Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Alaska Comprehensive Program Integrity Review

Final Report

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Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, the CMS Medicaid Integrity Group (MIG) identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report*.

The purpose of this review was to determine whether Alaska's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring.

The review of Alaska's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team did note the state's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities. Ranked below in order of risk to the program these are:

1) Inadequate attention to program integrity controls by failing to suspend payments or document a good cause exception not to suspend in cases with a credible allegation of fraud.
2) Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, properly implement new provider enrollment and screening regulations, and properly handle the reporting and notification requirements for adverse actions taken against providers who are denied enrollment or removed from the program.

These risks include instances of regulatory non-compliance by the state as well as areas where the state does not have adequate program safeguards, creating a risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

Methodology of the Review

In advance of the onsite visit, the review team requested that Alaska complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and relationship with the MFCU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted an in-depth telephone interview with representatives from the MFCU.

During the week of December 4, 2012, the MIG review team visited the Department of Health and Social Services (DHSS) and the fiscal agent offices. The team conducted interviews with numerous DHSS officials as well as with staff from the fiscal agent. The team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Alaska's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program Integrity Unit (PIU) within DHSS but also considered the work of other components and contractors responsible for a range of program integrity functions, including surveillance and utilization review and provider enrollment. Alaska operates its Children's Health Insurance Program (CHIP) as a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Alaska's Title XIX program. The same risks discussed in relation to the Medicaid program also apply to the CHIP expansion program. Unless otherwise noted, Alaska provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the DHSS provided.

Medicaid Program Integrity Unit

In Alaska, the PIU is the organizational component dedicated to fraud and abuse activities. The 2010 CMS review found that Alaska's program integrity function was not centralized. The employees performing these functions were located in various divisions reporting to separate DHSS Deputy Commissioners. At the time of this review, the DHSS had reorganized, aligning those various divisions under the Deputy Commissioner for Medicaid and Health Care Policy. The PIU had 7 full-time equivalent (FTE) positions allocated to Medicaid program integrity functions, while the Division of Behavioral Health and Division of Senior Disability Services had an additional 13.5 FTEs for quality assurance work. In addition, the Division of Health Care Services had 2 FTEs. Together with fiscal agent staff, they conducted most surveillance and utilization review activities, thereby supporting the core functions of state program integrity staff.

The table below presents the total number of preliminary and full investigations, and the amount of identified and recouped overpayments related to program integrity activities in the last four

complete state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amounts Recouped as a Result of State Imposed Administrative Sanctions ***
2009	56	Not tracked by state	$1,907,000	$ 814,000
2010	102	"	$2,598,017	$1,714,084
2011	103	"	$3,385,002	$1,510,522
2012 ****	23	"	$1,592,109	$1,960,822

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
***Recoupments do not include global settlements.
****The drop in preliminary investigations is due both to contracted audits no longer being counted unless they result in a referral to the MFCU and a reduction in the number of referrals from other state agencies. The reduction in overpayments identified is due to a new process requiring a legal review of audit findings prior to reports being released. This has the effect of slowing down the identification process.

Results of the Review

The CMS review team found a considerable number of regulatory compliance issues and a vulnerability related to program integrity in Alaska's Medicaid program. Several of these issues are significant and represent risks to the integrity of the state's Medicaid program. These issues fall into two major categories of risk as outlined and discussed below. To address them, Alaska should improve oversight and build more robust program safeguards.

RISK 1: Inadequate attention to program integrity controls by failing to suspend payments or document a good cause exception not to suspend in cases with a credible allegation of fraud.

The federal regulation at 42 CFR 455.23(a) requires that upon the state Medicaid agency determining that an allegation of fraud is credible, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the state Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in states with no certified MFCU not later than the next business day after the suspension is enacted. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The team reviewed the files for the eight cases Alaska sent to the MFCU since March 25, 2011 for compliance with the regulation. It was noted that some informal consultation took place between the PIU and the MFCU on these cases. When the MFCU confirmed that there was a credible allegation of fraud, the state did not then issue a formal referral to the MFCU, suspend payments or always document each case to reflect a good cause exception not to suspend. The

MFCU did ultimately send a written good cause exception request to the state. However, these notifications were only issued on a quarterly basis, allowing for program payments to be made in the interim. In one case, a good cause exception not to suspend payments was documented at the time the credible allegation of fraud was determined. In four other cases, no payments were issued. In the remaining three cases, payments totaling $16,703 were made to providers from the time the credible allegation was determined until the quarterly report was received. These payments were potentially at risk.

