Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Kansas Focused Program Integrity Review

Final Report

January 2019

Table of Contents

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Kansas to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review did not include a follow up on the state's progress in implementing corrective actions related to CMS' previous comprehensive program integrity review conducted in calendar year 2013, as the corrective action plans were found to be satisfied in July 2016.

Background: State Medicaid Program Overview

The Kansas Department of Health and Environment (KDHE) administers the Kansas Medicaid program. As of January 1, 2018 the program served approximately 385,813 beneficiaries. Kansas has a managed care program which operates statewide and serves approximately 345,756 beneficiaries or 90 percent of Kansas' Medicaid population.

At the time of the review, the Kansas Medicaid program had 31,937 participating fee-for-service (FFS) providers. As of May 2018 Kansas had three managed care organizations (MCOs) and a total of 73,055[1] providers enrolled in the state's managed care program. These MCOs included full-risk health maintenance organizations (HMOs) and provider service networks. Therefore, all entities will be referred to as MCOs throughout this report. Total Medicaid expenditures for federal fiscal year (FFY) 2017 were approximately $3,453,172,194.

The Program Integrity Unit (PI) is located within KDHE's Division of Healthcare Finance and has the overall responsibility for the prevention and detection of fraud, abuse, and improper payments within the Medicaid program. This unit is tasked with conducting all program integrity and audit fraud investigation activities. However, program integrity functions are also performed by other divisions, including the Medicaid Fraud Control Unit (MFCU) and the Kansas Attorney General Office (KAGO). At the time of the review, the PI unit had three full-time equivalent (FTE) staff and ten FTE fiscal agent representatives. There is no contractual requirement for the number of FTEs needed at the state to manage PI oversight. Given the level of responsibility and the number of required activities necessary for proper oversight, the small number of state employees devoted to Medicaid PI activities may pose a risk to the oversight of KanCare's managed care program.

Methodology of the Review

In advance of the onsite visit, CMS requested that Kansas and the MCOs selected for the focused review complete a review guide providing the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person-member review team reviewed these responses and materials in advance of the onsite visit.

[1] This number represents the sum of the three MCO networks and is not reflective of the number of unique providers. This number is inflated as a unique provider likely participates in all three MCO networks. KDHE is currently working on a mechanism that will improve provider counts and remove duplicative representation.

During the week of June 25, 2018 the CMS review team visited KDHE. The CMS review team conducted interviews with numerous state staff involved in program integrity and managed care. The team also conducted interviews with MCO representatives from their special investigations units (SIUs) and/or compliance offices. In addition, the CMS review team conducted sampling of randomly selected program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating 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. These issues and CMS' recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

Approximately 345,756 beneficiaries, or 90 percent of the state's Medicaid population, were enrolled in three MCOs during FFY 2017. The state spent approximately $2,018,265,074 on Medicaid managed care contracts in FFY 2017.

Summary Information on the Plans Reviewed

Each MCO contracts solely with the Kansas Department of Health and Environment Division of Health Care Finance (DHCF) to serve Medicaid-eligible and CHIP members through the KanCare program. The CMS review team interviewed all three of the participating MCOs as part of its review.

Amerigroup Kansas, Inc. (Amerigroup) is a local subsidiary of the national health plan, Anthem, Inc., that provides comprehensive health coverage to approximately 127,199 Medicaid beneficiaries. With its network of 20,647 providers, Amerigroup has served the state of Kansas since January 2013. Amerigroup is part of Anthem Inc.'s (Anthem) Government Business Division (GBD). Through its GBD, Anthem serves approximately 7.4 million individuals, which includes seniors, people with disabilities, low-income families, other state and federally sponsored beneficiaries, and National Government Services enrollees (including the Federal Employee Program) in 26 states.

