Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Kentucky Focused Program Integrity Review

Final Report

May 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Kentucky 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 also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2012.

Background: State Medicaid Program Overview

The Cabinet for Health and Family Services (CHFS) is home to most of the state's human services and health care programs including Medicaid, the Department for Community Based Services, and the Department for Public Health. The CHFS is one of the largest agencies in state government, with nearly 8,000 full and part-time employees. The Department of Medicaid Services (DMS) is responsible for administering the Medicaid program.

As of June 2016, the Kentucky Medicaid program served approximately 1.4 million beneficiaries; Medicaid expansion members comprised 453,054 of those beneficiaries. Approximately 10 percent of the total Medicaid population, or 137,701 beneficiaries, was served on a fee-for-service (FFS) basis and the remaining 90 percent, or approximately 1.2 million beneficiaries, was enrolled in one of the five managed care organizations (MCOs). Kentucky's total Medicaid expenditures for federal fiscal year (FFY) 2015 totaled $9.5 billion, which includes FFS expenditures of $2.6 billion and MCO expenditures of $6.9 billion. The Federal Medical Assistance Percentage for Kentucky for FFY 2015 was 70.32 percent. At the time of application for Medicaid, the beneficiary is requested to choose the MCO of preference. If the beneficiary does not select an MCO, the beneficiary will be automatically assigned to one.

Methodology of the Review

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

During the week of June 13, 2016, the CMS review team visited the DMS. They conducted interviews with numerous state program integrity and managed care staff. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of 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, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 1.2 million beneficiaries, or 90 percent of the state's Medicaid population, were enrolled in five MCOs during FFY 2015. The state spent approximately $6.9 billion on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

WellCare Health Plans, Inc., (WHP) is a national company that operates Medicaid managed care programs in Florida, Georgia, Illinois, Kentucky, Hawaii, Missouri, New York, New Jersey, South Carolina, and Nebraska. The WHP is the ultimate parent of WellCare of Kentucky (WellCare). The WHP provides managed care services targeted to government-sponsored health care programs focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and for aged, blind, and disabled people. As of September 2015, WHP served approximately 3.8 million members. The WHP contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (DMS) to provide Medicaid and Kentucky Children's Health Insurance Program (KCHIP) managed care services in seven of the state's eight regions. The WHP has a special investigations unit (SIU) with one investigator physically located in Kentucky and the remaining SIU team members located at their home office in Tampa, FL. The Corporate Compliance Investigations Department is directed by a vice president who reports to the chief compliance officer. The SIU consists of 28 staff members; of that total, two and one-half FTEs are fully-dedicated to the Kentucky plan. The SIU senior director provides guidance to and supervision over two SIU managers. Additional staff located at WHP's home office include investigators, a clinical nurse, and a senior analyst.

Aetna Better Health of Kentucky (Aetna Better Health) changed its name from Coventry Health Care of Kentucky, effective November 2015. Aetna Better Health is a subsidiary of Aetna Inc. Aetna Inc. acquired Coventry Health Care, Inc., on May 7, 2013. Aetna Medicaid owns or administers Medicaid managed health care plans under the names of Aetna Better Health, Coventry Cares, and other affiliate names. The Medicaid SIU is comprised of 13 employees which include a project manager, a project lead, investigators, and analysts. The SIU provides investigative services to Medicaid health plans in Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Virginia,

West Virginia, and Texas. There is one SIU investigator dedicated to Medicaid investigations in the Kentucky plan. Currently, one data mining analyst is fully-dedicated to the Medicaid line of business and is responsible for the 16 Medicaid states. There are plans to hire an additional data analyst to assist with the Medicaid line of business.