Further, the Memorandum of Understanding between the state and the MFCU that was in effect at the time of the review did not address the post-March 25, 2011 regulatory requirements on payment suspensions. The PIU Director indicated that the Memorandum of Understanding was being revised to take these into account.

Recommendations: The state should consider each case referred to the MFCU on its own merits in order that the state agency identify where it can safely suspend Medicaid payments to problem providers without jeopardizing further investigation of those providers. Ensure that in the absence of a written good cause exception, provider payments are suspended after determination of a credible allegation of fraud in accordance with the requirements at 42 CFR 455.23. Update and strengthen the PIU's policies and procedures and the Memorandum of Understanding between the state agency and the MFCU to formalize procedures to suspend payments after determination of a credible allegation of fraud in the absence of a documented good cause exception and follow these procedures. Refer to the technical assistance resources section of this report for further recommendations to address this area of risk.

RISK 2: Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, properly implement new provider enrollment and screening regulations, and properly handle the reporting and notification requirements for adverse actions taken against providers who are denied enrollment or removed from the program.

Exclusion Searches

The 2010 CMS review found that the state did not conduct exclusion checks on its fee-for-service (FFS) providers. The state has taken steps to correct these issues, but is not in compliance with the regulation at 42 CFR 455.436 in three respects – the databases being checked, the names being checked, and the frequency of the debarment checks conducted.

Alaska checks all of the names disclosed during the application process for possible debarments and exclusions at the start of provider enrollment. However, it had not developed a method to

download Excluded Parties List System (EPLS)[1] information from the System for Award Management website (where the EPLS is now housed) on a monthly basis to check for post-enrollment debarments. The state did check the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE) on a monthly basis as required. However, only the name of the provider is captured in the Medicaid Management Information System for monthly database searches. The state had not worked out a method to access the Social Security Administration's Death Master File, which also must be checked as part of the provider enrollment process, but it was accessing the National Plan and Provider Enumeration System to verify National Provider Identifiers. Also, there were issues with the names collected on both the individual and group application forms. Alaska's "Individual Application" did not require the provider to list the names of his/her managing employees or agents so that these names could be checked for exclusions and debarments, and the state was not utilizing any other method to capture this information from the provider. In contrast, the "Group Application" did request the disclosure of the relevant parties; however, the team found that there were quality control issues with the names provided by the entity. The state checked only the names that an entity provided regardless of whether all required names had been submitted, such as board of directors, officers, and managing employees. The quality assurance checks did not require, for example, that a corporate entity include all applicable names. The documents only required a minimum of one managing employee for the field. If this was included, the document was considered complete, even though one would expect to see a greater number of managing employees in large institutional providers.

Ownership and Control Disclosures

The State of Alaska requires that all provider types enroll with its fiscal agent. This includes providers paid on a FFS basis, waiver providers serving programs run by the Division of Senior Disability Services, behavioral health providers, and providers contracting with the non-emergency medical transportation (NEMT) broker, which arranges air and ferry transportation. The 2010 CMS review found that the state did not capture all required ownership and control and relationship information from FFS, waiver, and NEMT providers and the fiscal agent. The state has taken steps to correct the issues identified in 2010. As part of its corrective action plan (CAP), the state modified its provider enrollment forms to capture most of the information required under an earlier version of 42 CFR 455.104. However, it had not updated its forms to meet the new 455.104 ownership and control disclosure requirements that went into effect on March 25, 2011. The current forms did not capture the enhanced address information for the entity or for all corporations that may have an ownership or controlling interest in the entity (42 CFR 455.104 [b][1][i]). In addition, the state was not collecting the names of other disclosing entities in which any person with an ownership or controlling interest in the entity has other

[1] On July 31, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

ownership or controlling interests (42 CFR 455.104[b][3]). The state also did not collect ownership and control interest disclosures from its new fiscal agent as required by the regulation.

Criminal Offense Disclosures

In Alaska, a group application form is used to enroll all entities except individual practitioners and sole proprietorships. This form requires applicants to disclose health care-related criminal convictions "within the past ten years." It did not require disclosures since the inception of the program as specified in 42 CFR 455.106. Otherwise, the form addresses all individuals who are required to disclose within the entity, including "any employee, managing member, agent or any person or entity with ownership or a controlling interest in this group or business entity, or an employee or managing member of a subcontractor for this group or business entity."

