Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Kentucky Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Kentucky Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Medicaid Services (DMS). The review team also conducted a telephone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Cabinet for Health and Family Services' DMS Division of Program Integrity (DMS-PI) and the Office of Inspector General (OIG), which are responsible for Medicaid program integrity in Kentucky. This report describes two noteworthy practices, three effective practices, seven regulatory compliance issues, and one vulnerability in the State's program integrity operations.

The CMS is concerned that the review identified two uncorrected partial repeat and one uncorrected repeat findings from its 2009 review of Kentucky. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

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

Overview of Kentucky's Medicaid Program

The DMS administers the Kentucky Medicaid program. As of January 1, 2012, the program served 863,751 beneficiaries, 64 percent of whom were enrolled in four managed care entities (MCEs). Kentucky requires all fee-for-service (FFS) and managed care Medicaid providers to enroll through the State Medicaid agency. As of January 1, 2011, Kentucky had 37,667 enrolled providers. Of those enrolled providers, 21,921 are providing services in MCEs. Medicaid net expenditures in Kentucky for the State fiscal year (SFY) 2011 totaled $5,695,941,830.

Medicaid Program Integrity Division

In Kentucky, the DMS-PI is the organizational component primarily dedicated to fraud and abuse activities. At the time of the review, DMS-PI had 45 full-time equivalent positions, which includes the Provider Enrollment Branch. In order to manage with limited staff, DMS-PI contracts with the Kentucky OIG for certain types of investigations. Although DMS-PI conducts some preliminary investigations, the majority of suspected provider fraud cases are investigated by the OIG. OIG is the agency responsible for determining and referring cases of credible

allegation of fraud to the MFCU. The OIG has its own fraud hotline and initiates investigations on its own. The table below represents the total number of investigations and overpayment amounts identified and collected in the last four SFYs because of program integrity activities.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2009	21	14	$1,956,877.84	$1,956,877.84
2010	15	11	$3,951,339.15	$3,951,339.15
2011	12	17	$2,649,629.54	$2,649,629.54
2012	19	10	$20,443,220.21	$20,443,220.21***

* 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, administrative, or legal disposition.
*** The State attributes this significant increase to its emphasis on increasing program integrity efforts and the Recovery Audit Contractor's (RAC) program integrity efforts.

Methodology of the Review

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

During the week of July 24, 2012, the MIG review team visited the DMS office. The team conducted interviews with numerous DMS-PI and OIG officials. To determine whether MCEs were complying with the contract provisions and other federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team met separately with DMS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Kentucky's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DMS-PI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Kentucky operates both a stand-alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. The expansion program operates under the same billing and provider enrollment policies as Kentucky's Title XIX program. The same effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion of CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

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

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified two practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Increased focus on program integrity

Although the State program integrity unit has several vacant positions and is currently under a hiring freeze, it reports that additional emphasis has been placed on program integrity efforts. Since the last CMS review, DMS-PI has hired a Medicaid Specialist who, through courses at the Medicaid Integrity Institute, has obtained her coder certification. The State has also engaged a RAC. Since the implementation of the RAC contract, from July 1, 2011 through June 30, 2012 DMS-PI has issued over 1,500 demand letters and collected $13,479,711 in improper payments. Prior to the implementation of the RAC, collections for the past four SFYs ranged from $11,666 to $401,922.

Mandatory enrollment of all FFS providers, managed care network providers, personal care services (PCS) agencies, and transportation brokers into the State Medicaid program

The State enrolls all FFS providers, managed care network providers, PCS agencies, and non-emergency medical transportation (NEMT) brokers. By having one focal point of enrollment, the Medicaid agency ensures that all provider types are subject to the same enrollment processes in which required disclosures are made, license verifications conducted and exclusion searches performed. In the 2009 MIG review, it was noted that for providers who were once deactivated or excluded from the program, the State further checks CMS' Fraud Investigation Database, the OIG fraud tracking database, the Kentucky Secretary of State's website, and the State Bureau of Prisons database when such providers seek to re-enroll in Medicaid. This standardization has eliminated essential discrepancies found in many other states, especially for providers participating in managed care networks who may be subject to different credentialing standards.

