ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES
ALASKA DEPARTMENT OF LAW

JOINT LEGISLATIVE REPORT

Fraud, Abuse, and Waste,
Payment and Eligibility Errors
for FY 18

November 2018

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Below is a joint report from the Department of Law (DOL) and Department of Health and Social Services (DHSS) as required by AS 47.07.076. 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 taken in FY18 and does not repeat information from the report filed on November 15, 2017.

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)

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

DEPARTMENT OF HEALTH & SOCIAL SERVICES (funding: 50% federal/50% state general fund):

- Commissioner's Office (Program Integrity)[1]
  - Six staff in Anchorage.
  - The state FY 18 component budget was approximately $960,430.

- Division of Public Assistance (Fraud Control Unit)[2]
  - The fraud unit currently consists of 14 staff (10 in Anchorage, 2 in Fairbanks, 1 in Kenai, and 1 in Wasilla).
  - The state FY 18 fraud Investigation component budget was approximately $1,999,000.[3]
  - The Division of Public Assistance also has claims collection staff located in Juneau to pursue debt collection.

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[1] The Program Integrity Office has statewide responsibility for 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 (DPA) 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 currently consists of 17 staff (all in Anchorage). There are currently 2 vacant PCNs (QA Manager, Long-term non-perm Investigator).
    - The state FY 18 component budget was approximately $1,656,106.

- Division of Health Care Services (Quality Assurance)[5]
    - The Quality Assurance unit currently consists of 9 staff (all in Anchorage). There is currently one vacant PCN.
    - The state FY 18 component budget was approximately $ 1,100,000.

- Division of Behavioral Health
    - The Medicaid Services unit currently consists of 2.5 staff (all in Anchorage).
    - The state FY 18 component budget was approximately $332,383.

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[4] The Division of Senior and Disabilities Services (SDS) 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 family. QA collaborates with stakeholder and other DHSS agencies to investigate fraud. Quality Assurance unit activities include critical incident report review, investigations, remediation reporting, SDS fair hearings and mortality review. SDS QA utilizes a variety of tools to correct provider non-compliance to include technical assistance and training, corrective action requests or plans, or sanctions depending on the seriousness of the non-compliance.

[5] The Division of Health Care Services 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 collaborates with Program Integrity and MFCU for cases that warrant the escalation.

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

DEPARTMENT OF LAW:

Criminal Division/MFCU:

- 20 individuals were criminally charged.
- 8 criminal convictions.[6]
- One case with a civil resolution.[7]
- Including prior FY cases, the Unit began with 107 open cases, added 149 new cases and closed 98 cases by the end of FY 18, leaving 158 active cases.
- 68 cases reviewed and declined based on a lack of sufficient evidence.

Civil Division:

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

DEPARTMENT OF HEALTH & SOCIAL SERVICES:

- **Commissioner's Office (Program Integrity)**
    - Number of referrals to the DOL/MFCU (Credible Allegations of Fraud): 16
    - Number of incoming referrals from incoming complaints: 32
    - Number of audits issued under AS 47.05.200: 64
    - Number of focused reviews: 110

- **Division of Public Assistance (Fraud Control Unit)**
    - The FCU received 286 fraud referrals for the Medicaid program:
        - Applicant or Early Fraud Detection Investigations : 2
        - Categorically Ineligible Investigations : 244
        - Recipient or Post Certification Investigations : 40

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[6] Convictions relate to convictions received in FY 18 but the cases may have originally been brought in prior years as well as FY 18.

