Department of Health and Human Services

Centers for Medicare & Medicaid Services

Kentucky Focused Program Integrity Review

Final Report

May 2022

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Kentucky Medicaid managed care program. The primary objective of the review was to assess the level of program integrity oversight of efforts for Medicaid managed care. A secondary objective was to provide the state with feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In April 2021, CMS conducted a virtual review of Kentucky's single state Medicaid agency, the Department of Medicaid Services (DMS), which is responsible for administering the Medicaid program. This focused review helped CMS to assess the program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Kentucky's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

During the review, CMS identified a total of six recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Kentucky Medicaid

For the Commonwealth of Kentucky, DMS, housed within the Cabinet for Health and Family Services (CHFS), is the single state agency charged with overseeing medical assistance plans. The DMS' Division of Program Integrity has primary responsibility for the overall program integrity operations, although other units within the organization maintain roles in program integrity functions.

In 2019, Kentucky's total Medicaid program expenditures exceeded $10 billion, and the state had approximately 1,370,838 beneficiaries enrolled. Kentucky's managed care Medicaid expenditures exceeded $7.5 billion. The Federal Medical Assistance Percentage matching rate was 71.67 percent for the Medicaid population and 100 percent for the Children's Health Insurance Program (CHIP) population.

During the virtual review, three MCOs were interviewed: Aetna Better Health of Kentucky, Anthem BlueCross BlueShield, and WellCare of Kentucky. Enrollment, SIU, and expenditure data for each MCO is provided in Table 1 and Table 2 below.

Table 1. Summary Data for KentuckyKentucky MCOs[2]

	Aetna	**Anthem**	**WellCare**
Beneficiary enrollment total	210,834	131,446	442,482
Provider enrollment total	33,794	27,683	26,540
Year originally contracted	2012	2014	2011
Size and composition of SIU (FTEs)	3	16	11
National/local plan	National	National	National

Table 2. Medicaid Expenditure Data for KentuckyKentucky MCOs[3]

MCOs	**FY 2017**	**FY 2018**	**FY 2019**
Aetna	$1,201,400,175	$1,119,045,231	$1,108,908,647

[2] The beneficiary enrollment numbers for each plan are as of January 2019.

[3] Each of the MCOs submitted the expenditure data reported in Table 2. The state confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

MCOs	FY 2017	FY 2018	FY 2019
Anthem	$638,661,014	$711,842,105	$795,817,299
WellCare	$2,590,886,170	$2,681,688,674	$2,810,156,932

Results of the Review

CMS evaluated the following six areas of Kentucky's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified eight areas of concern with Kentucky's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

In accordance with the state monitoring requirements set forth in §§ 438.66 and 438.602, the SMA must have in effect a monitoring system for all managed care programs that includes mechanisms for the evaluation of MCO performance in several key areas. Kentucky reported that the Division of Program Quality and Outcome (DPQO) is responsible for monitoring compliance and programmatic oversight of the MCO contracts. The DMS' Division of Program Integrity has primary responsibility for the overall program integrity operations.

Additionally, DPQO facilitates the resolution of any contractual issues for the Division of Program Integrity and the MCOs. Kentucky also reported that the state has operational guidelines, policies and procedures, or interagency agreements that govern the interaction between Kentucky's program integrity efforts and programmatic oversight for each MCO.

In accordance with § 438.66(d)(4)(i), the State must assess the ability and capacity of the MCO to provide the appropriate administrative and program integrity staff on a regular basis. Kentucky's MCO model contract establishes the standards for appropriate administrative and program integrity staffing in the following contract section, "The contractor shall maintain two (2) full-time investigators with a minimum of three (3) years Medicaid fraud, waste and abuse investigatory experience located in Kentucky, and dedicated 100 percent to the Kentucky Medicaid program; and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) days with a contingency plan to remain compliant with the other contract requirements in the interim; and meeting the requirements of Appendix N." Kentucky's MCO model contract under Appendix N. Program Integrity

Requirements states, "The Program Integrity Unit (PIU) shall be organized so that there are a minimum of two (2) full-time investigators." **During the virtual interview, Aetna stated that they have a lack of appropriate staff working on cases of suspected provider fraud, waste, and abuse. Aetna had one full-time investigator dedicated to program integrity activities related to fraud, waste, and abuse during the three federal Fiscal Years (FYs) reviewed.**

In addition, Kentucky's contract contains language that requires an MCO to conduct "a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse." However, it is unclear whether the visits should be unannounced or announced. There is no CMS requirement that a state conduct unannounced and announced site visits when developing investigations; however, such an activity is an effective practice. No Kentucky MCO verified if it received guidance from the state regarding whether a site visit should be unannounced or announced to meet the site visit contract requirement for SIU investigations. CMS encourages the state to consider providing such guidance in the future.

