



Medicaid Management
And Program Integrity:
Update On Recommendations From
Three Program Review Reports

Research Report No. 404

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Medicaid Management And Program Integrity: Update On Recommendations From Three Program Review Reports

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Abstract

The Program Review and Investigations Committee adopted three reports from 2004 and 2007 that contained recommendations for Medicaid and related programs. This follow-up describes the status of the recommendations and provides current findings. The Cabinet for Health and Family Services has made progress in some areas, but some areas still need improvement. The Medicaid fraud control unit in the Office of the Attorney General has carried out its recommendations. Statutory changes have implemented some recommendations, and the General Assembly may still wish to consider others. There are lessons learned on the broad issues of program management; planning; measurement; and fraud, abuse, and waste. The report includes a brief summary and analysis of the 2011-2012 Medicaid managed care expansion plan.

Foreword

This follow-up on three previous Program Review and Investigations Committee reports builds on the work of current and former members of the Program Review staff and former officials of the executive branch and outside entities.

For the current report, Program Review staff express appreciation to officials and staff of the Cabinet for Health and Family Services' Department for Medicaid Services, Office of Inspector General, Department for Community Based Services, and Department for Income Support. These cabinet agencies and the Office of the Secretary were exemplary in the timeliness and thoroughness of their responses to numerous information requests. Staff also gratefully acknowledge the responsiveness of the Office of the Attorney General's Office of Medicaid Fraud and Abuse Control.

Staff extend thanks to the University of Kentucky's College of Pharmacy, the Utah Office of the Legislative Auditor General, the Florida Office of Program Policy Analysis and Government Accountability, the National Conference of State Legislatures, and the Centers for Medicare and Medicaid Services for their help in developing this report.

Program Review staff would like to thank their colleagues who staffed the legislative Medicaid Cost Containment Task Force for their advice and help, especially Pam Thomas, who drafted the original summary of Medicaid laws that was adapted for this report.

Robert Sherman
Director

Legislative Research Commission
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Summary And Glossary

This is a combined follow-up review of three Program Review and Investigations Committee studies related to Medicaid and covering cost containment, fraud and abuse, information systems, and related topics. The reports' 56 recommendations are updated in this follow-up.

Many of the findings in this report are based on statute or best practice, without considering budgetary or staffing limitations. The Cabinet for Health and Family Services may be unable to achieve all of them with its current resources. It will be necessary for the cabinet to prioritize and focus on areas with the greatest return on investment.

Medicaid Administration

Many reports over the past 6 years, by entities such as the federal Centers for Medicare and Medicaid Services, the Kentucky Auditor of Public Accounts, and the Program Review and Investigations Committee, expressed concern that Kentucky Medicaid has inadequate administrative staffing. That concern remains. In addition, the Department for Community Based Services appears to remain inadequately staffed despite improvements in technology and efficiency.

Another previous concern was the lack of written documentation of internal policies and procedures. The current review finds that the Department for Medicaid Services (DMS) has no formal policy or standard for creation and maintenance of written internal procedures but has made progress in documenting its procedures.

Kentucky Medicaid should measure the return on investment and outcomes of all interventions that attempt to reduce costs or improve quality of care. This is a practical requirement because all interventions come with a cost as well as potential savings, and they do not always work as anticipated. The Cabinet for Health and Family Services must prioritize limited resources, should focus on the interventions with the greatest return on investment, and should ensure that the net savings actually occur without harm to recipients. Past reviews have found little evidence of this kind of measurement, and the finding remains in the current review. Many sections of this report include examples of cost containment interventions that the cabinet should measure to determine their effectiveness both initially and over time.

Previous reports recommended that the cabinet increase the use of internal audits and investigations by the Office of Inspector General (OIG) to ensure that vendors and DMS itself are performing their tasks properly and have adequate internal controls. Medicaid is subject to audits by a variety of federal and state agencies, but a need for internal audits and reviews remains. The current review finds that DMS has taken a more active role in monitoring vendor performance, but OIG should conduct more internal audits and reviews.

The cabinet has taken action to implement aspects of many other recommendations related to Medicaid administration, such as collecting drug rebates and educating medication prescribers and dispensers. Several recommendations remain outstanding and are described in this report.

Program Integrity

Collectively, the reduction of fraud, abuse, and waste is called “program integrity.”

Much, perhaps most, fraud is difficult to detect because the perpetrators are hiding their activities. It is essential to motivate insiders, who know what is going on, to report fraud. Program Review reports in 2006 and 2007 recommended that the General Assembly consider passage of a state false claims act to provide such motivation. DMS, OIG, and the Office of the Attorney General have consistently expressed support for such an act. The current review reiterates the recommendation.

The Cabinet for Health and Family Services historically retained neither an adequate number of staff nor sufficiently qualified staff for program integrity and turned to vendors for staff and expertise. The cabinet retained three program integrity vendors since 2003 but was without a vendor for a total of 30 months since 2006. None of the vendors was instructed to look for improper payments in all types of Medicaid services at all times.

As a result, the cabinet has lost its ability to recover some improper payments older than 5 years, which may have amounted to many millions of dollars. The cabinet should ensure that the new vendor institutes an ongoing review of all Medicaid service types and should immediately request a similar historical review to prevent the loss of additional recoveries from aging claims. The cabinet also should ensure that there are no gaps between program integrity vendors in the future. When the vendor changes, the new vendor should begin work early enough to be fully productive by the time the previous contract ends.

There is consensus in the literature on fraud and abuse that it is better to prevent an improper payment than to try to recover it later. Prepayment review of claims can occur in a variety of ways, but a key element is human review of suspicious claims. Automated systems can suspend certain claims that match suspicious patterns, and health plan staff can determine whether to investigate or pay those claims. The cabinet has moved toward more prepayment reviews, and a new federal law mandates further movement. Program Review staff are concerned that point-of-sale claims adjudication, which pharmacies use almost universally, makes manual review difficult. The cabinet should attempt to implement prepayment review of pharmacy claims and should not consider point-of-service adjudication for additional providers unless it includes robust prepayment review.

Adult Medicaid recipients typically use more expensive services. The cabinet has targeted some institutionalized adults for eligibility quality control. However, the adult Medicaid eligibility error rate rose from 7.5 percent in 2004 to 10 percent in 2009, some of which might represent fraud or abuse. In 2010, the department increased the intensity of its adult Medicaid case reviews in order to identify problems and take corrective action.

To prevent ineligible applicants from receiving Medicaid, three Program Review reports recommended starting and expanding a program to investigate suspicions of fraud before the applications are approved. In 2005, the cabinet created within OIG such a program that serves Medicaid and other public assistance programs. The return on investment has been much less than the amount reported for a similar program in previous years. The cabinet should take steps to improve the returns on this program.

The working relationships among DMS, OIG, and the Office of the Attorney General's Medicaid fraud control unit have improved and appear to be functioning well. Most of the concerns about these relationships from previous reports have been addressed.

Other Recommendations Directed To The Cabinet For Health And Family Services

The cabinet has taken actions to implement several other recommendations, such as auditing pharmacies and medical providers, restricting the use of phone-in prescriptions for controlled substances, expanding the health insurance premium assistance program, and producing drug use review reports.

Cabinet action is still needed on some recommendations. For example, Medicaid continues to operate with fragmented information systems and incomplete claims data.

Recommendations Directed To The Office Of The Attorney General

The Medicaid fraud control unit within the Office of the Attorney General continues to investigate and prosecute cases of fraud and to take civil action against pharmaceutical manufacturers for price and market manipulation. The office appears to be making the fullest use of its state funds for the unit and does not need additional funding at this time. In the future, the unit's caseload might increase with greater federal emphasis on fraud detection, improved program integrity efforts by Kentucky Medicaid, and new federal regulations. Also, the unit's workload would increase if a state false claims act were passed.

Actions Of The General Assembly

The General Assembly has made statutory changes that addressed some of the recommendations. For example, statutes related to information about third-party insurance were strengthened and 2010 budget language directed the cabinet to operate the Drug Management Review Advisory Board. Some other recommendations are no longer relevant, but some recommendations remain that the General Assembly may still wish to consider.

Lessons Learned

In addition to conclusions directly related to previous recommendations, Program Review staff identified factors that may have created obstacles to efficient operation of Medicaid. Some of the factors were inability to hire health plan industry expertise, management turnover, provider and recipient resistance to cost containment interventions, failure to measure return on investment, and lack of investment in efforts to combat fraud and abuse.