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

- The DPA FCU completed 355 investigations involving the Medicaid program:
    - Applicant or Early Fraud Detection Investigations : 2
    - Categorically Ineligible Investigations : 244
    - Recipient or Post Certification Investigations : 109
    - Closed cases for reasons other than fraud pertaining to the Medicaid program: 2,041

- **Senior and Disabilities Services (Quality Assurance)**[8]
    - 12,805 intakes to SDS Quality Assurance
    - 21 investigations referred to Medicaid Program Integrity Unit and/or Medicaid Fraud Control Unit
    - 232 Investigations were conducted
    - 61 allegations were substantiated
    - 14 Providers where required to submit a Corrective Action Plan
    - 37 Notice to Correct letters were sent to providers
    - 100% of mortality cases receiving services in SDS programs were reviewed through committee

- **Division of Health Care Services (Quality Assurance)**
    - 112 Surveillance and Utilization Review Cases Opened. Recoveries in FY 18 totaled $88,283
    - 515 Recipients assigned to the Care Management Program with cost savings estimated at $2,774,000
    - Worked with numerous providers related to repayments associated with the go live of the MMIS system in 2013. This effort had a $18 million dollar impact on the Medicaid program through the Account Reconciliation Management (ARM) project

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

III. STATUS OF PRIOR YEARS' INITIATIVES TAKEN TO PREVENT FRAUD AND ABUSE

- Please request a copy of DHSS/DPA Fraud Control Unit's Annual Accomplishments Report for all fraud initiatives taken.
- Enrolling direct care providers 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.
  - **Current Status**: Continue to work on enrolling direct service providers.
- Put Conduent on a corrective action plan to improve the process for manually processing claims.
  - **Current Status**: In Process
- Enter 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. This would allow real-time information sharing, leading to a more coordinated Department fraud, waste, and abuse prevention effort.
  - **Current Status**: Continue to research case tracking systems.
- Amended regulations to:
    - Increase clarity in dental regulations regarding service limits and better define emergent and enhanced dental services.
    - Implemented new SDS regulations related to PCA and Waiver to provide more detail requirements around eligibility and service levels.
  - **Current Status**: COMPLETED
- In the process of amending regulations to:
    - Follow Medicare guidelines regarding rounding of time-based procedure codes, to clarify what is allowable for a time-based code. Reduces confusion about how to bill for a partial code (how to bill for 5 minutes of a 15 minute unit).
  - **Current Status**: COMPLETED
    - Increase the use of functioning service authorizations and benefit/service limits in order to create a more thorough prepayment review process.
  - **Current Status**: In Process
    - Provide a definition of "contemporaneous" to clarify what is meant related to records to support a submitted claim.
  - **Current Status**: COMPLETED

        - Implement provision from SB74 including civil fines and self-audits.
    - **Current Status**: Self-audit portion COMPLETED
- 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
    - **Current Status**: Continues to be updated monthly

IV. INITIATIVES TAKEN TO PREVENT FRAUD AND ABUSE

- Medicaid Program Integrity section is working with law enforcement and other state and federal agencies formed as the Alaska Healthcare Fraud Prevention Workgroup.
- Medicaid Program Integrity conducted education, outreach and audit follow-up on proper reporting of cost of care for assisted living homes.
- Medicaid Program Integrity conducted education, outreach and audit follow-up on proper billing of transportation and accommodations providers.
- Division of Health Care Services QA contracted with Truven/IBM Watson Health to build new software for the identification of fraud, waste and abuse by both providers and recipients.
    - Software is expected to go "live" in November 2018
- Division of Health Care Services QA worked to design and implement Medicaid Explanation of Medical Benefits (EOMB) throughout FY18
    - EOMB portal was opened to Adult (18+) recipients on October 10, 2018
- Division of Health Care Services QA worked to identify a new Decision Support System (DSS) to allow DHSS to have increased insight into Medicaid claims data, as well as track state and federal quality measures with confidence.
    - Buildout of this software solution is expected to take place in FY19
- The Division of Behavioral Health restructured the Medicaid Services Section into three primary units to provide more oversight to various providers as follows:
    - Provider Services and Enrollment