CMS encourages the state to ensure that all MCOs meet contract requirements and establish PIUs with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. CMS encourages the state to ensure that MCOs maintain sufficient staffing levels to conduct a full range of program integrity functions including, but not limited to, the review, investigation, and auditing of provider types where Medicaid dollars are most at risk, as well as the recovery of monies overpaid.

CMS also encourages the state to ensure MCOs fully comply with the contract language requiring SIU site visits for its Medicaid providers. CMS encourages the state to provide additional guidance to MCOs regarding this contract requirement, including further specifying whether unannounced and/or announced site visits are required.

2. Provider Screening and Enrollment

All Kentucky providers who seek participation in the Medicaid managed care program must first enroll in Medicaid through an online provider portal. The state performs all of the required provider enrollment activities in accordance with the requirements of § 455, subparts B and E. Upon the state's approval of the application, the providers may seek to secure contracts with participating MCOs. Moreover, as required by § 455.432, announced and unannounced site visits are an important verification mechanism that are used by Kentucky during the provider enrollment and screening process.

Kentucky's MCO model contract states, "The contractor shall have written policies and procedures that include the contractor's initial process for credentialing as well as its re-credentialing process that must occur at a minimum every three (3) years." Both Anthem and WellCare follow this requirement; however, Aetna stated it does not have internal written policies and procedures for credentialing or re-credentialing during the review period.

Recommendation #3: The state should ensure that all MCOs meet contract requirements for the development of written policies and procedures, including the MCO's initial process for credentialing and re-credentialing that must occur at a minimum every three (3) years.

3. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

As required by §§ 438.608(a)(1)(viii) and 455.13-17, Kentucky has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In Kentucky, the DMS Audit and Compliance Branch conducts medical record audits to ensure the integrity of both managed care encounter data and fee-for-service claims data. These audits involve requesting medical records for a sample of claims from the provider and reviewing those records to ensure they adequately document the goods and services billed in accordance with state and federal law and regulations, as well as medical billing code definitions and standard professional practices. In addition, the MCOs are required by contract to establish PIUs that proactively detect fraud through the use of algorithms, investigations, and medical record reviews.

The Kentucky PIU is the Audits & Compliance Branch, which maintains programmatic control of all the managed care fraud referrals from the MCOs. The MCOs are required by contract to immediately refer all cases of suspected fraud, waste, and abuse to DMS, which will review the allegations and, if appropriate, refer the matter to the Kentucky CHFS Office of Inspector General for review and/or preliminary investigation. If the findings of a preliminary investigation indicate that an incident of fraud or abuse involving substantial allegations or other indication of fraud may have occurred under the Medicaid program, a referral for a full investigation and possible prosecution is made directly to the Medicaid Fraud Control Unit (MFCU).

MCO Oversight of Network Providers

As further described below, CMS is concerned with the quantity and quality of Kentucky's MCO investigations of fraud, waste, and abuse. This conclusion is based on the interviews conducted, as well as the data and information collected for this review period of FYs 2017 - 2019.

The quantity of referrals by Aetna and WellCare is of particular concern, a repeat observation from the state's May 2017 program integrity review.[4] In addition, the MCO that has the least amount of expenditures is providing the greatest amount of suspected fraud referrals. This issue was also identified during the 2017 program integrity review.

Aetna. The Aetna SIU investigates reported potential fraud, waste, and abuse activities and, as appropriate, refers suspected or confirmed fraud, waste, and abuse to the DMS PIU. Regardless of the channel by which such suspected activities are received by the Aetna SIU (i.e., service verification, hotline, email, other), an initial review is conducted. The SIU investigator then gathers additional information necessary to further assess the allegation by utilizing industry-recognized databases; conducting internet searches; reviewing all appropriate internal systems; and running Geo Access reports where the potential fraud, waste, and abuse may have occurred. The SIU investigator takes all necessary initial actions to initiate a timely preliminary investigation. At the completion of the case, the Aetna SIU investigator provides an investigative