Cabinet For Health And Family Services' 2011-2012 Cost Containment Plan

It seems likely that the cabinet's plan will result in several managed care organizations (MCOs) covering different types of services in different parts of the state. The plan might include statewide MCOs for pharmacy and dental services. One advantage is that the responsibility for operating the program would fall on the MCOs, including claims payment, member relations, cost containment, and possibly enrollment and certification of providers. Presumably, professional health plan managers and clinical staff would administer the MCOs, and management turnover would be less of an issue. Because the MCOs would accept the risk of limiting costs, the cabinet's budget would be more predictable. Medical home and performance-based payment models might result in cost containment.

However, the plan presents serious challenges for management, oversight, vendor capacity, information sharing and coordination, program integrity, and access to care. The cabinet probably will require additional administrative resources to oversee and monitor the contracts. The cabinet should make appropriate plans and take all necessary steps to address these challenges.

Glossary Of Terms And Usage

This section clarifies some terms and conventions used in this report.

Abuse consists of unintentional

provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2).

Affordable Care Act (ACA) is a collective term for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act taken together.

Federal financial participation (FFP) is a schedule of federal matching rates for Medicaid administrative expenses, not health service costs. The rates are the same for all states but can vary from 50 percent to 90 percent, depending on the kind of expense.

Federal medical assistance percentage (FMAP) is the federal match for Medicaid health service costs. This rate varies by state and also can vary by quarter. Kentucky's FMAP historically has been near 70 percent. During the period of the federal stimulus under the American Recovery and Reinvestment Act, Kentucky's FMAP increased approximately 10 percentage points. For most purposes, this report rounds FMAP to 70 percent without the stimulus and 80 percent with the stimulus.

Fraud consists of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

Improper payment refers to any payment that should not have been made or was made in the wrong amount. If the amount was wrong, it might have been too high or too low. Payments may be improper because of an agency error, an eligibility error, an error on the claim, or abuse or fraud by a provider or recipient.

Overpayment refers to an improper payment that either should not have been paid at all or was too high.

Waste refers to expenditures that would be unnecessary under efficient medical and fiscal management by the Medicaid program. Examples include prescriptions that could be reduced with care management and claims system payment errors that could be eliminated with correct programming. Waste includes outstanding overpayments that could be reduced or collected more quickly with better recovery methods.

Chapter 1

Overview Of Conclusions And Lessons Learned

This is a combined follow-up review of three Program Review and Investigations Committee studies related to Medicaid and covering cost containment, fraud and abuse, information systems, and related topics. The reports' 56 recommendations are updated in this follow-up.

A 2004 committee report, *Uncollected Revenues And Improper Payments Cost Kentucky Millions Of Dollars A Year* (UR), contained some recommendations related to Medicaid program integrity and cost management.^a Those recommendations foreshadowed some of the recommendations of the subsequent Medicaid studies. This follow-up will mention and briefly describe the status of the 2004 recommendations.

On June 8, 2006, the committee adopted the report, *Information Systems Can Help Prevent, But Not Eliminate, Health Care Fraud And Abuse* (IS). The report examined the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, the Medicaid management information system (MMIS), and efforts to combat fraud and abuse in the Medicaid program.

At the time, Kentucky Medicaid was in the process of modernizing the Medicaid benefit program and information systems using new vendors. It was determined that a follow-up should be deferred until the new MMIS had been operational long enough to assess its effectiveness.

On December 13, 2007, the committee adopted the report, *Medicaid Prescription Drug Benefit Fraud, Abuse, And Cost Management* (Rx). The report examined the sources of fraud and abuse in the Medicaid prescription drug benefit; the efforts being made to combat fraud and abuse, including KASPER and the MMIS; and the management of prescription drug benefit costs.

At that time, the new MMIS was not yet fully functional and Kentucky Medicaid was in the process of evaluating proposals for a new program integrity vendor. It was determined that a follow-up should be deferred again until the MMIS had been fully operational and the new program integrity vendor had been selected and in place long enough to assess the effectiveness of both.

The entities to which recommendations were directed were the

- Cabinet for Health and Family Services, including the
 - Department for Medicaid Services (DMS),
 - Office of Inspector General (OIG),
 - Department for Community Based Services (DCBS), and
 - cabinet vendors;

^a In this report, unless otherwise noted, "Medicaid" and "Kentucky Medicaid" refer to the program outside the Passport managed care region; the three previous Program Review reports are cited using the abbreviations UR, IS, and Rx.

- Medicaid fraud control unit in the Office of the Attorney General; and
- General Assembly.

Major Conclusions

Many of the findings in this report are based on statute or best practice, without considering budgetary or staffing limitations. The cabinet may be unable to achieve all of them with its current resources. It will be necessary for the cabinet to prioritize and focus on those areas with the greatest return on investment.

Chapter 2 of this follow-up report includes detailed findings regarding all of the 56 recommendations from the prior reports. The significant conclusions directly related to the recommendations are summarized below.

Appendix A is an index of the recommendations listed in their original order with a brief note of current status and the page number on which the recommendation appears in this report. Agencies and vendors involved in this follow-up report are listed in Appendix B.

Medicaid Administration

The federal Centers for Medicare and Medicaid Services, the Kentucky Auditor of Public Accounts, and the Program Review and Investigations Committee have expressed concern over the last 6 years that Kentucky Medicaid has inadequate administrative staffing. That concern remains in the current review. In addition, the Department for Community Based Services appears to remain inadequately staffed despite improvements in technology and efficiency.

Another previous concern was the lack of written documentation of internal policies and procedures. The current review finds that DMS has no formal policy or standard for creation and maintenance of written internal procedures, but the department has made progress in documenting its procedures.

Kentucky Medicaid should measure the return on investment and outcomes of all interventions that attempt to reduce costs or improve quality of care. Such measurement is a practical requirement because all interventions come with a cost as well as potential savings, and they do not always work as anticipated. The Cabinet for Health and Family Services must prioritize limited resources, should focus on the interventions with the greatest return on investment, and should ensure that the net savings actually occur without harm to recipients. Past reviews have found little evidence of this kind of measurement, and the finding remains in the current review. Many sections of this report include examples of cost-containment interventions that the cabinet should measure to determine their effectiveness both initially and over time.

Previous reports recommended that the cabinet increase the use of OIG internal audits and investigations to ensure that vendors and DMS itself are performing their tasks properly and have adequate internal controls. Although Medicaid is subject to audits by a variety of federal and state agencies, there remains a need for internal audits and reviews. The current review finds that

DMS has taken a more active role in monitoring vendor performance, but OIG should conduct more internal audits and reviews.

The cabinet has taken action to implement aspects of many other recommendations related to Medicaid administration, such as collecting drug rebates and educating medication prescribers and dispensers. Several recommendations remain outstanding and are described in Chapter 2.

Program Integrity

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Much, perhaps most, fraud is difficult to detect because the perpetrators are hiding their activities. It is essential to motivate insiders, who know what is going on, to report fraud. Program Review reports in 2006 and 2007 recommended that the General Assembly consider passage of a state false claims act to provide such motivation. DMS, OIG, and the Office of the Attorney General have consistently expressed support for such an act. The current review reiterates the recommendation.

The Cabinet for Health and Family Services historically retained neither an adequate number of staff nor sufficiently qualified staff for program integrity and turned to vendors for staff and expertise. The cabinet retained three program integrity vendors since 2003 but was without a vendor for a total of 30 months since 2006. None of the vendors was instructed to look for improper payments in all types of Medicaid services at all times.

As a result, the cabinet has lost its ability to recover some improper payments older than 5 years. If the cabinet is correct that the new vendor can recover more than \$32 million per year, then the cabinet may have lost many millions of dollars. The cabinet should ensure that the new vendor institutes an ongoing review of all Medicaid service types and should immediately request a similar historical review to prevent the loss of additional recoveries from aging claims. The cabinet also should ensure that there are no gaps between program integrity vendors in the future. When the vendor changes, the new vendor should begin work early enough to be fully productive by the time the previous contract ends.

