Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Kansas Comprehensive Program Integrity Review

Final Report

July 2014

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Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report*.

The purpose of this review was to determine whether Kansas's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring.

The review of Kansas's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team did note the state's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities. Ranked below in order of risk to the program these are:

1) Inadequate oversight of managed care operations in the first year of statewide managed care implementation.
2) Inadequate fraud and abuse detection, including insufficient oversight over fiscal agent program integrity activities in the Medicaid fee-for-service (FFS) program and failure to suspend payments upon referring cases with credible allegations of fraud to the MFCU.
3) Ineffective practices in provider enrollment and screening, including failure to perform all required screening activities and properly search for excluded providers as well as failure to capture all disclosure information.
4) Inadequate handling of terminated providers, including two cases of improper payments to excluded providers and failure to provide public notice when providers are terminated from the Medicaid program.

These risks include instances of regulatory non-compliance by the state as well as areas where the state does not have adequate program safeguards, creating a risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS is concerned that some of the issues described in this review were also identified in CMS's 2009 review and are still partially uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

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. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and relationship with the MFCU. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the Kansas Department of Health and Environment (KDHE) Office of Inspector General, MFCU, and three MCOs.

During the week of March 18, 2013, the CMS review team visited the KDHE Division of Health Care Finance (DHCF). The team conducted interviews with numerous DHCF officials as well as with staff from the fiscal agent. To determine whether MCOs were complying with contract provisions and other federal regulations relating to program integrity, the team reviewed the state's managed care contracts. The team met separately with the DHCF staff to discuss managed care oversight and monitoring. The team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Kansas's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program & Contract Compliance (PCC) unit within the DHCF but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Kansas operates its Children's Health Insurance Program (CHIP) as a stand-alone Title XXI program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Kansas 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 the DHCF provided.

Medicaid Program Integrity Unit

In Kansas, program integrity operations for the FFS and managed care programs are located in the PCC unit within the DHCF. At the time of the review, the PCC unit had 11 full-time equivalent positions (which included three state employees and eight fiscal agent employees) allocated to Medicaid program integrity functions. There was also a new Program Integrity Manager, together with a Fraud Waste Abuse/Utilization Review Manager who came on board in 2012. Most surveillance and utilization review activities are contracted to the fiscal agent, which support core functions for state program integrity staff. The table below represents the total number of preliminary and full investigations and the amount of identified and recouped overpayments related to program integrity activities in the last four state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2010	144	24	$27,823,159	$2,619,466
2011	147	25	$10,443,048	$10,696,016
2012	126	80	$10,417,954	$10,148,784
2013	35	10	$6,286,216****	$6,494,083****

* 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.
***Figures do not include global settlements
****Figures as of March 8, 2013.

Results of the Review

The CMS review team found a considerable number of regulatory compliance issues and vulnerabilities related to program integrity in the Kansas Medicaid program. Several of these issues are significant and represent risks to the integrity of the state's Medicaid program. These issues fall into four major categories of risk as outlined and discussed below. To address these issues, Kansas should improve oversight and build more robust program safeguards.

RISK 1: Inadequate oversight of managed care operations in the first year of statewide managed care implementation.

Oversight of MCOs

Kansas began providing Medicaid services through a managed care delivery system in January 2013, entitled KanCare. KanCare is a statewide program operating under section 1115 waiver authority. It covers a broad spectrum of carved-in services including home and community based services (HCBS), behavioral health, non-emergency medical transportation (NEMT), dental, pharmacy and vision care. In general, the team found that the state had performed due diligence in laying the groundwork for the program by incorporating many essential program integrity provisions into its model managed care contract. These included instituting the requirement that MCOs report suspected fraud, adverse actions, case investigations, and overpayments and recoveries to the state agency. However, at the time of the review, neither the KDHE, the DHCF, nor the PCC unit had developed written policies and procedures or had methods to effectively monitor MCO program integrity activities to ensure that the baseline standards outlined at 42 CFR 438 Subpart H-*Certifications and Program Integrity* and 42 CFR 455 Subpart A–*Medicaid Agency Fraud Detection and Investigation Program,* were actually being met.

In Kansas, the responsibility for most core program integrity activities is delegated to both the state's fiscal agent and three MCOs. The KanCare program was still in the early stages of implementation when the CMS review team was onsite. Accordingly, large amounts of managed care encounter data and program integrity investigation data were not yet available for analysis. For example, the expected date for uploading the initial encounter data from MCOs into the state

agency's Medicaid Management Information System (MMIS) was April 19, 2013, one month after the team's onsite visit. However, the review team noted that the state agency had not yet developed plans or guidelines for evaluating encounter data or where the functional responsibility for encounter data mining would reside. The state also acknowledged that it had not yet developed or implemented policies for the performance of several key functions, such as monitoring MCO exclusion checking and conducting periodic MCO compliance reviews.