Implementing New Provider Enrollment and Screening Regulations

At the time of the review, Alaska was in the planning stages for implementing the new provider enrollment and screening regulations at 42 CFR 455 Subpart E. The single state agency had formed a committee to address these issues that was chaired by a staff member from the Division of Health Care Services. The committee had not yet developed any policies and procedures related to the new regulations, which include, but are not limited to, establishing risk levels for various provider types, utilizing information from Medicare and/or other state Medicaid programs where available in the provider screening process, and conducting site visits and collecting application fees in certain circumstances.

The state had not assigned providers to risk levels as required in 42 CFR 455.450. It had also not yet developed and implemented policies and procedures for conducting site visits to provider applicants in the "moderate" and "high-risk" categories per 42 CFR 455.432. The state indicated it would have to determine how or if site visits can be accomplished given available resources and Alaska's vast geography.

Notifications to HHS-OIG and State Agency Exclusion Notifications

The 2010 CMS review found that the state did not report adverse actions taken to limit a provider's participation in the program as required in 42 CFR 1002.3. This issue has been partially corrected. At the time of the review, the state was reporting provider terminations to HHS-OIG, but was not consistently reporting other adverse actions required by the regulation, such as when it:

- denies enrollment to a provider (for program integrity reasons),
- suspends a provider,
- disenrolls a provider mandatorily,
- permits a provider to voluntarily disenroll to avoid a formal sanction, or
- reaches a settlement with a provider on a formal sanction.

A review of a sample of provider enrollment files where adverse action had been taken revealed that the state had sent written notification to HHS-OIG in all but one case, and that two of the letters were not sent within the required 20 working days as stipulated in the regulation.

The Alaska Medicaid agency invoked permissive exclusions as allowed by 42 CFR 1002.210. In so doing, it provided notice to all applicable parties as stipulated in 42 CFR 1002.212. However, the state did not provide notice to all parties when it reinstated a previously excluded provider, as required under 42 CFR 1002.215. Only the provider was notified through the normal enrollment process that he/she has been accepted or denied. During the review, the state referenced three providers who had been excluded for various reasons. Two of these had been reinstated and were actively enrolled at the time of the review.

Business Transaction Disclosures

The 2010 CMS review found that the state did not include language related to 42 CFR 455.105 in its provider agreements. The Medicaid agency corrected the language in its agreements with individual, group, and institutional providers. However, since the 2010 review, the state developed separate provider agreements for new provider categories, including personal care attendants (PCAs), community health aides/practitioners, and dental health aide therapists. These agreements did not contain any reference to the provisions of 42 CFR 455.105. The state said it believed that since these provider types were not paid directly and were non-professionals, the regulation did not pertain to them, and the provider agreement could be simplified.

Recommendations: Implement procedures to ensure that provider enrollment and contracting processes include the collection of complete and accurate disclosure information. Ensure that every disclosed party affiliated with the state's program is checked against the EPLS, LEIE, and Social Security Administration's Death Master File during the enrollment process and monthly thereafter against the LEIE and EPLS. Make sure that adverse action reporting and provider notification requirements are met when the state denies enrollment to, terminates and reinstates providers. Implement the new provider enrollment and screening requirements, assign risk levels for provider types serving the Medicaid program, and determine how site visits can be accomplished for the moderate and high risk categories. Additional opportunities for technical assistance to address the provider enrollment risks identified in this report are located in the technical assistance resources section below.

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. CMS recommends that other states consider emulating this activity.

Individual enrollment of PCAs

In response to the state's identification of PCA services as a high-risk area for fraud, waste, and abuse, in July 2011, the Medicaid agency began requiring PCAs to enroll as individual rendering

providers. In addition, it mandated that all PCAs be employed with an agency that provides personal care services. These agencies were also enrolled as providers with the state. The enrollment of individual PCAs was a major endeavor for a small Medicaid program. It almost doubled the number of enrolled Medicaid providers in Alaska, with total provider enrollment increasing from approximately 10,000 to 19,000 after the new requirement was in place.

At the time of the review, the state had collected approximately 18 months of data, which it was beginning to analyze. While the process was too new for specific cost savings and cost avoidance data to be available, the state believed that it represented a significant program integrity breakthrough. By having PCAs individually enrolled and requiring the inclusion of their Medicaid identification number on claims, Alaska found that it could more easily track an individual's activity within a provider and across multiple providers when a PCA is employed by more than one agency. The Medicaid agency cited the example of one PCA provider who was discovered to be working for three different agencies and submitting time sheets for services that occurred in different towns with time frames that were inconsistent with the distances involved.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Alaska to consider utilizing:

- Consult CMS guidance on payment suspensions including the March 25, 2011 Informational Bulletin located at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Alaska to states that are further along in this process to address the areas of non-compliance identified in Risk 1.
- Consult with other states on methods of conducting site visits to provider applicants dispersed over a large geographical area. Consider using other available state, county and local government resources to assist in the provider screening process in order that the state can comply with the requirements of 42 CFR 455.432 as outlined in Risk 2.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity and provider enrollment efforts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Specific courses that may be helpful to Alaska based on its identified risks include the *Program Integrity Fundamentals Seminar* and the *Medicaid Provider Enrollment Seminar*. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Work with the assigned CMS MIG State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the annual program integrity review summary reports on the MIG's website at

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Alaska review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.