Program integrity resources are available through Anthem's corporate SIU, which operates as an internal proprietary function. The SIU has 266 associates dedicated to the detection and prevention of fraud, waste, and abuse, including 12 FTEs that perform various functions for Kansas' local plan. This team includes one manager, two investigators, three investigative assistants, and a certified professional coder. All FTEs receive support from the SIU Manager, three data analysts, and a regulatory compliance consultant. The total Medicaid plan expenditures for FFY 2017 were approximately $998,106,279. The SIU performs all investigative functions at the national level. The number of national employees devoted solely to

the oversight of Kansas fluctuates based on the relevant case volume. The SIU is operated by Anthem which performs all triage and determination of credible allegations of fraud, as well as provides specialized SIU units for some areas of expertise, on both the national and local level.

United Healthcare Community Plan of Kansas (UHC) is a national, for-profit health plan that provides comprehensive health coverage to approximately 131,958 Medicaid beneficiaries. With its network of 22,025 providers, UHC has served the state of Kansas since January 2013. Total plan expenditures amounted to approximately $821,054,445 million in 2017. Compliance activities for UHC are supported by a matrix of national and local United Health functional areas. The compliance unit staff consists of four FTEs and is headed by the local health plan compliance officer. Approximately 2.8 of these FTEs are at the national level and 1.2 FTEs are at the local level. The local compliance unit reports to a national compliance committee. The SIU performs all investigative functions at the national level. The number of national employees devoted solely to the oversight of Kansas fluctuates based on the relevant case volume. The SIU is jointly operated by UHC and Optum Insight (Optum), a shared subsidiary and vendor. Optum performs all triage and determinations of credible allegations of fraud functions and provides specialized SIU units for some areas of expertise. Oversight of Optum is performed by the local Director of Operations.

Sunflower Health Plan (Sunflower) provides comprehensive health coverage to approximately 127,470 Medicaid beneficiaries throughout 105 counties. With its network of 30,383 providers, Sunflower has served the state of Kansas since Total plan expenditures amounted to approximately $1.1 billion in 2017. Sunflower is a wholly owned subsidiary of Centene Corporation. The compliance program at Sunflower is supported by a matrix of national and local Centene functional areas. The compliance unit staff consists of 11.25 FTEs and is headed by the local health plan compliance officer. Approximately 9.25 of these FTEs are at the national level and 2 FTEs are at the local level. The local compliance unit reports to a national compliance. The SIU performs all investigative functions at the national level. The number of national employees devoted solely to the oversight of Kansas fluctuates based on the relevant case volume. The SIU is operated by Centene at the national level, with Sunflower referring cases to Centene for investigation and analysis. The Centene SIU performs all triage and determinations of credible allegations of fraud.

Enrollment information for each MCO as of May 2018 is summarized below:

Table 1.

	Amerigroup Kansas, Inc.	**United Health Care**	**(Sunflower Health Plan**
Beneficiary enrollment total	127,199	131,958	127,470
Provider enrollment total	20,647	22,025	30,383
Year originally contracted	2013	2013	2013
Size and composition of SIU	266 FTE with 12 FTE/PTE supporting KanCare	4 FTE, that includes analysts & investigators	110 FTE with 2 designated FTE that are located at Sunflower's Lenexa, KS location
National/local plan	National	National	National

Table 2.

MCOs	**FFY 20**15	**FFY 20**16	**FFY 20**17
Amerigroup Kansas, Inc.	$949,045,146	$976,975,995	$998,106,279
United Health Care	$750,585,096	$761,198,000	$821,054,445
Sunflower Health Plan	$1,134,500,000	$1,115,400,000	$1,097,400,000

State Oversight of MCO Program Integrity Activities

The Program Integrity Unit (PIU) is the state unit responsible for program integrity oversight. The state reported that oversight of the Medicaid system in Kansas is a collaborative effort between KDHE and the PIU, the MCOs, and the MFCU. The PIU is responsible for all program integrity, audit, and fraud investigation activities and reporting oversight.

The state does have written policies and procedures and interagency agreements detailing how each area will conduct oversight of the MCOs, including which unit within the Medicaid agency is responsible for each specific activity To date, the KDHE and the Division of Health Care Finance (DHCF) and the fiscal agent attest that no investigation of any MCO(s) has occurred.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Kansas's MCO contract states that the "The contractor shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and MFCU, located in Kansas Attorney General's Office."