The consensus in the literature on fraud and abuse is that it is better to prevent an improper payment than to try to recover it later. Prepayment review of claims can occur in a variety of ways, but a key element is human review of suspicious claims. Automated systems can suspend certain claims that match suspicious patterns, and health plan staff can determine whether to investigate or pay those claims. The cabinet has moved toward more prepayment reviews, and a new federal law mandates further movement. Program Review staff are concerned that point-of-sale claims adjudication, which pharmacies use almost universally, makes manual review difficult. The cabinet should attempt to implement prepayment review of pharmacy claims and should not consider point-of-service adjudication for additional providers unless it includes robust prepayment review.

Adult Medicaid recipients typically use more expensive services. DCBS has targeted some institutionalized adults for eligibility quality control. However, from 2004 to 2009, the adult

Medicaid eligibility error rate rose from 7.5 percent to 10 percent, some of which might represent fraud or abuse. For comparison, the overall eligibility error rate was less than 1 percent in 2007. The department recently increased the intensity of its adult Medicaid case reviews in order to identify problems and take corrective action.

To prevent ineligible applicants from receiving Medicaid, three Program Review reports recommended starting and expanding a program to investigate suspicions of fraud before the applications are approved. In 2005, the cabinet created within OIG such a program—Determining Eligibility Through Extensive Review—that serves Medicaid and other public assistance programs. Program Review and OIG staff calculated a return on investment, finding that overall the return declined after 2005 to only \$1.20 per \$1 invested in 2010. This was much less than the amount reported for a similar program in previous years. The cabinet should take steps to improve the returns on this program.

The working relationships among DMS, OIG, and the attorney general's Medicaid fraud control unit have improved and appear to be functioning well. Most of the concerns about these relationships from previous reports have been addressed.

Other Recommendations Directed To The Cabinet For Health And Family Services

The cabinet has taken actions to implement several other recommendations, such as auditing pharmacies and medical providers, restricting the use of phone-in prescriptions for controlled substances, expanding the health insurance premium assistance program, and producing drug use review reports.

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Actions Of The General Assembly

The General Assembly has made statutory changes that addressed some of the recommendations. For example, statutes related to information about third-party insurance were strengthened and 2010 budget language directed the cabinet to operate the Drug Management Review Advisory Board. Some other recommendations are no longer relevant, but some recommendations remain that the General Assembly may still wish to consider.

Lessons Learned

In addition to conclusions directly related to previous recommendations, Program Review staff made several observations based on those studies and the current follow-up. This section summarizes some of the most important lessons learned.

Medicaid Administration

Administrative Resources. Kentucky Medicaid is a multibillion-dollar health benefit plan that has struggled to achieve efficient operation. So much of its administrative effort is required for daily operations that it has had difficulty developing comprehensive strategic plans, measuring outcomes, and combating fraud and abuse. Since 2004, Kentucky's Medicaid administrative budget has remained close to 2 percent. That means almost 98 percent of funds have gone to health care, but some portion of that represents waste, abuse, and fraud that the program has been unable to address.

Two percent is much lower than comparable costs in private insurance. The US Congressional Budget Office reported that administration of employment-related insurance ranged from 7 percent to 26 percent, noting that the lower figure probably does not include some administrative tasks that large employers perform for the benefit plan (70). A health insurance actuarial consultant estimated that the average private insurance administrative costs were approximately 9 percent without premium taxes, commissions, and profit; with those factors included, the average would be almost 17 percent (Litow 7).

Management Expertise. A multibillion-dollar health insurance plan probably would choose a chief executive officer with considerable experience operating health insurance plans. Certainly, those holding key policy positions would have an extensive background in health insurance. However, state personnel rules, such as salary caps, make it difficult for any Medicaid program to hire industry leaders and experts. None of Kentucky's Medicaid commissioners since 2001 has operated a health insurance plan, although some held positions with such plans and some were involved with insurance regulation.

Management Turnover. State Medicaid programs nationally suffer frequent management turnover that challenges strategic and procedural continuity. Kentucky Medicaid has had six commissioners in the past 9 years, for an average tenure of 18 months.^b It might be worthwhile to look for management models that result in more stability.

Provider And Recipient Resistance. Medicaid has attempted to control costs in part by limiting reimbursement, but its reimbursement rates already are significantly lower than those of Medicare and private insurers. In addition, providers assert that Medicaid recipients are a difficult group, many of whom may not comply with medical advice and may miss appointments. For these reasons, many providers are reluctant to join the Medicaid program.

In some parts of Kentucky, there are few health care providers. Federal law, however, requires that Medicaid programs provide reasonable access to care for all their recipients. Any Medicaid

^b Program Review staff did not count the most recent change of commissioner in October 2010.

policy to contain costs or combat fraud and abuse can make it more difficult for honest providers to receive payment. Because providers already are dissatisfied with the program, they often threaten to leave, placing Medicaid at risk of violating federal law. Medicaid is so concerned that providers will drop out that it is reluctant to implement cost-cutting policies, tighten prepayment claims reviews, and recover improper payments aggressively.

Both providers and recipient groups turn to the governor and legislators to influence Medicaid's policies. Providers in some states also have sued Medicaid programs for insufficient reimbursement. Medicaid recipient groups can be forceful advocates and may file lawsuits if they believe the quality of, or access to, care is inadequate.

Some former Kentucky Medicaid officials expressed the opinion that providers would be more willing to work with the cabinet if the cabinet invited them into the policy-making process, and that providers could offer cost-containment solutions that the cabinet might not discover on its own. Others pointed to the importance of including recipients in the same process. The General Assembly created the Advisory Council for Medical Assistance in 1960, consisting of provider and recipient representatives, for this purpose (KRS 205.540). However, no one currently or formerly at the cabinet mentioned the council and there are no meetings listed on the cabinet's website. The cabinet should consider ways to involve providers and recipients deeply in its policy planning process, through the council or other means.

Program Review staff propose that insufficient resources, structural management limitations, and inadequate provider and recipient relations have accounted for many of the deficiencies noted by previous Program Review and Auditor of Public Accounts reports. It seems likely that these factors have made it difficult for the cabinet to sustain a strategic perspective, develop and maintain institutional knowledge, and implement aggressive cost-containment methods.

Waste, Savings, And Measurement

Despite all cost-containment efforts, Medicaid faces the same cost pressures as private health insurers. Private insurance premiums and costs continue to rise, and it seems unlikely that Medicaid could avoid similar increases. However, Medicaid should be able at least to match the cost-containment efforts of private insurers through reduction of waste, abuse, and fraud.

Waste as normally defined arises from failure to manage effectively. Any time the Medicaid agency overpays or underpays, or any time the agency fails to implement effective cost controls that are available and practical, there is waste.

The first step for effective cost containment is to bring adequate resources to bear. Using available resources, an organization has to prioritize and target its interventions to reduce waste and increase savings. Prioritization requires strategic planning and knowledge, not only about the interventions that have worked elsewhere, but also about how well each intervention is actually working here.

Only interventions with a proven positive return on investment should continue, and among those, the ones with the greatest impact on savings should receive the highest priority. Because

interventions often fail to work as intended, and even those that work for a while may become less effective, Medicaid should continually measure and regularly reassess every cost-containment effort.

Fraud And Abuse

Fraud and abuse by direct health care providers present a much larger opportunity for savings than recipient fraud and abuse.^c However, provider fraud and abuse can occur in a variety of ways, and it is difficult for a health insurer to monitor claims for all the possible schemes by all the many types of providers.

To the knowledge of Program Review staff, all state and private insurer efforts to combat provider fraud and abuse have reported significant positive returns on investment. Further, staff are unaware of any state's Medicaid program integrity effort reaching a point of diminishing returns. Rather, more effort uncovers more fraud and abuse and leads to more recoveries. With careful management, it seems advisable for Medicaid to increase its investment in postpayment fraud and abuse recovery, as quickly as possible, until there is a clear decline in recoveries per dollar spent.

Cabinet For Health And Family Services' 2011-2012 Cost-Containment Plan

On November 15, 2010, the secretary of the Cabinet for Health and Family Services appeared before the legislative Medicaid Cost Containment Task Force to present the cabinet's plan for cost containment. This section briefly summarizes some key elements of the plan and describes how the findings of the Program Review Medicaid follow-up relate to it. Appendix C provides background on state statutes that relate primarily to cost containment or expenditure reduction.

Managed Care Expansion

The secretary stated that the cabinet would issue requests for information to solicit ideas on how managed care could be implemented across the state outside the Passport region. There would be separate requests for information for managed care organizations (MCOs) to provide

- primary care, other health care, and behavioral health services;
- dental services;
- pharmacy services; and
- long-term care.