Passport Health Plan (PHP) is a local nonprofit community-based health plan administering Kentucky Medicaid benefits. The plan has been operational in Kentucky since 1997. In 2015, PHP's program integrity unit (PIU) was managed by a subcontractor, Evolent Health. Evolent Health has five staff members that are fully-dedicated to PHP program integrity activities and are physically located in Kentucky. The Evolent Health PIU staff members include a program integrity manager, two program integrity auditors, one program integrity specialist, and a recoupment specialist. Evolent Health has contracted with Optum-Insight to conduct data mining, run algorithms, perform medical record reviews, and conduct provider onsite audits. Evolent Health reports to PHP's chief compliance officer. The PHP reported that its member enrollment had nearly doubled in the past year, due to the Medicaid expansion. The PHP contracts with specialty vendors to oversee dental, vision, behavioral health, and third party administration services; however, the scope of this review did not include these vendors.

Enrollment information for each MCO as of May 2016 is summarized below:

Table 1.

	WellCare	**Aetna Better Health**	**PHP**
Beneficiary enrollment total	442,769	273,274	288,721
Provider enrollment total	26,369	26,613	29,986
Year originally contracted	2011	2011	1997
Size and composition of SIU	28.0 FTEs	13.0 FTEs	5.0 FTEs
Number SIU FTEs fully-dedicated to state plan	2.5 FTEs	1.0 FTE	5.0 FTEs
National or Local Plan	National	National	Local

Table 2.

MCOs	**FFY 2013**	**FFY 2014**	**FFY 2015**
WellCare	$1.0 billion	$1.8 billion	$2.3 billion
Aetna Better Health	$875.3 million	$1.1 billion	$1.0 billion
PHP	$645.0 million	$1.1 billion	$1.5 billion

State Oversight of MCO Program Integrity Activities

The DMS administers the Medicaid program, and the Division of Program Quality and Outcomes (DPQO) measures, analyzes, and reports the health outcomes of Kentucky Medicaid members. The DPQO also oversees MCOs to ensure compliance with all federal and state regulations, and contract provisions. The DPQO is made up of three branches: the Disease and Case Management Branch, the Managed Care Oversight-Quality Branch, and the Managed Care Oversight Management Branch. The DPQO consists of 24 staff members.

The Division of Program Integrity (DPI) is responsible for planning, developing, and directing agency efforts to identify and prevent fraud, waste, and abuse in the Medicaid program by providers and beneficiaries. The DPI is made up of five branches: the Recovery Branch; Third Party Liability; Audit and Compliance Branch; and the Provider Licensing and Compliance Branch. The DPI is responsible for enrolling and updating information for new and existing Medicaid providers. The DPI has 46 staff members. Both the DPQO and the DPI are responsible for different oversight functions of the managed care program. During the interview with the state, it was determined that the majority of oversight functions were conducted by the DPQO; however, there were no policies and procedures or an interagency agreement outlining the responsibilities of each department.

The DMS contracts with Island Peer Review Organization, Inc., (IPRO) for external quality review organization (EQRO) services. This contract is overseen by the DMS Managed Care Oversight-Quality Branch. The EQRO vendor is responsible for handling overall quality and financial performance monitoring in Medicaid and KCHIP managed care programs to include: monitoring of the quality improvement; performance improvement projects; maintaining a data platform and system to enable all functions of the EQRO; conducting special ad hoc analysis; reporting study and analytical findings; conducting data analysis activities; assisting in the development of quality improvement action plans; and providing consultation and support to DMS and the MCOs.

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. The MCOs submit monthly reports of fraud, waste, and abuse activity to the DMS, which is then sent to the DPI for review. The contract does include language that requires the MCO to report suspected provider fraud, waste, or abuse to the MFCU. Also, DMS contract contained language requires its MCOs to conduct provider onsite visits. However, the CMS review team determined that WellCare and Aetna Better Health did not conduct the contractually required unannounced provider onsite visits to determine fraud and abuse; the PHP advised that they specify a shorter time window when conducting provider onsite visits.

Kentucky's MCO contract states that the MCO Program integrity activities of the managed care plans will be evaluated to determine if they are identifying and resolving potential fraud and abuse issues. This will include reviewing the MCO contracts and policies. The DMS is responsible for ensuring MCO compliance with federal and state rules and regulations, and with the Medicaid contract. If fraud and abuse is detected within the MCO, the case will be referred to the Office of Inspector General/Division of Audits and Investigations (OIG/DAI) for a preliminary investigation. When evidence of possible fraudulent activity is present and a full investigation is required, a referral is made from OIG/DAI to the Office of the Attorney General/ Medicaid Fraud Control Unit (OAG/MFCU) and other law enforcement agencies for full investigation as required by 42 CFR 455.15.

