U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

November 7, 2025

TO: Daniel Brillman
Deputy Administrator and Director
Center for Medicaid and CHIP Services

FROM: John D. Hagg /S/
Acting Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the Office of the Kentucky State Auditor of Public Accounts: State Auditor's Report *How Kentucky Failed to Prevent Over $800 Million of Medicaid Waste* (A-09-23-02005)

This memo transmits the findings of the Office of the Kentucky State Auditor of Public Accounts' (APA's) special examination report *How Kentucky Failed to Prevent Over $800 Million of Medicaid Waste*, issued September 17, 2025. The APA conducts audits of accounts and financial transactions of all spending agencies of Kentucky. The APA's mission is to help reduce waste, fraud, abuse, and mismanagement and ensure that public resources are protected, accurately valued, properly accounted for, and effectively employed to improve the quality of life for all Kentuckians. This examination was conducted as part of APA's oversight of Kentucky's Medicaid program.

The objective of APA's special examination was to determine whether Kentucky Medicaid made capitation payments on behalf of beneficiaries who were enrolled in Medicaid (i.e., enrollees) in more than one State during the examination period, based on a random sample and additional review of certain subgroups (e.g., deceased enrollees).

As part of the Office of Inspector General's (OIG's) efforts to partner with State auditors and expand oversight coverage of the Medicaid program, OIG assisted APA with its audit by:

- matching Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS's) Transformed Medicaid Statistical Information System (T-MSIS) to identify capitated payments that Kentucky made on behalf of enrollees for whom another State also made capitated payments for the same enrollees in the same months,

- performing data validation procedures of the matched Medicaid claims,

- providing the resulting Medicaid matches to APA,

- meeting routinely with APA auditors to discuss the work, and

- monitoring the progress of APA's work.

To accomplish its purpose of the special examination, APA analyzed the results of OIG's data match provided for the examination period (January 1, 2019, through December 31, 2022) for managed care enrollees for whom: (1) Kentucky's Cabinet for Health and Family Services' (CHFS) Department for Medicaid Services (DMS) and Department for Community Based Services (DCBS) made capitated payments and (2) a concurrent capitated payment was made in another State or territory.[1] The APA examined the total data population and pulled a random sample of 100 Medicaid enrollees in Kentucky who were concurrently enrolled in another State. The APA also examined selected subgroups. The sample of 100 Medicaid enrollees was selected from the top ten States based on the total dollar amount of capitation payments made by Kentucky. In addition, a selection of subgroups was taken from the full data set and consisted of a sample of 19 enrollees in one subgroup and a sample of 14 enrollees in another subgroup. The APA examined case notes for each enrollee in the sample.

The APA also interviewed staff from DMS, DCBS, and CHFS; reviewed Federal and State laws, regulations, policies, and procedures, as well as other guidance; and studied MCO contracts. The examination did not include determining an enrollee's exact State of residency to identify which State should be making the capitation payments.

APA's analysis of the T-MSIS data revealed that Kentucky paid MCOs $836,364,425 in capitation payments for enrollees who were concurrently enrolled from calendar years 2019 to 2022. There were 103,907 unique enrollees who were concurrently enrolled in Kentucky and at least one other State for a minimum of 3 consecutive months (i.e., a series of months) during the examination period. The analysis also revealed that Kentucky's concurrent enrollment matches involved 48 States. Based on the 100 sampled enrollees, APA's observations included the following:

- Of the 100 sampled enrollees, 92 were linked to only one series of months. The remaining eight enrollees in the Public Assistance Reporting Information System (PARIS) were linked to more than one series of months. This means that alerts were issued for a series of months, stopped being issued, and then restarted for one or more series of months.

- Case files in the Worker Portal lacked any evidence that PARIS alerts had been issued for 37 enrollees, and it is unclear whether alerts were issued for the remaining 63 enrollees for the specific month in question.

- In one subgroup, Kentucky made capitation payments on behalf of deceased enrollees multiple months past the reported date of death. In the second subgroup, during the

[1] DMS and DCBS administer Kentucky's Medicaid program. DMS outsources to MCOs the responsibility for delivering the services to Medicaid enrollees and making payments to medical care providers for those services.

4-year examination period, Kentucky made 100 or more capitation payments on behalf of certain enrollees who were concurrently enrolled in two or more States.

The APA stated that concurrent capitation payments to MCOs often occur because States primarily rely on MCOs to deliver Medicaid benefits. The use of the MCO model requires coordination among three main actors—MCOs, the Federal Government, and State governments—to help curb the waste caused by concurrent capitation payments.

APA made two recommendations to DMS, multiple recommendations specifically to the DMS executive branch leadership, and one recommendation to CHFS.

APA recommended that DMS:

- work with current MCOs to amend relevant contracts to specifically require reports to be shared and processes to be undertaken to detect and reduce the amount of concurrent capitation payments made to MCOs by multiple States for the same enrollee and

- communicate with the Federal Government about: (1) obtaining greater access to T-MSIS data, (2) creating a process to monitor data and alert States about concurrent enrollment, or (3) modify the PARIS system to allow Kentucky to more efficiently identify concurrent enrollment.

APA made multiple recommendations to DMS executive branch leadership, including the following:

- offer detailed instructions addressing all aspects of completing PARIS match tasks and make training resources readily available to all Kentucky Medicaid caseworkers,

- consider adding certain steps for caseworkers during the initial enrollment and recertification process that could help curb concurrent capitation payment waste, and

- provide guidance to caseworkers on the referral process for confirmed cases of concurrent capitation payments across State lines.

APA recommended that CHFS consider requiring PARIS match task training at certain intervals, both by job level and time frame, and offer shorter refresher trainings.

In the comments on APA's report, CHFS did not provide a statement of concurrence or non-concurrence for each recommendation that APA included in the report. Rather, it stated that: (1) APA's report contained inaccuracies and failed to provide verifiable evidence of substantial loss of taxpayer funds; (2) Kentucky Medicaid is in full compliance with Federal requirements for Medicaid eligibility verification, including residency; (3) no State has access to the data necessary to identify when beneficiaries are concurrently enrolled in another State's Medicaid managed-care program; (4) it has not received any additional guidance from CMS to address the issue; and (5) it awaits information and is ready to partner with the Federal Government to address the issue.

APA replied to CHFS's comments and reiterated that its report identified ways CHFS could curb Medicaid waste.

APA is responsible for the attached report and the conclusions expressed in it. APA agreed to conduct the special examination in accordance with its policies and procedures. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with State Medicaid agencies to prevent payments resulting from concurrent enrollment from occurring in the future.

This memo and the APA report, including CHFS's written comments, will be posted on the OIG website.

If you have any questions or comments about this memo, please do not hesitate to contact Patrick Cogley, Acting Assistant Inspector General for Audit Services, at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-09-23-02005 in all correspondence.

Attachment

cc:

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How Kentucky Failed to Prevent Over $800 Million of Medicaid Waste

September 2025

AUDITOR ALLISON BALL
KENTUCKY AUDITOR OF PUBLIC ACCOUNTS

Contents

Figures & Appendices

ALLISON BALL
AUDITOR OF PUBLIC ACCOUNTS

September 17, 2025

Dr. Steven Stack, Secretary
Cabinet for Health and Family Services
275 E. Main St. 5W-A
Frankfort, Kentucky 40621
Via Email: steven.stack@ky.gov

Dear Secretary Stack,

The Auditor of Public Accounts (APA) has completed a special examination of Medicaid capitation payments made on behalf of enrollees who were concurrently enrolled in the Medicaid program in another state. As further described in the Examination Overview in Appendix A, the purpose of this special examination was not to provide an opinion on the Cabinet for Health and Family Services' financial statements but to review specific matters and to make recommendations to strengthen and improve internal controls to ensure operating activities are consistent and transparent. This report summarizes the procedures performed and communicates the results of those procedures. Detailed issues along with solutions and recommendations based on our special examination are presented to assist management in implementing corrective action.

Pursuant to KRS 43.090(1), "[w]ithin sixty (60) days of the completion of the final audit or examination report, the agency to which an Auditor's report pertains shall notify the Legislative Research Commission and the Auditor of the audit recommendations it has implemented and of the audit recommendations it has not implemented. The agency shall state the reasons for its failure to implement any recommendation made in the final audit or examination report. All audit reports and agency responses shall be, subject to KRS 61.870 to 61.884, posted online in a publicly searchable format."

Thank you for your attention to these matters and your cooperation with this special examination. If you have any questions regarding this report, please contact Alexander Magera, General Counsel, at alexander.magera@ky.gov.

Respectfully submitted,

Allison Ball
Auditor of Public Accounts

CC Lesa Dennis, Department for Community Based Services Commissioner, lesa.dennis@ky.gov
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CHAPTER 1: Introduction and Background

Introduction

During a four-year period, hundreds of millions of dollars of U.S. taxpayer money was wasted within the Medicaid program. That happened because Kentucky and at least one other state made concurrent capitation payments to managed care organizations for the same Medicaid recipients during the same time period. Since only one state should be responsible for making these payments on behalf of their residents, and because a person can be a resident of only one state, hundreds of millions of dollars of these payments were made unnecessarily.

The good news is the issues causing this waste are straightforward problems that can be fixed with relative ease. But the straightforwardness of the problems and the ease of the solutions should not diminish the financial impact of either. While these questionable payments represent only 2.06% of all capitation payments issued during the same period, we're still talking about saving hundreds of millions of dollars for Kentucky's Medicaid program. This report explains how.

An Overview of the Problem

Medicaid is a taxpayer-funded program that provides healthcare coverage to eligible low-income individuals and people with disabilities. To fund the program, states both receive federal taxpayer money and tax their own citizens. State Medicaid programs must then determine how that money is distributed to fund Medicaid healthcare services.

The main methods of funding services are (1) the state directly paying a healthcare provider for a Medicaid beneficiary's covered services (fee for services) or (2) the state paying a managed care organization (MCO) that then pays healthcare providers for a Medicaid beneficiary's covered services. Kentucky uses both methods, but the latter applies to the majority of Medicaid beneficiaries and is most relevant to this report.

Under the MCO method, Kentucky contracts with MCOs to make medical services available to Kentucky residents enrolled in the Medicaid program. Those contracts outline the MCOs' required duties, which can include developing a healthcare provider network, paying providers for covered services, and establishing care standards. To cover the cost of the MCOs' services, Kentucky makes monthly payments called "capitation payments" to those MCOs for each individual Medicaid beneficiary for whom they provide coverage.

Breaking that down a little more, a capitation payment is a fixed, per-beneficiary, per-month fee paid to MCOs. This per-beneficiary monthly fee is "fixed" based on an actuarial analysis of the projected costs of a state using the MCO method. From these capitation payments, MCOs are

responsible for paying healthcare providers for all covered healthcare services received by Medicaid beneficiaries. Notably, states make these capitation payments regardless of whether a Medicaid recipient actually receives healthcare services.

Enrollment in Kentucky Medicaid is tied to residency: Kentucky must provide Medicaid benefits to, and only to, Kentucky residents. So only Kentucky residents, not residents of other states, should be enrolled in Kentucky Medicaid. And because an individual's enrollment in Kentucky Medicaid triggers the making of a monthly capitation payment to an MCO, Kentucky should be making capitation payments to MCOs only for Kentucky residents.

But that's not what's happening. Right now, Kentucky taxpayer money is being spent on capitation payments made to MCOs for individuals *for whom other states are also making capitation payments*. In other words, our examination found that Kentucky and at least one other state are making capitation payments to MCOs for the same individual.

To be clear, this is, in fact, a waste of money. It is not as though the individual for whom double (or more) capitation payments are made is getting double (or more) the medical benefits. Medical-benefit coverage is based on the MCO's contract with the state, state law, and federal law, laying out what services are actually covered. And if the actuarial analysis has correctly determined the per-beneficiary, per-month capitation-payment amount (which should assume that states are making capitation payments on behalf of their residents only), one capitation payment for one individual should be more than sufficient to cover all necessary costs attributed to that individual (the individual's healthcare costs, as well as appropriate amounts for an MCO's administrative expenses, reserves, and profit or reinvestment).

So the waste comes not only from states making capitation payments for non-residents when they legally don't need to. Waste, *in fact,* is occurring because two or more states are making capitation payments for the same individual with essentially no benefit to that individual. Instead, the excess of that double payment is presumably going to the benefit of the MCO(s).

Only the state of residency should be using its taxpayer money to make capitation payments for that individual. That is what federal law provides. But, as we discovered in this examination, those involved directly and indirectly with the administration of Kentucky's Medicaid program are not doing what they need to do to prevent Kentucky from making unnecessary capitation payments. The good news is that there are simple solutions to fixing this problem. Implementing these solutions could save hundreds of millions of dollars of Kentucky taxpayer money every year.

CHAPTER 2: The Medicaid Program

In 1965, President Lyndon Johnson signed into law Title XIX of the Social Security Act. That created the Medicaid program. The goal of the Medicaid program is simple: To provide health insurance coverage for certain low-income individuals and individuals with disabilities.