The cabinet would use the responses to the requests for information to develop and issue requests for proposals. Implementation would occur sometime in the second year of the 2011-2012 biennium.

In addition to separating MCOs by type of service, the secretary reported that the cabinet would consider plans that geographically divided the state among several MCOs. The cabinet expects

^c Price and market manipulation by pharmaceutical manufacturers has been the largest source of recoveries in the past decade, but the Department for Medicaid Services is not responsible for pursuing it. This section focuses on ways DMS can increase fraud and abuse recoveries.

there might be areas of the state that no MCO providers would agree to cover. Those areas would remain in the conventional fee-for-service program.

The MCO plan would build on the medical home concept that assigns each recipient to a primary care provider who is responsible for coordinating that recipient's care. The plan also would have incentives called "pay for performance" to reward providers that exceed predetermined benchmarks in areas such as preventive health screenings, preventive education, and emergency room utilization rates.

Related Program Review Findings

This section is based on the assumption that the cabinet's plan is likely to result in several MCOs covering different types of services in different parts of the state. The plan might include a single statewide MCO for pharmacy services. The plan presents challenges for management, oversight, vendor quality, information sharing and coordination, program integrity, and access to care.

Advantages. The responsibility for operating the program would fall on the MCOs, including claims payment, member relations, cost containment, and possibly enrollment and certification of providers. Presumably, professional health plan managers and clinical staff would administer the MCOs, and management turnover would be less of an issue. Because the MCOs would accept the risk of limiting costs, the cabinet's budget would be more predictable. The medical home and performance-based payment models might result in cost containment.

Cabinet Administrative Capacity. It seems unlikely that the cabinet would be able to conduct adequate oversight of MCOs with its current administrative capacity. The complexity of the plan appears likely to require significant additional staff for contract monitoring and oversight. Any combination of MCOs that leaves some recipients in a fee-for-service program would require DMS to continue all its current administrative functions in addition to performing much more oversight.

Tracking Costs And Benefits. In the past, the cabinet has not made a concerted effort to measure and track the return on investment for cost-containment interventions. MCOs make this effort more difficult because they accept risk in exchange for administrative independence. Before beginning such a significant new venture, the cabinet should demonstrate how it will ensure sufficient transparency with the MCOs and how it will measure the actual savings achieved over the existing system. This is another function that might require additional administrative capacity.

Because the cabinet is considering private for-profit companies as MCOs, the question of cost and value becomes more complex. The not-for-profit Passport MCO has reported administrative costs of between 7 percent and 8 percent (Passport. 2009; Passport. "Medicaid"). As noted earlier, an industry expert estimated that private health plans averaged 17 percent when profit and other costs were included. The US Government Accountability Office found that Medicare Advantage managed care plans reported on average 12.2 percent in combined profit, administration, and marketing costs, compared to 15 percent for conventional Medicare Advantage plans (31). The Florida legislature has considered ways to limit the profits and

administrative costs of Medicaid MCOs (Saunders. “Medicaid”). The cabinet should ensure that contracts with for-profit MCOs include auditing and oversight provisions sufficient to determine their expenses and profits accurately.

Obtaining Adequate MCO Capacity. The federal focus on cost containment and program integrity means that the federal government and state governments are seeking vendors to provide similar services at the same time. There has been some concern about the capacity of the private sector to meet all these requirements simultaneously (Grantmakers 5). With such high demand, vendors may bid on dozens of requests for proposals and probably will be unable to carry out all the contracts they win. Vendors may be unable to expand their staffs quickly enough because all of them will be competing for the same pool of talent.

Information Challenges. Under this plan, one recipient might have multiple MCOs, such as a health care MCO, pharmacy MCO, and dental MCO. If so, all those MCOs will need to share information. Proper care management requires the providers in all the MCOs to have access to each recipient’s complete medical history, including all health services, no matter who provided them. In addition, each MCO needs to have this information for program integrity purposes. Because a recipient may travel or relocate and receive services from another MCO, there must be a method for the MCOs to transfer medical history and other information.

The cabinet retains the responsibility to verify all health service records from MCOs, as it currently does with Passport. The new managed care administrators probably will have their own proprietary claims information systems. It will be essential that the cabinet structure its agreements carefully so that it can receive information that is compatible with the MMIS. This information should include not only service and payment information but also any additional information that is useful for program integrity.

Program Integrity Fragmentation. Under the current arrangement, the Passport MCO is responsible for its own program integrity, including identifying and recovering improper payments resulting from fraud, abuse, and error. If there are multiple MCOs serving different regions and specializing in different services, the program integrity effort could become fragmented in a way that would hamper the effectiveness of improved technology. Effective program integrity operations require simultaneous information about all providers, recipients, and services across all service types and, preferably, all geographic areas. The cabinet should describe in detail how it will ensure the most effective program integrity before entering into any MCO contracts and should include the necessary contract provisions to implement a Medicaid-wide program integrity function.

Quality Of Care. When it began to grant managed care waivers, the Centers for Medicare and Medicaid Services recognized that the model created incentives for MCOs to limit or refuse care in order to increase revenues. Recent examples include Medicaid MCOs that limited services in Florida, Georgia, and Ohio (Saunders. “State”; US. Federal; Ohio). In Kentucky, AmeriHealth Mercy, the administrator for Passport Health Plan, settled allegations that its evidence of providing some care was not adequate but was used to receive incentive payments from Medicaid (Kentucky. Office. “AmeriHealth”).

Previous federal waivers required states to hire an external quality review organization to audit access to care for recipients under an MCO. Program Review staff assume the cabinet will have to hire a similar quality-review organization for the MCOs that implement its plan. In any case, the cabinet should take steps to ensure appropriate access to quality care.

Chapter 2

Detailed Findings

This chapter reviews all 56 recommendations related to Medicaid from the previous Program Review and Investigations Committee reports. Each section focuses on one or a group of related recommendations from those reports. Sections begin with a brief background, including the recommendations and a summary of agency responses. Sections conclude with current findings, updating the background information and adding new information when relevant. Summary lists of findings include information, conclusions, and updated recommendations.

Medicaid Administration

It appears that the Department for Medicaid Services (DMS) historically spent too little on administration and understaffed many of its functions, including the monitoring of vendors and internal performance auditing. Program Review reports found that Medicaid was stretched further by implementing a new management information system, a new prescription drug claims system, and a new administrative agent almost simultaneously.

According to a 2007 report from the Kentucky Auditor of Public Accounts,

The Department for Medicaid Services operates with an administrative budget of less than 3 percent of its benefits. Kentucky's Medicaid administrative cost has been historically in the lowest three of all states. The Cabinet's own budget request notes the Centers for Medicare and Medicaid Services has expressed concern that Kentucky's administrative costs may be "too low to provide adequate oversight and monitoring" of this program. The Cabinet for Health and Family Services has contracted with Accenture, LLP to monitor and report on its four most important contracts, but not all contracts (Kentucky. Auditor. *Medicaid* 27).

Staffing level also appeared to be an issue for the Department for Community Based Services, which processes Medicaid applications. Inadequate staffing might have resulted in improper eligibility and failure to terminate eligibility promptly upon receiving updated information.

The 2007 Program Review report on the Medicaid prescription drug benefit made the following recommendations related to staffing:

The Department for Medicaid Services should ensure that an adequate staffing resource plan is developed and maintained. To the extent possible, such planning also should be implemented by the department's vendors, both governmental and private. The Cabinet for Health and Family Services should present an adequate staffing plan in its budget proposals to the governor and the General Assembly (Rx 36).

The Department for Community Based Services should determine a staffing level adequate to ensure quality results in the Division of Family Support. The department should develop a staff retention plan to reduce turnover. To the extent that either an

adequate staffing level or a retention plan requires additional positions or funding, the department should include the needed resources in its budget requests (Rx 61).

The 2007 Program Review report also found that documentation of internal procedures was incomplete and that much institutional knowledge might be lost through Medicaid staff turnover. This finding might have been related to lack of staff to maintain documentation. The report made the following recommendation:

The Department for Medicaid Services should develop a process to ensure that the documentation of policies and procedures is comprehensive and kept up to date. The department should work with all vendors, both governmental and private, to ensure that they also maintain comprehensive and up-to-date documentation of their policies and procedures (Rx 33).