In order to ensure appropriate oversight of MCO PI activities, the contract further specifies that, in collaboration with KDHE/DHCF and MFCU,, the "Contractor acknowledges and agrees that the Kansas MFCU, which is part of the KAGO, will have the right to recover fraudulent Medicaid payments directly from participating and nonparticipating providers and subcontractors of Contractor, and from any other third parties in Contractor's provider network. Contractor acknowledges and agrees that it is not entitled to any portion of any recovery by the Kansas MFCU. Further, Contractor agrees to be subrogated to the State for any and all claims Contractor has or may have against pharmaceutical companies, retailers, providers, or other subcontractors, medical device manufacturers, or durable medical equipment manufacturers in the marketing and pricing of their products." The state has provided guidance on the types of referrals to submit and how to submit a referral.

The MCOs submit quarterly reports of fraud, waste, and abuse activity to the KDHE. These reports are then sent to the DHCF Fraud/Utilization Review Manager for inspection and analysis. The contract does include language that defines where the MCO submits reports of suspected provider fraud, waste, or abuse. The plan make referrals directly to the both KDHE/DHCF and the MFCU simultaneously. Guidance on what materials are needed for a comprehensive referral are provided to each of the MCOs. During the onsite review, one of the MCOs indicated they had not received guidance from KDHE. The State has agreed to redistribute guidance to that MCO

In accordance with the contract, Amerigroup identifies and investigates potential cases of fraud, making the state aware when required. Amerigroup handles potential fraud and abuse through the Special Investigations Unit (SIU) at the national level for Anthem. The procedures are specified within the SIU Antifraud Plan which includes the most recent Kansas state addendum, which outlines, in detail, the expectations for identifying and investigating potential cases of fraud, waste and abuse for each line of business

Under the direction of the staff Vice President, the SIU maintains adherence to Federal and state regulations for staffing Amerigroup's investigations. Leads are received through various mechanisms, including internal data mining, internal and external referrals, and beneficiary outreach. The primary source for detection is the data mining of anomalous behaviors and aberrant health care analytic patterns. All cases are tracked from initiation to case closure at the national level through a shared internal data warehouse. The national SIU team, including the staff assigned to Kansas, have accessibility to files of any case entered into the system.

The Amerigroup SIU functions as a subdivision of the PI unit, which also develops cost containment strategies and algorithms to analyze claims data. Cases are assigned to specific SIU areas based on the geographic market the case originates in. Investigators are assigned to a specific state and do not fluctuate based on case volume; the SIU manager assigned to Kansas Medicaid activities is located in Nashville, TN. The SIU moves cases forward in stages, first gathering information, then evaluating the case files and finally reporting to the local and national SIU the case findings and recommendations for closure. There are several units involved in the full case investigation to ensure a comprehensive review of the files. Cases that rise to the predetermined level of fraud or abuse are forwarded to the state, then MFCU and in some cases law enforcement. The SIU reports trends and special cases to the local health plan each month through the SIU dashboard report.

UHC identifies and investigates potential fraud in accordance with their contract and refers this information to the state when appropriate. UHC's investigations of potential fraud and abuse activities originate with the intake of a referral. Referrals are received through multiple channels, including local tips and nationally administered analytics programs. For cases received through local sources, the local unit acts as the liaison; referring allegations to the national level. All cases are tracked and triaged from this initial stage using a comprehensive referral and validation system, named, DETECTS, accessible at both the national and local level.

