Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Kentucky 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 Kentucky Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Medicaid Services (DMS), which is within Kentucky's Cabinet for Health and Family Services (CHFS). The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of DMS' Division of Program Integrity (DMS-PI) and the CHFS Office of Inspector General (CHFS-OIG), which are responsible for Medicaid program integrity in Kentucky. The DMS-PI contracts with CHFS-OIG to conduct investigations of suspected Medicaid fraud. This report describes eight effective practices, three regulatory compliance issues, and one vulnerability 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 Kentucky improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Kentucky's Medicaid Program

The DMS administers the Kentucky Medicaid program. In the State fiscal year (SFY) ending June 30, 2008, the program served a total of 920,119 recipients. Of the total Medicaid recipients, 183,592 were enrolled in the State's one managed care contractor. Based on data reported to CMS, total Medicaid expenditures during SFY 2008 were approximately $5 billion. The State had 39,955 participating providers at the time of the review. During Federal fiscal year 2008, the Federal medical assistance percentage for Kentucky was 69.78 percent.

Program Integrity Section

In Kentucky, the DMS-PI is the organizational component primarily dedicated to fraud and abuse activities. In order to manage with limited staff, DMS-PI contracts with CHFS-OIG for certain types of investigations. The DMS-PI launches some preliminary investigations on its own but also refers suspected provider fraud cases to CHFS-OIG for further investigation, and where appropriate, the development of referrals to the MFCU. The CHFS-OIG has its own fraud hotline and also initiates investigations on its own. The table below summarizes the preliminary investigations undertaken by DMS-PI and CHFS-OIG in the past four SFYs. The recovery totals, which averaged $2.8 million per year, reflect recoupments from provider audits and global settlements, as well as investigations.

Table 1

SFY	Number of Preliminary Investigations DMS-PI*	Number of Preliminary Investigations CHFS-OIG*	Amount of Overpayments Collected
2005	7	36	$2,217,570.70
2006	12	49	$3,060,053.58
2007	3	46	$4,722,864.83
2008	12	95	$1,362,927.17

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

Methodology of the Review

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

During the week of July 19, 2009 the MIG review team visited the DMS-PI and MFCU offices. The team conducted interviews with numerous DMS-PI and CHFS-OIG officials, the State's transportation contractor, the pharmacy claims administrator and the MFCU director. To determine whether the contracted Medicaid managed care organization (MCO) was complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed DMS staff responsible for managed care oversight. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of the MCO. In addition, the team conducted sampling of provider enrollment applications, fee-for-service and MCO case files, selected claims, 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 DMS-PI and CHFS-OIG as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation.

Kentucky operates both a Medicaid expansion and a stand alone Children's Health Insurance Program (CHIP). The expansion program operates under the same billing and provider enrollment policies as Kentucky's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP. The stand alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Kentucky 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 DMS-PI and CHFS-OIG provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Kentucky has highlighted several practices that demonstrate its commitment to program integrity. These practices include the cooperative relationship among DMS-PI, CHFS-OIG and the MFCU, a Date of Death data match agreement with the State Office of Vital Statistics, innovative techniques in collecting provider debt, enhanced regulatory authority to terminate problem providers, quarterly MCO meetings with the agencies involved in program integrity, and access to a database of all controlled substance prescriptions filled in the State.

Cooperative relationship among DMS-PI, CHFS-OIG and the MFCU

To make the most of its limited staffing resources, the Commonwealth has elaborated a division of labor among DMS-PI, CHFS-OIG, and the MFCU. A three-way memorandum of understanding clearly delineates each agency's responsibilities and obligations. The Commonwealth believes the division of labor allows the limited number of staff in each department to concentrate on specific responsibilities and do them well. For example, the DMS-PI staff can focus efforts on running algorithms and identifying aberrant provider practices. They refer the aberrant providers to the CHFS-OIG for further investigation. Once the CHFS-OIG substantiates fraud allegations referred by DMS-PI or other sources, then the case is referred to the MFCU for legal action. The close coordination of work by the different agencies stands in contrast to the low level of coordination in the years prior to the MIG review, in which the State reported unusually low numbers of program integrity investigations.

Date of Death data match for providers and recipients

Kentucky has established procedures for efficiently identifying and recouping postmortem payments for services to recipients provided after the date of death and to deceased providers. The DMS-PI fiscal agent (FA) receives a monthly file from the Commonwealth's Department of Vital Statistics containing data on individuals who have died in the last 30 days. The FA compares this file to data in the Medicaid Management Information System (MMIS) to determine if any of the deceased individuals were recipients or providers and if any claims were submitted for or by these individuals after the date of death.

The system automatically checks on postmortem payments for services to recipients. Where paid claims are found, the FA generates a recoupment letter to the provider. On the provider side, the system will automatically insert any date of death information found into the MMIS provider file, and DMS-PI will generate a recoupment letter to any practices associated with the deceased provider numbers. According to DMS-PI, the data match for deceased recipients saved the Kentucky Medicaid program $288,604 between January 2007 and July 2009. The incorporation of provider date of death information was implemented too recently for recoupment information on deceased provider claims to be available.

