Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Kansas Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Kansas Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Kansas Health Policy Authority (KHPA). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Divisions of Contracts and Fiscal Agent Operations and Health Resources Management, components of KHPA, which are responsible for Medicaid program integrity. This report describes eight effective practices, three regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Kansas improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Kansas' Medicaid Program

The KHPA administers the Kansas Medicaid program through a combination of fee-for-service (FFS) and managed care services. As of January 1, 2009, the program served 257,632 recipients. Kansas has enrolled 123,369 recipients, or 48 percent of its Medicaid population, in managed care programs that deliver physical health services. Program integrity functions for managed care entities (MCEs) are delegated to the Division of Health Resources Management. Kansas delivers mental health services through a Prepaid Ambulatory Health Plan and substance abuse services through a Prepaid Inpatient Health Plan. Contract oversight and program integrity functions for the behavioral health services are delegated to the Department of Social and Rehabilitation Services (SRS). As of January 1, 2009, KHPA had 28,546 providers participating in the FFS program and approximately 9,330 participating managed care providers. Medicaid expenditures in Kansas for the State fiscal year (SFY) ending June 30, 2009 totaled $1,643,201,181. The Federal medical assistance percentage (FMAP) for Kansas for Federal fiscal year (FFY) 2009 was 60.08 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 66.28 percent for the first two quarters of FFY 2009, 68.31 percent for the third quarter and 69.41 percent in the fourth quarter.

Division of Contracts and Fiscal Agent Operations

The Division of Contracts and Fiscal Agent Operations, within KHPA, is the primary organizational component dedicated to Medicaid fraud and abuse activities. At the time of the

review, the Division had approximately five full-time equivalent employees. The table below presents the total number of preliminary and full investigations, the number of State administrative actions, and amount of overpayments identified and collected for the last four SFYs as a result of program integrity activities. The amount of overpayments collected includes program integrity activities and recoveries for inpatient hospital claims.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	not available	not available	5	$10,626,860	$8,209,103
2007	not available	not available	6	$11,711,057	$10,736,752
2008	not available	not available	9	$14,982,700	$16,480,223
2009	7	7	1	$23,306,663	$21,478,899

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Kansas complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment and disclosures, program integrity, managed care, and the MFCU. A three-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of November 16, 2009, the MIG review team visited the KHPA and MFCU offices. The team conducted interviews with numerous KHPA officials, as well as with staff from the fiscal agent, provider enrollment contractor, and the MFCU director. Finally, to determine whether the MCEs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG review team interviewed State staff from the Division of Health Resources Management and SRS. The review team also reviewed the managed care contract provisions and gathered information through interviews with representatives from the MCEs. In addition, the team conducted sampling of provider enrollment applications, selected claims, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Divisions of Contracts and Fiscal Agent Operations and Health Resources Management. Kansas' Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, KHPA provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that KHPA provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include fraud prevention practices by MCEs, the attitude of KHPA regarding program integrity, the creation of a durable medical equipment (DME) provider attestation form, updating the provider agreement, establishing a Medicaid provider workgroup, enhancing provider enrollment disclosure questions, and the use of the KHPA website for global communication.

Fraud prevention practices by MCEs

Kansas MCEs have implemented several effective fraud prevention practices that include:

- A recently contracted transportation broker verifies 100 percent of the transportation services by having the medical provider sign-off on a log to verify that the recipient did attend the appointment. The logs are faxed to the provider with a request that the provider (or designee) indicate whether the recipient kept the appointment, and then fax the log back to the broker. The broker will not pay the claim until the service has been validated.

- One of the physical health MCEs closely monitors the prior authorization for home health services and DME. The MCE achieves this by establishing a prior authorization requirement for specific codes and setting a low dollar threshold for these services, which triggers an extensive prior authorization review process for any additional services requested outside of the established threshold. In addition, medical necessity and appropriateness are highly scrutinized including conducting a post-pay review of claims to ensure the services were rendered in accordance with information obtained from the provider during the prior authorization process and as approved by the MCE.

- All of the MCEs attend a monthly meeting with the MFCU that also includes KHPA and SRS staff. At this meeting, cases are discussed, training is informally provided on fraud and abuse, and information about problem providers is shared.

Attitude of Administration –"Program integrity is everybody's business"

The KHPA fosters the attitude that "program integrity is everybody's business." The attitude of agency-wide program integrity, as opposed to this responsibility being solely that of one department, is evidenced by the following:

- The KHPA and MFCU meet monthly, communicate frequently, and work collaboratively to develop referrals, discuss cases, and improve fraud detection. The MCE representatives attend these meetings to allow for collaboration and to ensure that fraud and abuse issues are shared with all interested parties.

- The KHPA lent two nurse reviewers to the MFCU for a year to assist with an extensive records review for a home health fraud case. Several home health nurses have been charged with falsifying documentation as a result of the investigation.