In 1997, the Children's Health Insurance Program (CHIP) was signed into law. CHIP provides matching funds to states, including Kentucky, to provide health coverage to children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. This report does not address the eligibility of or the capitation payments made on behalf of CHIP recipients.

The General Cost of Medicaid

Today, over 85 million Americans receive Medicaid or CHIP benefits. That's approximately one in every four Americans. The annual cost of Medicaid nationwide is almost a trillion dollars of taxpayer money.

Almost 1.4 million Kentuckians receive Medicaid benefits. That's also about one in every four Kentuckians. The cost of Medicaid in Kentucky is more than $16 billion of taxpayer money per year.

Because of, in part, the number of Medicaid beneficiaries and the amount of money involved in the Medicaid program, the United States Department of Health & Human Services' (HHS) Office of Inspector General (OIG) has characterized it as a high-risk program. This means the Medicaid program must be consistently monitored and audited to ensure that taxpayer funds are not wasted.

Cooperative Partnership

Funding for Kentucky Medicaid comes from taxpayer money at both the federal and state levels. The administration of that program also occurs at both levels. The Centers for Medicare & Medicaid Services (CMS) handles federal-government responsibilities, while Kentucky's Cabinet for Health and Family Services' (CHFS) Department for Medicaid Services (DMS) and Department for Community Based Services (DCBS) handle state-government responsibilities. See Appendix B for CHFS's organizational charts relevant to this examination.

The Medicaid system was designed to allow Kentucky (as well as every other state) to tailor its Medicaid program to best serve the needs of Kentuckians. Although its state Medicaid plan must meet basic federal requirements and ultimately obtain approval from CMS, Kentucky has a lot of flexibility in designing and operating its Medicaid program. As long as Kentucky complies with the baseline requirements established by federal law, it has considerable flexibility in: (1)

establishing eligibility standards; (2) determining the type, amount, duration, and scope of services; (3) setting the rate of payment for services; and (4) administering the program.

As mentioned, DMS and DCBS administer Kentucky's Medicaid program. DMS would normally oversee Kentucky Medicaid recipients' receipt of services and Kentucky's payouts to medical care providers for those services, but it has outsourced much of that responsibility by contracting with MCOs. Through those contracts, MCOs take on the responsibility of administering Kentucky's Medicaid program for most Kentucky Medicaid beneficiaries.

Program Administration Models

As mentioned, Kentucky Medicaid can administer healthcare assistance to eligible residents using two methods. The first, less utilized way is the fee-for-service (FFS) model. This model cuts out the MCO middleman; Kentucky directly pays providers for covered services to Medicaid recipients.

But the more significant method here is the MCO model. In this model, Kentucky contracts with MCOs to administer the Medicaid program on behalf of the state in exchange for a fixed, per-month, per-member fee (the capitation payment). Note that Kentucky makes monthly capitation payments to MCOs regardless of whether beneficiaries even receive reimbursable medical care during the covered period.

Kentucky must report its capitation payments to MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). As shown in Figure 1, around 80–90% percent of Kentuckians receiving Medicaid benefits do so within the MCO model. And in calendar year 2021, Kentucky exceeded $10 billion in expenditures to MCOs.

Figure 1: Breakdown by Calendar Year of Medicaid Dollars Spent and Beneficiaries Served by Each Method

Calendar Year & Method	Dollars Spent	Percentage	Total Eligibles	Percentage
CY 2019				
MCO Method	$7,540,537,646	71.43%	1,455,078	88.97%
FFS Method	$3,015,646,690	28.57%	180,307	11.03%
Totals	**$10,556,184,336**	**100.00%**	**1,635,385**	**100.00%**
CY 2020				
MCO Method	$9,030,339,267	69.87%	1,443,414	79.11%
FFS Method	$3,893,577,129	30.13%	381,213	20.89%
Totals	**$12,923,916,396**	**100.00%**	**1,824,627**	**100.00%**
CY 2021				
MCO Method	$11,800,418,131	78.22%	1,676,731	89.37%
FFS Method	$3,285,196,146	21.78%	199,478	10.63%
Totals	**$15,085,614,277**	**100.00%**	**1,876,209**	**100.00%**
CY 2022				
MCO Method	$12,229,158,381	78.99%	1,639,089	87.73%
FFS Method	$3,252,447,221	21.01%	229,201	12.27%
Totals	**$15,481,605,601**	**100.00%**	**1,868,290**	**100.00%**

Source: APA, based on information provided by CHFS. Note that dollar amounts have been rounded to the nearest whole dollar.

CHAPTER 3: The Problem Explored

Kentucky must provide Medicaid benefits to eligible residents, including those residents who are temporarily absent from Kentucky. And when an individual is officially enrolled in Kentucky Medicaid, Kentucky makes capitation payments for that individual to an MCO, if that is the method chosen.

But the clear line for when an individual is no longer eligible for Kentucky Medicaid is when that individual establishes residency in another state. At that point, Kentucky should remove that individual from Kentucky Medicaid and cease capitation payments to the MCO on behalf of that now-ineligible individual.

The critical processes used by Kentucky to identify concurrent enrollees in multiple States' Medicaid programs must be fine-tuned to prevent wasteful spending. To fix the problem of concurrent capitation payments, concurrent enrollment must be identified and eliminated.

Identifying Concurrent Enrollees

To start, Kentucky is under a general duty to redetermine every Medicaid recipient's eligibility once every 12 months. But that 12-month period is just the baseline requirement. Kentucky must also ensure that it has procedures in place to capture changes occurring throughout the year that affect Kentucky Medicaid recipients' eligibility.

Specifically, Kentucky must ensure that beneficiaries make timely and accurate reports of their changes of residency, since, after all, Kentucky Medicaid eligibility is tied to residency. This is in addition to Kentucky's general duty to promptly redetermine eligibility when information is received about beneficiaries that may affect eligibility.

To ensure that Kentucky complies with these duties, the federal government requires Kentucky to use particular data systems and technology that can assist in the Medicaid eligibility review and redetermination processes. One of these tools is the Public Assistance Reporting Information System (PARIS), managed by HHS's Administration for Children and Families (ACF).

PARIS is a data reporting system that, through its "Interstate Match" function, compares the data of Medicaid beneficiaries to identify those beneficiaries enrolled in two or more states' Medicaid programs. When a concurrent enrollment is detected, a PARIS Match Alert is sent to all the matching states where the person is enrolled. This is the trigger for those states, then, to take the initiative of conducting an investigation to determine that individual's true state of residency. The individual's true state of residency is the only state that should be making capitation payments on behalf of that individual to an MCO.

PARIS is a helpful tool, but it has its limitations. For one, although states are required to participate in PARIS to receive federal funding for automated data systems, states have flexibility as to the type of data match conducted (like whether to participate in the Interstate Match function) and the frequency of how often matches are conducted. Flexibility like that, unfortunately, in this case, affects the ability of the system to generate a concurrent enrollment match and the overall quality of the match.

Additionally, even for states that fully participate in the Interstate Match function, PARIS data is collected and matched only on a quarterly basis by a non-Medicaid agency. That is in addition to the fact that data is only available for the current quarter and not maintained in a database readily accessible for states to utilize in the residency-determination process. These aspects of PARIS can be a challenge for states to quickly and accurately address potential matches to limit the number of wasted capitation payments.

While PARIS is helpful, the federal government has an even better tool that could assist states in identifying concurrent Medicaid enrollment in other states. That tool is the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS is maintained by CMS and exists to establish an accurate, current, and comprehensive database of standardized enrollment, eligibility, and paid claim data about Medicaid recipients. Naturally, then, T-MSIS is used for administering Medicaid federally and to assist in detecting fraud, waste, and abuse in Medicaid.

Because states must submit their T-MSIS data to CMS monthly, T-MSIS contains more up-to-date information about beneficiary eligibility, beneficiary and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. While HHS's OIG has full access to T-MSIS data for all states, CMS has traditionally limited a state's access to other states' T-MSIS data.

The exception to this limitation is that states have access to the T-MSIS Analytic Files (TAF). TAF is available to all states upon request and approval from CMS. The problem, though, is that TAF does not contain personally identifiable information that is needed to identify beneficiaries with concurrent Medicaid enrollment. So states would need greater access to T-MSIS to more efficiently and effectively identify concurrent Medicaid enrollment in other states.[1] And on that point, the federal government has recently announced a greater willingness to share helpful information like this to tackle the issue of concurrent Medicaid enrollment. If Kentucky had full T-MSIS data access, it could better address the problem of concurrent enrollment in Medicaid across state lines far better than it can now.

[1] According to CMS, however, even though states submit data every month, accumulating the totality of the necessary data for a given month is typically not complete until three months after the end of the given month.

Eliminating Concurrent Enrollment

When Kentucky is notified, by a PARIS match alert or otherwise, that an individual for whom it is making capitation payments is also enrolled in another state's Medicaid program, there is a general process that Kentucky must follow.

First, Kentucky must provide that individual with an opportunity to reasonably explain the notification of dual enrollment and to provide documentation to refute the state's evidence. Kentucky cannot terminate that individual's Medicaid benefits unless it has first sought this information.

If the individual does not respond to that request or provides an insufficient response, and Kentucky does not have sufficient information to make a determination of continued eligibility, then Kentucky can determine that the individual is no longer eligible for Kentucky Medicaid. It is only at this time that the individual's Kentucky Medicaid eligibility can be terminated. When Kentucky terminates that eligibility, it must provide notice to the individual of that termination no later than the date of the termination.

So when Kentucky receives a PARIS alert or other information that suggests an individual's residency has changed, this represents a potential change in circumstances that requires Kentucky to use the process outlined above to investigate the situation. That alert and other information received then make it Kentucky's duty and responsibility to verify the beneficiary's residency so that Kentucky taxpayers are not paying Medicaid benefits for non-residents.

For a while during our examination period, however, there was a modification of the usual process described above. Our examination period focused primarily on activity between January 1, 2019, and December 31, 2022. This period obviously included the COVID-19 Public Health Emergency (PHE). And as one can imagine, the PHE significantly disrupted routine Medicaid eligibility and enrollment operations.

In response to the PHE, in March of 2020, Congress passed the Families First Coronavirus Response Act (FFCRA). That law temporarily increased the percentage of federal taxpayer funds that Kentucky received to offset Medicaid costs. That percent share is referred to as the Federal Medical Assistance Percentage (FMAP). To qualify and maintain qualification for the FMAP increase, Kentucky had to satisfy a variety of conditions. One of these conditions was the continuous enrollment condition.

The continuous enrollment condition had two aspects. First, Kentucky needed to ensure that it maintained eligibility standards, methodologies, and procedures no more restrictive than what it had in place as of January 1, 2020. Second, Kentucky needed to ensure that most individuals

enrolled in Kentucky Medicaid as of or after March 18, 2020, continued to be enrolled through the end of the month in which the PHE ended. All that being said, Section 6008(b)(3) of the FFCRA did still permit Kentucky to terminate any beneficiary who was determined to be a non-resident.

Kentucky DMS was, therefore, able to receive the increased FMAP at the same time that it was still expected to disenroll Kentucky Medicaid recipients that it confirmed had moved out of state. But DMS did not do this. Even worse, DMS not only stopped investigating leads on Kentucky Medicaid recipients who may have moved out-of-state, but DMS also stopped annually reviewing the eligibility of Kentucky Medicaid recipients. So for a long period of time, DMS exacerbated the concurrent capitation payment problem.

This was so even though, in light of Section 6008(b)(3) of the FFCRA, CMS explicitly outlined a process for disenrolling from Kentucky Medicaid individuals deemed no longer to be Kentucky residents. Effective November 2, 2020, CMS published a regulation instructing states on how to terminate individuals not validly enrolled and still claim the increased FMAP. That regulation specifically provided that a state may terminate Medicaid coverage for an individual when: (1) a PARIS Interstate Match alerts the state to potential concurrent enrollment; (2) the state takes all available reasonable measures to determine state residency prior to termination; (3) and the beneficiary fails to respond to a request for information to verify residency.

So Kentucky DMS could have still reviewed Medicaid recipient eligibility for changes in residency and helped curb the concurrent capitation payment problem. But it didn't.

Even more so now that the PHE has ended, CMS has made it clear that states need to transition back to normal operations. As outlined in letters to states on August 13, 2021, and March 3, 2022, CMS gave states between 12 and 14 months following the end of the PHE to initiate eligibility renewals and address any outstanding eligibility and enrollment actions. The PHE officially ended on May 11, 2023. But it wasn't until after our entrance conference with CHFS on August 22, 2023, that DMS hired contract workers to assist with addressing the backlog of PARIS matches showing concurrent enrollment.

Unfortunately, by that point, hundreds of millions of dollars of Kentucky taxpayer money had already been wasted because of the concurrent capitation payments problem. And because the hiring of more workers really only puts a band-aid on that problem, Kentucky is still wasting money unless it implements the suggested solutions offered in this report.