- Clinical Services
  - Autism Services and Program Integrity
- The following procedures have been enacted to review and support behavior health providers prior to enrollment in Medicaid:
  - On-site visits involving full clinical chart reviews
  - Interviews of clients and staff
  - Training on Alaska Medicaid regulations
- Division of Behavioral Health moved forward with the 1115 waiver.
- As the Division of Health Care Services deploys a new Provider Enrollment system, the Division of Behavioral Health will begin to require the following change for all providers:
  - All individual rendering providers must enroll in the Medicaid payment system to all Medicaid claims to be identified by individual rendering provider
- In the process of amending regulations to:
  - updated accommodations regulations to ensure proper payment when recipients utilize escorts during Medicaid travel
- Senior & Disabilities Services moved their waiver transportation claims processing to Health Care Services fiscal agent, resulting in improved controls in claims payment.
- The Division of Public Assistance is implementing and Asset Verification. System, which will search for financial accounts on a national level for the Aged, Blind, and Disabled Medicaid.
- The Division of Public Assistance is in the Initial phases of the RFP process for an eligibility verification system.

V. 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.

VI. 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.
- Enroll all direct service providers
- Obtain 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. This would allow real-time information sharing, leading to a more coordinated Department fraud, waste, and abuse prevention effort.
- Ensure all provider audits and Surveillance and Utilization Review reports be vetted by Medicaid Program Integrity and the cognizant Medicaid division.

VI. DOLLAR RETURN FOR EFFORTS, INCLUDING COST AVOIDANCE

DEPARTMENT OF LAW:

Criminal Division/MFCU:

- Restitution ordered from criminal convictions resolved during FY 18: $71,735.61
- Restitution recovered from all outstanding matters: $50,081.57
- Recoveries from nationwide false claims cases: $568,637.52
- Return on investment for MFCU: approximately $1.35 dollars for every dollar spent
- Fines ordered in criminal cases: $13,500
- Restitution ordered for civil settlements: $2,299,392.08

Civil Division:

- Awarded in court orders: unidentified/unknown[9]
- Amounts agreed upon in settlements: $2,334,181.95

DEPARTMENT OF HEALTH & SOCIAL SERVICES:

Program Integrity:	
Recoveries:	$2,478,031
Cost Avoidance:	$1,307,711
Total Program Integrity Return to state:	$3,785,742
Return on Investment:	$3.94 Returned to $1.00 Spent

Fraud Recovery Unit:	
Recoveries:	$95,596
Cost Avoidance:	$676,897

Quality Assurance (SDS)	
Recoveries:	$30,517
Cost Avoidance:[10]	

Quality Assurance (DHCS):	
Recoveries:	$88,283[11]
Care Management - Cost Avoidance:	$2,774,000

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[9] There are seven pending decisions with the Office of Administrative Hearings, which may results in recoveries to the state, but those amounts have not been established as of the date of this report.

[10] Due to the database conversion, this number is not available as of this date.

[11] 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 $18,680,724 since October of 2016 when the project began.

VII. EXAMPLES OF FRAUD ABUSE THAT WAS PROSECUTED/PREVENTED

DEPARTMENT OF LAW:

Criminal Division/MFCU:[12]

1. Flamingo Eye, LLC Assisted Living Home:

In March 2017, a grand jury indicted Flamingo Eye, LLC, Margaret Williams, the owner of Flamingo Eye, LLC Assisted Living Home, and company administrator Princess Turay on three felony counts of Medical Assistance Fraud, one count of felonious Scheme to Defraud, one count of Evidence Tampering, one count of Attempted Evidence Tampering, and multiple counts of misdemeanor Medical Assistance Fraud. Since 2012, Williams billed the Alaska Medicaid program over $8 million dollars for Home and Community Based Waiver services. On July 30, 2018, the trial began and concluded on September 4, 2018 with guilty verdicts for Ms. Williams and Flamingo Eye, LLC. Margaret Williams and Flamingo Eye, LLC were found guilty on several counts of felony Medical Assistance Fraud and felony Scheme to Defraud. In addition, Flamingo Eye, LLC was convicted on an additional count of Attempted Evidence Tampering. The sentencing hearing is currently scheduled for January, 2019, and the restitution amount will also be determined at that time. Princess Turay, who is Williams' daughter, was acquitted of all charges.