The DMS requires their MCOs to establish PIUs to identify fraud, waste, and abuse, and refer to the DMS any suspected fraud or abuse committed by members and providers. The DMS requires the PIU to have written policies, procedures, and standards of conduct to demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards. In addition, the DMS contract requires the MCOs to establish a compliant system to receive, investigate, and track the status of fraud, waste, and abuse complaints from members, providers, and all other sources which may be made against the contractor, providers, or members. Each MCO's PIU shall conduct a preliminary inquiry to determine the validity of the complaint, review background information and Medicaid Management Information System data, and shall not include interviews with the subject concerning an alleged instance of fraud or abuse. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute fraud or abuse, the PIU should not refer the case to OIG. However, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments. If the preliminary inquiry results in a credible allegation of fraud or abuse, the PIU shall refer the case and all supporting documentation to the OIG, and copy the DMS.

The OIG will review the referral and attached documentation, make a determination, and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report, and forward this information to the department, the PIU, or, if warranted, to the OAG/MFCU for appropriate action. Finally, if the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the DMS and the PIU of the referral. The DMS and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral.

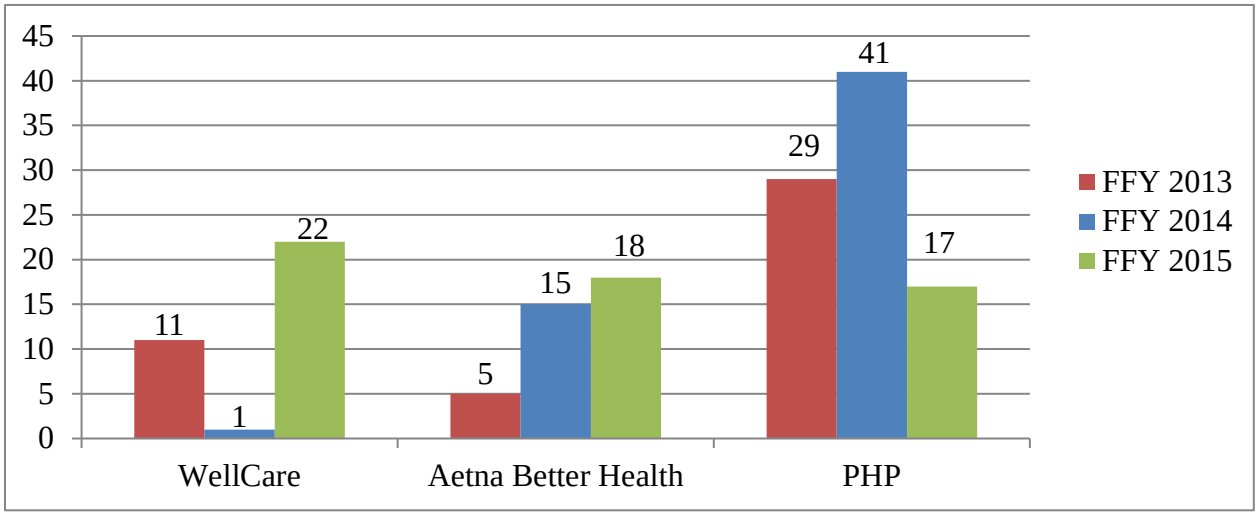
The WHP's SIU employs a senior analyst who uses data mining to proactively identify potential fraud and abuse. The senior analyst runs targeted claims queries, utilizing the *Statistical Analysis System* data network, to identify members and providers with suspicious activity or aberrant patterns of billing behavior which may indicate fraud and abuse. The SIU also uses IBM's *Cognos Analytics* business intelligence software to produce trend reports by provider specialty, and General Dynamics' *STARS Solutions* software as the fraud, waste, and abuse analytical tool. These reports include visit trend analysis and abnormal utilization by providers.