CHAPTER 4: Solutions

The underlying reason that the problem of concurrent capitation payments by states to MCOs for the same individual exists is that states most often use MCOs to distribute Medicaid benefits. The use of the MCO model requires coordination among three main actors: MCOs, the federal government, and state government. All three actors here can take measures to help curb the waste caused by concurrent capitation payments. But the solutions that Kentucky itself implements will have the greatest impact.

Solution 1: DMS should place more responsibility on MCOs to act.

One potential solution would be to require more of MCOs in this realm. This is something that Kentucky can do in its contracts with MCOs. Apart from some basic MCO responsibilities outlined in the law, most of an MCO's responsibilities and duties exist through its contractual relationship with Kentucky. DMS can specifically spell out in its contracts with MCOs what those MCOs must do to curb the concurrent capitation payments problem.

Based on contracts in existence at the time of our examination, Kentucky has contracted with about seven different MCOs. Figure 2 illustrates which vendors held contracts with DMS during what portion of what time period.

Figure 2: Vendors with Contracts with DMS

Contract Periods	1/1/2017 - 12/31/2020	1/1/2021 - 12/31/2024
Managed Care Organizations	Aetna Anthem Humana Passport WellCare	Aetna Anthem Humana Molina United HealthCare WellCare

Source: APA, based on information provided by CHFS DMS.

A review of those eleven contracts revealed two glaring issues.

First, none of the contracts specifically mentions Kentucky's ability to recover concurrent capitation payments made to MCOs for individuals enrolled in another state's Medicaid program. Without such a provision, Kentucky arguably has no way of recovering from MCOs those concurrent payments.

Second, none of the contracts require MCOs to conduct proactive and timely review procedures to identify concurrent Medicaid beneficiaries on their rosters. True, some of the contracts include

provisions generally requiring MCOs to report potential waste, fraud, and abuse. But those provisions do not require MCOs to proactively search for such waste, fraud, and abuse. In other words, MCOs may only be required to report waste, fraud, and abuse when they stumble upon it, instead of being required to actively look for it.

At the very least, none of the contracts have any specific requirements for MCOs to regularly review their Medicaid beneficiary rosters to identify concurrent enrollees across state lines. Nor do any of the contracts have any specificity about creating and implementing any other regularly conducted processes or procedures designed to address the specific issue of concurrent capitation payments made to MCOs for individuals enrolled in multiple states' Medicaid programs.

Figure 3 compares the total amount of capitation payments paid by Kentucky for Medicaid beneficiaries concurrently enrolled in Medicaid programs in one or more other states to the total amount Kentucky paid to MCOs in a given calendar year. While the amount questioned for the full examination period represents just over 2% of Kentucky's MCO expenses for the four-year period, think about what extra funding of up to $836 million could do for Kentucky, especially within its Medicaid program.

Figure 3: Percentage of Kentucky's Capitation Payments Attributed to MCO Expenses

Calendar Year	Concurrent Capitation Payments	Kentucky's Payments to MCOs	Percentage of Concurrent Capitation Payments to Kentucky's Payments to MCOs
2019	$125,388,151	$7,540,537,646	1.66%
2020	158,518,830	9,030,339,267	1.76%
2021	233,872,076	11,800,418,131	1.98%
2022	318,585,368	12,229,158,381	2.61%
Totals	**$836,364,425**	**$40,600,453,424**	**2.06%**

Source: APA, based on information provided by HHS's OIG and CHFS.

There are not many MCOs operating in the United States, so many of the MCOs that exist operate in multiple states. And those MCOs obviously maintain information on all the Medicaid beneficiaries, including those across state lines, for whom they provide services. It would seemingly not take much effort for those MCOs to consult those lists and alert states when other states are making capitation payments on behalf of an individual. This would trigger the investigation process described above and lead to the right result—either Kentucky or the other state eliminating that concurrent enrollment.

Recommendations

We recommend that DMS work with current MCOs to amend relevant contracts to specifically require reports to be shared and processes to be undertaken to detect and reduce the amount of concurrent capitation payments made to MCOs by multiple states for the same individual.

Solution 2: The federal government can assist Kentucky more.

To its credit, as described above, the federal government has created the PARIS system to assist states in identifying concurrent enrollment in Medicaid across state lines. However, also as described above, PARIS has its limitations.

The better data for states is that which comes from T-MSIS. As mentioned, CMS has traditionally refused to readily provide states with T-MSIS data. That could change in light of a recent CMS announcement evidencing a greater willingness to provide states with information helpful to tackling the concurrent Medicaid enrollment issue. And if CMS did provide states with greater access to T-MSIS data, states would be able to detect the concurrent Medicaid enrollment issue much sooner. But if access to T-MSIS data is not an option for Kentucky, at the very least, CMS could more readily monitor T-MSIS data and alert states to concurrent Medicaid enrollment.

Otherwise, tweaks can be made to the PARIS system and the data that must be reported to it so that it functions more like the T-MSIS system. The federal government could require all states to participate fully in the Interstate Match process. The federal government could also provide PARIS data to states on a monthly, not quarterly, basis. If the PARIS system operated more like the T-MSIS system, Kentucky should be able to identify concurrent Medicaid enrollment sooner and on a more regular basis.

Recommendations

We recommend that DMS communicate with the federal government about obtaining greater access to T-MSIS data for regular and timely identification of concurrent Medicaid enrollees. If the federal government does not wish to provide this access to states, DMS can also inquire about the federal government creating a process to monitor T-MSIS or other data and alert states about concurrent enrollment on a more regular basis. Or DMS can inquire about the federal government modifying the PARIS system, both in the data submitted to it and the reports generated by it, to allow Kentucky to more efficiently identify concurrent Medicaid enrollment.

Solution 3: Kentucky state agencies need to more actively engage with this issue.

By far, the most direct, immediate, and impactful solutions for eliminating Medicaid waste reside at the state level. In reviewing the issue of waste caused by concurrent capitation payments across state lines, three main issues arose: 1) eliminating that waste is not of real interest to executive-branch leadership; 2) there are little to no written procedures or trainings instructing executive-branch employees as to how to eliminate that waste; and 3) for the few procedures and trainings that are maintained, changes are needed to ensure that waste is indeed eliminated. Solutions to these problems exist, but an in-depth discussion of these issues is needed to truly understand those solutions.

State Issue 1: Executive-branch leaders failed to set the proper tone at the top to take seriously the issue of waste caused by concurrent capitation payments across state lines.

Discussions with various Kentucky Medicaid employees confirmed management failed to set a proper tone at the top. Management did not give proper emphasis to tackling the issue of concurrent capitation payments across state lines—more specifically, to address the PARIS alerts that Kentucky Medicaid receives from the federal government signaling the issue. Some staff members stated that during the COVID-19 pandemic, they were "basically told not to look at the alerts" because "addressing PARIS matches wasn't a priority during COVID." But even beyond the pandemic, staff stated that PARIS alerts, in general, are not addressed in a timely manner and are seen as "low on the totem pole" of priorities.

This sentiment was confirmed in interviews with CHFS's Secretary and other high-level officials. In June 2023, they acknowledged that Kentucky Medicaid was not reviewing for concurrently enrolled beneficiaries and was still "unwinding" from the PHE requirement of continuous enrollment. CHFS simply was not taking action to address the problem of waste resulting from concurrent capitation payments across state lines.

In mid-September—after this examination was underway—CHFS relayed that it planned to contract with about 50 people to focus on addressing PARIS alerts, but that it would be months before implementation. And in January 2024, CHFS stated that this group of individuals would receive a daily listing of PARIS alerts to address, with internal system changes planned to take effect in February, allowing this group to directly receive PARIS match tasks through those internal systems. The efficacy of these changes was not examined in detail, as they fell outside the relevant examination period, but auditors did notice increased PARIS alert processing after that time period.

State Issue 2: State workers are not being given the written procedures and periodic trainings needed to address this issue.

A review of available Kentucky Medicaid manuals and forms within the examination period revealed only a high-level overview of its process for addressing some residency issues arising from Medicaid recipients moving to or from Kentucky. No step-by-step directions about addressing PARIS Match alerts were found, however.

For example, both Volumes IVA and B of DCBS's Division of Family Support's Operation Manual generally state that, for individuals applying for Kentucky Medicaid who have received Medicaid benefits in another state, the employees should contact that other state to determine the effective date of discontinuance and document that discontinuance in that individual's case notes. Yet there is no guidance on, for example, how one should go about identifying that other state, how that state should be contacted, what exactly should be documented in the individual's case notes and how that should occur, or what to do if the state doesn't respond, among other key omissions.

As another example, DCBS's IEES/Worker Portal User Manual tells Kentucky's Medicaid employees what to do when an applicant for Kentucky Medicaid self-reports having received benefits in another state at the enrollment stage. But outside of guidance for that specific scenario, there is not much else, especially as to addressing PARIS alerts for someone already enrolled.

Unsurprisingly, no one interviewed cited either of those documents as valuable resources to use in addressing PARIS alerts. In fact, one Kentucky Medicaid official indicated that there is no section, chapter, or other consolidated guidance on addressing PARIS alerts, and that any guidance is instead scattered within guidance about other topics.

In general, Kentucky Medicaid officials and employees indicated that guidance on addressing PARIS alerts is given once to Medicaid caseworkers, and only briefly, during new-employee training, and again, only briefly, when that employee progresses to processing and addressing Medicaid cases and tasks. One Kentucky Medicaid official speculated that the last training offered on PARIS alerts may have occurred in 2018 or 2019, with some information shared in 2022. But no other Kentucky Medicaid official or employee interviewed confirmed even just this limited training.

Instead, Kentucky Medicaid officials and employees shared that their knowledge about addressing PARIS alerts came through on-the-job training and assistance from co-workers. One employee said that she was just told to start working PARIS matches despite not having received training on how to properly address them.

The only document that was mentioned by caseworkers and others as a valuable resource was a 2018 memo written by a former DCBS Director of the Division of Family Support. The memo was sent generally to each local office to remind employees of their duty to address PARIS alerts and provide some specific guidance for doing so. But with all of the more recent regulatory changes to the PARIS alert processing system, there is a high risk that this memo is outdated.

As noted, after the start of this examination, Kentucky Medicaid maintained that it would hire contract workers to assist with addressing PARIS alerts. To prepare for that, Kentucky Medicaid created a PARIS Match Task Training Guide dated September 19, 2023, developed web-based training, and provided access to certain helpful resources. But it is unclear if those materials were shared with all Kentucky Medicaid caseworkers instead of just the newly contracted ones, as none of the caseworkers interviewed mentioned these resources.

State Issue 3: Changes need to be made to the processes that do exist for addressing concurrent capitation payments.

Multiple CHFS sub-agencies are involved in the Medicaid process. While this approach may lead to the development of helpful expertise in those groups' respective focuses, this can also lead to the siloing of functions in ways that prevent greater process improvements.

According to CHFS officials, DCBS Medicaid caseworkers use the Worker Portal application to process eligibility and enrollment information for Kentucky Medicaid. Each type of task is assigned to a specific queue containing a particular group of staff eligible to work that type of task. The staff in that queue will see the tasks appear on their Dashboard home page screen as available tasks. Caseworkers then choose or can be assigned tasks within that application based on their level of training. Tasks appearing in certain queues include general daily recurring tasks, support services tasks, and, importantly, PARIS match tasks.

That description by CHFS officials, however, conflicts with what caseworkers relayed. According to caseworkers, PARIS alerts are worked separately from daily tasks and do not appear on a caseworker's Dashboard home page screen. Instead, a PARIS alert appears as a banner notification on the "Non-Financial" screen that caseworkers must navigate to on their own to view. If a caseworker doesn't navigate to the Non-Financial screen, the caseworker would not be aware that there may be a PARIS alert to investigate.

As a general matter, either setup can create serious inefficiencies and disorganization. Because individual cases are not assigned to a specific worker, Medicaid enrollment, recertification, case updates, and other tasks related to a single case may be processed by multiple workers statewide. And within each of these steps in the process, other problems exist that could be prevented if

additional controls are implemented to ensure that PARIS alerts are addressed promptly, consistently, and fully, with the process completed and well-documented.

Enrollment and Recertification

Medicaid applications come to CHFS in a variety of ways. Electronic applications can be submitted to the Integrated Eligibility and Enrollment System (IEES) either through the Self-Service portal by the applicant or through the Worker Portal by a CHFS employee who interviewed an applicant in-person or by phone. Electronic applications can also be emailed. Hardcopy applications can be mailed or dropped off at local CHFS offices or faxed, which then requires the submission of that information into IEES by a CHFS employee. Initial enrollment in Medicaid, then, does not require an in-person interview or other direct interaction with the applicant, unless questions are left unanswered or the application is not signed.