Recommendations:

- Develop and implement policies and procedures to facilitate stronger DHCF oversight of MCO program integrity activities.
- Ensure that managed care oversight staff in DHCF continues to meet with MCOs to discuss program integrity issues and provide fraud and abuse prevention and detection training.

RISK 2: Inadequate fraud and abuse detection, including insufficient oversight over fiscal agent program integrity activities in the Medicaid FFS program and failure to suspend payments immediately upon referring cases with credible allegations of fraud to the MFCU.

In Kansas's FFS program, the fiscal agent has full delegated authority to perform all program integrity activities. The program integrity activities performed by the fiscal agent include but are not limited to, data mining, preliminary investigations, developing fraud referrals to the MFCU, taking other administrative actions, and undertaking data mining as well as other surveillance and utilization review activities. The state agency exercises only limited oversight over how these activities are carried out and their outcomes. For example, the state does not require the fiscal agent to submit for prior review and approval a data mining plan identifying provider types to be targeted. Similarly, while the fiscal agent copies state staff on MFCU referrals, no advance consultation takes place with the oversight staff and no concurrence is solicited. In this sense, too little state monitoring takes place to ensure that the fiscal agent's program integrity activities are being performed appropriately.

In addition, the state agency also delegates full responsibility to the fiscal agent for reporting provider terminations to CMS's provider terminations database, which state agencies use to identify providers who have been terminated by Medicare or other state Medicaid and Children's Health Insurance programs as required by 42 CFR 455.416. Without directly checking on the fiscal agent's actions, the state cannot determine if they are fully compliant with the regulatory requirements. The review team found additional issues relating to the handling and reporting of terminated or excluded providers. These issues are discussed in Risk 4 below.

Payment Suspensions

The regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a

MFCU or to an appropriate law enforcement agency in states with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The fiscal agent refers credible allegations of fraud to the MFCU and informs the state agency; however, the state agency does not suspend payments, nor does it document good cause exceptions. The small number of program integrity staff in the state agency had only limited involvement with the cases referred by the fiscal agent to the MFCU.

The MFCU does provide the state agency with a quarterly summary of provider fraud and abuse cases being considered for prosecution. These lists identify all cases for which the MFCU requests that payments not be suspended. However, because of a time interval in each quarterly reporting period, the MFCU quarterly response generally does not allow the state agency to make timely payment suspensions where appropriate. Unless a MFCU report comes out on the day a credible allegation of fraud is made, the state agency would be unable to comply with the specific requirements of the regulation.

According to state records, the fiscal agent referred 100 cases to the MFCU from March 25, 2011 until December 26, 2012. There was no evidence of payment suspensions or good cause exception requests in these cases. A total of approximately $67 million was paid to these 100 providers after the referrals were made. These payments were potentially at risk.

To validate, the CMS review team sampled ten cases. These cases were well documented and met the CMS fraud referral performance standards referenced in 42 CFR 455.23(d)(2)(ii). However, the team found no payment suspension notices or good cause exception requests in the case files; and the state confirmed that such documentation had not been filed when the cases were referred to the MFCU.

Recommendations:

- Ensure that the state agency is reviewing and evaluating individual cases that the state's fiscal agent is referring to the MFCU.
- Ensure that in the absence of a written good cause exception, provider payments are suspended after determining that an allegation of fraud is credible in accordance with the requirements at 42 CFR 455.23.
- Update and strengthen the state agency's policies and procedures and existing Memorandum of Understanding with the MFCU to formalize procedures to suspend payments upon referral of cases to MFCU in the absence of a documented good cause exception to address the requirements of 42 CFR 455.23.

RISK 3: Ineffective practices in provider enrollment and screening, including failure to perform all required screening activities and properly search for excluded providers as well as failure to capture all disclosure information.

Provider Screenings and Site Visits

The review team found that the state had not yet implemented a number of the provider screening measures required by the implementing regulations to the Affordable Care Act at 42 CFR 455 Subpart E, which took effect on March 25, 2011. Examples include:

The state was not performing pre- and post-enrollment site visits for providers designated as “moderate” and “high” risk to the Medicaid program as required by the regulation at 42 CFR 455.432. Although the state was able to identify categorical risk level providers as defined by Medicare, the state indicated that it did not have the staffing resources to conduct pre- and post-enrollment site visits.