Aetna Better Health's data mining plan utilizes the Verisk Analytics' *Fraud Finder Pro* tool. This software conducts peer-to-peer analysis, as well as targeted ad hoc reports, to identify outliers for known schemes, and sends the results to the SIU daily for prepayment review. Aetna employs IBM's *Fraud and Abuse Case Management* tool to proactively identify providers exhibiting billing behavior which differs significantly from that of their peers. Providers are profiled by peer group, specialty, product, and geography.

The PHP did not have a formal case tracking system. Instead, PHP utilized an excel spreadsheet which thereby limits their ability to run queries and detailed reports. The MCO is able to track most dates when cases are opened and closed, and note if the case was reported to the state.

Table 3 lists the number of referrals that WellCare's SIU, Aetna Better Health's SIU, and PHP's SIU 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. During FFYs 2013 through FFY 2015, MCO investigations for WellCare revealed that 34 investigations were referred to the DMS. Aetna Better Health referred 38 investigations, and PHP referred 87 investigations to the state during the same time period. In addition, PHP made more than twice the number of referrals to DMS, in comparison to the other MCOs.

Table 3.



During the onsite review, sampling of case tracking revealed that there was not a standardized format for case documentation; this made it difficult to determine the exact date cases were opened and closed. Out of five files reviewed for the PHP, one case lacked detail regarding dates when the case was opened and closed; this resulted in not being able to determine the length of time spent on the investigation. The documentation also mentioned that there was a previous investigation for the provider; however, this information was not included in the case file.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs. As required by 42 CFR 438.608, the state does review the MCE's compliance plan and communicates approval/disapproval with the MCEs.

The DPQO is the state agency responsible for oversight of the managed care program and requires the MCO contractors to have policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the federal Deficit Reduction Act of 2005, which governs fraud, waste, and abuse requirements. In accordance with their required program integrity plan, DMS requires the MCOs' contractors to develop internal controls, policies, and procedures for preventing, identifying, and investigating

enrollee and provider fraud, waste, and abuse. If the DMS changes its program integrity activities, the contractor has up to six months to provide a new or revised program.

The review team reviewed the compliance plan which revealed no issues. All of the MCOs provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The DMS requires the MCO contractor to ensure that encounter data is consistent with the terms of the contract as well as all applicable state and federal laws. The MCO is required to have an automated system sufficient to accurately produce the data, reports, and encounter files in the formats and timelines prescribed by DMS's contract. The automated system should be capable of following an encounter using a unique encounter identification number for each encounter. At a minimum, the MCO should be required to electronically provide encounter files to the DMS weekly.

During the onsite interview with DMS, it was determined that all of the MCOs were submitting encounter data, as required. The DMS stated that when encounter data is inaccurate or late, a penalty is accessed. Also, DMS stated that, although encounter data is being submitted as required, the state is not currently conducting any analyses or performing any state-initiated data mining activities to identify fraud, waste, and abuse issues with MCO network providers.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. If the DMS or its delegate identifies an overpayment, the DMS will notify the provider, collect, and retain any overpayment. The DMS will instruct the contractor to recoup any outstanding overpayments owed by the provider, if the provider has exhausted all appeals and fails to pay within 60 days. Under current contract, MCOs are not required to return to state any overpaid monies discovered as a result of self-initiated investigations and audits.

Current MCO contract language states, "The contractor shall work with DMS's agent to obtain monies collected through court ordered payments. Any outstanding payments not collected within six months shall be subject to be collected by the Commonwealth and shall be maintained by the Commonwealth. The foregoing provisions shall be construed to require contractor's reasonable cooperation with the Commonwealth in its efforts to recover payments made on behalf of ineligible persons, and shall not create any liability on the part of the contractor to reimburse amounts paid due to fraud that the contractor has been unable to recover." Currently, any MCO-identified overpayments are not verified by DMS and the overpayments are not incorporated in the rate setting process.