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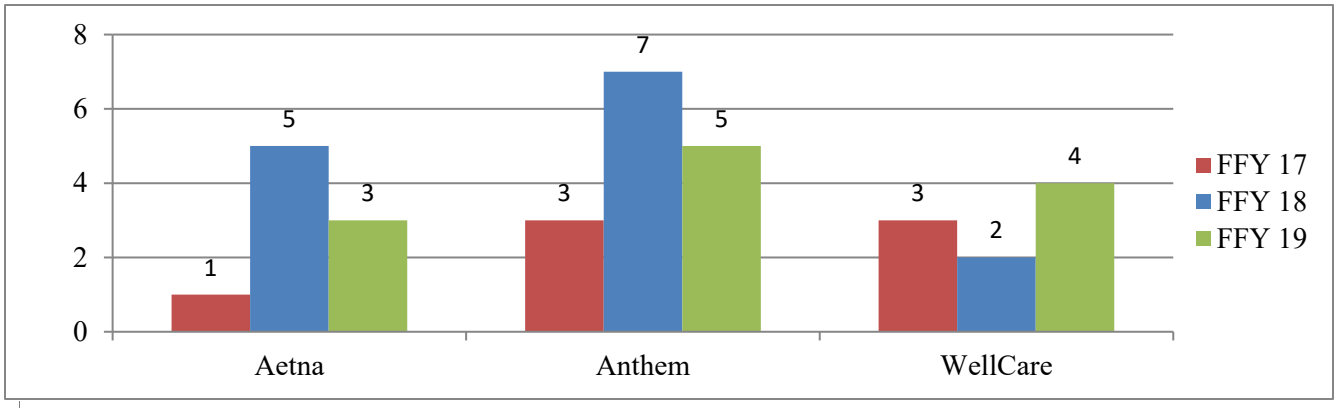
memo of the case investigation to the DMS PIU. Subsequently, the MCO's compliance officer sends the investigative memos electronically to DMS PIU. **Aetna referred nine investigations to the state during the three FYs reviewed.**

Anthem. The Anthem SIU examines providers suspected of fraud and/or abuse through prevention activities and claims submission reviews. Referrals come to the SIU from both internal and external sources; however, the MCO reported that internal claims data mining is the primary way investigators detect and deter fraud and abuse. The Anthem SIU conducts preliminary investigations pursuant to § 455.14. The SIU reviews information supplied from complaints received regarding Medicaid fraud and abuse from any source, as well as internal methods, to determine if a credible allegation of fraud exists and warrants a full investigation. A full investigation continues until resolution is reached or until the case is closed. **Anthem referred fifteen investigations to the state for the three FYs reviewed, which was the most cases referred during the review period across all three MCOs.**

Wellcare. The WellCare SIU is responsible for the detection, prevention, investigation, reporting, correction, and deterrence of fraud, waste, and abuse. Once a referral is received, the matter is immediately logged into the secure Compliance 360 case tracking database by the SIU information case administrator. The referral will be preliminarily assessed by the intake team to confirm that the matter concerns potential fraud, waste, and abuse. The SIU pursues reactive and proactive investigations to either corroborate the allegations or determine them unfounded. Once a determination has been made that the target party has engaged in fraud, waste, and abuse, a referral is submitted to KY DMS outlining the findings. Referrals are then uploaded to Kentucky's MOVEit online portal. **WellCare referred nine investigations to the state for the three FYs reviewed.**

Figure 3 lists the number of referrals that the Aetna, Anthem, and WellCare SIUs made to the state in the last three FYs. Of the five Kentucky-contracted MCOs, these three MCOs received approximately 63 percent of the total managed care expenditures, totaling more than $7.5 billion in FY 2019. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low compared to the size of the plans reviewed. The number of referrals in comparison to expenditures is also inconsistent among the plans. For example, while WellCare accounts for more than 350 percent the expenditures of Anthem, it produces significantly less fraud referrals. Furthermore, the level of investigative activity has significantly decreased for Aetna and WellCare across the CMS program integrity review periods. As previously mentioned, during the review period, Aetna had just one investigator on staff.

Figure 3. Number of Investigations Referred to the State by Each MCO



During the interview with the state, it was mentioned that the DMS PIU wanted to work more with the MCOs to improve the quality and increase the quantity of cases referred. In addition, the MCOs stated their desire to have better communication and/or training around case referrals. The state has committed to continuing information sharing and other communication efforts to ensure better quality and quantity of case referrals.