- The KHPA created a single audit tool to include questions related to compliance with the False Claims Act. The audit tool has been incorporated into every type of audit that is conducted across KHPA programs. This has resulted in compliance with Federal regulations without adding an additional burden to existing program integrity efforts.

- To date, 17 KHPA staff members have attended various courses offered at the Medicaid Integrity Institute.

- The KHPA is dedicated to identifying potential internal problems by conducting program reviews, which are internal self-audits of all the KHPA programs. These program reviews were developed to identify service gaps, review overall trends, and review overall financial activities.

- The KHPA demonstrates a commitment to collaboration throughout its divisions. When a new policy is being considered, it is shared throughout KHPA, as well as with the MFCU, to solicit comments and identify possible conflicts with existing policies.

DME provider attestation form

Beginning in 1994, onsite visits were made to DME providers to ensure compliance with Kansas Administrative Regulation 30-5-59. The visits were initially conducted by the investigations unit at SRS, and later conducted by the provider representatives at the Medicaid fiscal agent. The State indicated that the onsite visits were very effective in ensuring compliance with the regulation. In July 2009, the provider representative positions were eliminated due to budget reductions. Although not as effective as onsite visits, the Division of Contracts and Fiscal Agent Operations developed a unique method to help maintain some degree of program integrity by creating a DME attestation form that was added to the enrollment packet. As a result of information collected on the DME attestation form, three applications have been denied since July 2009 for not meeting the regulation.

Updated provider agreement

Although the State does not require periodic re-enrollment for all providers, the State updated the provider agreement in June 2008, and required all providers, except custodial care providers, to sign the new agreement in order to continue their enrollment in the Medicaid program. The State deactivated approximately 3,800 providers who failed to return a new provider agreement.

Medicaid provider workgroup
In order to develop a better working relationship with Medicaid providers, a Medicaid provider workgroup was created several years ago. The workgroup consists of office managers, staff from several provider types, representatives of provider associations, fiscal agent staff, and State program managers. The workgroup has provided recommendations on changes to the provider manuals resulting in the manuals being more user-friendly; assisted in the implementation of beneficiary identification cards to ensure a smooth transition process; and helped resolve issues with claims processing. Overall, the workgroup has helped to create a positive and effective working relationship between the State agency, provider associations, and Medicaid providers.

Enhanced provider enrollment disclosures
The KHPA revised the provider application in late 2007 to include specific questions to prevent providers from avoiding payment on outstanding debt owed to the Medicaid program. The Disclosure of Ownership and Control Interest Statement contains questions to identify providers who are attempting to re-enroll in the Medicaid system with a different business name to avoid paying debt owed under a previous provider number.

Use of KHPA website for global communication
The State began posting bulletin and global message notices on the KHPA website in July 2009 through a web feed. The web feed notifies providers and other interested parties when information on the website has been updated. This is especially helpful for providers with multiple locations who rely on corporate offices to communicate information. The web feed allows all providers to directly receive notification of updates, and they do not have to rely on the offices to notify them.

Additionally, the MIG review team identified one practice that is particularly noteworthy. The CMS recognizes Kansas' fraud prevention questions on FFS provider enrollment applications.

High-risk screening questions on FFS provider enrollment applications
The KHPA, MFCU, and the Surveillance and Utilization Review unit collaboratively developed specific questions for the provider enrollment applications with a particular focus on identifying high-risk providers. Questions include relationships to family members who may have been excluded from the Medicaid program or other Federal programs; whether family members have outstanding debts to Medicaid programs; and disclosure of the location for provider records during a change of ownership. In several instances, providers did not answer these questions truthfully which resulted in the State being able to use the failure to disclose in legal proceedings.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosure of ownership, control, and relationship information, certain business transactions and criminal convictions.

The State does not capture required ownership, control, and relationship information in its FFS operations and contract with the fiscal agent. (Repeat Issue)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

This issue was also identified in CMS' Medicaid Alliance for Program Safeguards program integrity review conducted in FFY 2003. While KHPA does request some information required by 42 CFR § 455.104, it does not request disclosures from subcontractors of the provider. Additionally, KHPA does not request disclosure information from applicants or the fiscal agent regarding ownership or control interest of other disclosing entities as required under the regulation at 455.104(a)(3).

Recommendation: Modify provider enrollment applications and the contract with the fiscal agent to capture all required ownership, control, and relationship information.

The State does not require disclosure of business transactions in its FFS operations and from MCEs.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The FFS provider agreements do not include a reference to 42 CFR § 455.105(b)(2) as required by the regulation. In addition, Kansas' contracts with the MCEs do not require the disclosure of business transaction information, upon request, identified in 42 CFR § 455.105.

Recommendation: Modify provider enrollment agreements and contracts with MCEs to meet the requirement at 42 CFR § 455.105(b).