The table below shows the respective amounts reported by WellCare for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	469	217	$0*	$16,369
2014	604	198	$1.3 million	$45,804
2015	594	284	$1.7 million	$273,903

*WellCare's SIU did not track this information during this time period.

The table below shows the respective amounts reported by Aetna Better Health for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	148	101	$15,599	$31,674
2014	70	74	$82,151	$65,589
2015	171	129	$150,512	$59,986

The table below shows the respective amounts reported by PHP for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	56	7	$575,258	$494,674
2014	64	28	$1.3 million	$1.1 million
2015	96	27	$784,922	$598,241

The WHP's program integrity activities identified approximately $3.0 million in overpayments and recovered $336,076, during the last three FFYs. Aetna Better Health**'s** program integrity activities identified $248,262 in overpayments and recovered $157,249, during the last three FFYs. The PHP**'s** program integrity activities identified approximately $2.7 million in overpayments and recovered $2.2 million, during the last three FFYs.
Overall, recoveries from program integrity activities for the MCOs showed that PHP recovered more than both WellCare and Aetna Better Health combined. The PHP recovered six and one-half times more monies than WHP, and 14 times more monies than Aetna Better Health. In FFY 2013, PHP began to track provider overpayments resulting from fraud and abuse investigations. In FFY 2014, PHP stated that the significant increase in overpayments could be attributed to one provider being paid the incorrect rate due to a rate adjustment.

Payment Suspensions

In Kentucky, 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.

The DMS had requested seven network provider payment suspensions for all five of its MCOs in the past FFY. According to DMS, when a provider is suspended, they will be suspended in all MCOs. The DMS also stated there were 151 law enforcement good cause exceptions in accordance with 42 CFR 455.23, for FFYs 2012 through 2015.

Although DMS requires all MCOs to suspend providers, WHP reported that they did not have any provider payment suspensions in the last four FFYs.

Aetna Better Health cooperates with the state when payment suspensions are imposed against Medicaid providers by the state, due to credible allegations of fraud. The MCO awaits the state's notification to suspend the provider's payments. The state sends the provider written notice that it is withholding program payments within five calendar days of the date the suspension began. The MCO contract with the state requires that the MCO suspend provider payments upon notification. Notices from the state are sent to the compliance team. The compliance team forwards the notification to the finance team. The notification is reviewed to determine whether it is a hold or release notice. The hold noticed is placed on the provider and payments will not be rendered. This escrow amount is not reported to the state, unless a request is received from the state for this information.

The PHP reported that it had issued 32 payment suspensions in the past four FFYs. During the onsite interview, the MCO reported it does not have an official policy regarding payment suspensions; however, there is language in a PHP policy which states that the plan should initiate the suspension of provider payments, when investigating a credible allegation of fraud. The plan reported that it has yet to apply this policy. During the onsite interview, the PHP revealed that it had not initiated a payment suspension; provider payments were only suspended at the request of the state. When the PIU refers a case with a credible allegation of fraud, it does not suspend the provider's payments. The plan reported that it typically has the provider's payment denied or pended, and will wait until the state suspends payments and/or will take direction from the state to suspend payments.

Terminated Providers and Adverse Action Reporting

The state MCO contract states the following:

> "The MCO shall terminate from participation any provider who engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; has a license, certification, or accreditation terminated, revoked, or suspended; has medical staff privileges at any hospital terminated, revoked, or suspended; or engages in behavior that is a danger to the health, safety, or welfare of members.
>
> The DMS shall notify the contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The contractor shall terminate the provider effective upon receipt of notice by the DMS. The contractor shall notify the DMS of termination from contractor's network taken against a provider under this subsection within three business days via email. The contractor shall indicate in its notice to DMS the reason or reasons for which the primary care physician (PCP) ceases participation.
>
> The contractor shall notify any member of the provider's termination provided such member has received a service from the terminated provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and within 30 days for any other provider. In the event a provider terminates participation with the contractor, the contractor shall notify the DMS of such termination by provider within five business days via email. In addition, the contractor will provide all terminations monthly via the Provider Termination Report. The contractor shall indicate in its notice to the DMS the reason or reasons for which the PCP ceases participation. The contractor may terminate from participation any provider who materially breaches the provider agreement with contractor and fails to timely and adequately cure such breach in accordance with the terms of the provider agreement."