Kentucky accepts self-attestation with eligibility verification through electronic data sources. The eligibility verification process includes asking the applicant about the receipt of Medicaid benefits in another state. If the applicant confirms receipt, follow-up questions are asked.

When an application is submitted for approval, the Worker Portal automatically runs the applicant's social security number against the latest Interstate Match file. If a match arises, a PARIS match task is generated. A caseworker should then pin the case and send a PAFS-28 form to the state noted in the alert.

As discussed above, federal law mandates state agency review of eligibility when that state agency receives reliable information, like a PARIS alert, signaling a change in a beneficiary's circumstances that may affect eligibility. And even with the occurrence of the COVID-19 pandemic, federal law still identified ways to address concurrent capitation payments.

Finding a PARIS Match Task

CHFS's Worker Portal is, in and of itself, simply not designed to prevent the payment of concurrent capitation payments across state lines. CHFS, then, only uses the PARIS match system to identify such payments.

As mentioned, when an application is submitted into the Worker Portal, a social security check against the latest Interstate Match file is automatically run. And if an applicant's social security number appears on that Interstate Match file, which denotes that another state is making capitation payments on behalf of that individual, a PARIS Match task in the Worker Portal is generated. There are three main ways in which Medicaid caseworkers can address these matches. Of these

methods, though, the first two are available only to certain staff, while the third is available to all staff authorized to work on Medicaid cases.

First, according to CHFS officials, PARIS Match tasks are assigned to the "PARIS" default queue, where caseworkers assigned to this queue will see these tasks on their dashboard, but workers not assigned to that queue will not see them. Again, however, this conflicts with information from caseworkers who indicated that PARIS matches are separate from their daily tasks on the Dashboard home page screen. This requires caseworkers to navigate on their own to the Non-Financial screen to see a banner notification for a PARIS alert. Additionally, while CHFS officials indicated PARIS Match tasks are assigned with a seven-day due date, caseworkers suggested that their due date to complete a PARIS alert task may be two weeks or 30 days, the latter being the time for an out-of-state agency to respond to a caseworker's PARIS alert inquiry.

Second, there is a report that can be run within the Worker Portal application, using the "Report" module, to locate PARIS matches. This report can be run on-demand with workers inputting certain parameters and filters, generating an Excel-based report. One caseworker noted, however, that during the examination period, regional leadership did not send out these reports.

Third, caseworkers who simply happen to navigate to the "Non-Financial" screen in the Worker Portal while working a daily task for a specific individual may notice a pop-up banner at the top of the screen indicating the receipt of a PARIS alert. These workers can, but are not required to, address this task, since it was not the original reason for working the case. Staff echoed the frequency of the path of the third approach, stating that PARIS alerts are not addressed at all unless staff are already doing another task in a case and happen to see the pop-up banner noting the PARIS alert. And again, at that point, the task "might" get done. That's because, again, caseworkers noted that the banner for the PARIS alert conveys simply a tip or notification that no one is "forced to" address before completing the actual noted task within the case.

Addressing a PARIS Match Task

When a caseworker does address a PARIS match, there is a general process to follow. What follows is a summary of that process based on interviews with caseworkers, the 2018 memo discussed above, and a review of materials created after the examination period for a particular set of contractors. As mentioned previously, caseworkers and other individuals interviewed did not acknowledge any awareness of the materials created for the contractors hired to work on PARIS alerts despite their continued involvement with addressing PARIS Matches.

First, the caseworker should review relevant task information by accessing the case's Non-Financial screen. This information usually includes: the state from which the recipient is potentially receiving concurrent benefits; the totality of programs from which the individual

received benefits in that state; whether additional family members are involved in the match; the time-period for potential overlap; and the other state's contact information.

Second, the caseworker should attempt to contact the state noted on the match by submitting a PAFS-28 form or by phone. The contact information on the PARIS match task should be the primary contact; however, the National Directory of Contacts provides a list containing additional contact options for certain states. Several individuals interviewed, however, noted that this list has not been updated since 2017 and that phone calls made rarely get answered. The State Interstate Match Contact Directory was not mentioned by any CHFS official or employee. This is a resource posted by PARIS officials on HHS's Office of the Administration for Children & Families' website and is included in the PARIS Match Task Training Guide dated September 19, 2023, as prepared for the contract employees.

When using a PAFS-28 form (the official form notifying another state that an interstate match has been found in Kentucky), caseworkers must manually initiate contact with the associated state to confirm an individual's benefit details and the terminated or active status of that individual's account. This form is normally sent through encrypted email or fax but can be mailed. Although auditors were provided with a template for out-of-state emails and case notes, caseworkers indicated they were unaware of any specific guidance as to what information goes into the email or fax that accompanies the form.

Finally, the caseworkers should update the case notes with any actions taken. Despite the instruction in the PARIS Match Task Training Guide prepared for the contract employees to include the static message "TEK-28 Action [state abbreviation]" in case notes, caseworkers indicated they were unsure as to what specific information should be included in case notes once contact was initiated with another state. A review of a variety of case notes revealed that they varied greatly in detail and relied heavily on abbreviations and shorthand that may not be known by other users.

Updating a PARIS Match Task

According to the PARIS Match Task Training Guide prepared for the contract employees, after a state is contacted about a PARIS match, if the state doesn't respond within two weeks, caseworkers should fill out a second PAFS-28 form, mark it as a second request, and resend the form. If two or more weeks pass without a response after the second form is sent, staff should contact the state by phone. Interviews revealed that this timeline may be flexible, however. One caseworker stated that the other state has 30 days to respond before a repeat request is sent, and other caseworkers indicated that no time limit or deadline for a state to respond exists.

Currently, the Worker Portal does not notify caseworkers when requests to other states must be resent. And even if the state responds to an inquiry, those responses may be received by email, fax, mail, or a returned phone call and are not necessarily received by the individual who initiated the inquiry.

In any event, staff should update the case's notes with each outreach attempt and should not delete any existing notes. The outcome of the inquiry should also be documented. Caseworkers were unsure about the specific documentation requirements for calls, and a review of selected case notes revealed very little detail added about the inquiry's outcome, few documents were uploaded, and the use of abbreviations and personal shorthand by the caseworker making the entry.

If it is confirmed that concurrent capitation payments across state lines have been made for the individual, claim referrals should be sent for processing. Caseworkers indicated confusion as to whom exactly these referrals should be sent. Caseworkers also indicated confusion about whether all cases should be referred or whether a minimum financial threshold must be met before making a referral.

Completing a PARIS Match Task

If a worker initiates the PARIS match task but cannot close it because the worker is waiting on a response from another state, the task will remain in an "In Progress" state until the response is received. However, workers may check a box in the Worker Portal at any time that confirms the PARIS match has been reviewed, and once the case has been updated in the system, the system will show the task as complete. This will remove the task from the task queue.

So if a caseworker checks the completion box prior to a response from the other state, the PARIS match will go unaddressed. That is, until the next set of interstate files is received from the federal government, which will cause a new PARIS match task to appear in the queue. Despite all of this, some CHFS employees relayed that caseworkers could prematurely check the completion box before actually acting on the task.

Recommendations for Improvement

To start, executive-branch leadership needs to get serious about curbing the waste created by concurrent capitation payments for the same individual across state lines. CHFS staff should not be told to ignore PARIS alerts. Every month a PARIS alert goes unaddressed, it is another month of wasted taxpayer dollars. Executive-branch leadership should periodically reemphasize the importance of completing PARIS alert tasks to those who are responsible for them. That is their duty under federal and Kentucky law.

Executive-branch leadership also needs to offer detailed and understandable step-by-step instructions addressing all aspects of completing PARIS match tasks. If leadership has done so in the form of the PARIS Match Task Training Guide described above, then that guide must be offered and accessible to all Kentucky Medicaid caseworkers. Other resources should be offered and readily available, as well, including, among other things: on-demand web-based training, both full trainings and refreshers; the PASF-28 form; contact information for other states; and a template to guide caseworkers in leaving comments in case notes and in communicating with other states. And with respect to trainings, CHFS should consider requiring PARIS match task training at certain intervals, both by job level and time frame, as well as offering shorter refresher trainings.

Executive-branch leadership additionally needs to consider the following to address issues discovered within the PARIS match task process itself. First, leadership should consider adding certain steps during the initial enrollment and recertification process that could help curb concurrent capitation payment waste. These steps may include:

- For currently enrolled beneficiaries who have not received services in a set period and have reached the point for redetermination of eligibility, proactively reviewing their cases for signs that may indicate that the beneficiary no longer resides in Kentucky.
- For currently enrolled beneficiaries for whom returned mail has been received a certain number of times or for a certain period of time, and have reached the point for redetermination of eligibility, review their cases for signs that might indicate the beneficiary no longer resides in Kentucky.

Second, leadership should consider ways to ensure that PARIS match tasks are handled more efficiently by caseworkers across the state. Steps for doing so may include:

- Incorporating PARIS match tasks into the daily tasks queue, which would expedite the handling of such tasks.
- Automatically assigning PARIS match tasks to a particular staff member.
- Automatically calculating and notifying caseworkers when follow-up on a previously sent PAFS-28 form should occur.
- Incorporating a means to easily transition from the Worker Portal to email when needing to submit a PAFS-28 form to another state.
- Sharing with all staff who are responsible for working PARIS match tasks all helpful comment template language.
- Preventing caseworkers from checking off a task as complete until it is actually complete. Controls should be in place to require a supervisory review before any task is marked complete.

Finally, leadership should provide guidance on the referral process for confirmed cases of concurrent capitation payments across state lines. And to the extent leadership remains committed to using the 50 hired contract workers previously discussed, leadership should evaluate the efficiency and effectiveness of that process to see if it would be most cost-effective to move that task to an established group of in-house employees.

Outside of internal systems, there are other things that executive-branch leadership can be doing to curb the waste resulting from concurrent capitation payments for the same individual across state lines. Leadership has a duty under Kentucky law to "explore joining any multistate cooperatives" that could help identify individuals dually enrolled in Medicaid across state lines. As mentioned above, executive-branch leadership should take advantage of CMS's recent willingness to provide more helpful information to states and consider periodically requesting T-MSIS data from CMS to assist with the identification of potentially concurrently enrolled beneficiaries across state lines. Leadership can also amend contracts with MCOs to place a duty on their part to help curb that issue.

Ideas to Consider from Other States

Other states examining this issue have offered certain strategies and programs to attempt to curb this issue, as well.

Massachusetts has employed several strategies to curb waste caused by concurrent capitation payments across state lines. PARIS alerts trigger more substantial investigations where Massachusetts officials will check whether a beneficiary (1) is residing in a Massachusetts long-term care facility, (2) has had a recent fee-for-service claim or MCO encounter, and (3) has certain information on Accurint, a program that helps, but does not definitively, determine whether a particular individual is residing in-state. Massachusetts additionally requires Medicaid beneficiaries flagged by PARIS alerts to substantiate in-state residency. And both during and after the COVID-19 pandemic, Massachusetts implemented a process that shifted individuals for whom concurrent capitation payments across state lines were being made from receiving services from MCOs to receiving services from a fee-for-service model. It conservatively estimated the savings from this strategy to be $65 million. Finally, Massachusetts consistently reminds beneficiaries of their duty to update their changes of residency with state officials.

Rhode Island is another state that uses Accurint to assist in confirming a beneficiary's address. As for other internal processes, Rhode Island: (1) generates "high priority caseworker tasks when PARIS notifications remain unresolved on a member case for 60 days or more"; (2) develops monthly reports that detail "the amount of PARIS matches reported, the number of related documentation requests sent to members, and the number of case terminations resulting from member non-response"; and (3) implements regular caseworker training. Rhode Island also uses

two other information databases to help it identify out-of-state individuals for which Rhode Island is making capitation payments: (1) the United States Postal Services' (USPS) National Change of Address database, a secure dataset that includes change-of-address records reported to USPS, to research returned mail from Medicaid beneficiaries; and (2) Equifax's "The Work Number" in the same way and for the same purpose.

Oregon's auditing team suggested exploring using Massachusetts' strategy and moving flagged individuals to a fee-for-service instead of an MCO model. Oregon also suggested instilling the use of the federal government's Do Not Pay program into the process for identifying when Oregon is making a concurrent capitation payment on behalf of an individual residing in another state.

Louisiana has identified additional databases that could assist in identifying beneficiaries for whom multiple states are making capitation payments. First, almost all states belong to the Interstate Driver's License Compact, a multi-state cooperative where states agree to notify each other when a driver from one state obtains a driver's license in another state. Louisiana has employed the use of this data in its process for identifying beneficiaries concurrently enrolled in Medicaid across state lines. Second, Louisiana discussed the federal government's National Provider Identifier Registry, a database containing the practicing location of each Medicaid service provider for all 50 states. Louisiana identified that "[j]oining the provider's practice location contained in [that] database with [Louisiana's] Medicaid claims and encounter data would allow [the state] to identify the locations where beneficiaries are receiving their services. Individuals who are identified as receiving all of their services out-of-state could then be flagged to have their residency reviewed."