MCO Program Integrity Contract Language

The Kentucky MCO model contract does not specifically include program integrity provisions addressing corrective action plans (CAPs) for MCO network providers. However, all of the MCOs reviewed have a process for developing a CAP for a network provider. Despite the fact that each of the MCOs had such a process, the issuance of CAPS during the review period varied widely; during the three FYs reviewed, Anthem issued 47 CAPs to network providers, WellCare issued one, and Aetna issued none.

Aetna. Aetna routinely monitors the performance of its contracted individual providers and entities. If deficiencies are identified, Aetna works with the contracted individual provider or entity to set priorities and develop a CAP. The contracted individual provider or entity is sent an analysis report that explains the deficiencies identified that do not meet standards. Aetna may request the contracted individual provider or entity to outline the cause of the issue and implement strategies to correct the issue. The contracted individual provider or entity has an opportunity to provide feedback on root causes and possible barriers along with actions they will take to correct.

Anthem. As a tool to address the finding of investigations or audits, the Anthem SIU utilizes CAPs with network providers to educate the providers, correct their billing or documentation practices when billing irregularities have been validated via claims analysis, or after a record review. With permission from DMS, the Anthem SIU issues a CAP with the notification of overpayment letter. The CAP outlines the specific findings from the audit while providing education and a directive for the provider to adhere to the local/federal and company reimbursement policies as a condition of eligibility to remain in the network. The SIU frequently

collaborates with providers on revising the CAP in such a way that is acceptable to both parties. The SIU requests the providers sign and return the CAP within 30 days of receipt.[5]

Wellcare. The WellCare Network Integrity department notifies any provider who falls below acceptable standards of a certain area of their non-compliance via written communication. This letter also informs the provider that a second audit will be conducted approximately 90 days after the receipt of the letter. The provider relations representatives contact the non-compliant provider to explain the audit results and to reinforce the need for compliance. Any provider found non-compliant after the second audit is sent written notification that a CAP is required to be returned within 30 days of receipt of the letter. Providers who are not compliant after the second audit and fail to respond to the CAP, or do not provide an acceptable CAP are referred to the Kentucky Medical Director and the Provider Relations Director for further action/outreach. Providers who provide an acceptable CAP or written notification will be sent a communication confirming that sufficient documentation has been provided and their status will be changed from non-compliant to compliant.

Overpayments

Kentucky's MCO model contract does not require MCOs to return overpayments recovered from the providers as a result of fraud and abuse investigations. However, consistent with § 438.608(a)(2), Kentucky's MCO model contract does require the MCOs to promptly report to the state all overpayments identified or recovered, specifically identifying the overpayments linked to potential fraud activities. The potential fraud overpayments are captured in the investigative report when the MCOs recommend referrals for a "reasonable belief of fraud." The state confirmed that overpayment recoveries are reported through the encounter data received from the MCOs and in an MCO reported/attested financial template, consistent with requirements in § 438.608(d)(3).

Overall, the MCO overpayment procedures are inconsistent, resulting in the overpayment activities of each MCO varying from plan to plan. In addition, the number of overpayments identified and recovered by the MCOs is low for a managed care program of Kentucky's size.

The state does not audit the case data from which the overpayments are calculated to verify and validate the MCO overpayment amounts. Although MCOs are not required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. (§ 438.608(d)(4)) Without these adjustments, MCOs could be receiving inflated rates per member per month. Tables 4-A, 4-B, and 4-C describe each ACO's recoveries from program integrity activities. In addition, Aetna asserts that the MCO is pursuing all potential overpayments, while Anthem and WellCare presented views on why they do not recover any overpayments. As a result, Aetna appears to be the only MCO that is successfully recovering a portion of the overpayments identified.

[5] Aetna and Anthem stated they engage in prepayment cost avoidance practices, but the information could not be verified by CMS and not within the scope of this section, as such, related findings on that issue are not included in this report.

Table 4-A. Aetna Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	1	0	$112,691.39	$14,689.52
2018	6	0	$712,298.04	$134,391.27
2019	7	0	$1,251,965.13	$267,968.87

Table 4-B. Anthem Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	20	0	$79,043.72	0
2018	24	0	$1,040,473.72	0
2019	49	0	$1,090,864.44	0

Table 4-C. WellCare Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	12	0	$5,618.42	0
2018	16	0	$95,535.78	0
2019	14	0	$754,021.59	0

Aetna. The overpayments identified and recovered by Aetna as a result of its fraud and abuse investigations are tracked by the Aetna SIU and reported to the state on a quarterly basis.