In addition, DMS stated that provider terminations are reported by the MCOs to DPQO on a monthly or quarterly basis. The report identifies all active providers and providers who were disenrolled or terminated for cause. The MCOs also notify the DPI regarding any provider terminations that are related to fraud, waste, and abuse. The DMS stated that, although providers' contracts may be terminated from the MCO network, they are not automatically removed from Medicaid program without the DMS's approval.

Finally,
DMS states that there is no comprehensive process to initiate more frequent information sharing with its contracted MCOs regarding terminations, and decredentialed or disenrolled network providers.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
WellCare	2013 2014 2015	23 103 57	2013 2014 2015	23 103 57
Aetna Better Health	2013 2014 2015	477 260 296	2013 2014 2015	0 4 2
PHP	2013 2014 2015	35 49 41	2013 2014 2015	33 44 38

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 MCOs networks and compared to the number of providers disenrolled or terminated for any reason. Aetna Better Health terminations of providers for cause is low, in comparison to the number of providers who disenroll or are terminated for any reason. Both WellCare and the PHP's providers terminated for cause are proportionate with the number of providers disenrolled or terminated for any reason. The DMS requires the reporting all terminations or denials, regardless of the reason, to HHS-OIG. Also, the terminated providers are entered into TIBCO, as required.

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.

The DMS is responsible for the enrollment process for Medicaid and the managed care program and conducts checks on the above listed databases as required by 42 CFR 455.436.

Recommendations for Improvement

- The DMAS should ensure that the MCOs build program integrity units with sufficient resources and staffing commensurate with the size of their managed care programs to conduct a full range of program integrity functions including the review, investigation, auditing of provider types where Medicaid dollars are most at risk, and recovery of monies overpaid.
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- The state should develop written policies and procedures, or an interagency agreement that outlines which state unit is responsible for the various program integrity-related oversight functions.
- The state should ensure that its MCOs are in compliance with contract language requiring unannounced provider site visits. Unannounced provider site visits by the MCOs provide increased program integrity oversight, in addition to the state Medicaid agency's existing review tools.
- The state should ensure that all of its MCOs have formal case tracking systems. The case tracking system should capture opened/closed dates. A standardized tracking system would enable an MCO to run queries, produce detailed reports regarding the length of time a case remains open, and determine if the case was referred to the state.
- Continue efforts to improve the state's ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities to identify fraud, waste, and abuse activities by MCO network providers.
- The state should verify that identified and collected overpayments are fully reported by the MCOs and that they are incorporated into the rate setting process, along with the overpayments determined by state-initiated reviews.
- The state should work with the MCOs to develop policies consistent with the payment suspension requirements in the federal regulation at 42 CFR 455.23. The state should also verify that the MCOs are consistently suspending payments to providers against whom an MCO or the state documents a credible allegation of fraud. The state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate and should require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.
- Develop a comprehensive process to initiate more frequent information sharing within its contracted MCOs regarding terminations, decredentialed, or disenrolled network providers.

Section 2: Status of Corrective Action Plan

Kentucky's last CMS program integrity review was in July 2012, and the report for this review was issued in May 2013. The report contained seven findings and one vulnerability. During the onsite review in June 2016, the CMS review team conducted a thorough review of the corrective actions taken by Kentucky to address all issues reported in calendar year 2012. The findings of this review are described below.

Findings –

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

   Status at time of the review: Corrected

   - The DMS and OIG have implemented regularly scheduled monthly meetings with MFCU.
   - The DMS documents any verbal request for a law enforcement exception and retains a copy in the file.
   - Memorandum of understanding (MOU) updates related to credible allegations of fraud as required by 42 CFR 455.23; 42 CFR 455.14; and 42 CFR 455.15.
   - The OIG's draft policy and procedure manual has been updated to reflect the process of regularly scheduled meetings to discuss cases prior to making an official referral to MFCU, and included the synopsis addressing CMS' performance standards for each referral to the MFCU.