The cabinet agencies generally agreed with these recommendations. The agencies mentioned budgetary limitations and proposed streamlining and other efficiencies to reduce the need for additional staff.

Current Findings

Staffing: Department For Medicaid Services And Office Of Inspector General. At the same time that Kentucky Medicaid faces more demanding federal requirements and increasing recipient rolls, it still operates with a limited administrative budget. DMS stated that it is actively working to fill all vacant positions. However, the department acknowledged needing more administrative positions. For example, the DMS Division of Program Integrity provided Program Review staff with a work plan stating that several key positions would be added in fiscal year 2011 but that budget constraints would prevent the division from meeting all its needs. The department also stated that it would need additional staff and funding in order to carry out other Program Review recommendations, such as documenting internal procedures, conducting cost-benefit analyses for all interventions, and reviewing the claims of all types of providers. At the October 18, 2010, meeting of the Medicaid Cost Containment Task Force, an Office of Inspector General official stated that additional staff would allow the unit to accomplish more.

For its vendors, the cabinet stated that the contract monitoring process ensures that the vendors are meeting their requirements and so a separate accounting of vendor staff is unnecessary.

Program Review staff find the following:

- The Department for Medicaid Services has made efforts to determine its staffing needs but should have a narrative explanation of its staffing proposals. The department should have a formal staffing plan that it can use as a basis for budget requests.
- The cabinet remains unable to fill all needed positions in the Department for Medicaid Services and Office of Inspector General. The cabinet should present an adequate staffing plan in its budget requests to the General Assembly.
- Assuming vendor and interagency contracts adequately specify outcomes, then Program Review staff agree that appropriate contract monitoring can ensure that vendor and sister agency staffing are adequate.

Staffing: Department For Community Based Services. For DCBS, the cabinet stated that caseload and staffing reports are used to assign caseworkers to field offices. The volume of Medicaid applications has increased significantly since 2007 because of the economic downturn and additional federal requirements. In addition, numerous caseworkers retired. In September 2010, 84 of the 120 county offices had weighted caseloads greater than the cabinet's target range, and the statewide weighted caseload average was 18 percent higher than the average reported in 2007. The cabinet cited budget constraints as the reason it could not hire more caseworkers.

Budget reductions caused termination of the tuition assistance program for caseworkers. However, DCBS has nonmonetary employee recognition programs and has publicized notable employee accomplishments.

Program Review staff find the following:

- The Department for Community Based Services does not have a formal staffing resource plan. The department should have a plan that it can use as a basis for budget requests.
- Caseloads have increased, and the department has been unable to hire additional staff.
- The department has taken steps to streamline the application process and to make caseworkers more efficient, including improvements in technology.
- The department should have a formal staff retention plan.
- Staff retention efforts continue at a reduced level. Additional incentives may be needed.

Documentation. The cabinet provided information indicating that, while there is no formal policy or standard for documenting internal Medicaid procedures, there are written internal procedures in some cases and that the department is working to document its internal procedures more thoroughly based on the relative importance of each program and operation.

The cabinet pointed out that many of Medicaid's policies and operating rules are part of federal and Kentucky regulations and the State Medicaid Plan. The cabinet stated that vendor documentation is required by vendor contracts and is monitored along with other contract requirements. Program Review staff examined some samples of vendor documentation and found them commendable.

Program Review staff find the following:

- The Department for Community Based Services has maintained an exemplary set of manuals for the Division for Family Support that outlines the steps required for caseworkers to perform their jobs.
- The Department for Medicaid Services should have a formal policy or standard for creation and maintenance of written internal procedures, including a method of determining which internal procedures need to be documented.
- The department does not have documentation for all internal procedures, but most of the examples reviewed were acceptable. Examples of vendors' documentation of their own internal procedures were commendable.

- The department should have documentation for all internal procedures adequate for a new employee to perform the primary duties of the position.
- The department should have a central repository or index of internal procedure documentation that tracks the location and status of those documents and can report on them.

Measuring Cost Containment

Two previous Program Review and Investigation Committee reports and two Auditor of Public Accounts reports found that the Department for Medicaid Services did not have adequate measures to assess the effectiveness of its programs generally or of specific cost-containment interventions (IS; Rx; Kentucky. Auditor. *Assessment 72-78*; Kentucky. Auditor. *Medicaid*).

These four reports specially noted KyHealth Choices, the comprehensive Medicaid modernization effort. When first proposed in 2005, the Centers for Medicare and Medicaid Services (CMS) required states to include program evaluations. However, the Deficit Reduction Act of 2005 eliminated the need for CMS approval, and the cabinet removed the evaluation plan in 2006.

In June 2007, the department entered into a three-way contract with Eli Lilly and Comprehensive NeuroScience for a Behavioral Pharmacy Management Program. The agreement was contingent on approval from CMS, which was not obtained before the four reports were issued.

Comprehensive NeuroScience would advise physicians and other prescribers on best practices for the use of behavioral health drugs. The objectives of the program were to promote the most cost-effective use of such drugs and to improve quality of care. Eli Lilly offered to pay all costs of the program in lieu of supplemental rebates on Zyprexa, its antipsychotic medication. The contract also placed limitations on Kentucky's ability to manage antipsychotic drugs through the preferred drug list. In addition to the conflict of interest, concern was expressed that these limitations might reduce supplemental rebates on other antipsychotic medications and that the benefits of the program would be difficult to quantify.

The 2006 and 2007 Program Review reports made three recommendations.

The Department for Medicaid Services should report the following information to the Program Review and Investigations Committee by December 2006:

- What measurements will be used to determine the health improvements and cost effectiveness of the pharmacy benefit administrator? Who will conduct the assessment and when will it be done?
- What measurements will be used to determine the health improvements and cost effectiveness of the Kentucky Medicaid administrative agent? Who will conduct the assessment and when will it be done?
- What measurements will be used to determine the health improvements and cost-effectiveness of the KyHealth Choices program? Who will conduct the assessment and when will the assessment be done (IS 55-56)?

The Department for Medicaid Services should conduct a complete cost-benefit analysis of the behavioral health drug use review program, including historical trend data by drug class and the effect of the agreement on the preferred drug list and supplemental rebates. The department should ensure that a tracking system is in place to monitor the results of the program and should compare actual and expected results. The department should report to the Program Review and Investigations Committee:

- the cost-benefit analysis by September 2008 and
- the results after the 2-year program (Rx 127).

The Department for Medicaid Services should implement a comprehensive program to evaluate the performance and outcomes of Medicaid as a whole and of each vendor and each benefit program. To the extent possible, the program should attempt to measure the outcomes and calculate a return on investment for each agency and vendor activity and each benefit plan change and innovation (Rx 47).

The cabinet did not respond to the 2006 recommendation. In response to the later recommendations, the cabinet committed to creating comprehensive program evaluations for the entire Medicaid program that would include enhancing or creating evaluations of the performance of various agency contractors. These evaluations were to include an analysis of proposed versus actual savings of key program and benefit changes (Rx 189). The cabinet agreed that a cost-benefit analysis and outcome evaluation of the behavioral health drug review program were desirable but expressed concern that any delay might endanger the program (Rx 199).

Each cabinet is required to develop and submit a strategic plan and progress report along with its biennial budget request (KRS 48.810). The Auditor of Public Accounts found that the cabinet's strategic plan progress report was incomplete and recommended that the cabinet "include adequate Medicaid and KCHIP [Kentucky Children's Health Insurance Program] program descriptions and analyses of program changes and strategic plan progress" (Kentucky Auditor. *Medicaid* 30).

Current Findings

The main intent of all three recommendations was that the cabinet should measure the net changes in cost and quality of care when attempting to contain costs, increase efficiency, or improve quality. The cabinet agreed but has not achieved the intended objectives.

The cabinet did not file the reports recommended in 2006. From more recent information, it appears that the cabinet does have some measures of the effectiveness of the pharmacy benefit administrator, such as the level of generic drug substitution and estimated savings. The cabinet does not appear to have measured some other important factors, such as the effectiveness of prior authorizations, the preferred drug list, and point-of-sale messages to the pharmacist.