The DETECTS system allows for a comprehensive review of data from all available sources, including commercial and Medicaid lines of business, and is administered by Optum. At this stage, the Optum staff determines the credibility of the allegation through data querying and other relevant intelligence gathering activities. If credibility is established, the case will proceed to the preliminary review stage. All investigations occur at the national level. UHC has specialized SIU departments to address specific subject matter and the appropriate department is determined during the bi weekly triage committee for all cases requiring preliminary review. If the appropriate UHC or Optum SIU determines that there is insufficient evidence of possible fraud, waste, or abuse, the case will be closed. If a credible allegation of fraud is determined during the preliminary review, an extensive review will be performed by the SIU. Following investigation, relevant information is then communicated back to the local UHC staff via the summary investigative report; this unit is then responsible for communicating that information to the state for further review and action directives. UHC estimates that this report is typically referred to the state within 2 business days. All SIU investigations are reported to the state through the quarterly Fraud, Waste and Abuse Report. Trends and unique cases are also discussed at a monthly meeting with the state and MFCU, as well as representatives of the other MCOs.

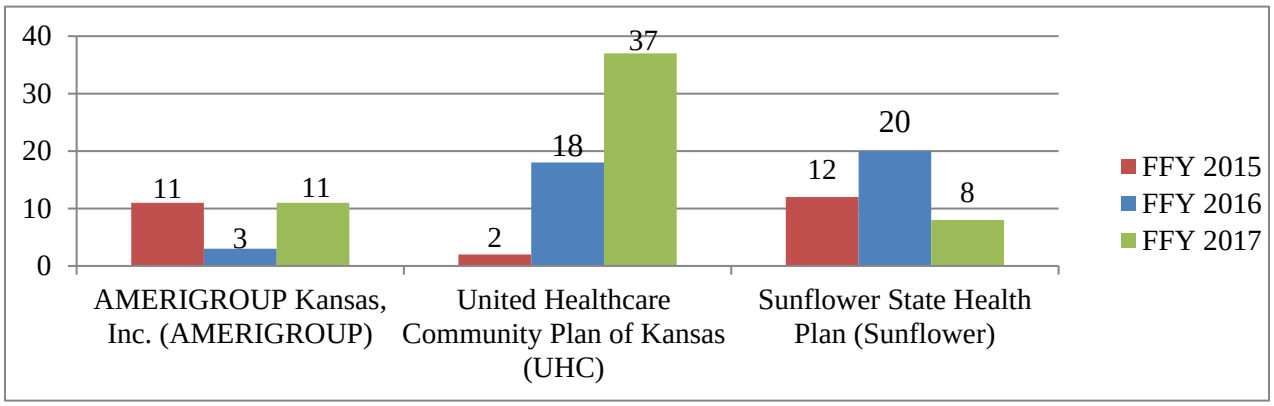
Sunflower, utilizes Centene's nationally based SIU to address member complaints and perform provider oversight of suspected provider fraud or abuse. The SIU conducts meetings with Sunflower's Compliance Officer as needed on a daily and weekly basis and have monthly meetings. Quarterly SIU/Compliance meeting, monthly SIU workgroup, and monthly roundtable meetings are held to discuss schemes across markets. When the MCO refers cases of suspected fraud to the state, a Final Investigative report in pdf form is completed and sent to KDHE/DHCF and MFCU, along with all supporting materials.

Centene created its Fraud, Waste and Abuse (FWA) Program to provide mechanisms for the prevention, detection, investigation, and recovery of suspected or actual fraud, waste, and abuse activities. The Sunflower PI unit utilizes the FWA Program by working with Centene's SIU to conduct routine audits of provider billing and coding practices to comply with Sunflower's state contract requirements and other state and Federal regulations, to include those contained in the Affordable Care Act.