Ohio's auditing team confirmed the benefits of using data from the Interstate Driver's License Compact to help confirm Medicaid beneficiaries' state of residency. Ohio's team also suggested exploring the benefits of employing Massachusetts' strategy of shifting PARIS-flagged beneficiaries from receiving services through an MCO to receiving services within a fee-for-service model. Ohio's team additionally suggested a strategy for proactively reviewing the residencies of individuals who have not received Medicaid services in Ohio for some time.

Illinois has indicated it would "research and pursue use of other states' enrollment data from new clearinghouse sources to check applicants for benefits in other states and to regularly check enrolled individuals for benefits in other states." Washington and Minnesota indicated the same, specifically noting that SNAP clearinghouse and Social Security Administration information can be strategically used to assist in determining a Medicaid beneficiary's true state of residency.

Kentucky can borrow from the work on this issue by other states to help it ensure that it is doing everything it can to save taxpayer money without causing harm to Medicaid beneficiaries.

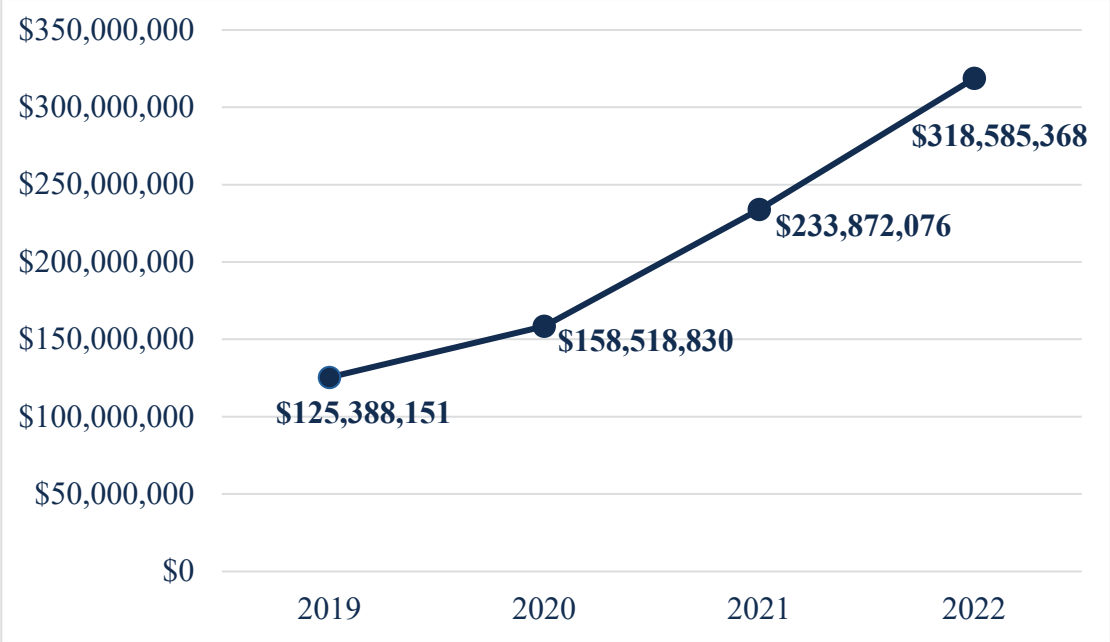
CHAPTER 5: What the Data Showed

Concurrent Capitation Payments

The issue of concurrent capitation payments across state lines is not simply a theoretical problem. It is a real issue with real effects. Auditors gained insight into the extent of those effects by utilizing T-MSIS data from HHS's OIG. Recall that this data is maintained by CMS and contains critically important information from all 50 states, Washington, D.C., and all U.S. territories on eligibility, enrollment, and claims data for Medicaid beneficiaries.[2]

Analysis of the full set of T-MSIS data revealed that Kentucky paid MCOs $836,364,425 in capitation payments for concurrently enrolled individuals over a four-year period. Figure 4 shows Kentucky's concurrent capitation payments for calendar years 2019 to 2022.

Figure 4: Kentucky's Capitation Payments for Concurrently Enrolled Individuals by Calendar Year



Source: APA, based on information provided by HHS's OIG.

As can be seen, Kentucky's capitation payments for concurrently enrolled individuals during calendar years 2019 to 2022 increased each year. As discussed above, had Kentucky's executive-branch leaders taken an interest in the issue of capitation payments being concurrently issued for the same individual across state lines, residency questions could have been answered, and

[2] Note that KCHIP data was not reviewed for purposes of this examination.

capitation payment refunds could have been requested from MCOs, when relevant, in a timelier manner.

Analysis of the full set of T-MSIS data provided by HHS's OIG also revealed that 103,907 unique individuals were concurrently enrolled in Kentucky and at least one other state for a minimum of three consecutive months during the examination period. The analysis also revealed that Kentucky's concurrent enrollment matches involved 48 states. Figure 5 summarizes, by state, both (1) the number of unique individuals concurrently enrolled in Medicaid in Kentucky and in another state and (2) the number of monthly capitation payments made by Kentucky for beneficiaries also enrolled in another state during the examination period. Note that the total number of unique individuals enrolled in each state does not match the overall total number of unique beneficiaries, as some individuals were enrolled in two or more states at the same time they were enrolled in Kentucky Medicaid.

Figure 5: Concurrent Beneficiary Matches by State/Territory

Number of Concurrent Capitation Payments	Number of Unique Individuals	State/Territory
298,059	19,168	Indiana
228,360	14,535	Tennessee
165,335	12,879	Ohio
116,208	8,417	Florida
77,003	5,072	Illinois
67,606	4,069	California
62,222	3,759	Georgia
61,103	4,913	Michigan
51,898	3,459	West Virginia
44,737	2,977	Virginia
38,574	2,897	Texas
36,651	2,479	North Carolina
31,426	2,144	Missouri
29,838	2,183	Colorado
27,428	1,622	Louisiana
27,261	1,558	South Carolina
24,830	1,999	Arizona
24,642	1,519	Alabama
19,772	1,982	New York
14,592	1,228	Arkansas
14,171	1,549	Pennsylvania
12,712	1,211	Washington
11,854	859	Maryland
11,388	992	Wisconsin
11,048	696	Massachusetts
10,565	884	Nevada
8,640	601	Minnesota
8,633	925	Oklahoma
8,516	593	Puerto Rico
8,388	987	Iowa
6,940	553	New Jersey
5,559	711	Oregon
4,955	468	Kansas
4,430	357	New Mexico
4,222	243	Hawaii
3,740	310	Utah
3,140	251	Connecticut
2,705	184	Delaware
2,649	217	Montana
2,457	244	Nebraska
2,305	122	District of Columbia
2,162	174	Rhode Island
1,538	230	Idaho
1,387	156	Maine
1,385	131	New Hampshire
1,115	73	South Dakota
538	78	North Dakota
411	127	Mississippi

Source: APA, based on information provided by HHS's OIG.

Selection of a Stratified, Random Sample

Because of the sheer volume of data received from HHS's OIG, auditors chose to focus their review work on the top ten states in which Medicaid recipients had concurrent capitation payments occurring, based on the total dollar amount of capitation payments made by Kentucky. This allowed auditors to focus on 77% of the concurrent capitation dollars spent and 76% of individuals with concurrent capitation payments being made on their behalf.

The sample size was determined to be 100 individuals, with the proportion of value each of the top ten states held versus the total dollar value of the ten states together being used to stratify the population for random selection. The proportion was then multiplied by the full sample size to determine the number of individuals to be randomly selected from each of the 10 states. The states, along with Kentucky's capitation payment amounts for individuals for whom those states also made capitation payments, the proportion of Kentucky's total capitation payments, and the number of samples per state, are presented in Figure 6.

Figure 6: Number of Samples Per State Based on Kentucky's Concurrent Capitation Payments for Kentucky Enrollees in Other States

State	Concurrent Capitation Payments	Percentage of Total Capitation Payments	Number of Samples
California	$ 36,927,698	6%	6
Florida	56,949,205	9%	9
Georgia	24,108,585	4%	4
Illinois	43,944,276	7%	7
Indiana	159,248,218	25%	25
Michigan	35,076,055	5%	5
Ohio	102,026,647	16%	16
Tennessee	124,792,634	19%	19
Virginia	27,867,815	4%	4
West Virginia	33,189,985	5%	5
Total	**$ 644,131,118**	**100%**	**100**

Source: APA, based on information provided by HHS's OIG.

Results from Testing a Stratified Random Sample

For this section of the sample, the total dollar amount of concurrent capitation payments tested was $718,221, while the average number of concurrent capitation payments noted per individual was 15. Auditors gathered three main observations from analyzing this specific data:

- T-MSIS data revealed that while 92 of the 100 individuals sampled were linked to only one series of concurrent capitation payments, seven were linked to two distinctly separate periods of concurrent capitation payments, and one was linked to three distinctly separate periods of concurrent capitation payments. This means that for eight individuals, PARIS alerts were issued for a series of months, stopped being issued, and then restarted being issued for one or more series of months.
- It is unclear if three of the 100 individuals sampled were enrolled in Kentucky's Medicaid program during the examination period. One individual could not be found in the Worker Portal, and two individuals lacked adequate information about enrollment history.
- Worker Portal case files lacked any evidence that PARIS alerts had been issued for 37 individuals, and it is unclear if an alert was issued for the remaining 63 individuals for the specific month in question.

Selection of and Results from Testing Additional Subgroups

Two other observations came from further analysis of subgroups: (1) Kentucky made capitation payments on behalf of deceased beneficiaries multiple months past the death date; and (2) Kentucky made 100 or more capitation payments on behalf of certain beneficiaries in a four-year period who were concurrently enrolled in two or more states.

Subgroup 1: Capitation Payments Made on Behalf of Deceased Beneficiaries

Inspired by a November 2023 HHS's OIG report on capitation payments made after enrollees' deaths, auditors examined whether Kentucky made capitation payments on behalf of deceased individuals. Obviously, Kentucky should not be making capitation payments to MCOs for individuals who are deceased, as they are no longer eligible for or receiving benefits. Yet data showed that Kentucky is doing that very thing.

First, a bit about the mechanism that exists that should prevent that. CHFS's Worker Portal application should receive daily updates from the Kentucky Vital Events Tracking System (KVETS), a "Date of Death" file containing the most recent list of deceased Kentuckians. The Worker Portal application should match individuals receiving Medicaid benefits with individuals from that Date of Death file using both an individual's social security number and date of birth.

If both the social security number and date of birth match a Medicaid recipient in the Worker Portal, the application should automatically enter the date of death and process eligibility without caseworker action. If there is a social-security-number match but not a date-of-birth match, the Worker Portal creates a "Death Match" task for a caseworker to determine if the individual designated by the KVETS death record is the same as the Medicaid recipient in the Worker Portal. This task should go to the "Supportive Services" queue and has a seven-day due date.

No matter what, if the deceased individual was the head of household in a case involving other Medicaid recipients, a "Death of Head of Household Match Through KVETS/SVES" task should be created. This task requires a caseworker to reach out to the other members of the household to attempt to identify a new head of household who should apply for Medicaid for the remaining members. This task will also go to the "Supportive Services" queue and has a seven-day due date.

Analysis of T-MSIS data revealed that Kentucky, unfortunately, made capitation payments to MCOs on behalf of deceased enrollees. Auditors selected a sample of 19 individuals from the full dataset on whose behalf Kentucky made capitation payments for at least four months after their date of death. On average, it took CHFS 319.5 days to reflect the deaths of these 19 individuals in their files. Figure 7 reflects the days between the date of death and when that date was added to the beneficiary's file.

Figure 7: Days Between Date of Death and When the Death Date Was Added to the Case File

Date of Death	Date the Death Date was Added to Beneficiary's File	Days Between Date of Death & Date Added to File
12/12/2021	5/30/2023	534
8/10/2022	N/A	N/A
6/14/2021	N/A	N/A
10/30/2020	6/21/2021	234
10/7/2021	3/25/2022	169
4/25/2019	4/9/2020	350
7/26/2022	1/17/2023	175
7/1/2022	9/19/2022	80
6/28/2020	6/17/2022	719
8/8/2021	1/12/2022	157
7/1/2021	N/A	N/A
6/29/2021	10/7/2021	100
1/26/2018	7/16/2020	902
10/29/2019	11/10/2020	378
7/27/2021	12/3/2021	129
5/10/2022	12/21/2022	225
9/27/2021	11/4/2021	38
2/28/2021	4/15/2021	46
1/10/2021	6/5/2023	876

Source: APA, based on information from the Worker Portal between June and September 2024.

Delay occurred not only in the addition of the date of death to a beneficiary's file but also in the termination of capitation payments made on behalf of the deceased individual after death. While concurrent capitation payments may have been made immediately preceding the beneficiary's

death, these payments were still made to MCOs, on average, 205 days after a beneficiary's date of death. As shown in Figure 8, the last capitation payment for one beneficiary was 857 days following the date of death.