Because the Kentucky Medicaid administrative agent contract with First Health ended, the recommendation related to it is moot. The cabinet provided its cost justification for bringing those tasks in house, assigning some to outside entities such as Electronic Data Systems (EDS). The justification was based exclusively on the costs of the contract, additional personnel, and

modifications to the EDS contract. DMS reported that provider enrollment times improved from 90 days to less than 21 days. However, the cabinet did not provide an evaluation of the diabetes management program that was transferred to the Department for Public Health. The program has the potential to save significant Medicaid dollars and improve the quality of care, and the actual outcomes should be measured.

Although the cabinet provided Program Review staff with several examples of amounts recovered or costs avoided from various initiatives, in only a few cases did the cabinet also provide an accounting of the amounts spent—invested—to identify and recover those amounts or to identify the avoided costs. Therefore, it was not possible to calculate a return on investment. However, in the various sections of this report, staff attempted to present returns on investment whenever staff could estimate them.

Contract Monitoring. The cabinet provided examples of completed monitoring tools used for the pharmacy benefit administrator and other contracted vendors. A review of a random sampling of these documents demonstrated that the cabinet is monitoring contracts regularly. The contract monitoring process does not include cost-benefit analyses of vendor performance.

The monitoring documents generally appeared thorough and complete. There were a few cases in which the monitor's notes were insufficient to determine whether the vendor had not met a deliverable or the deliverable was no longer required. Occasionally, a monitor noted that a vendor had failed to fulfill a requirement but there was no note of corrective action.

Program Review staff did not assess how effective contract monitoring has been, and the cabinet has not performed its own cost-benefit analyses of the monitoring process. However, for such major contracts as the Medicaid management information system, monitoring may result in penalties if the vendor does not fulfill all requirements. The cabinet reported that it had recouped nearly \$3 million over 3 years, for a return on investment of over \$160 for each \$1 spent on monitoring major vendors.

Behavioral Pharmacy Management Program. After receiving approval from CMS, the program began operation in November 2008. The cabinet requested that CMS grant an extension, but CMS declined, ending the program in July 2009. CMS stated that Kentucky would have to restart the entire state plan amendment process. The cabinet indicated that staff reductions, time restrictions, and competing issues led it to drop the request.

The cabinet did not report a cost-benefit analysis of the program or a comparison of results with baseline measures as recommended. The limited information available was insufficient to demonstrate effectiveness. The shortened duration of the program could have prevented it from achieving measurable goals. The program contract and statements from the cabinet indicated an intent to measure the program's results.

Planning For Performance And Outcomes. Since 1994, Kentucky statutes, particularly KRS 205.6310 to 205.6338, have mandated that the cabinet make efforts to contain Medicaid costs. The cabinet has implemented many interventions intended to contain costs. However, the

cabinet generally has not performed adequate cost-benefit analyses to determine how well the interventions have worked.

Among the 1994 statutes, KRS 205.6336 requires the cabinet, along with the Finance and Administration Cabinet, to provide quarterly cost-containment reports to the Interim Committee on Appropriations and Revenue. The reports are to describe all the specific procedures used to achieve savings and are to explain the calculations and assumptions for each. At least since 2005, the General Assembly has included similar language in its budget bills. When asked in 2010, the cabinet stated that it intends its quarterly reports to satisfy both the statute and budget language.

In October 2007, the Cabinet for Health and Family Services (CHFS) secretary stated in testimony before the Interim Joint Committee on Health and Welfare that the reports at the time did not reflect many of the significant Medicaid cost-containment efforts. He proposed changing the content and extent of the report. In the past year, the cabinet changed the format of the reports, but they still do not list all cost-containment interventions. Notably, the reports did not list prepayment pharmacy cost avoidance, which amounted to almost \$136 million in federal FY 2009. The reports also do not explain the calculations and assumptions.

Staff review of the cabinet's statements, documents, and cost-containment reports showed that Medicaid has not followed the recommendation that it implement a comprehensive performance and outcome evaluation program. The cabinet did point to evaluations by outside agencies, such as CMS and the Kentucky auditor. A few of these evaluations could be considered program evaluations or limited audits, such as a CMS program integrity evaluation. None of them appeared to focus on cost-benefit analyses and return on investment.

The most recent strategic plan and progress report by the Cabinet for Health and Family Services is from 2007 and has a brief outline of five objectives for the Department for Medicaid Services and seven related objectives for the Office of Inspector General (Kentucky Cabinet). There should be progress reports for 2008 and 2010, but legislative Budget Review staff stated they had not received such reports. The cabinet should keep its strategic plans and progress reports up to date and should develop a more detailed strategic plan for Medicaid and related agencies, either within or separate from the cabinet-level plan required by statute.

The 2011-2012 budget bill included a requirement that the cabinet develop a plan for evaluating Medicaid benefits and efficiencies, including a cost and savings analysis, and report to the Interim Joint Committee on Health and Welfare and the Interim Joint Committee on Appropriations and Revenue by December 1, 2010. The cabinet asserted that its presentation to the Medicaid Cost Containment Task Force on November 15 satisfied the requirement. However, the testimony and handouts from that meeting did not include a plan for evaluating Medicaid benefits and efficiencies or a cost and savings analysis.

In order to meet its statutory responsibilities and to carry out the recommendations of the Program Review and Investigations Committee and the state auditor, the cabinet should design and implement evaluations of the effectiveness of every intervention intended to reduce costs, increase efficiency, or improve quality. The cabinet should report the results of its evaluations on

its cost-containment reports and should examine the results routinely as part of its strategic planning process in order to determine whether to continue, modify, or drop each intervention.

Methods Of Measuring Cost Containment. Measuring the effects of cost-containment interventions in a program as complex as Medicaid is difficult. Program Review staff asked the cabinet to suggest ways to measure cost containment. The cabinet acknowledged the complexity and suggested starting with measurements from the beginning of an intervention and comparing repeated measurements over time. The cabinet pointed out additional factors that interfere with simple comparisons and stated that the specific method would depend on the circumstances of each cost-containment item. This section summarizes some of the difficulties and possible solutions. The process also requires a significant investment of cabinet and vendor staff, which the cabinet should address as described in the section on administration.

The most common evaluation method is to compare measurements before and after the intervention. This method has many disadvantages; it is particularly poor at accounting for the effects of outside influences and interacting factors. Health care inflation is an example of an outside influence. Internally, a change in Medicaid reimbursement rates would change the cost of services and could distort comparisons of provider payments over time.

Another method uses actuarial calculations to predict what the outcomes would be without the intervention and then compares those with the results of the intervention. This method is used, for example, to assess the budget neutrality of the Medicaid managed care organization. Actuarial methods are complex and subject to errors if they do not properly account for all factors.

Experimental and quasi-experimental methods are the most reliable but are difficult to use for programs like Medicaid. There are some situations, however, that permit quasi-experimental methods. For example, when a program is piloted, such as diabetes management or behavioral health drug use review, the recipients and providers who participate in the program can be compared with similar recipients and providers outside the program.

Program Review staff find the following:

- It appears that the cabinet did not develop a formal evaluation plan for the behavioral health drug use review program. The cabinet's documents were inadequate to demonstrate the value or effectiveness of the program.
- The cabinet has some measures of the effectiveness of the pharmacy benefit administrator.
- Outside agencies, including the Centers for Medicare and Medicaid Services and the Kentucky auditor of public accounts, conduct some performance and financial reviews of the program. These reviews do not constitute the recommended cost-benefit analyses or calculations of return on investment.
- The cabinet appears to monitor most of its contracts regularly. In some cases, there have been measurable returns on this investment.
- The cabinet has conducted a cost-benefit analysis or calculated a return on investment for only a few of its contracts and cost-containment interventions.

- The cabinet should design and implement evaluations of the effectiveness of every intervention intended to reduce costs, increase efficiency, or improve quality.
 - Each evaluation should provide the best practical measurement of outcomes and return on investment, taking into account indirect and unintended consequences where possible.
 - Evaluation of an intervention should continue as long as the intervention continues, because the effectiveness can change with different circumstances.
- The cabinet's cost-containment reports under KRS 205.6336 could be improved by including all interventions and, for each intervention, the calculations and assumptions for determining the amount saved.
- The cabinet should examine outcomes and return on investment routinely in order to determine whether to continue, modify, or drop each intervention.
- The cabinet should keep its strategic plan and progress reports under KRS 48.810 up to date and should have a more detailed strategic plan for Medicaid, including related agencies.
- The cabinet should fulfill the planning and reporting requirements of HB 1 of the 2010 Extraordinary Session.