In addition, at the time of the review, the state was screening all providers the same way utilizing the federal requirements for “limited” risk providers only. This runs counter to the regulation at 42 CFR 455.450, which mandates that different types of screenings must be done based on the categorical risk levels of ‘‘limited,’’ ‘‘moderate,’’ or ‘‘high.’’ The state’s failure to differentiate its screenings by risk is a concern because it means more stringent review criteria may not currently apply to providers with a history of billing abuse or other questionable actions.

Exclusion Searches

The regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[1], the Social Security Administration Death Master File (DMF), and the National Plan and the Provider Enumeration System (NPPES) upon enrollment and reenrollment. State agencies must also check the LEIE and EPLS no less frequently than monthly.

One of the responsibilities delegated to the fiscal agent is conducting exclusion checks for all FFS providers. However, during the on-site interview with the state and the fiscal agent, neither could confirm that the fiscal agent performs exclusion database checks against the LEIE (or Medicare Exclusion Database [MED]) and EPLS on a monthly basis for FFS providers. A review of the sampled provider enrollment files revealed that less than half contained evidence of LEIE, EPLS and DMF checks done at enrollment. Furthermore, there was no evidence that the LEIE or MED and EPLS were checked monthly.

In the managed care program, KDHE delegates MCO-level exclusion checking to its fiscal agent. As part of the MCO contracting process, the fiscal agent collects ownership and control disclosure information from MCOs for persons with both direct and indirect ownership and control interests as well as managing employees. However, the state agency does not collect all the information required under 42 CFR 455.104. Furthermore, the state acknowledged that not all the required LEIE and EPLS checks were being performed at the point of contracting or that exclusion checking was done monthly. The evidence suggests that neither the exclusion checks

[1] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

which the state performs on FFS providers nor those conducted at the managed care plan organizational level were in full compliance with the regulation.

Specific vulnerabilities were also identified related to exclusion searches in the personal care services (PCS) program and in the enrollment activities conducted by the MCOs. The Kansas Medicaid program has multiple methods of providing personal care services to their beneficiaries. In FFS, personal care services are provided through the Work Opportunities Reward Kansans (WORK) program. The WORK program is a Medicaid buy-in program that offers people with disabilities who are working or interested in working the opportunity to get or keep Medicaid coverage while on the job. In the WORK program, the beneficiaries hire their own personal care attendants (PCAs), who are screened by a Medicaid enrolled Fiscal Management Service provider. The Fiscal Management Service provider completes LEIE database checks upon initial screening; however, there is no evidence that the DMF and EPLS are checked during the PCAs' initial screening. In addition, there is no evidence that the Fiscal Management Service provider checks the PCAs against the LEIE and EPLS on a monthly basis.

The state has six additional HCBS waiver programs managed by KanCare MCOs which include PCS. Under these six programs, all PCAs are employed by home health agencies. During on-site interviews, the state confirmed that the MCOs administer the personal care services benefit through the HCBS programs, but ultimate oversight remains a state responsibility. The state was unable to provide evidence that the home health agencies check their PCAs against the LEIE or MED and EPLS upon initial enrollment, re-enrollment, and monthly or that DMF checks were conducted upon enrollment.

Kansas MCOs are contractually required to perform all federal database checks on network providers and subcontractors required by the regulation at 42 CFR 455.436. At the time of the review the review team found that all three MCOs checked the LEIE, EPLS and DMF at enrollment/credentialing, re-enrollment/re-credentialing and monthly for providers. However, the three MCOs were only in the process of expanding their capacity to undertake the required database checks on persons with ownership and control interests, agents and managing employees for core providers and some of the specialty networks they directly enroll. Similarly, subcontractors, who manage many of the specialty networks, showed a wide variation in the scope and frequency of the database checks they undertook.

For example, one MCO documented that it contractually binds its subcontractors to check the LEIE and EPLS, but the contract did not specify the required frequency of such checks. It was not clear how many subcontractors actually performed monthly searches. In addition, most subcontractors limit their searches to provider names and failed to check any affiliated parties. Without conducting routine searches of federal exclusion and debarment databases for providers, as well as those with an ownership or control interest, or who are agents or managing employees of the provider at both the MCO level and of the network providers they enroll, the KDHE cannot ensure that excluded or debarred parties did not receive federal health care funds through Medicaid managed care contracts.

Ownership and Control Disclosures

In the 2009 CMS review, it was noted that the state was not collecting complete ownership and control information from FFS providers or the fiscal agent as required by the regulation at 42 CFR 455.104. The state largely corrected the omissions in its current Disclosure of Ownership and Control Interest Statement, but a few minor discrepancies still exist. For example, when asking if providers, fiscal agents, and MCOs have ownership or control interest in entities that participate in other federal health care programs, a typographical error in the form erroneously refers to Medicare as Title XVII rather than Title XVIII. In addition, the form includes a question (#7) that asks for the appropriate identifying information from the provider but does not indicate that fiscal agents and MCOs are supposed to provide the same information.