Anthem. The overpayments identified and recovered by Anthem as a result of its fraud and abuse investigations are tracked by the Anthem SIU and reported to the state on a quarterly basis. Anthem's identified overpayments increased during FY 2018 due to the increase in the number of cases opened in FY 2018; the number of identified overpayments continued to grow in FY 2019 as the cases progressed through post-payment medical review. Anthem advised CMS that there were no overpayment recoveries that were a result of fraud, due in part to elements that are beyond the MCO's control once they have identified fraud, waste, and abuse. These comments are in reference to the process that takes place at the state/federal judicial levels; typically, when a provider is being investigated, the MCO must not compromise the investigation that is taking place, which adds to this complexity of being able to recoup the overpayments. Anthem added that civil and/or criminal activity forces all MCO actions in regard to the case to stop, which makes future recoupment more difficult.

Wellcare. The overpayments identified and recovered by Wellcare as a result of its fraud and abuse investigations are tracked by the Wellcare SIU and reported to the state on a quarterly basis. WellCare stated that, when the SIU refers a matter to KY DMS and requests they review

for a credible allegation of fraud, WellCare is to stand down on recovery efforts until DMS notifies them to move forward. If the case is accepted, the WellCare SIU is not permitted to issue a demand letter to the provider to request the overpayment be remitted. If the case is returned, most often the claims are past the lookback period and unable to collect any overpayments.

CMS had difficulty collecting the total overpayments identified and recovered by the MCOs for this review. For example, Anthem submitted a 2019 identified overpayment figure of nearly $5 million, but when the MCO was informed that CMS was seeking only overpayments related to suspected fraud, the submission changed to approximately $1 million. None of this identified amount has been recovered. Moreover, for the three-year review period, the overpayments identified for the three MCOs reviewed combined totaling $5.1 million. The recovery amount for the $5.1 million identified was only approximately $417,000, which was attributed solely to Aetna.

Finally, the state and MCOs were inconsistent in their reporting of how many overpayments were identified and recovered. In comparison, the state was able to provide CMS with timely and accurate statistical information regarding MFCU collections and convictions. The state should adopt standard processes for reporting MCO overpayment identification and recovery that ensure consistency and accuracy. . This will also likely prove to be beneficial as other state and federal audit entities request similar data from the state in the future. It is important to note that the state stated there is a two-year lookback restriction with the Kentucky Department of Insurance that impedes MCOs' ability to collect overpayments.

Recommendation #2: Because the MCOs are on the frontline of program integrity oversight in Kentucky, CMS encourages the state to work with the MCOs to develop more case referrals and routinely provide specific program integrity training related to enhancing the quality of case referrals from the MCOs. CMS also encourages the state to provide more frequent feedback to the plans regarding the quality and quantity of MCO cases referrals forwarded to the state. Finally, CMS encourages the state to also ensure the appropriate MCO staff is receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.

Recommendation #3: CMS encourages the state to ensure that MCOs have sufficient CAP procedures for its Medicaid providers, while also ensuring the full requirements of the CAP are completely satisfied.by providers who are placed on a CAP.

Recommendation #4: The state should verify that identified and collected overpayments are fully reported by the MCOs and routinely audit the overpayments reported through state-initiated reviews of cases investigations to verify and validate the overpayment amounts reported by MCOs, in accordance with the requirements in § 438.608(d)(1). In addition, the state should ensure they are able to provide timely and accurate MCO overpayment and recovery amounts when requested and the overpayment amounts are accurately and appropriately reported to CMS, as well as reflected or incorporated into the rate setting process, in accordance with the requirements in § 438.608(d)(2)-(4).

4. Encounter Data

According to § 438.602, the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP).

The state's contract with its MCOs, as well as their policies and procedures, comply with the federal regulations regarding the collection and completeness of the encounter data. CMS did not identify any recommendations regarding Kentucky's use of encounter data for Medicaid oversight.

5. Payment Suspensions Based on Credible Allegations of Fraud

Consistent with § 438.608(a)(8), the Kentucky MCO model contract includes a provision regarding the suspension of payments to a network provider for instances in which the state determines there is a credible allegation of fraud in accordance with § 455.23. Specifically, the Kentucky MCO model contract states that "[t]he contractor shall have written procedures for the termination or suspension of providers; and written procedures for, and implementation of, reporting to the appropriate authorities, serious quality deficiencies resulting in suspension or termination of a provider."