Internal Audits And Controls

When reviewed in 2004, the Department for Medicaid Services and the Office of Inspector General (OIG) had reorganized Medicaid's program integrity operation and the cabinet's internal audit function into three divisions within OIG. Two of the divisions involved internal audits and special investigations.

The Division of Audits was expected to

- audit contractors for compliance with contract terms, laws, and regulations;
- conduct performance audits to improve accountability and operational effectiveness;
- expand the review of cabinet monitoring activities; and
- perform internal audit functions to protect state funds.

The Division of Special Investigations was expected to

- revive and expand the Cooperative Review of Eligibility program,
- conduct preliminary investigations of Medicaid provider fraud and abuse, and
- perform field investigations of potential fraud in public assistance programs.

The 2004 Program Review report recommended that

The CHFS Inspector General should implement the planned expansion of audit and investigative functions and ensure the financial integrity of public benefit programs administered by the cabinet. The Inspector General should develop a method to report the results of audits and investigations. The Office of Inspector General should report to the Program Review and Investigations Committee before the 2005 session of the General Assembly all actions taken to strengthen the audit and investigative functions of the cabinet (UR 37).

The cabinet offered the following response but did not report as recommended.

In addition to the tasks already listed, the Division of Special Investigations is expected to perform the following:

- Conduct investigations of potential fraud in public assistance through desk reviews using various databases and correspondence to develop cases;
- Investigate allegations of employee malfeasance;
- Make referrals to CHFS agencies for administrative recoupment;
- Operate the statutorily required Medicaid & Welfare Fraud Hotline and disseminate hotline ... information to all parties, necessary, regulatory and otherwise;
- Serve as the law enforcement liaison for the Cabinet and make criminal referrals; and,
- Conduct investigations related to the Cabinet and its programs.

... The Office of Inspector General currently has a method in place regarding investigative and audit results (UR 131).

In its 2005 follow-up, Program Review staff reported that OIG had added about 15 new investigators and auditors for looking into suspected improprieties by providers, contractors, and cabinet personnel (Kentucky. Legislative. Staff.).

By 2006, The OIG Division of Audits became the Division of Audits and Detection. Its mission was to perform internal audits of Cabinet for Health and Family Services' programs to increase program efficiency and effectiveness and ensure program policies and procedures were being carried out. The division's transition from primarily accounting functions to internal audit activities was completed in December 2005.

Because the divisions were so new, few results were available for discussion in the 2006 report.^a The report recommended:

The Office of Inspector General should conduct a cost-benefit analysis of the initiatives of its Division of Special Investigations and its Division of Audits and Detection and report the results to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (IS 91).

The cabinet did not respond to the 2006 recommendations and did not report to the committees.

Current Findings

In 2008, the cabinet reorganized again. Program integrity functions were moved from OIG back to the Department for Medicaid Services. The remaining functions that directly or indirectly involved Medicaid were combined into the OIG's Division of Audits and Investigations. This division performs the duties of the former Division of Special Investigations and some auditing functions.

The Department for Medicaid Services performs contract monitoring using staff from multiple divisions. This contract monitoring does not reach the level of compliance audits that validate and cross-reference information, but it is a form of performance auditing.

^a The 2006 Program Review report was drafted in late 2005.

The cabinet stated that OIG has conducted audits and reviews of Medicaid at the request of that department, including an audit of Passport in 2010. Some audits of provider cost reports were done in order to confirm the costs used to set rates. These activities might constitute reviews of cabinet monitoring activities and internal audits. The cabinet provided the number of full-time equivalent staff associated with specific activities, but it was not clear how much effort went into audits of vendors and internal audits of the department itself.

Medicaid provided an accounting of contract savings based on contract monitoring and indicated that the cost was one-tenth of a full-time staff person, but this was not a routine analysis. OIG performed a special calculation of return on investment for one investigational program at the request of Program Review staff. The cabinet did not offer evidence of conducting routine cost-benefit analyses of any audit and control activities.

Kentucky Medicaid also is subject to audits, reviews, and oversight by outside entities, including the Centers for Medicare and Medicaid Services and the Kentucky auditor of public accounts. These may or may not alleviate some of the need for internal audits of vendors and of internal controls.

Program Review staff find that

- Medicaid is subject to audits by a variety of outside agencies, including federal agencies, the auditor of public accounts, and legislative committees, but there remain situations that require internal audits or reviews;
- the Office of Inspector General should conduct targeted compliance audits of vendors when appropriate;
- Medicaid's contract-monitoring activity constitutes performance auditing of vendors;
- OIG should conduct targeted performance audits of Medicaid itself when appropriate;
- OIG should conduct internal audits and reviews, in addition to those requested by Medicaid, when appropriate; and
- cabinet agencies should calculate a return on investment for audit and control activities.

Prescription Cost Containment

When Program Review staff examined the Medicaid drug benefit program in 2007, it was noted that management of prescribing practices was a significant opportunity for reducing costs. Prescribers such as physicians, dentists, and nurse practitioners represent the main access point for individuals to obtain prescription drugs. Outdated or incomplete knowledge of pharmaceutical trends and prescribing guidelines was noted as a major reason for inappropriate or inefficient prescribing (Murphy). This problem likely contributed significantly to the cost of the Medicaid prescription drug benefit. Measures needed to be taken to appropriately influence the practices and behaviors of prescribers.

Rather than rely on pharmaceutical salespersons to provide this information, "academic" or "counter" detailing programs are independent from the drug companies and provide unbiased, balanced, evidence-based information to physicians and other medical providers. These

programs use physicians, pharmacists, nurses, and other clinical professionals to present scientific evidence to medical providers (Treat 2).

Counter-detailing has been used by Medicaid programs in other states, including Michigan, Pennsylvania, and Vermont. First Health offered to provide this service when it bid on Kentucky's pharmacy benefit administrator (PBA) procurement. The cabinet chose not to include counter-detailing in the PBA contract.

The Medicare Modernization Act of 2003 required Medicare prescription drug benefit programs to include medication therapy management, a process by which pharmacists are paid to meet with patients and do a comprehensive review of all their prescribed medications. Medicaid programs are not required to provide this service, although it has the potential to improve care and reduce costs.

Department for Medicaid Services officials in 2007 expressed support for counter-detailing and medication therapy management.

Based on these findings, the 2007 Program Review report recommended:

The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine effective and acceptable education regarding best practices for prescribing and dispensing (Rx 127).

The Department for Medicaid Services should consider whether to implement counter-detailing to provide unbiased prescribing information to physicians and other prescribers. The department also should consider Medication Therapy Management by pharmacists as a means of improving care and reducing costs. If either program appears to be effective and feasible, the department should request any necessary enabling legislation and should implement the program (Rx 129).

The cabinet responded that the Office of Inspector General and the Kentucky Board of Medical Licensure had created a training program for prescribers covering board policies, guidelines regarding controlled substance prescribing, and improved use of the Kentucky All Schedule Prescription Electronic Reporting system. The cabinet was hoping to work with the Board of Pharmacy to develop a similar training program for dispensers. The cabinet also stated that DMS would evaluate the potential benefits of counter-detailing and medication therapy management.

Current Findings

In its current response to Program Review staff questions, cabinet officials stated that, to their knowledge, the Kentucky Board of Pharmacy has not altered its continuing education requirements. However, the Drug Management Review Advisory Board can recommend additional educational topics for pharmacies and prescribers.

The cabinet described efforts it is making to improve provider practices. Pharmacy audits are used as an opportunity to educate pharmacists on best practices. The pharmacy benefit

administrator uses the routine review of prescriptions claims data to identify subject areas for educating providers, including prescribers. The PBA also conducts provider workshops in various areas of the state and is considering webinars on the same subjects.

The cabinet stated that it considers counter-detailing an additional opportunity to provide prescriber and pharmacist education. However, budget constraints do not permit implementation. The cabinet stated that it continues to evaluate such programs as medication therapy management but is not moving forward with that program at present.

Program Review staff find that

- it appears that cabinet efforts have not resulted in new continuing education requirements for prescribers or dispensers,
- pharmacy audits are used as educational opportunities for dispensers,
- the pharmacy benefit administrator conducts provider education as part of its prescription claims review and through contracted provider workshops,
- the cabinet has not implemented counter-detailing or a medication therapy management program, and
- the cabinet should continue to assess whether the return on investment would make counter-detailing or medication therapy management worthwhile.