Innovative methods of checking and collecting outstanding provider debt
The State agency has developed innovative techniques of checking for providers with outstanding debt. One technique is the Application Collection process. When providers try to re-enroll in Medicaid after being terminated or inactivated due to non-billing for two years, they are reviewed for outstanding debt. Another tool is the 270 Day Report on active providers which allows staff to review the accounts receivable database for debts which are over 270 days old in order to collect the outstanding debt. Using these processes, Kentucky was able to collect $2,880,221.09 between July 2002 and March 2009.

Regulatory authority to terminate providers at will
Kentucky's standard provider agreement, which is included as part of the provider application, contains language from the Kentucky Administrative Regulations (KAR) at 907 KAR 1:671 which gives the State the right to terminate providers at its discretion prior to a hearing. Thirty days notice must be given prior to the termination. This provision enables the State to remove potentially problematic providers from the program before questionable outlays to those providers can accumulate. In addition, the State's provider agreement provides that DMS may terminate a provider agreement "immediately for cause or in accordance with state and federal laws" as long as written notice is served by registered mail. Kentucky's provider enrollment staff also makes use of regulatory authority to terminate providers who do not submit bills over a 24 month period.

Quarterly MCO meetings with State agencies involved in program integrity
The State's program integrity components meet quarterly with Kentucky's Medicaid MCO contractor. Attendees at this meeting include the MCO's chief compliance officer, the program integrity coordinator for the MCO's administrative contractor, and DMS-PI and CHFS-OIG staff, along with Medicaid financial management and medical management staff when warranted. The MFCU staff may also attend on occasion.

The meetings include a review of recipient and provider fraud cases as well as a discussion of member issues (e.g., lock-in program status and collection letters) and provider issues (e.g., outstanding debts and date of death notices). Detailed minutes of the meetings are maintained. The meetings enable the State to monitor MCO activities closely and offer the State the opportunity to provide ongoing education and guidance to the MCO.

Access to the electronic Kentucky All Schedule Prescription Electronic Reporting (eKASPER) system
The DMS-PI has access to the eKASPER system which is a database of all controlled substance prescriptions filled in Kentucky. It is intended to prevent the diversion of controlled substances and facilitate the early detection of drug diversion. Access to the eKASPER system also helps the CHFS-OIG identify outliers and reduces the time and cost involved in Medicaid investigations. The success of eKASPER has prompted at least one other State to look at modeling a system based upon Kentucky's.

Additionally, the MIG review team identified two practices that are particularly noteworthy. The CMS recognizes Kentucky's efforts to deter the submission of fraudulent claims by billing agents though the use of a formal billing agreement. The CMS also recognizes the State's innovative use of provider enrollment and re-enrollment methods and unusually thorough process of checking for provider exclusions.

Required billing agent agreements and attestations

In an effort to deter providers and billing agents from submitting false claims, Kentucky requires billing agents and payees to sign an agreement, the Medical Assistance Program (MAP)-246 Form, with DMS which includes all applicable electronic billing rules and regulations. The agreement also includes an attestation that the billing agent understands that "the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to commit fraud or deceive, makes or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes." This form is always used in conjunction with the MAP-380 Form, which is the electronic billing agreement between the Department and the provider. The MAP-246 serves to commit billing agents to the same standards of accurate and truthful claims submission as providers.

Innovative provider enrollment and exclusion checking techniques

Kentucky utilizes several innovative techniques during the process of initial provider enrollment and re-enrollment, including an especially thorough exclusion checking process. Its techniques include a centralized provider enrollment process in which all providers, including managed care network providers, must be enrolled by DMS provider enrollment (DMS-PE) staff, and a link on the Kentucky DMS website to the Kentucky Sanctioned Provider list for public viewing. The DMS-PE staff utilizes this list and encourages providers to scrutinize it during enrollment.

In addition, as evidenced during onsite demonstrations to the review team, Kentucky engages in robust exclusion checking during the provider enrollment and re-enrollment process. During initial enrollment, the State reviews not only the List of Excluded Individuals/Entities (LEIE) which is maintained by the U.S. Department of Health and Human Services Office of Inspector General, but also checks the Excluded Parties Listing System, which is maintained by the General Services Administration, the Kentucky Sanctioned Provider list, and the State's Medical Licensing Board. For providers who were once deactivated or excluded from the program, the State further checks CMS' Fraud Investigation Database, the CHFS-OIG fraud tracking database, the Kentucky Secretary of State's website, and the State Bureau of Prisons database when such providers seek to re-enroll in Medicaid.