Figure 8: Days Between Date of Death and Last Capitation Payment

Date of Death	Date of Last Capitation Payment	Days Between Date of Death & Last Capitation Payment
12/12/2021	5/1/2022	140
8/10/2022	12/1/2022	113
6/14/2021	9/1/2021	79
10/30/2020	6/1/2021	214
10/7/2021	3/1/2022	145
4/25/2019	11/1/2019	190
7/26/2022	11/1/2022	98
7/1/2022	10/1/2022	92
6/28/2020	6/1/2022	703
8/8/2021	12/1/2021	115
7/1/2021	1/1/2022	184
6/29/2021	10/1/2021	94
1/26/2018	6/1/2020	857
10/29/2019	12/1/2020	399
7/27/2021	11/1/2021	97
5/10/2022	12/1/2022	205
9/27/2021	11/1/2021	35
2/28/2021	4/1/2021	32
1/10/2021	5/1/2021	111

Source: APA, based on information from the Worker Portal between June and September 2024.

Analysis revealed that a total of $237,123 in capitation payments were made by Kentucky on behalf of this selection of 19 beneficiaries. This does not include the amount of concurrent capitation payments paid by other states after the individual's death or prior to death.

Other observations from testing this selection include the following:

- T-MSIS data revealed that while 18 of the 19 individuals selected for review were linked to only one series of concurrent capitation payments, one individual was linked to two distinctly separate periods of concurrent capitation payments.
- Case files lacked evidence that eight of the deceased individuals had received PARIS alerts.
- Concurrent benefits were paid on behalf of all 19 beneficiaries after their deaths.

Subgroup 2: 100 or More Concurrent Capitation Payments Made Over Four Years

Auditors observed another major issue identified from the data received. Added together, one hundred or more concurrent capitation payments were made on behalf of certain Medicaid beneficiaries in Kentucky and in one or more states during the examination period. Fourteen such beneficiaries from the full dataset were selected for testing. Further information about these individuals and their concurrent capitation payments, as they relate to Kentucky, is shown in Figure 9.

Figure 9: Breakdown by Number of States, Number of Payments, and Amounts Paid for Selected Medicaid Beneficiaries Concurrently Enrolled

Selection #	Number of Other States Concurrently Enrolled in During the Exam Period	Number of Months Where Kentucky Made Concurrent Payments	Total Amount of Payments Issued by Kentucky When Concurrently Enrolled Elsewhere
1	4	37	$ 7,115
2	3	42	9,732
3	3	48	163,843
4	3	39	56,791
5	3	48	42,587
6	3	44	8,170
7	3	46	8,354
8	5	33	15,325
9	3	48	10,112
10	4	48	8,431
11	3	48	23,382
12	2	48	94,047
13	1	25	20,912
14	8	28	20,751
Totals		**582**	**$ 489,552**

Source: APA, based on information provided by HHS's OIG.

Kentucky made concurrent capitation payments totaling, on average, $34,968 per individual for this group. The individuals selected averaged nearly 42 months in which concurrent payments were being issued by Kentucky on their behalf during a 48-month period. In addition, the individuals were enrolled in, on average, 3.4 other states during the examination period.

Auditors also observed the following issues:

- T-MSIS data revealed that while 13 of the 15 individuals selected for review were linked to only one series of concurrent capitation payments, two individuals were linked to two distinctly separate periods of concurrent capitation payments.
- The case file for one individual lacked evidence that a PARIS alert had been issued.

Other Observations and Areas for Further Study

This examination did not entail determining a beneficiary's exact state of residency to identify which state should be the one making capitation payments. CHFS and the General Assembly should consider conducting the following reviews:

- Performing a similar process review and data analysis related to the payment and recoupment side of Medicaid as administered by DMS.
- Reviewing other sub-populations within the T-MSIS data maintained by HHS. This could include such groups as:
    - Beneficiaries enrolled in KCHIP; and
    - Beneficiaries who have been assigned multiple ID numbers.

In fact, a December 2021 report released by HHS's OIG did that very thing. That report looked at a sample of 100 beneficiaries with multiple Medicaid ID numbers and determined that Kentucky had made capitation payments totaling $455,296 ($323,126 federal share) on behalf of 97 of those beneficiaries. From those results, HHS's OIG estimated that Kentucky made unnecessary capitation payments totaling approximately $2.7 million ($1.9 million federal share) for such individuals between July 1, 2015, and June 30, 2019.

According to HHS's OIG, Kentucky officials responded that the beneficiaries had multiple ID numbers because either the beneficiaries themselves or the caseworkers entered demographic data incorrectly during the application process. CHFS's implementation of corrective actions related to that examination could be an area for further study.

APPENDICES

Appendix A: Examination Overview

Examination Impetus and Timeline

In January 2023, staff from the state audit offices of Ohio, Oregon, and Washington met with staff from HHS's OIG to discuss a multi-state project to examine the problem of concurrent capitation payments made by states to MCOs for the same Medicaid beneficiary. Using data provided by HHS's OIG, participating states would work together to determine, if possible, in which state the beneficiary should have been enrolled. Each state would produce its own audit report with results. By the next meeting in March 2023, the APA joined the project. Discussion through mid-summer between the four states and HHS's OIG included fine-tuning the states' data requests and proposed objectives, as well as administrative matters such as establishing timelines, meeting frequency, and the method of sharing data between states.

On June 20, 2023, the APA met with then-CHFS Secretary Eric Freelander and his staff to discuss the proposed project. HHS's OIG was to provide the APA with a list of capitation payment statements for a certain period. Using this list as a springboard, the APA would try to determine whether capitation payments had indeed been paid on behalf of Kentucky beneficiaries who were concurrently enrolled in and residents of one or more other states at the time of the payment. The APA sent an engagement letter to CHFS on July 7, 2023, and subsequently held an entrance conference with DMS staff members on August 22, 2023, to introduce the project, discuss logistics and expectations, and ask initial questions to finalize their examination addendum.

That same month, the APA entered into a Memorandum of Understanding with HHS's OIG, fleshing out the details of the project and each party's respective responsibilities. Data was then provided from the T-MSIS database by HHS's OIG for the agreed-upon time-period, and fieldwork began.

Scope and Methodology

The examination the APA conducted here is best described as a limited-scope special examination of the problem of concurrent capitation payments made by states to MCOs for the same Medicaid recipient. Based on preliminary analysis by the APA of the data provided by HHS's OIG, the objective of the special examination was to determine whether Kentucky Medicaid made capitation payments on behalf of beneficiaries who were enrolled in more than one state during the examination period, based on a random sample and additional review of certain sub-categories.

To address these objectives, auditors: reviewed other examinations of this issue; interviewed staff from DMS, DCBS, and CHFS more generally; reviewed federal and state laws, regulations, policies, and procedures, as well as other guidance; and studied MCO contracts. The auditors

analyzed the data provided by HHS's OIG. The auditors examined the total data population and pulled a random sample of 100 beneficiaries from the top ten states, plus a selection of outliers. Case notes for each individual included were examined.

Auditors from all four states focused primarily on activity between January 1, 2019, and December 31, 2022, but maintained the authority to expand this time-period (or scope) pending the detection of other high-risk areas. This period allowed auditors to view data and processes in place prior to, during, and after the pandemic that began in early 2020 to understand the pandemic's impact on this issue.

The APA acknowledges that, due to the period of time selected for this examination, subsequent events and changes in procedure may have occurred in the two calendar years that have passed since that time. Whenever possible and whenever it has been made known to the auditors, such information about these events and changes have been noted in this report. These latter events, however, have not been scrutinized as heavily as the events that occurred within the examination's focused time-period.

Other Examinations and Audits

Both HHS's OIG and other states have conducted similar examinations of this issue that the reader may find instructive and helpful.

HHS's OIG Audits

Ohio Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State, HHS OIG (Nov. 12, 2020), available at https://oig.hhs.gov/reports/all/2020/ohio-made-capitation-payments-to-managed-care-organizations-for-medicaid-beneficiaries-with-concurrent-eligibility-in-another-state/.

Illinois Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State, HHS OIG (Feb. 03, 2021), available at https://oig.hhs.gov/reports/all/2021/illinois-made-capitation-payments-to-managed-care-organizations-for-medicaid-beneficiaries-with-concurrent-eligibility-in-another-state/.

Minnesota Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State, HHS OIG (May 06, 2021), available at https://oig.hhs.gov/reports/all/2021/minnesota-made-capitation-payments-to-managed-care-organizations-for-medicaid-beneficiaries-with-concurrent-eligibility-in-another-state/.

Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States, HHS OIG (Sept. 19, 2022), available at https://oig.hhs.gov/reports/all/2022/nearly-all-states-made-capitation-payments-for-beneficiaries-who-were-concurrently-enrolled-in-a-medicaid-managed-care-program-in-two-states/.

Florida Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State, HHS OIG (Feb. 16, 2023), available at https://oig.hhs.gov/reports/all/2023/florida-made-capitation-payments-for-enrollees-who-were-concurrently-enrolled-in-a-medicaid-managed-care-program-in-another-state/#:~:text=What%20OIG%20Found,Medicaid%20benefits%20in%20another%20State.

Other States' Examinations

Audit of the Office of Medicaid (MassHealth)—Review of Capitation Payments, Office of the Massachusetts State Auditor (June 28, 2023), available at https://www.mass.gov/audit/audit-of-the-office-of-medicaid-masshealth-review-of-capitation-payments.

Medicaid Residency, Office of the Louisiana Legislative Auditor (Aug. 16, 2023), available at https://app2.lla.state.la.us/publicreports.nsf/0/77d5ae734c926b2a86258a0d005d8e16/$file/000026d4b.pdf?openelement&.7773098.

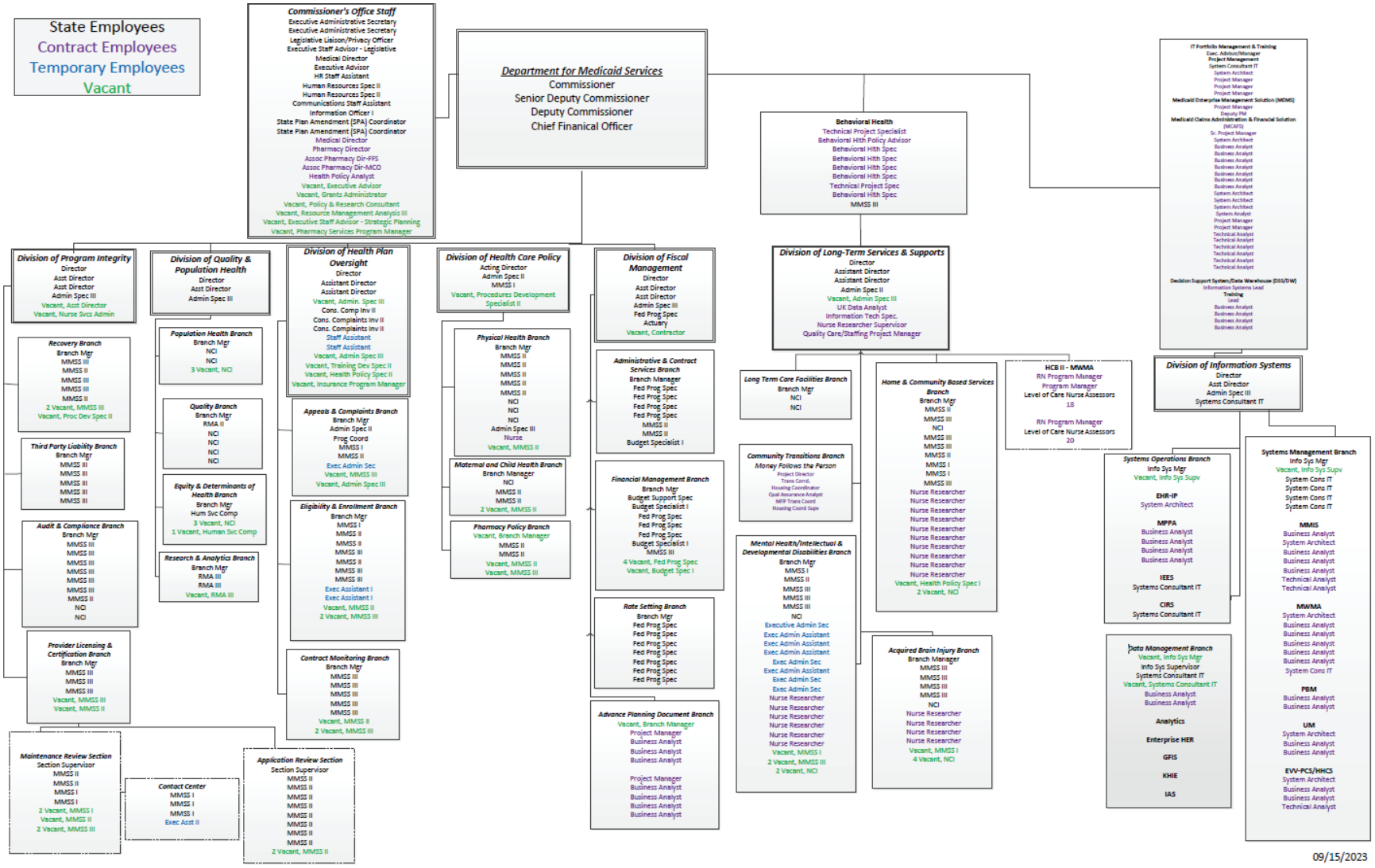
The Cost of Concurrent Enrollment, Office of the Ohio Auditor of State (Mar. 2024), available at https://ohioauditor.gov/auditsearch/Reports/2024/Concurrent_Enrollment_Public_Interest_Audit_2024_Franklin_FINAL.pdf.