Notwithstanding the value of the centralized provider enrollment, the CMS team found issues with Kentucky's provider enrollment process during the 2012 review, which are detailed later in the report. When the identified findings are corrected, Kentucky's provider enrollment process will be strengthened.

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Kentucky reported innovative methods of checking and collecting outstanding Medicaid debt, access to the controlled substance database, and quarterly managed care meetings with State agencies involved in program integrity as effective program integrity tools.

Innovative methods of checking and collecting outstanding debt
In the 2009 MIG review, it was noted that the State agency had developed innovative techniques of checking for providers with outstanding Medicaid debt. One technique is the Application Collection process. When providers submit their annual disclosure information or try to re-enroll in Medicaid after being terminated or inactivated due to non-billing for two years, they are reviewed first for outstanding Medicaid debt. Not all accounts collected through this process are set up initially by DMS-PI. Another tool is the 270 Day Report on active providers which allows staff to review the accounts receivable database for debts which are over 270 days old in order to collect the outstanding debt. During the past three SFYs, the continued use of the Application Collection process has resulted in collections of $557,493 in SFY 2010, $532,694 in SFY 2011, and $95,470 in SFY 2012.

Additionally, Kentucky has instituted a process called the Non Court Ordered Member Collections, where they attempt to collect member Medicaid overpayments that were declined for prosecution by the courts for a variety of reasons, such as overpayments that did not meet the monetary threshold for prosecution and large caseloads. The cases in which a Medicaid overpayment is established against beneficiaries and the courts decline to prosecute, the beneficiaries are referred by the OIG to DMS-PI for administrative collection. During this process DMS-PI sends the beneficiary a Medicaid Program Violation letter stating the reason for ineligibility and the amount of the overpayment. The letter asks the beneficiary to voluntarily repay the Medicaid overpayment in full or agree to enter into a payment plan to eliminate the overpayment debt. Since SFY 2009, the administrative collections from beneficiaries totaled $49,518.

DMS access to the Prescription Drug Monitoring Program (PDMP) database
The DMS-PI has access to the Kentucky PDMP database that tracks controlled substance prescriptions dispensed within the state. The PDMP, which began in 1999, is housed within the OIG's Drug Enforcement & Professional Practices Branch (OIG-DEPP). This is a reporting system designed to be a source of information for practitioners and pharmacists as well as an investigative tool for law enforcement.

The DMS-PI sends requests to OIG-DEPP to assist with reviews for Medicaid member or provider history and prescribing or utilization patterns for a specific amount of time. The DMS-PI also uses PDMP reports for surveillance and utilization reviews. If it appears that there is an enabling provider, the provider is referred to the OIG for investigation. Based upon the final outcome of the case, a provider could be terminated.

Quarterly MCE meetings with State agencies involved in program integrity
The DMS-PI, OIG, and the MFCU staff meet quarterly with Kentucky's managed care chief compliance officers, the program integrity coordinator for the MCEs' administrative contractor, and when warranted, the Medicaid financial management and medical management staff. The meetings enable the State to monitor MCE activities closely and offer the State the opportunity to provide ongoing education and guidance to the MCEs.

Despite these meetings, the CMS review team did find a vulnerability related to the State's

oversight of the MCE program integrity activities, which is detailed later in the report.

Regulatory Compliance Issues

The CMS review team found seven regulatory compliance issues related to program integrity in Kentucky. These issues are significant and represent risk to the Kentucky Medicaid program. Ranked in order of risk to the program, these compliance issues include: not suspending Medicaid payments in cases of credible allegations of fraud, not conducting complete exclusion searches, not capturing provider disclosures, not reporting adverse actions to the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), and not providing adequate notice of exclusions.

The State does not suspend payments in cases of credible allegations of fraud and is not conforming to the regulatory performance standards.

The federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency 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 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.

