reviews.
   a. The Quality Assurance Unit evaluates
      i. program documents referred by SDS reviewers for further investigation,
      ii. fiscal agent reports, and
      iii. audit reports.
   b. For findings of possible overpayments, the Quality Assurance Unit
      i. collects any additional information necessary to evaluate the findings;
      ii. identifies the dates and amounts of possible overpayment;
      iii. refers the findings to the Medicaid Program Integrity Unit for investigation and remediation; and
      iv. provides technical assistance as requested.

4. Remediation.
   The Quality Assurance Unit remediates provider non-compliance in accordance with SDS Policy and Procedure 12-1 *Provider Certification and Oversight.*

C. Oversight of SDS financial accountability activities

1. The SDS Financial Accountability Task Committee
   a. reviews claims analysis and audit reports;
   b. identifies problems and trends related to provider payments;
   c. reviews the status and disposition of referrals made to the Medicaid Program Integrity Unit; and
   d. develops a report, with recommendations regarding financial accountability systems improvement, for the SDS Quality Improvement Workgroup.

2. The SDS Quality Improvement Workgroup
   a. reviews and analyzes the data and recommendations in the Task Committee report;
   b. develops recommendations for financial accountability systems improvements, including the amount and type of resources needed, for the Quality Improvement Steering Committee; and
   c. implements system improvements as directed by the Quality Improvement Steering Committee.