Medicaid Capitation Paid for Members Residing in Other States, Office of the Auditor General of Rhode Island (Mar. 26, 2024), available at https://www.oag.ri.gov/reports/2024_MedicaidCapPaid_OtherStates.pdf.

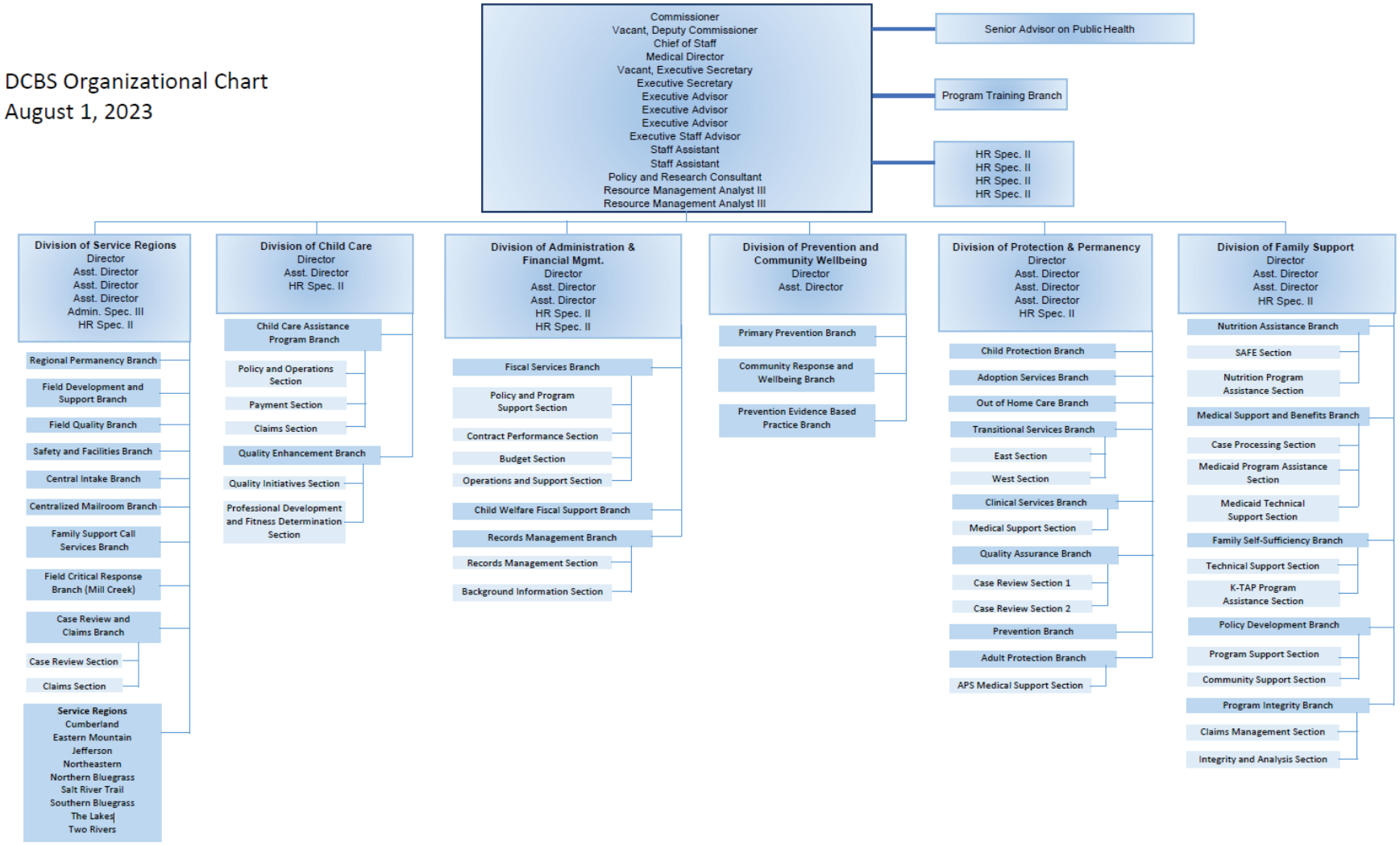
Oregon Health Authority: Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments, Oregon Secretary of State Audits Division (Oct. 2024), available at https://sos.oregon.gov/audits/Pages/audit-2024-29-OHA-Medicaid.aspx#:~:text=Home,Oregon%20Health%20Authority%3A%20Without%20Federal%20Action%2C%20States%20Will%20Continue%20to,Dollars%20in%20Duplicate%20Medicaid%20Payments&text=For%20this%20audit%2C%20we%20collaborated,the%20Washington%20State%20Auditor's%20Office.

Examining Washington's Concurrent Medicaid Enrollments, Office of the Washington State Auditor (Oct. 28, 2024), available at https://sao.wa.gov/reports-data/audit-reports/examining-washingtons-concurrent-medicaid-enrollments.

Appendix B: CHFS Organizational Charts



DCBS Organizational Chart
August 1, 2023



CABINET FOR HEALTH AND FAMILY SERVICES' RESPONSE

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

Steven Stack, MD
SECRETARY

275 East Main Street, 5W-A
Frankfort, Kentucky 40621
Phone: (502) 564-7042
Fax: (502) 564-7091

September 10, 2025

The Honorable Allison Ball
Auditor of Public Accounts
209 St. Clair Street
Frankfort, Kentucky 40601

RE: APA "Special Examination" on Medicaid Concurrent Capitation Payments

Dear Auditor Ball:

The Cabinet for Health and Family Services (CHFS) is fully committed to preserving the integrity and ensuring proper administration of the Kentucky Medicaid program. Kentucky Medicaid is in full compliance with federal requirements for Medicaid eligibility verification, including residency. However, as the federal government acknowledges, no state has access to the data necessary to identify when beneficiaries are concurrently enrolled in a Medicaid Managed Care program in another state.

The issue of concurrent enrollment in Medicaid Managed Care was identified by a federal inspector general in 2022 and is happening in nearly all 50 states, making the APA's "special examination" a rehash. It also contains significant inaccuracies, relies heavily on unsubstantiated assumptions, and fails to provide verifiable evidence of any substantial loss of taxpayer funds.

Ongoing Issue Impacting Nearly All 50 States

In 2022, the Office of Inspector General (OIG), within the U.S. Department of Health and Human Services (HHS), issued a report that found "nearly all states made capitation payments for beneficiaries who were concurrently enrolled in a Medicaid Managed Care program in two states."[1] The issue, OIG concluded: "States did not have full access to data [from CMS] that they needed to identify beneficiaries who were concurrently enrolled in another state." This national-level data, particularly the Transformed Medicaid Statistical Information System (T-MSIS) enrollment data, "would assist [states] in identifying beneficiaries who were concurrently enrolled in a Medicaid Managed Care program in two states." Further, OIG concluded: "CMS does not take all available steps, either directly or through the states, to identify and prevent state capitation payments for non-resident beneficiaries." OIG recommended that CMS "provide

[1] U.S. Dep't of Health and Human Services, Office of Inspector General, *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States*, A-05-20-00025 (Sept. 2022), available at https://oig.hhs.gov/documents/audit/7881/A-05-20-00025-Complete%20Report.pdf (last visited Sept. 10, 2025).

states with matched T-MSIS enrollment data that identify Medicaid beneficiaries who were concurrently enrolled."

Unfortunately, CMS did not concur with OIG's recommendation at the time, and all states continued to operate without access to the recommended data. Then, in July 2025, the new Administrator of the Centers for Medicare and Medicaid Services (CMS) issued a press release committing to "partner with states" to address the issue and provide the necessary data to verify residency.[2] The release states: CMS will "provide additional guidance to state Medicaid and CHIP agencies in early August [2025]…follow up with lists to each state of individuals concurrently enrolled in Medicaid or CHIP and ask states to make their best efforts to recheck eligibility by late fall." CHFS is committed to partnering to address this issue, but it is almost mid-September and our agency has yet to receive any additional guidance or lists of individuals from CMS.

APA Draft Report Contains Factual Inaccuracies and Unsubstantiated Claims

The Auditor's draft report contains a series of inaccuracies and unsubstantiated claims.

The draft report falsely claims Kentucky did not follow federal laws and regulations related to terminating non-residents during the PHE. That is not true: In fact, 56,440 individuals were disenrolled from Medicaid based upon residency during the period of your review.

The draft report does not determine members' actual state of residence for each overlapping month. So, a significant portion of the counted overlap happened during time periods when Kentucky Medicaid was the correct state of residence instead of the other state, and vice versa.

The draft report also inaccurately states that Kentucky Medicaid ceased conducting annual eligibility reviews. That is false: Eligibility reviews continued throughout the PHE. During the PHE, Kentucky Medicaid was restricted from disenrolling individuals in certain cases as a condition of receiving the enhanced Federal Medical Assistance Percentage ("FMAP").

The draft report contains findings related to capitation payments made after an enrollee's death. With limited exceptions, the electronic data sources used to report or verify date of death typically process within one to two months. CHFS is dependent on the death being officially recorded in the applicable database and there are reasons why that could be delayed. Upon receiving notification, Kentucky's system is designed to recoup any capitation payments for months following the month of death and recoup any payment of claims for services afterwards.

Making hastily drawn conclusions about an individual's Medicaid enrollment without conducting a full eligibility review, as the APA does in its draft report, is inappropriate.

CHFS Ensures the Integrity of the Medicaid Program

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[2] *See* Centers for Medicare & Medicaid Services. (July 17, 2025). *CMS finds 2.8 million Americans potentially enrolled in two or more Medicaid/ACA Exchange plans* [Press release]. CMS Newsroom, available at https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans (last visited Sept. 10, 2025).

As the primary federal agency that oversees the Medicaid program, CMS requires states to primarily use and rely on electronic data sources to verify an individual's information. Kentucky's Integrated Eligibility and Enrollment System (IEES) uses more than 35 federal, state, and commercial data sources to support eligibility determinations, including those required or recommended by CMS. As it relates to residency, Kentucky Medicaid relies on several federal databases such as the Social Security Administration's Beneficiary and Earnings Data Exchange (BENDEX) and State Data Exchange (SDX), Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) system, and the federally-mandated Public Assistance Reporting Information System (PARIS). Kentucky Medicaid uses all available sources to determine whether requirements are met, but still does not have access to T-MSIS.

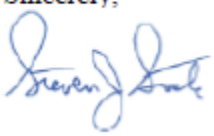
CHFS checks the PARIS system as often as possible—on a quarterly basis—through a multi-step process. When potential dual enrollment is detected, CHFS takes appropriate actions, including terminating the duplicate coverage, recouping any capitation payments to managed care organizations, recovering claim payments to providers, and referring cases for further investigation when warranted. CHFS has no control over the actions of federal agencies or other state Medicaid agencies, or the reliability of federal data sources. CHFS agrees about the benefits of using T-MSIS as a tool to more timely identify concurrent enrollment, as information is submitted by states on a monthly basis. However, T-MSIS would still require states having access to necessary personally identifiable information to match enrollment.

Conclusion

The APA's draft report contains significant inaccuracies, relies heavily on unsubstantiated assumptions, and fails to provide verifiable evidence of any substantial loss of taxpayer funds. It also fails to recognize the disagreement between federal agencies about the tools needed to identify and prevent double enrollment and the failure of our federal partners to provide the necessary guidance and technical assistance they have committed to send to states. We await that information and stand ready to partner with the federal government to address the issue.

If verifiable analysis identifies dual enrollment payments for which reimbursement is appropriate and legally permissible, CHFS will reclaim all taxpayer dollars at issue. We have done so in the past and will continue to do so when properly identified. If CMS provides the data and program guidance necessary to assess dual enrollments, CHFS will take prompt action and continue to ensure program integrity and safeguard taxpayer resources.