In the KanCare program, the state has delegated the collection of ownership and control disclosures from MCO network providers to the three MCOs which contract with the state. All plans directly enroll and credential general acute care and ancillary providers. At the same time, they all delegate most of their sub-specialty network enrollment and credentialing to several subcontractors who specialize in managing certain service delivery networks. This applies in the three MCOs to NEMT, dental, pharmacy and vision care services. In addition, two MCOs directly credential HCBS providers and one MCO directly credentials behavioral health providers.

All three MCOs utilize the state agency's Disclosure of Ownership and Control Interest Statement to enroll providers, which requires minor revisions as discussed above. Most of the subcontractors also use the same form or a federally compliant form. However, some subcontractors do not. For example, two subcontractors do not ask providers at the point of credentialing and re-credentialing whether persons with ownership and control interests in the providers have ownership or control interests in other disclosing entities. They also do not request information about subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more, or request information on managing employees.

One of the MCOs reported that it has put two subcontractors on a corrective action plan related to collecting disclosures. Another subcontractor has instituted all required procedures on new enrollments but is just now going back to collect disclosures on older enrollments. The subcontractor issues as described were identified by the team even though all subcontractors are reviewed and approved in advance and are generally audited by the MCOs on an annual basis. Without collecting complete disclosure information from providers, the KDHE cannot ensure that excluded or debarred parties did not receive federal health care funds through Medicaid managed care contracts.

Criminal Offense Disclosures

A similar risk was identified in the managed care program with regard to capturing health care-related criminal conviction disclosures from MCO network providers, which is contractually required in the KanCare program. All three MCOs use the Kansas Disclosure of Ownership and Control Interest Statement for their core providers, which meet the requirements of 42 CFR 455.106 on criminal conviction disclosures, and most subcontractors use either this form or a

federally compliant form. However, some subcontractors use standard industry or other forms that ask broader questions about criminal history convictions and whether providers have ever been sanctioned by federal health care programs, but the questions are geared to the individual provider. In these entities, the applications and enrollment procedures do not always inquire about the criminal history of persons with ownership and control interests, agents or managing employees. The failure to obtain the same range of healthcare related criminal conviction information from key parties that are affiliated with providers places the state at risk for inappropriate parties to participate in the Medicaid managed care program.

Business Transaction Disclosures

The review team found similar inconsistencies in the manner in which business transaction disclosures are addressed in the MCO network provider enrollment agreements. The 2009 CMS review found that the state's contracts with the MCOs did not require the disclosure of business transaction information that is required by FFS providers under 42 CFR 455.105. This was partially corrected in the 2013 review. The KanCare model contract requires the disclosure of business transaction information consistent with 42 CFR 455.105. Although the MCOs request business transaction information consistent with the above federal regulation at the point of enrolling providers and contracting with subcontractors, with the exception of one MCO, the ongoing obligation to provide this information upon state or HHS request is not included in MCO provider agreements or subcontracts.

The other two MCOs either did not reference the 42 CFR 455.105 requirements at all or they provided a general requirement for complying with federal law that did not specifically address 455.105 or 42 CFR 455 Subpart B.

Recommendations:

- Develop and implement policies and procedures to assign all providers categorical risk levels and execute pre- and post-enrollment site visits based on providers or provider types that are designated as "moderate" or "high risk".
- Execute policies or procedures to ensure that provider enrollment and contracting processes include the collection of complete and accurate disclosure information.
- Ensure that any person with an ownership or control interest or who is an agent or managing employee of the provider is checked against the EPLS and the LEIE during the enrollment process and monthly thereafter.
- Ensure that MCO and subcontractor enrollment applications solicit information about the criminal history of persons with ownership and control interests, agents or managing employees.
- Update provider agreements used by MCOs and their subcontractors which require providers to furnish the state or HHS with information about certain business transaction information upon request.

RISK 4: Inadequate handling of terminated providers, including two cases of improper payments to excluded providers and failure to provide public notice when providers are terminated from the Medicaid program.

Payments to Excluded Providers

Under the regulation at 42 CFR 1002.211, no payment may be made by the state agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

The CMS review team identified two providers that were paid a total of $13,523 for services rendered after they were put on the LEIE by the HHS-OIG. The review team examined the claims paid to these providers after they were excluded and confirmed that the payments were incorrectly made to these providers. At the time of the review the state indicated that it would report the full amount of the improper payment on the CMS-64 form in the third quarter of federal fiscal year 2013.