Kentucky's State statute that addresses referrals to the MFCU requires raw complaints to be sent to from the Kentucky OIG to the MFCU for informational purposes at the time they are received. The MFCU made this request to ensure that it did not already have an open criminal case related to a raw complaint. During case sampling by the MIG review team, it was noted that when the MFCU recognized and accepted a raw complaint as a credible allegation of fraud, the State did not suspend payments to the provider nor was the case documented with a good cause exception not to suspend payments to a provider.

Additionally, on October 28, 2011, the DMS revised its policy for instances when OIG conducts a preliminary investigation and determines there is a credible allegation of fraud. The DMS, OIG, and MFCU are required to meet informally to discuss cases prior to making a formal referral to the MFCU. During the meetings, in cases where the MFCU determines there is a credible allegation of fraud that warrants a suspension of payments to the provider, the MFCU will issue a verbal law enforcement exception and follow up with a written notice once further investigation is done on the referral. The review team noted during sampling that cases were not documented to reflect a verbal law enforcement exception nor did they have a written notice from the MFCU. The State also failed to suspend provider payments prior to sending the referral to the MFCU. Although DMS, OIG, and MFCU are making progress with communications, the OIG was still sending cases directly to the MFCU without giving DMS the opportunity to suspend provider payments or document a good cause exception not to suspend payments when there was a credible allegation of fraud.

Furthermore, the State uses an investigative checklist which meets the CMS minimum standards for referring cases to the MFCU. However, the checklist was not always consistently used in

cases sampled by the review team. For instance, some referrals were missing addresses, payments to the provider made in the past three years, communication between the State agency and the provider, and Medicaid statutes.

Recommendations: Adhere to DMS' policies to conduct meetings with OIG and the MFCU to discuss cases prior to making a referral to the MFCU to determine if payments to the provider should be suspended or document the reason for the good cause exception for not suspending payments. Consistently implement the *CMS-MIG Performance Standard For Referrals Of Suspected Fraud From A Single State Agency To A Medicaid Fraud Control Unit* in documenting all MFCU referrals as required at 42 CFR 455.23(d).

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)

The federal 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 List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)[1] no less frequently than monthly.

The State is conducting exclusion searches of all FFS providers, PCS providers, managed care network providers, MCEs, and NEMT brokers, and persons with an ownership or control interest in the provider, agents, and managing employees of the provider against the LEIE and EPLS upon enrollment and annually, and against the LEIE on a monthly basis. However, the EPLS checks are not conducted on a monthly basis. The State has submitted a change order for the Medicaid Management Information System to include automatic exclusion checks of the EPLS.

Recommendations: Search the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay federal funds to excluded persons or entities.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

In the 2009 MIG review, the team found that Kentucky's provider enrollment application included instructions to providers not to provide a list of the board of directors if no one on the board has ownership and control interest of 5 percent or more. During the 2012 review, the team found that the provider agreement instructions had been amended to instruct providers to disclose information about officers and board members.

Kentucky's Disclosure of Ownership and Control Interest form in the provider agreement used for FFS, PCS, managed care network providers, and NEMT brokers and the Annual Disclosure of Ownership form used for MCEs do not solicit the primary business address, every business location, and P.O. Box address for corporate entities. The forms only solicit a P.O. Box number or address. In addition, both disclosure forms do not capture relationship information from persons with an ownership or controlling interest in the disclosing entity as required by the regulation. The forms only ask the applicant to list the names of any other disclosing entity in which person(s) listed on the application have ownership of other Medicare or Medicaid facilities. This limits the applicant to disclosing information only about Medicare or Medicaid facilities.

Additionally, the State has not updated the fiscal agent disclosures for persons with an ownership or controlling interest in the disclosing entity as of March 25, 2011.

Recommendations: Modify disclosure forms to capture enhanced addresses of disclosing corporate entities and the names of any other disclosing entity in which person(s) listed on the application have ownership in any other disclosing entity, not limited to Medicare or Medicaid facilities. Update the disclosures from the fiscal agent.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)

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

Kentucky's provider agreement and the Annual Disclosure of Ownership form obligate providers and MCEs to report changes in name, ownership, and address within a 35-day timeframe. However, there is no reference that providers furnish business transaction information within 35 days of the date of a request by the Secretary or the Medicaid agency. This issue remains uncorrected from the 2009 MIG review.