Sincerely,



Steven Stack, M.D.
Secretary
Cabinet for Health and Family Services

THE AUDITOR OF PUBLIC ACCOUNTS' REPLY

ALLISON BALL
AUDITOR OF PUBLIC ACCOUNTS

September 17, 2025

Dr. Steven Stack, Secretary
Cabinet for Health and Family Services
275 E. Main St. 5W-A
Frankfort, Kentucky 40621
Via Email: Steven.Stack@ky.gov

RE: Auditor's Reply to CHFS's Response

Dear Secretary Stack:

When correctly managed, Kentucky Medicaid provides crucial healthcare coverage to our most vulnerable Kentuckians at low cost to the taxpayer. The Auditor of Public Accounts ("APA") discovered issues with the Cabinet for Health and Family Services' ("CHFS") management of Kentucky Medicaid. These management failures contributed to over $800 million of wasted taxpayer money, not a penny of which benefited any Medicaid recipient.

But if CHFS chooses to follow the APA's recommendations for fixing those management failures, Kentucky can curb that waste. And that will mean more money for Kentucky Medicaid for the benefit of Medicaid recipients without any additional cost to the taxpayer.

CHFS's response, however, does not confirm that any of that will happen. While CHFS does not actually challenge that much in the APA's report, they do make many concerning, flippant, and face-saving assertions. Even so, all of those assertions are directly refuted by a common-sense reading of the report and the evidence the APA uncovered in its examination.

CHFS Assertion: "Kentucky Medicaid is in full compliance with federal requirements for Medicaid eligibility verification, including residency."

The APA's examination centered around a discrete issue within Kentucky Medicaid: Whether, for the time period examined, CHFS did everything possible to ensure that it was not making capitation payments to managed care organizations for Medicaid beneficiaries at the same time that another state was making those payments to those organizations for those same beneficiaries. Our examination found that CHFS did not do everything possible to prevent the waste arising from that issue.

Outside of the examination period, CHFS informed the APA that CHFS hired 50 contract workers—after the APA's examination began—to assist CHFS caseworkers with processing the PARIS alerts that CHFS receives from the federal government, those alerts being the current mechanism that flags potential wasteful concurrent capitation payments. CHFS did not provide any other specifics in its response as to what it is doing to address that issue of waste, nor did it address any of the recommendations offered by the APA.

Outside of the concurrent-capitation-payments issue and the issue of CHFS's failure to timely remove deceased beneficiaries from Kentucky Medicaid, the APA can neither confirm nor deny whether "Kentucky Medicaid is in full compliance with federal requirements for Medicaid eligibility verification, including residency." CHFS's failure to curb the waste arising from those two issues, however, calls into question that assertion. So too do the APA's most recent Kentucky Medicaid findings, outlined in the APA's Statewide Single Audit of Kentucky.[1]

CHFS Assertion: "[A]s the federal government acknowledges, no state has access to the data necessary to identify when beneficiaries are concurrently enrolled in a Medicaid Managed Care program in another state."

That is false. At a base level, CHFS already does have all the data it needs to identify concurrent enrollment. As the federal government's Centers for Medicare & Medicaid Services ("CMS") noted in the same report to which CHFS cites, "[t]he PARIS Interstate Match already allows states to compare eligibility with other state Medicaid programs to identify beneficiaries that may be concurrently enrolled in more than one state."[2]

CHFS selectively quotes from and takes out-of-context statements in that report in an attempt to refute that point. But, when read in totality, what those statements indicate is that while states do not have access to data that would allow them to *more quickly* identify concurrent enrollment, they do have access to data that would allow them to complete that job in general:

> CMS does not actively monitor beneficiaries' concurrent Medicaid managed care enrollments; instead, it relies on the individual States to identify concurrent enrollments and potential erroneous payments. CMS does not provide States with T-MSIS national enrollment data that would *assist* them in identifying beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States. Two States often made capitation payments for the same Medicaid beneficiary in part because States did not have *full* access to data they needed to identify beneficiaries who were concurrently enrolled in another State. Therefore, CMS does not take *all available steps*, either directly or through the States, to identify and prevent State capitation payments for non-resident beneficiaries.[3]

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[1] Auditor of Public Accounts, Report of the Statewide Single Audit of the Commonwealth of Kentucky Volume II, 18–29 (Mar. 31, 2025), https://www.auditor.ky.gov/Auditreports/Miscellaneous/SSWAK%20Volume%20II%20FY24%20s.pdf.

[2] Office of Inspector General, *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States*, Department of Health and Human Services, 20 (Sept. 2022), https://oig.hhs.gov/documents/audit/7881/A-05-20-00025-Complete%20Report.pdf.

[3] *Id.* at 4 (emphasis added).

When read in context, the Office of Inspector General's report CHFS cites makes it clear that, while states have everything they need to stop concurrent capitation payments to managed care organizations across state lines at a base level, there is another tool—T-MSIS data—that would allow states to *more quickly* identify those wasteful payments. And as the APA's report notes, access to that data would allow CHFS to do that very thing. But the point is that CHFS's assertion that it doesn't have any access to any helpful data that would allow it to identify concurrent enrollment *at all* is false.

CHFS Assertion: "The issue of concurrent enrollment in Medicaid Managed Care was identified by a federal inspector general in 2022 and is happening in nearly all 50 states, making the APA's 'special examination' a rehash."

CHFS trivializes the Biden administration's request for a four-state partnership, which included Kentucky, Ohio, Oregon, and Washington, to conduct this examination. As noted in the report, this examination began under Auditor Harmon's administration at the request of President Biden's Department for Health and Human Services' Office of Inspector General. To call this examination a "rehash" is to call into question the Biden administration's reasons for requesting and the Harmon administration's reasons for joining this examination.

And those reasons are good ones. The basis for this examination was to see what is happening in Kentucky that is contributing to the problem of concurrent capitation payments across state lines. That is why numerous states have conducted this examination—to provide a state-specific look into state management of Medicaid and uncover state-specific reasons causing concurrent capitation payment waste. Each state's report, including this one, identifies state-specific issues needing state-specific solutions, something that CHFS's cited federal inspector general report does not do.

CHFS Assertion: The APA's report "contains significant inaccuracies, relies heavily on unsubstantiated assumptions, and fails to provide verifiable evidence of any substantial loss of taxpayer funds."

CHFS provides only a few specifics here, all of which are refuted below.

CHFS Assertion: "CHFS is committed to partnering to address this issue, but it is almost mid-September and our agency has yet to receive any additional guidance or lists of individuals from CMS."

As CHFS notes, the Trump administration has signaled a willingness to provide more detailed information than previous federal government administrations to CHFS and other state Medicaid offices to help tackle the issue of concurrent capitation payments waste. While CMS prepares that information, CHFS can immediately take the APA's outlined steps to combat concurrent capitation payment waste at the state level.

CHFS Assertion: "The draft report falsely claims Kentucky did not follow federal laws and regulations related to terminating non-residents during the PHE. That is not true:

In fact, 56,440 individuals were disenrolled from Medicaid based upon residency during the period of your review."

Our report makes no assertions about CHFS *generally* failing to remove nonresidents from Kentucky Medicaid. The examination did not analyze whether CHFS removed individuals from Kentucky Medicaid after, for example, those individuals voluntarily informed CHFS that they were no longer residents, something that all Medicaid beneficiaries have a duty to do. Rather, the specific issue addressed in the report is CHFS's failure to do everything possible to curb concurrent capitation payment waste. This includes CHFS's refusal to investigate PARIS alerts to determine a Medicaid beneficiary's true state of residency and, if not Kentucky, remove that individual from Kentucky Medicaid.

The APA cannot confirm nor deny whether CHFS truly removed 56,440 individuals from Medicaid during the examined period. Regardless, its failure to address the issues outlined in the APA's report contributed to over $800 million of Medicaid waste borne by United States taxpayers.

CHFS Assertion: "The draft report does not determine members' actual state of residence for each overlapping month. So, a significant portion of the counted overlap happened during time periods when Kentucky Medicaid was the correct state of residence instead of the other state, and vice versa."

The APA did not determine members' actual state of residence for each overlapping month because it would be inappropriate for the APA to do so. Federal law places that responsibility in the hands of CHFS. That responsibility entails investigating each individual Medicaid recipient to determine his or her true place of residency, which involves personally contacting that individual. The APA does not conduct such investigations into the affairs of private individuals—that is CHFS's job and is what CHFS purportedly contracted with 50 people to do.

What this report shows is that CHFS did not perform its duty to prevent $800 million of Medicaid waste. That number can be said to be waste because that is the amount of money that Kentucky paid for individuals who were enrolled in Medicaid in both Kentucky and at least one other state, which was also making capitation payments totaling a similar amount (to no benefit of the Medicaid enrollee). Whether Kentucky or another state is the true state of residency for those concurrently enrolled individuals matters only for determining whether more of that waste falls on the shoulders of Kentucky taxpayers or another state's taxpayers.

At the end of the day, however, Kentucky taxpayers have shouldered the burden of this waste in at least *some* capacity as federal taxpayers. And because CHFS failed to take the necessary steps outlined in the APA's report to combat the waste caused by concurrent capitation payments across state lines for the same individual, CHFS cannot refute the potential that Kentucky taxpayers shouldered the burden of most of the $836,364,425 of Kentucky Medicaid money spent on concurrent capitation payments across state lines for the same individual.

CHFS Assertion: "The draft report also inaccurately states that Kentucky Medicaid ceased conducting annual eligibility reviews. That is false: Eligibility reviews continued

throughout the PHE. During the PHE, Kentucky Medicaid was restricted from disenrolling individuals in certain cases as a condition of receiving the enhanced Federal Medical Assistance Percentage."

The APA's documented interview notes with CHFS officials and employees confirmed that Kentucky Medicaid did not emphasize actively conducting annual eligibility reviews during the PHE. CHFS's assertion here would carry more weight if it provided evidence to the contrary, which it has not. Even then, though, CHFS would have to reconcile that evidence with what CHFS officials and employees told the APA during its examination.

And as identified in the report, Section 6008(b)(3) of the Families First Coronavirus Response Act, in conjunction with 42 C.F.R. § 433.400(d)(3)(ii), outlined a process for states to use to remove from Kentucky Medicaid individuals deemed to be nonresidents. CHFS could have used that process to address the concurrent capitation payment issue, but the evidence obtained during this examination did not reflect that this process was used to effectively curb concurrent capitation payment waste.

CHFS Assertion: "The draft report contains findings related to capitation payments made after an enrollee's death."

It does not appear that CHFS actually disputes anything the APA says about those observations.

CHFS Assertion: "Making hastily drawn conclusions about an individual's Medicaid enrollment without conducting a full eligibility review, as the APA does in its draft report, is inappropriate."

Had CHFS conducted full eligibility reviews of all individuals for whom it received PARIS alerts, then the APA would not have had needed to conduct this examination at all. And apart from what has already been addressed above, CHFS identifies no other "hastily drawn conclusions" that it considers the APA to have made.

CHFS Assertion: "CHFS checks the PARIS system as often as possible—on a quarterly basis—through a multi-step process. When potential dual enrollment is detected, CHFS takes appropriate actions, including terminating the duplicate coverage, recouping any capitation payments to managed care organizations, recovering claim payments to providers, and referring cases for further investigation when warranted."

The quantity, value, and repetition of the concurrent payments identified in this examination, coupled with interviews conducted with CHFS officials and employees, reflect that these steps were either not taken at all or minimally taken during the examination period. If CHFS is doing this now, though, then this is a step in the right direction. The APA cannot confirm nor deny whether that is the case, however.

CHFS Assertion: "CHFS has no control over the actions of federal agencies or other state Medicaid agencies, or the reliability of federal data sources."

The APA has identified in its report the things over which CHFS does have control, and it should focus on addressing those things.

CHFS Assertion: "T-MSIS would still require states having access to necessary personally identifiable information to match enrollment."

As outlined above, CHFS currently has access to all the information it needs to address the issue of concurrent capitation payments across state lines for the same Medicaid beneficiary. T-MSIS would allow CHFS to *more quickly* address that issue, but access to that data is not *necessary* to do so.

CHFS Assertion: "The APA's draft report contains significant inaccuracies, relies heavily on unsubstantiated assumptions, and fails to provide verifiable evidence of any substantial loss of taxpayer funds."

CHFS provides only a few specifics here, all of which are refuted above.

CHFS Assertion: The APA's report "also fails to recognize the disagreement between federal agencies about the tools needed to identify and prevent double enrollment and the failure of our federal partners to provide the necessary guidance and technical assistance they have committed to send to states."

Again, CHFS's reactive, and not proactive, vision for addressing the issue of concurrent capitation payments across state lines for the same beneficiary is concerning. As the APA has outlined in its report, CHFS can take numerous steps right now to address this issue without federal government guidance. It should take those steps while the Trump administration prepares to give states tools for combating this issue that previous administrations have not.

Conclusion

Our report identifies ways in which CHFS can curb Medicaid waste for the benefit of the Kentucky taxpayer and the Kentucky Medicaid enrollee. It is now for CHFS to decide whether it wants to take those steps to curb that waste.

Sincerely,

Allison Ball
Auditor of Public Accounts

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2025 *Medicaid Special Examination*