State Agency Exclusion Notices

The CMS review team confirmed that when the state terminates a provider for any reason, the MMIS generates a letter to the affected beneficiaries. The state agency also sends certified letters to the provider, the state licensing board, HHS-OIG and the Provider Relations Manager of the fiscal agent. However, the state confirmed that it does not provide any form of public notice about terminated or excluded provider,[2] as the regulation at 42 CFR 1002.212 requires.

Recommendations:

- Implement measures to ensure that providers excluded from any federal program are not paid by the state agency.
- Create a notification procedure to provide the public with information about terminated or excluded providers.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. The state reported that the Kansas Department of Aging and Disability Services (KDADS) developed an electronic visit verification system.

Web-based electronic visit verification system in the PCS program

In January 2012, a contractor developed a web-based electronic scheduling, tracking, and reporting system. The KDADS uses this system to monitor HCBS program vendors and customers. HCBS programs provide a large array of services to a diverse clientele, including the frail elderly, persons with physical disabilities, intellectual and developmental disabilities,

[2] For reporting purposes, CMS refers to state actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions".

traumatic brain injury, and persons in need of assistive technology. The providers of waiver services in each HCBS program are required to use the system to capture and bill for services. Another feature of the system provides for contractor staff to randomly call the home of consumers during a time when the direct support workers have "checked in" to provide care. The purpose of the call back system is to verify that the worker is present and providing the necessary care. The system offers providers seven day, round-the-clock client support services, live training opportunities, and quarterly user group forums, as well as bimonthly provider assistance calls.

At the time of the review, the system had been in place for only one year, and the state agency was unable to provide data on its cost effectiveness. However, the state was impressed with the system's versatility and believed it had the potential for enhancing the accountability of providers serving waiver clients.

Although the state reported this system's utility, the CMS review team identified several issues with the exclusion checking process in the state's PCS program. These were discussed in Risk 3 above.

Technical Assistance Resources

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

- Consult with other states that have large Medicaid managed care programs to discuss best practices for effective program integrity oversight of MCOs and obtain examples of comprehensive policies and procedures to address the issues outlined in Risk 1. These include areas such as: training for managed care staff regarding program integrity issues; MCO contract compliance reviews; monitoring of MCO exclusion searches; and evaluation and mining of MCO encounter data.
- Consult CMS guidance on payment suspensions including the March 25, 2011 Informational Bulletin located at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Kansas to states that are further along in this process to address the areas of non-compliance identified in Risk 2.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Kansas review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, especially the course offered on *Program Integrity Managed Care Seminar*. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Access the Regional Information Sharing System (RISS) to find appropriate provider enrollment applications and provider agreements to assist in complying with the full range of current disclosure requirements and consider posting requests for states to share their provider enrollment packets to correct deficiencies described in Risk 3.
- Access the annual program integrity review summary reports on the CMS's website. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Kansas review the effective practices related to the handling of terminated providers to address the issues identified in Risk 4.

Summary

Kansas applies some effective practices that demonstrate program capabilities and the state's commitment to program integrity. CMS supports Kansas's efforts and encourages it to look for additional opportunities to improve overall program integrity. However, the identification of significant areas of risk and numerous findings of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the state to provide a corrective action plan (CAP) for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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

Official Response from Kansas
August 2014

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August 8, 2014

Peter Leonis
Director of Field Operations
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Dear Mr. Leonis:

The Kansas Department of Health and Environment / Division of Health Care Finance (KDHE/DHCF) appreciates the opportunity to address the identified compliance issues identified in the Kansas Comprehensive Program Integrity Review Final Report.

KDHE/DHCF values CMS' recommendations and shares the commitment to continuously improve practices to ensure program integrity, as demonstrated by the additional practices put in place since the review occurred during the first 12 weeks of Kansas' new statewide integrated managed care program. That said, KDHE/DHCF vigorously disagrees with CMS' assessment that Kansas's Program Integrity (PI) activities are inadequate and ineffective. KDHE/DHCF has implemented many PI best practices and continues to research emerging program integrity activities.

Enclosed is the corrective action plan addressing each identified compliance issue. Many of the corrective actions have been implemented since the Program Integrity Review was completed.

Please contact Krista Engel at 785-296-7285 or kendel@kdheks.gov for questions or additional information.

Sincerely,

Christiane Swartz
Deputy Medicaid Director

cc: Susan Mosier, MD, Director, KDHE/DHCF
Jason Osterhaus, Program Integrity Manager, KDHE/DHCF
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Enclosure