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

   Status at time of the review: Corrected

   The DMS addressed this issue and has been in compliance since October 2012. They currently conduct complete searches for individuals and entities excluded from participating in Medicaid, as required. These checks are conducted during initial enrollment, re-enrollment, and during monthly provider searches of the required databases.

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

   Status at time of the review: Corrected

   The DMS has requested an updated disclosure of ownership from the fiscal agent after the previous CMS review conducted in calendar year 2012. Currently, all applications have been updated to capture all required ownership and control disclosures information.

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

   Status at time of the review: Corrected

   The DMS has modified the disclosure of ownership and provider application to request the business transaction information required in 42 CFR 455.105(b). This information is captured on the disclosure of ownership and on the provider application

5. ***The state does not capture criminal conviction disclosures from providers or contractors.***

   Status at time of the review: Corrected

   The state now requires that the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, XX, or XXI of the Social Security Act, or any criminal offense in this state or any other state be provided.

6. ***The state does not report any adverse actions taken on provider applications to HHS/OIG.***

   Status at time of the review: Corrected

   The DMS has updated the program integrity manual to include the requirement for reporting all terminations or denials, regardless of the reason, to HHS-OIG. Currently, provider termination information is being reported by the state for entry into TIBCO.

7. ***The state does not provide notice of exclusion consistent with the regulation.***

   Status at time of the review: Corrected

   The DMS has updated the letter template to include notifying the appropriate medical licensure board, when a provider is terminated from the Kentucky Medicaid program. Additionally, DMS has updated the public notice on their website to include the reason and the time frame, if any, of the exclusion, and a statement that no Medicaid monies will be paid for services provided by the excluded provider.

Vulnerabilities

1. ***Not having adequate written policies and procedures for the oversight of managed care***

   Status at time of the review: Corrected

   Each MCO contract specifically requires the MCO to establish policies and procedures for provider enrollment to identify and investigate suspected fraud cases, and to coordinate and

communicate those efforts with DMS. The DMS approved each MCOs policies and procedures to ensure compliance, and when needed, DMS issues corrective actions. Currently, the MCOs report any cases of suspected fraud for review to DMS and OIG through the established law enforcement referral process for credible allegations of fraud. This process is contained in the program integrity manual as well as the MOU between DMS, OIG, and MFCU. To track MCO activity, DMS requires the MCOs to submit quarterly reports of their identification and investigative activities.

Technical Assistance Resources

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

- 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 Kentucky 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 and the Regional Program Integrity Directors 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.

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

CABINET FOR HEALTH AND FAMILY SERVICES
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July 21, 2017

Mark Majestic, Director
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Centers for Medicare and Medicaid Services
Department for Health and Human Services
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Dear Mr. Majestic,

The Department for Medicaid Services (Department) received your May 23, 2017 letter and the Kentucky Focused Program Integrity Review Final Report resulting from the focused review of Kentucky's Medicaid program integrity procedures and processes related to managed care conducted in June, 2016. The Department requested and received an extension until July 21, 2017 to review the findings and provide a response.

We appreciate the work of the review team and found the interaction informative and very collaborative in nature. However, the Department would like to note that while your letter and the report references deficiencies, the review only identified areas of concern and recommendations for improvement, not actual deficiencies. Further, the report did not indicate nor provide specific examples of the Department being noncompliant with any federal regulations. To that extent, the Department disagrees that its program is deficient.

The Department would also like to bring to your attention two pieces of information contained in the report that are inaccurate but were not noted in our response to the draft report. On page 3 of the report it states that Wellcare of Kentucky is in seven of the state's eight regions but, in fact, Wellcare is in all eight regions. The other information we wanted to note is on page 5 where it indicates that the Division of Program Integrity has five branches, however, the correct number of branches is four.