2. The ARC of Anchorage:

In 2016, Alaska began an investigation of an intellectual and developmental disabilities provider allegedly billing for services not provided, billing for individual and group services at the same time and billing for overlapping services with the same servicing provider. The provider performed an audit of the services and found an overpayment. However, the provider 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, entered into a civil monetary penalty settlement and accompanying corporate integrity agreement to settle the case in April 2018. The Provider agreed to pay $2,299,392 in restitution and civil monetary fines and agree to be subject to the corporate integrity agreement for 5 years

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[12] 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.

3. Tundra Suites:

In January 2018 the MFCU was tipped off that Tundra Suites, an accommodation provider in located in Bethel, Alaska, was billing for services not provided, charging higher rates than normal and customary, and charging for an escort and recipient to stay in the same room. Tundra was billing utilizing the information prepared on the service authorization vouchers from taxi cabs taken by the recipients during their stay in Bethel. Investigation revealed that Mi Ae Young, who had previous significant overpayments from Medicaid when she operated a Bethel Taxi Company, was now assisting Tundra Suites in billing Medicaid on behalf of the hotel. She lost her Medicaid provider status as a cab owner and was thus prohibited from participating in any activity related to Medicaid. It is estimated that Tundra received over $144,000 in fraudulent Medicaid payments. The matter is currently charged, but in pre-indictment negotiations.

4. Anchorage Business Owner Mi Ran Yu:

In September 2018, Mi Ran Yu was sentenced to eight-months in prison, ordered to pay $90,000 in restitution and was placed on a three-year supervised release following service of her custody sentence. The litigation originated in 2016 when the U.S. Attorney's Office for the District of Alaska initiated charges in a 20 count indictment alleging that she devised a scheme to defraud the State of Alaska Medicaid Program of more than $239,000. The indictment alleged that Yu misrepresented the condition of her parents in order for them to receive PCA benefits from the State of Alaska Medicaid Program. In January 2017 the defendant plead guilty of 20 counts of committing health care fraud. At sentencing, Judge Burgess noted that cases of fraud against social service programs such as Medicaid are often hard to detect, and that sentences of incarceration in these types of case are especially warranted as a general deterrence to the public. As stated by Judge Burgess "people need to understand that there are serious consequences to committing this type of fraud beyond simply paying the money back."

This matter was investigated by the Medicaid Fraud Control Unit in conjunction with the Federal Bureau of Investigation.

DEPARTMENT OF HEALTH & SOCIAL SERVICES:

Division of Public Assistance (Fraud Control Unit):

- Mao LEE:

Evidence procured as part of this investigation substantiated allegation that LEE (1) resided outside of Alaska from November 2013 through March 2017; (2) failed to report her out-of-state residency to DPA as required under Adult Public Assistance and Senior Benefits Program rules, and (3) continued to receive and utilize Alaska Public Assistance benefits (Adult Public Assistance, Medicaid & Senior Benefits) to which she otherwise was not entitled totaling $36,837.10. As part of 3AN-17-00640SW, deposited funds were frozen in Credit Union One account 503958. This case referred to the Department of Law for criminal prosecution. Default Judgments and Orders were obtained as part of 3AN-17-06284CI ordering Credit Union One to release $34,627.17 and $1,837.00. Credit Union One issued two payments in the aforementioned amounts.

- Simfroniana M. MAYA:

Evidence procured as part of this investigation substantiated allegation that MAYA and her Authorized Representative, Jerry M. MAYA JR., failed to report Simfronia MAYA's residency outside of Alaska from April 2014 through January 2017. DPA was unaware of MAYA's passing on or about 07 January 2017, thus allowing continued Adult Public Assistance, Medicaid and Senior Benefit payment benefits to be issued through May 2017. The undersigned executed a search warrant on FNBA, seizing $12,795.88 in deposited funds. Thereafter, this case referred to the Department of Law and a civil action against Jerry M. MAYA Jr. was filed under 3AN-17-07094CI. On 07 August 2017, Jerry MAYA signed a Confession of Judgment, which on 21 August 2017 was accepted by the Court, causing an order to issue releasing the $12,795.88 of aforementioned deposited funds to the State of Alaska/Division of Public Assistance.