These procedures give DMS-PI greater control over who can enter Kentucky's Medicaid provider network than many States exercise. The practice of publicly posting the Sanctioned Provider list is in compliance with CMS State Medicaid Director Letter

(SMDL) #09-001 issued on January 16, 2009. This SMDL discussed the ongoing responsibilities of network providers to check their staff for exclusions. In addition to posting its sanctions list on the DMS website, the State also wrote to all of its Medicaid providers on February 17, 2009, reiterating the obligation of providers to screen all employees and contractors, at least on a monthly basis, to determine if they have been excluded from Federal health care programs. This letter reminded providers that CMS would not pay for items or services provided by an excluded individual who works for an entity receiving Medicaid funds, nor would it pay for equipment sold by an excluded manufacturer, even if the service or supply was otherwise medically necessary at the time it was prescribed.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to several disclosure requirements. The State also fails to identify certain prohibited affiliations in its managed care contract.

Kentucky does not collect specific board of director information for certain types of corporate entities.

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.

The information requested on Kentucky's standard provider enrollment application correctly tracks the disclosure requirements at 42 CFR § 455.104. However, the application includes instructions to providers not to provide a list of the board of directors if no one on the board has ownership and control interest of 5 percent or more. In practice, these instructions make it impossible for DMS-PE staff to obtain ownership and control information for nonprofit corporations. During interviews with the review team, the State indicated that it did not ask for board of director lists for nonprofit corporations. As a result, the State cannot conduct searches of the LEIE or the Medicare Exclusion Database for all corporate officers and directors with ownership or control interests.

Recommendation: Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers.

Kentucky's provider agreement and enrollment application do not require the disclosure of business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Providers must submit business information within 35 days of the date of a request by the Secretary or the Medicaid agency.

Kentucky's administrative regulations at KAR 1:671 and 1:672 contain the appropriate business transaction language required in 42 CFR § 455.105(b)(2). However, the State's combined provider agreement and enrollment application does not include all essential elements of the regulatory requirement. It does not mention that providers must disclose all significant business transactions during the prior five-year period upon request by the State Medicaid agency or the HHS Secretary. Also, while the agreement obligates providers to report changes in ownership and control and criminal conviction information within a 35 day time frame, there is no reference to the requirement that providers furnish business transaction information within the same time period when so requested.

Recommendation: Modify the application/provider agreement to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Kentucky's MCO contract does not adequately restrict certain prohibited affiliations.

Under the regulation at 42 CFR § 438.610, an MCO, primary care case manager (PCCM), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) may not have a relationship with a director, officer, partner, an employee, consultant, a person with a 5 percent or more ownership interest, or a contractor for items or services that are material to the managed care entity's obligations to the State who has been debarred, suspended, or excluded, or who is an affiliate of a person who is debarred, suspended, or excluded. If the State Medicaid agency learns that the MCO, PCCM, PIHP, or PAHP has a relationship with such a debarred, suspended, or excluded person, or a person who is an affiliate of a person who is debarred, suspended, or excluded, the State Medicaid agency must notify the Secretary. The State may continue the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary instructs the State Medicaid agency to terminate the contract; and the State may not renew or extend the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary provides the State and Congress with compelling reasons for continuing the contract.

Section 4.43 of Kentucky's MCO contract requires the MCO to certify that "neither it nor its principals and/or subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal

department or agency." This language does not include all of the prohibited relationships for managed care entities which are addressed in the Federal regulation at 42 CFR § 438.610(b). Such relationships include employees as well as directors, officers, partners, consultants, persons with ownership interests of 5 percent or more and significant subcontractors.

Recommendation: Modify MCO contract language to include all of the prohibited relationships for managed care entities that are addressed in the Federal regulation.

Vulnerabilities

The review team identified one area of vulnerability in Kentucky's program integrity practices related to the failure to capture managing employee information during provider enrollment.

Not capturing managing employee information during the provider enrollment process.
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." While the standard Kentucky provider application requests information on managing employees who have had prior health care-related criminal convictions (as required by 42 CFR § 455.106), the form does not solicit managing employee information more generally for the purpose of exclusion checking. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendation: Modify provider enrollment 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.

CONCLUSION

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

- a cooperative relationship among DMS-PI, CHFS-OIG and the MFCU
- Date of Death data match for providers and recipients,
- innovative provider enrollment\re-enrollment techniques,
- regulatory authority to terminate providers at will with 30 days notice,
- quarterly MCO meetings with the State agencies involved in program integrity,
- access to a database of all controlled substance prescriptions filled in the State,
- required contractual agreements and attestations for all billing agents, and
- innovative provider enrollment techniques and unusually thorough exclusion checks

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, one area of vulnerability was identified. The CMS encourages DMS-PI to closely examine the area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Kentucky 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 area of vulnerability identified in this report.

The corrective action plan should address how the State of Kentucky 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 Kentucky 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 Kentucky on correcting its areas of non-compliance, eliminating its area of vulnerability, and building upon its effective practices.