The State does not require disclosure of criminal conviction information from MCEs.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The State's contract with MCEs related to disclosure of criminal convictions does not specifically address healthcare-related crimes. In addition, the language of the contract limits the requirement for disclosure to those individuals with ownership and/or control interest of 25 percent or more.

Recommendation: Modify contracts with MCEs to meet the requirements of 42 CFR § 455.106.

Vulnerabilities

The review team identified five areas of vulnerability in Kansas' practices including not verifying recipient receipt of managed care services, not capturing managing employee information, not conducting complete searches for excluded individuals, not reporting to HHS-OIG adverse actions taken on managed care provider applications, and a lack of program integrity processes within the managed care division.

Not verifying with recipients whether managed care services billed by providers were received.
While Kansas meets the requirements of 42 CFR §455.20 by sending explanations of medical benefits to FFS recipients, managed care divisions for physical health and behavioral health do not verify with recipients if services were received, nor do they contractually require the MCEs to conduct verification of services.

Recommendation: Revise MCE contracts to require MCEs to develop and implement a method for verifying with recipients whether billed services were received.

Not capturing managing employee information on FFS provider enrollment and managed care credentialing forms. (Repeat Vulnerability)
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Neither the State nor the MCEs solicit managing employee information in provider enrollment or credentialing forms. Thus, the State has no way of knowing if excluded individuals are working for providers or healthcare entities in such positions as billing managers and department heads.

Recommendations: Modify FFS provider enrollment and managed care credentialing packages to require disclosure of managing employee information. Maintain such information in a

database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR § 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply some disclosures upon request. Even if the State were compliant with the requirements in the regulations, the State is not maintaining complete information on owners, officers, and managing employees in a searchable database such as the Medicaid Management Information System (MMIS). Therefore the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED).

The KHPA is unable to check for exclusions of owners and managing employees after enrollment because that information is not disclosed as part of the credentialing process.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information, including healthcare-related criminal convictions, about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE or the MED upon enrollment, re-enrollment, and at least monthly thereafter, by the names of the above persons and entities.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.

The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State-MCE contract does not require MCEs to report provider enrollment denials, disenrollments, and terminations to the State. Currently, neither the Division of Contracts and Fiscal Agent Operations nor the Division of Health Resources Management is informed of such actions, so the State is unable to report such actions to HHS-OIG.

Recommendations: Require MCEs to notify the State when taking adverse action against a provider's participation in the program, including when it denies credentialing for fraud-related concerns. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

Lack of program integrity processes within the Division of Health Resources Management and inadequate oversight of MCEs.

Kansas' Division of Health Resources Management has a lack of program integrity processes, making the managed care system particularly vulnerable. Although some of the State's MCEs

have effective practices, the State's oversight of the MCEs' program integrity activities was less than adequate. The issues include:

- The Division of Health Resources Management did not have overall guiding policies and procedures related to the requirements in the regulations. The Division relied on its contract with the MCEs to outline all policies and procedures.

- Division of Health Resources Management staff stated that they were not aware of the regulation for reporting to the Secretary if an MCE was out of compliance with 42 CFR § 438.610 and did not have procedures in place to follow the regulation. Staff indicated they would report instances of non-compliance; however, the Division is not verifying MCEs' disclosures or processing disclosures through the Excluded Parties List System, and does not require MCEs to update the information. Therefore, the Division is not in a position to know whether an MCE was out of compliance with the regulation.

- Kansas requires that MCEs submit encounter data on a bi-weekly basis and the data is entered into the MMIS system. However, the review team did not detect any utilization review processes implemented to analyze the data.

- The sister State agency, SRS, contracted with an MCE to deliver mental health services prior to the company having a formal structure. The fact that a formal contract between the State and the MCE was signed before officers of the MCE were identified or installed was of concern to the MIG review team. The disclosure of officers at the initiation of the contract was not required by SRS, as the MCE had been required to enroll with the State as a Medicaid provider. The disclosure forms completed as part of the provider enrollment only included the newly formed entity's name. Names of directors and their addresses were not provided on the form.

Recommendations: Develop and implement policies and procedures within the managed care division that reflect all applicable program integrity regulations including the requirements of 42 CFR § 438.610 and disclosure of MCE officers and board members. Develop and implement utilization review processes for encounter data submitted by the MCEs.

CONCLUSION

The State of Kansas applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- MCE fraud prevention practices,
- the attitude of KHPA regarding program integrity,
- using a DME provider attestation form,
- updating the provider agreement,
- establishing a Medicaid provider workgroup,
- enhancing provider enrollment disclosures,
- using the KHPA website for global communication; and
- adding high-risk screening questions to the FFS provider enrollment applications

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS encourages KHPA to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require KHPA to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Kansas will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Kansas has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Kansas on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.