The managed care contracts do require, within 35 days of the date of the request, the MCEs to provide information for any subcontractors or suppliers with whom the contractor has had business transactions totaling more than $250,000 during the immediately preceding twelve month period. However, the contract incorrectly cites the regulation at 42 CFR 455.104 as the regulatory basis for this requirement.

Recommendations: Revise the provider agreement and the Annual Disclosure of Ownership form to include the business transaction information as required in 42 CFR 455.105(b). Modify the MCE contract to cite the correct regulation for this requirement. The MIG made the same recommendation in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.
The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Kentucky's disclosure forms and the provider agreement instructions ask for individuals or organizations with a direct or indirect ownership or controlling interest in the provider and the name of any agent or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX, XX of the Social Security Act or any criminal offense in this state or any other state. However, the forms failed to ask these parties to disclose criminal convictions that they have ever had or since the inception of the State's Medicaid program as specified by the regulation. Since the State is not collecting this information, such disclosures cannot be reported to the HHS-OIG, as required by the regulation.

Recommendations: Modify disclosure forms to capture the regulatory language "since the inception of the program" or add the qualifier of "ever" as required under the regulation.

The State does not report any adverse actions taken on provider applications to HHS-OIG.
The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State is notifying HHS-OIG of terminations of providers for fraud, integrity, or quality reasons. However, the State is not notifying HHS-OIG of other adverse actions such as denials or situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction in accordance with the regulation.

Recommendation: Develop procedures to notify HHS-OIG of all program integrity-related adverse actions taken on a provider's participation in the Medicaid program including denials and voluntary withdrawals to avoid a formal sanction.

The State does not provide notice of exclusion consistent with the regulation.
Under the regulation at 42 CFR 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in 1001.2005 and 1001.2006.

When initiating permissive exclusions, Kentucky does not provide notice to the State medical licensing board and the public as required by the regulation. The State maintains a list of excluded[2] providers on its website for notifying the public, beneficiaries, other providers, and other State agencies of its State-initiated excluded providers. However, the website does not inform the user of the scope or the effect of the provider exclusion as required by the regulation.

Recommendations: Develop and implement policies and procedures to ensure that the applicable medical licensure board is notified of a State-initiated exclusion. Modify the public notice on the website to include the reason for and the time frame of the exclusion so the public is aware that no Medicaid monies will be paid for services provided by excluded provider.

Vulnerabilities
The review team identified one area of vulnerability in the State's practices regarding not having adequate written policies and procedures for oversight of managed care.

Not having adequate written policies and procedures for the oversight of managed care.
Under the regulation at 42 CFR 455.13, the State Medicaid agency must have methods and criteria for identifying and investigating suspected fraud cases. The regulations prescribe additional requirements for the effective functioning of the States' Medicaid program integrity operations. Kentucky does not have written policies and procedures for program integrity functions for managed care. The shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff.

Kentucky's managed care program expanded as of November 1, 2011. The State now offers managed care services on a statewide basis. With the expansion, a new branch within DMS was created to provide oversight of the MCEs. During the review, the State was unable to provide the review team with operational policies and procedures related to oversight of managed care program integrity activities.

Recommendations: Develop and implement policies and procedures to ensure coordination and communication across the Medicaid program. Protocols addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals should include mechanisms for tracking and reporting program integrity activities.

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

CONCLUSION

The identification of seven areas of non-compliance with federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. The CMS is particularly concerned over the two uncorrected partial repeat findings and one uncorrected repeat finding. The CMS expects the State to correct them as soon as possible.

To that end, we will require Kentucky to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerability identified in this report.

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

The State of Kentucky applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity. The MIG looks forward to working with the State of Kentucky on correcting its areas of non-compliance, eliminating its area of vulnerability, and building on its effective practices.