Conclusion

The identification of significant areas of risk and numerous instances of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the state to provide a CAP for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with Alaska to build an effective and strengthened program integrity function.

THE STATE of ALASKA
GOVERNOR SEAN PARNELL

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February 21, 2014

Mark Majestic, Acting Director
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Dear Mr. Majestic,

This letter is in response to your comprehensive review report of the Alaska Medicaid program integrity procedures and processes. We appreciate the efforts of the review team during Alaska's review.

Thank you for identifying the noteworthy practice of requiring all personal care attendants to be enrolled with Alaska Medicaid. This requirement is now paying dividends in terms of program integrity and fraud prevention efforts. Although not mentioned in your report, Alaska continues to be proud of the results of the payment error rate measurement process. Alaska's Medicaid error rate for FY 2011 was the second best in the 2011 cycle at 1.4%. This error rate compares favorably was the national average error rate of 5.8%.

Many changes have occurred within program integrity, provider enrollment and the Medicaid Fraud Control Unit since the base period of your review. A new Memorandum of Understanding is in effect between the Department of Health and Social Services and the Medicaid Fraud Control Unit which addresses payment suspensions in cases where a credible allegation of fraud has been determined.

Alaska would like to formally thank CMS and the Medicaid Program Integrity Group for the support given in the area of program integrity. The education and training that is made available through the Medicaid Integrity Institute is tremendous and has directly contributed to overpayment recoveries and fraud convictions in Alaska. We look forward to a continued partnership working toward reducing fraud, waste and abuse in the Medicaid program.

Sincerely,

Margaret Brodie
Division Director

cc: Andrew Peterson, MFCU Director
Jackie Garner, CMCHO Consortium Administrator
Carol Peverly, DMCHO Associate Regional Administrator

State of Alaska
Department of Health and Social Services
Response to CMS Comprehensive Program Integrity Review report

Thank you for the opportunity to respond to the Program Integrity review report issued on January 23, 2014. Alaska appreciates the consideration given to our response to the draft report.

Risk 1:

Inadequate attention to program integrity controls by failing to suspend payments or document a good cause exception not to suspend in cases with a credible allegation of fraud.

Response:

Alaska respectfully disagrees with this finding. A law enforcement good cause exception under 42 CFR 455.23 (e) (1) was documented for all cases. The issue is the timing of the good cause exception request in relation to the credible allegation determination.

Alaska agrees that we did not always receive a written request for law enforcement good cause exception on the exact same date as the credible allegation determination. However, 42 CFR 455.23 (e)(1) does not require the good cause exception be requested on the same date as the credible allegation determination. The amount CMS characterizes as "potentially at risk" is without regulatory support for the position.

CMS Issued guidance on credible allegations and law enforcement good cause exceptions through the CPI-CMCS Informational Bulletin, CPIB 11-04 dated March 25, 2011, frequently asked questions section page 2 of 5:

Q. If a MFCU accepts a fraud referral from the State but does not want the State to suspend payments because it may alert a provider to a pending investigation, what should the state do?

A. If law enforcement officials have specifically requested that a State not impose a payment suspension due to the fact that such suspension may compromise an existing investigation, this qualifies as good cause to not suspend under the final rule. The State should get this request in writing and include the request in its file for purpose of annual reporting to the Secretary.

This guidance does not specify the timing of the law enforcement good cause exception. There is no mention the good cause exception must be documented on the same date as the credible allegation determination. Alaska believes our protocol was in alignment with 42 CFR 455.23 and this guidance.

Our revised MOU with MFCU which reflects the post March 25,2011 requirements has now been finalized. In addition, Alaska is in the process of reviewing and updating our policy and procedure surrounding credible allegations and will ensure compliance with all applicable regulations and guidance.