All potential cases of FWA are entered into their Healthcare Fraud Shield (HCFS) system and referral calls received by the FWA hotline or customer service are also entered into a customer relationship management (CRM) system. Furthermore, the SIU has partnered with several software vendors to help identify aberrant billing patterns in the prepayment and retrospective review process, they include: Fraud Finder Pro, PostShield, CaseShield, QueryShield, SIRIS, and PLATO. Once the billing patterns are identified by one of these vendors, the Centene SIU has responsibility to review and accept or reject the recommendation. Sunflower's President/Chief Executive Officer (CEO) has the ultimate responsibility for all FWA activities and procedures; however, the CEO delegates the daily oversight of the FWA activities to Sunflower's Vice President of Compliance. Centene's SIU has a support relationship with Sunflower's Compliance Department and oversees staff dedicated to detecting, preventing and recovering potential FWA payments. The majority of the investigative process occurs within this nationally based unit. The SIU is dedicated to all lines of business. Sunflower's subcontractors follow established reporting protocols within their functional outlines. Various mechanisms that subcontractors may use to report instances of suspected FWA may include but are not limited to; assigning cases to an SIU Investigator, utilizing the FWA Hotline or Customer Services, or by emailing Sunflower's Vendor Management or Compliance Department. Information received through these channels is subsequently communicated to the SIU directly for further review of the identified allegation.

Table 3 below reflects the number of referrals that Amerigroup Kansas, Inc., United Healthcare Community Plan of Kansas, and Sunflower Health Plan SIUs made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has changed over time with improved data analytic spectrums.

Table 3.



MCO Compliance Plans

The MCEs are required by contract to have a compliance plan that meets the requirements of 42 CFR 438.608 to guard against fraud and abuse. The state does have a process to review the compliance plans and programs on an annual basis.

As required by 42 CFR 438.608, the state does conduct compliance program reviews of all providers and MCEs .and communicates approval/disapproval with the MCOs.–Each MCO compliance plan was reviewed at a readiness review prior to implementation of the KanCare contract and annually thereafter. If the MCO modifies the compliance plan KDHE/DHCF must review and approve the requested changes. There is not a formal policy for this review. The compliance plan is compared to the requirements outlined in 42 CFR 438.608 and the plan must contain each of the required elements.

All of the MCOs provided the review team with a copy of their most recent compliance plans that have been submitted to the state. In accordance with 42 CFR 438.608, the review of the compliance plan revealed no issues.

Encounter Data

Each of the MCOs submits encounter data on a regular basis through the state's encounter attestation process. All claims processed are submitted as encounters to the state. Given the small number of state employees managing the program, it is critical for the state to expound on all data mining capabilities and develop algorithms for analyzing encounter data received by the MCOs.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state agency's MCE contract does not require MCE's to return overpayments recovered from providers to the State agency. However, while overpayments are not required to be returned to the state all overpayments are required to be reported.

As stated in the contract MCOs are required, when directed by KDHE, to recover overpayments made to a provider. KDHE is notified when funds are recovered, including the amounts identified to be recovered. If the payment has not been collected, KDHE or its fiscal agent, reserves the right to withhold the amount recovered from a payment otherwise owed to the MCO. In instances in which the overpayment cannot be recovered, the MCO is required to notify the state that includes an explanation for the uncollected funds

Amerigroup monitors overpayments and prepares a monthly report that comprehensively identifies all overpayments that could potentially lead to an investigation by the Cost Containment Unit (CCU) and the SIU. All recoveries are reported quarterly, to the state via the Program Integrity Activity Report. The monthly Adverse Action Report includes overpayment recoveries specifically linked to providers against whom an adverse action is taken (including repayment of overpayment as an adverse action). Recovered amounts are reported in the quarterly FWA and PI reports. The SIU continuously measures recovery goals and tracks open cases.

UHC's identified and recovered overpayments are monitored by their national SIU and the local PI manager. All instances of overpayments and appeal processes, along with appropriate documentation, collections and recovery information are tracked through a web based application, Overpayment Documentation and Accounts Receivable (ODAR). Recoveries are reported to the state on the quarterly Program Integrity Activity Report, monthly Provider Participation-Adverse Actions Report and quarterly Fraud, Waste and Abuse Report, as required by contract. UHC has experienced a decrease in their overall retrospective identified overpayments and recoveries due to a company-wide initiative to develop more comprehensive prospective review algorithms. As a result of these algorithms, UHC does not attribute this change to a decrease in the effectiveness of their retrospective review process.