- Claro G. VALERIO:

Evidence procured as part of this investigation substantiated allegation that VALERIO resided outside of Alaska from at least March 2015 through February 2017, and that VALERIO failed to report his out-of-state residency to DPA thereby receiving at least $23,891.80 worth of various Alaska welfare benefits (Adult Public Assistance, Medicaid & Senior Benefits) to which he otherwise was not entitled. Search Warrant 3AN-17-00969SW was served on Wells Fargo Bank N.A. which ordered that $15,663.01 be frozen until such time that a court order released the funds. On 11 January 2018, a Default Judgment ordered Wells

Fargo to release $15,633.01 as restitution in part in 3AN-17-06420CI. Wells Fargo issued Cashier's Check no. 0001393167 in the amount of $15,663.01 made payable to the Alaska Division of Public Assistance. The Default Judgment also ordered VALERIO to make remaining restitution.

• Juana A. CARLOS/Luis H. CARLOS ACOSTA/Luis H. CARLOS-MARTINEZ:
Evidence procured as part of this investigation substantiated allegation that Juana A. CARLOS and Luis H. CARLOS-ACOSTA resided outside of Alaska from at least June 2010 through May 2017, and that Luis H. CARLOS-MARTINEZ committed an ongoing scheme to defraud in order to obtain welfare benefits (Adult Public Assistance, Medicaid & Senior Benefits) on their behalf during the aforementioned time period. Three separate criminal cases against each Defendant were indicted on 28 June 2017. On 24 October 2017, Luis H. CARLOS-MARTINEZ entered a plea of guilty to one count of Public Assistance Fraud in case 3AN-17-05079CR; the Rule 11 Plea Agreement was accepted by the court. At the Change of Plea Hearing, CARLOS-MARTINEZ made restitution in full via Ingaldson Fitzgerald P.C. Trust Account check #4133 in the amount of $111,150.02. A 90 day SIS was entered against CARLOS-MARTINEZ. The Rule 11 Plea Agreement included dismissal of cases 3AN-17-05080CR and 3AN-17-05081CR.

• Nenita R. RABINO:
Evidence including certified First National Bank of Alaska account records substantiated allegation that RABINO did not reside in Alaska from January 2016 through June 2017 thereby receiving at least $18,991.60 worth of various Alaska welfare benefits (Adult Public Assistance, Medicaid & Senior Benefits) to which she otherwise was not entitled. Additionally, the account records reflected Ethel QUEZADA was a co-signer on the account and substantiated that she wrote checks to herself totaling at least $6,500.00. A balance of $14,788.97 was frozen via search warrant in July 2017. This case referred to the Department of Law for civil action. On or about 05 November 2017, QUEZADA submitted a signed Confession of Judgment Without Action and AKUSA FCU Cashier's Check no. 01 0001273456 in the amount of $4,202.63. On or about 21 November 2017, Judge Brian Clark signed a Court Order as part of 3AN-17-09563CI ordering FNBA to release the frozen funds previously secured via search warrant. FNBA issued Cashier's Check no. 00352538 in the amount of $14,788.97 resulting in full restitution being made by QUEZADA.

** There were a total of 9 cases resolved by the AG's office involving the Medicaid program office during FY18. Five of them have been summarized above.

Senior and Disabilities Services (Quality Assurance):

- Recipient and PCA charged with a scheme to defraud Medicaid.
- PCA charged with submitting timesheets for services that were not provided to the recipient.
- Quality Assurance Investigators provided a number of Assisted Living Home providers, Care Coordinators and waiver providers with technical assistance and training during the course of investigations this year.
- 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.
- SDS QA investigators made referrals to Medicaid Fraud Control Unit/Medicaid Program Integrity after conducting preliminary investigations which resulted in recoveries noted by Medicaid Fraud Control Unit/Medicaid Program Integrity.

VIII. 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.

Federal fiscal year 2017 PERM program report is expected to be released in late November, 2018.

IX. 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 finalizing round five of the eligibility pilots. Round five is the final round of eligibility pilots.