Much has changed in the Program Integrity-Medicaid Fraud Control Unit dynamic since the base period of this review. DHSS, working collaboratively with the MFCU suspended payment to 57 providers during Fiscal Year 2013

State of Alaska
Department of Health and Social Services
Response to CMS Comprehensive Program Integrity Review report

Alaska now has metrics available for FY 2013 which was not included as part of the scope of your review:

SFY	Number of Preliminary Investigations	Amount of Overpayments Identified*	Amounts Recouped*
2013	29	$6,235,361	$4,952,306

*The above amounts do not include global settlements and include all internal Program Integrity audits and reviews.

Risk 2:

Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, properly implement new provider enrollment and screening regulations, and properly handle the reporting and notification requirements for adverse actions taken against providers who are denied enrollment or removed from the program.

Concern: Exclusion Searches

The state did not conduct exclusion checks on its fee-for-service providers. The state has taken steps but is not in compliance with the regulation at 42 CFR 455.436 in three respects

a. The databases being checked
b. The names being checked
c. Frequency of the debarment checks conducted

State needs to develop a method to download Excluded Parties List System (EPLS) information from the System for Award Management (SAM) website on a monthly basis to check for post-enrollment debarments.

Response:

Alaska has corrected this finding. State has developed a method to download EPLS information from the System for award management (SAM) website to check for post-enrollment debarments effective January 1, 2013. State has established a monthly process and has performed two post-enrollment debarments verifications thus far.

Concern: Ownership and Control Disclosures –Individual Applications

State is not collecting names of managing employees or agents under "Individual Application."

Response:

Alaska agrees with this finding, however most individual applicants represent a rendering professional with services billed by the professional health corporation; therefore collecting managing employees or agents is not applicable as those managing employees or agent information would be collected under the group enrollment. The exception is sole proprietors that do enroll as an individual. Alaska will need to modify our

State of Alaska
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Response to CMS Comprehensive Program Integrity Review report

new MMIS to require the sole proprietor enrollment application to capture ownership and managing/directing employees. We are working with our fiscal agent to determine the level of effort and expect to begin to collect required information later this year.

Concern Ownership and Control Disclosures

Response:

Alaska agrees with this finding. We are developing policy and procedure to collect ownership and control disclosures and expect to be in substantial compliance with this requirement later this year. This data collection will be collected with new enrollments and at re-validation.

Alaska is in the process of obtaining ownership and control interest disclosures from our fiscal agent as required by regulation. State has sent a letter to the Fiscal Agent by the Director of HCS requesting his information.

Concern: Criminal Offense Disclosures

Response:

This has been corrected. The current application does not put timeframes on convictions that must be disclosed.

Concern: Implementing New Provider Enrollment and Screening Regulations

Response:

Alaska agrees with this finding. The State will begin work on this requirement. Will need to develop policy and procedures, and leverage other resources where available. Senior and Disabilities Services and the division of Behavioral Health may be able to help with their provider types. In addition, our Division of Public Assistance has many field offices throughout Alaska and may be recruited to conduct local site visits.

Concern: Notifications to HHS-OJG and State Agency Exclusion Notifications

Response:

Alaska agrees with the finding and notes that we are in substantial compliance with the adverse action notices to HHS-OIG. Alaska will strive for improvement in the areas of noticing all parties upon reinstatement.

Concern: Business Transaction Disclosures

Response:

Provider agreements for personal care attendants, community health aids and dental health aids do not contain a reference to the provision of 42 CFR 455.105 regarding disclosures of significant business transactions. We appreciate that CMS recognizes the benefit of the additional controls and oversight gained as a result of enrolling theses providers. As identified in your noteworthy practices section, the benefit of having these rendering providers enrolled with Medicaid far overshadows this technical finding concerning disclosures that would probably never apply to an individual rendering provider.

State of Alaska
Department of Health and Social Services
Response to CMS Comprehensive Program Integrity Review report

Conclusion

Alaska is proud of the combined efforts that together form the backbone of Medicaid Program Integrity in the State of Alaska. A new partnership has been forged with the Medicaid Fraud Control Unit which is under new Leadership. Alaska has suspended payments to 57 providers since the transition at MFCU. We have worked with MFCU and other Federal partners on several collaborative investigations which have increased our fraud and abuse enforcement results. The increase in payment suspensions is a direct result of these efforts. We look forward to working through remaining issues focusing on provider enrollment disclosures and implementing the new enrollment and screening regulations

Alaska's Division of Health Care Services {HCS) has recently created a new quality assurance unit which includes provider enrollment, surveillance and utilization review and the care management (lock-in) program. The new quality assurance provider enrollment section is working closely with the Medicaid program integrity section to develop processes that will ensure compliance with 42 CFR 455 subparts B and E.