Sunflower's identified and recovered overpayments are monitored by their national SIU. Centene investigators review cases for potential unbundling, upcoding, mutually exclusive procedures, incorrect procedures and/or diagnosis for member's age, duplicates, incorrect modifier usage, and other billing irregularities. They consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. Investigators issue an audit results letter to each provider upon completion of the audit, which includes a claims report that identifies all records reviewed during the audit. If the investigator determines that clinical documentation does not support the claims payment in some or all circumstances, Sunflower will seek recovery of all overpayments. Depending on the number of services provided during the review period, Sunflower may calculate the overpayment using an extrapolation methodology.

The table below shows the amount of recoveries reported by Amerigroup for the last three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	96	28	$363,176.02	$113,684.15
2016	61	34	$945,068.38.	$51,802.24
2017	7	23	$724,890.88.	$113,705.29

These amounts do not include Kansas overpayments identified and recovered from Amerigroup's broader program integrity unit that are not related to provider specific fraud and abuse investigations. For FFYs 20115-201717, Amerigroup reported a total of $7,436,392.40 in cost avoidance savings. The savings were attributed to prepayment edits implemented as a result of SIU case findings.

The table below shows the amount of recoveries reported by UHC for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	139	53	$1,234,081.68	$318,392.00
2016	172	115	$1,853,991.97	$432,741.00
2017	83	135	$3,294,122.01	$1,304,559.00

The information included in the table above includes both prospective and retrospective review activities. In cases of prospective activities, savings are included in the Total Overpayments Identified section, but initial payment was never made and therefore cannot be recovered.

The table below shows the amount of recoveries reported by Sunflower for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	0	82	$1,105,693.64	$864,106.44
2016	0	55	$1,019,871.79	$1,019,871.79
2017	0	10	$371,435.98	$371,435.98

There are no requirements to identify preliminary investigations. Sunflower has not historically tracked the number of preliminary investigations opened therefore, the preliminary investigations column in the table above reflects zero.

Payment Suspensions

In Kansas, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

KDHE instructs MCOs and vendors to establish formalized policies that address the procedures on payment suspension due to credible allegations of fraud. When a payment suspension is issued, all three MCOs are required to send PI staff copies of the suspension letter that is sent to the provider, in instances when the provider is a part of the MCO networks.

To ensure accuracy, the fiscal agent runs a quarterly claims report of the suspended providers to identify any claims/encounters which show in the MMIS as paid. If there are claims or

encounters identified, the state will send a request for information to the MCO for explanation and correction. This does not pose a risk for the state in that the state is made aware of all payment suspensions put into place.

In accordance with 42 CFR § 455.23, the MCOs suspends providers when KDHE determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless KDHE has identified in writing good cause for not suspending payments or to suspend payments only in part. The standard mechanism for notifying the MCOs is generally secured email. In addition to acting upon state directives, the MCOs are required to notify the state of all adverse actions, including payment suspension, taken internally against providers and providers contracted with their delegated vendors via the monthly Provider Participation-Adverse Actions Report.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "The contractor shall terminate contracts with any provider who's MCO Contract or Medicaid Provider Agreement has been terminated by the State. Such contract termination shall be effective 30 calendar days after notification from the State that the provider's state fair hearing rights have expired or the state fair hearing has been completed related to the Medicaid termination. The contractor shall provide written notice of the provider termination to its members assigned to such provider at least 15 days prior to the effective contract termination date. In addition, contractor's subcontractors, and members of contractor's or subcontractor's provider networks are prohibited from employing or contracting with persons or entities that State has terminated from participation in the Kansas Medicaid program."

Each of the three MCOs are required to submit the monthly Provider Participation-Adverse Actions Report, which details terminations and suspensions for cause. This information is also reported quarterly to KDHE, in conjunction with all termination, de-credentialing and disenrollment actions, both for cause and not for cause. The MCOs do not typically communicate provider trends and case specifics to other MCOs unless it is discussed during the monthly MFCU or KDHE Program Integrity meeting. When the MCOs receives provider action notifications, they perform a series of actions throughout various operational units, and in many cases also notify the contractor to also perform all necessary system activities and notifies network owners as necessary. Each MCO is required to notify and report to KDHE all actions taken in terminating a provider from the network.