While Anthem and WellCare confirmed they both follow this requirement, Aetna confirmed that they did not have internal written policies and procedures for payment suspensions; however, Aetna stated they are in the process of developing the payment suspension policy.

Recommendation #5: The state shall ensure all MCOs develop written policies and procedures for payment suspensions, consistent with § 438.608(a)(8).

6. Terminated Providers and Adverse Action Reporting

Consistent with §§ 438.608(b) and 455, subparts B and E, the Kentucky MCO model contract requires MCOs to meet CMS' provider enrollment and screening requirements, including the requirement at § 455.416 to terminate network providers in certain circumstances, including fraud, integrity, or quality. Specifically, the Kentucky MCO model contract states that the, "Contractor shall notify the Department via email of a provider termination from the contractor's network within three (3) business days of any adverse actions. The contractor shall notify any enrollee of the provider's termination provided such enrollee has received a service from the terminated provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP [Primary Care Provider] and within thirty (30) days for any other provider. The contractor will report all terminations monthly via the provider termination report. Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceased participation."

During the virtual interview, the Kentucky PIU confirmed there is a monthly process in place to ensure that the MCOs are terminating providers for cause. Additionally, the Kentucky PIU notifies MCOs of any terminated providers from other plans, so that the MCOs may ensure that

terminated providers are not operating in another plan. The three MCOs interviewed confirmed that they report all terminated providers to the Kentucky PIU within three business days of any provider termination via email and on a monthly basis.

Aetna. Aetna submits a monthly termination report, which includes the reason for termination, to the Kentucky PIU. The MCOs compliance department receives notifications via email from the states PIU that it has terminated a provider for cause. Daily compliance calls are held which include staff from all departments. Provider contracts are then pulled to discuss next steps.

Anthem. Similarly, Anthem submits a monthly termination report, which includes the reason for termination, to the Kentucky PIU. The MCOs regulatory department receives notifications from the states PIU regarding providers who have been terminated for cause. The regulatory department then checks to see if the provider is listed in their system as par or non-par. If the provider is found in the system, a review is performed to see if the provider Medicaid identification (MAID) number is termed. Upon completion, if the provider's MAID number is terminated, the provider's agreement is changed, and the termination process is complete. Termination letters are then sent to the providers.

Wellcare. WellCare submits a monthly termination report, which includes the reason for termination, to the Kentucky PIU. The MCOs Regulatory Affairs (RA) team receives notification from the Kentucky PIU regarding providers whom have been terminated for cause. The WellCare RA specialist adds the termination notification information into the termination escrow tracker and the LIONS system. Termination notifications are then processed and tracked through the compliance 360 system.

The state uploads the for-cause terminated providers to the CMS-Data Exchange (DEX) managed file transfer server.

Overall, the number of providers terminated for cause by the plans appears to be low compared to the number of providers in each of the MCOs networks and compared to the number of providers disenrolled or terminated for any reason. As seen in Table 5 below, the amount of for cause terminations depicted are low in comparison to the total terminations. For example, Aetna had 3,528 not for-cause adverse actions taken against providers in 2017, but reported zero for-cause provider terminations.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated For Cause in Last 3 Completed FFYs
Aetna	2017 3528 2018 1845 2019 1051	2017 0 2018 0 2019 11
Anthem	2017 168 2018 1106 2019 883	2017 1 2018 14 2019 25

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated For Cause in Last 3 Completed FFYs
WellCare	2017 2497 2018 2528 2019 2017	2017 39 2018 50 2019 35

Recommendation #6: In accordance with the requirements in § 438.66(a)(4), the state should improve its oversight and develop a comprehensive process to initiate more frequent information sharing within its contracted MCOs regarding all adverse actions taken to limit managed care provider participation to include, but not limited to terminations, de-credentialed, or disenrolled network providers.

Status of Kentucky's 2016 Corrective Action Plan

Kentucky's previous focused program integrity review was in June 2016, and the final report was issued in May 2017. The report contained eight recommendations. The state requested an extension until July 2017 to review the findings and develop a response. At that time, the state issued a letter to CMS disagreeing with the findings of the report and declining to develop or implement a corrective action plan to remedy the six issues identified. This 2021 managed care program integrity review has several recommendations that were similar to those issued in the 2017 report.

Technical assistance resources

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

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf.
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx.
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx.

- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address enrollment site visit requirements.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute.
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practice.

Conclusion

CMS supports Kentucky's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified eight areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Kentucky to build an effective and strengthened program integrity function.