Monthly, KDHE retrieved the TIBCO MFT files, and distributes, via email to its contracted MCOs, for the purpose verifying excluded and/or terminated providers. The MCOs upon receipt of the TIBCO files, are required to review and take the appropriate action. KDHEs manual review of the Medicaid State Terminations match (TIBCO) through distribution of the report to date has not yielded adverse results, however, CMS believes that strengthening the TIBCO review and attestation process, would increase oversight safeguards.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		# of Providers Terminated For Cause in Last 3 Completed FFYs	
Amerigroup Kansas, Inc.	2015 2016 2017	712 1,091 799	2015 2016 2017	87 218 137
United Healthcare Community Plan of Kansas	2015 2016 2017	1,777 6,314 5,576	2015 2016 2017	12 12 12
Sunflower Health Plan	2015 2016 2017	43 157 225	2015 2015 2017	4 66 23

Overall, the number of providers terminated for cause by all of the plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason. The MCOs do rely on the state to notify them of actions taken at the state level, against providers, before taking action.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or 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); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

All three MCOs interviewed by the review team are in compliance with all required federal database checks. All screenings are performed monthly during initial enrollment, credentialing and recredentialing. This is outlined in the MCE Provider Credentialing & Recredentialing, policy and procedure. Amerigroup credentialing and recredentialing procedure requires all delegated vendors to perform the required search of LEIE, SSDMF, NPPES, OIG/SAM, and GSA/SAM (formerly EPLS) every thirty-six months. These lists are checked for all associated names of the agency as well as the name of the institutional providers, and out of state providers that have claims on file.

All MCOs are also compliant in verifying ownership and disclosure information for the leadership and corporate board of directors, with a controlling interest greater than 5%.

Recommendations for Improvement

- The state should consider adding additional FTE's to the KDHE Medicaid Program Integrity Unit to increase the functionality and oversight potential of the department. Additional employee positions would allow the unit to take on additional PI responsibilities and improve the program.
- The state should consider establishing a minimal staffing requirement for all contracted MCOs. The requirement should also specify the minimal levels for the number of investigative staff members who are fully-dedicated to KS' Medicaid program. In addition, the state should define the frequency and level of contact it expects the local MCO staff to have with those MCO investigative staff members assigned to the program integrity activities for the state plan.
- The state should consider adding specific language to their contract that requires reporting of all identified and/or recouped overpayments from the MCOs for purposes of rate setting. This language should include specifications on terminology for identified and recouped overpayments to maintain continuity for purposes of comparison.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in the overpayments as the direct result of cost avoidance activities or proactive measures in place.
- The state should consider developing guidance that outlines an acceptable timeframe for FWA cases being investigated by MCO SIU units. This timeframe should include checkpoints to assess case progression and the inclusion of metrics on existing reporting to assess the general performance within these guidelines.
- The state should consider implementing a verification mechanism to ensure that TIBCO providers are not being included in provider networks. This could potentially be an attestation that distributed TIBCO files are being cross checked against the provider network or could be a state level control mechanism.
- The state should conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, in addition to the data mining contractually required and conducted by the MCOs. The state should require the MCOs to provide regular updates on performance improvement plans for changing algorithms and data mining updates.

Section 2: Status of Corrective Action Plan

Kansas's last CMS Program Integrity review was in March 2013, and the report for this review was issued in July 2014. The report contained 12 findings. Prior to the onsite review in July 2016, the CMS review team conducted a thorough desk review of the corrective actions taken by Kansas. It was determined that the findings of this review were found to be compliant. The corrective actions were considered compliant and the issues closed.

Technical Assistance Resources

- Use the Program Integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts.
- Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Kansas are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas 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 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 CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

Additionally, if the CMS focused review identified noteworthy and best practices in your state, they will be published and shared with others states so that they may consider those enhancements to their own State Medicaid programs.

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