Medicaid And Medicare Part D

Many individuals are eligible for both Medicaid and Medicare; these are called “dual eligibles.” Medicare is the primary payer and Medicaid covers items and services that Medicare does not.

In 2006, Medicare began covering prescription drugs through Part D. This would have cut prescription costs to Medicaid and the states. However, Congress required states to repay the federal government for a portion of the prescription drug cost that was shifted to Medicare. This repayment is commonly referred to as the “clawback.”

Measuring Program Performance

The Medicare Part D benefit and the clawback created an accounting dilemma. Three of the traditional measures of performance are the overall cost of the program, the average cost per recipient, and the average cost per user (a recipient who actually receives a prescription in a given month). Performance is measured by comparing these numbers over time and looking at their rate of growth. It is difficult to compare Medicaid prescription drug costs before and after January 1, 2006, when Part D took effect. Part D also makes it difficult to compare Medicaid program performance with that of commercial prescription plans that are unaffected by issues such as the partial coverage of dual eligibles by both programs.

The 2007 Program Review report did not propose a solution to these difficulties. Instead, it made the following recommendation:

When measuring the performance of the Medicaid prescription drug program, the Department for Medicaid Services and all its vendors should consider the effects of

Medicare Part D and the clawback. When presenting any performance information to the public, and particularly to the General Assembly, the department should explain these effects (Rx 116).

Determining Clawback Fairness

In 2006, the Attorney General estimated that Kentucky stood to lose \$18.5 million over 5 years from the Part D clawback (Kentucky. Office. “Attorney”). Kentucky was the first state to file a lawsuit challenging the clawback. Kentucky later joined Maine, Missouri, and New Jersey in a lawsuit initiated by Texas in the US Supreme Court challenging the clawback provision. The Supreme Court refused to hear the case, leaving clawback intact (Freking).

DMS indicated that it did not have an estimate of the potential clawback overpayment. The 2007 Program Review report recommended that

The Department for Medicaid Services should estimate the amount by which the Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual eligible recipients if they were still in the Medicaid prescription drug benefit. The department should report their estimate to the Program Review and Investigations Committee by September 2008 (Rx 115).

The cabinet stated that it would add a footnote to affected reports that will explain that the removal of pharmacy payments for Medicare recipients from Medicaid expenditure reports should be considered when Medicaid performance and expenditure trends are analyzed, and that failure to adjust for this anomaly will result in erroneous conclusions (Rx 198).

The cabinet also stated that it would analyze prescription drug data to determine whether Medicare Part D, presumably including the clawback, had resulted in a net increase or decrease to the Medicaid program and that it would provide the information to LRC (Rx 198).

Current Findings

In an interview, Medicaid officials noted that they do not compare prescription drug benefit costs before 2006 with those after 2006. This avoids problems associated with the inception of Part D. Medicare also provides a low-income subsidy, so that dual eligibles have no premiums, deductibles, or coverage gap.^b This protects the Medicaid program from changes in the cost of Part D. Although Medicaid covers some medications that Part D does not, Medicaid is not obligated to expand its coverage if Medicare drops certain drugs from the Part D formulary. Therefore, there are no ongoing changes in the costs to the Medicaid program.

In response to questions from Program Review staff, the cabinet stated that it has noted in its reports that comparisons between dual eligibles and other Medicaid groups are not valid. However, the cabinet did not provide requested examples of such reports.

^b In 2010, Medicare Part D required most members to pay 100 percent of the cost of drugs after the total drug cost reached \$2,830 until the out-of-pocket expense reached \$4,550. This is commonly called the “donut hole.” The amounts vary from year to year. In 2011, the donut hole will begin at \$2,840; the upper limit will not change.

As recently as 2009, the National Governors Association asserted that the clawback probably unfairly penalized some states (13.2). However, the cabinet did not carry out the recommendation to determine the fairness of the clawback for Kentucky. The cabinet stated that such an analysis would require access to Medicare claims, which the cabinet does not have, and that it would not be of value to DMS.

Program Review staff find the following:

- The cabinet did not demonstrate having placed appropriate notations on its reports regarding the effect of Medicare Part D and clawback on cost comparisons.
- Changes in the Medicare clawback probably need not be considered when evaluating cost trends over time because the clawback does not directly affect prescription drug benefit costs.
- The cabinet did not determine whether Kentucky has paid more in clawback than it would have paid for prescription drug coverage of dual eligibles in the absence of Part D.

Prescription Drug Rebates

The Medicaid drug rebate program requires drug manufacturers to enter into a legally binding agreement with the US Department of Health and Human Services before they can receive federal funding for outpatient drugs dispensed to Medicaid recipients. The program requires drug manufacturers to provide rebates to participating state Medicaid agencies. In return, states must cover all prescription drugs manufactured by participating pharmaceutical companies.

Each quarter, the Centers for Medicare and Medicaid Services sets the minimum rebate that drug companies must provide on their products. Individual states can also negotiate supplemental rebates with the drug companies. State Medicaid programs apply this federal unit rebate amount, plus any supplemental rebates, to the number of prescription drug units dispensed and paid by Medicaid to determine the rebate due to the state. The program then bills each participating drug manufacturer for the amount owed.

At the time of Program Review's 2004 report, Kentucky Medicaid sent drug manufacturers delinquency notices on rebates at 38 days and 60 days but did not include interest on the notices. Instead, Medicaid relied on the manufacturers to calculate and pay interest. Because this practice can result in states losing interest income on outstanding drug rebate receivables, the report made the following three recommendations:

- Medicaid should actively try to collect all drug rebates and interest owed by all pharmaceutical companies, including current and backlogged amounts (UR 40).
- Medicaid should monitor interest charges on all invoices to drug manufacturers. When an invoice remains unpaid, interest charges should be assessed on the outstanding balance from the due date (UR 40).
- Medicaid should resolve disputed amounts in the backlog of drug rebate receivables. If the backlogged amounts are not collectible, they should be removed from the receivable balance to enable Medicaid to concentrate on collectible amounts due (UR 40).

The Cabinet for Health and Family Services agreed with these recommendations. However, it also noted that

Work on the aged balances has revealed that these amounts are a reflection of previously overstated and erroneous pharmacy provider billing, and incorrect data from CMS. Thus, there was little, if any, interest to assess. In addition, the resolution of an aged balance can and does often result in the Cabinet owing the manufacturer (UR 132).

At the time of Program Review's report, the cabinet had programmed the payment system to begin calculating interest on aged balances but was waiting to hire a new pharmacy benefit manager before fully implementing it. With the new vendor, the cabinet noted, "all future invoicing and collections will be handled with adequate resources and expertise, and interest will be assessed on future collections, if applicable" (UR 132).

A Program Review staff follow-up in 2005 found that the new vendor was properly processing rebates from 2004 forward, fulfilling the first two recommendations. It also found that old debts remained unresolved, in part because employees with the knowledge and experience to resolve the amounts in dispute had retired (Kentucky. Legislative. Staff. "Uncollected").

Current Findings

The cabinet said that its goal is to collect at least 95 percent of invoiced rebates within the first 90 days, a benchmark it has met or exceeded each quarter for the past 3 years. The cabinet assigns the tasks of invoicing, collecting, and resolving disputed rebates to the pharmacy benefit administrator, Magellan Medicaid Administration. The PBA sends prior-period adjustment statements with every invoice when money is due from the prior quarter. The administrator also sends dunning notices every 45, 75, and 90 days. Finally, delinquent labelers are reported to CMS and then contacted directly for a dispute resolution conference. According to cabinet officials, interest is always collected once disputed rebates are settled.

The cabinet said that Magellan continues to work disputed rebates remaining from 2004 and earlier, but only the dollar amount and not the number of drug units is known, making them difficult to resolve. All disputes that are resolved are tracked and reported to the cabinet monthly. Information from the cabinet indicated that more than \$4.5 million in back rebates was resolved from July 2008 to June 2010.

Program Review staff find that

- the pharmacy benefit administrator, Magellan Medicaid Administration, appears to be collecting drug rebates effectively and collecting interest on delinquent rebate accounts. This appears to satisfy two of the three recommendations;
- Magellan also continues to attempt to recover disputed rebate amounts from 2004 and earlier; and
- the cabinet should continue to attempt to recover the older disputed amounts unless they are not recoverable or the cost of recovery would exceed the amount recovered, at which point the cabinet should write them off.

State False Claims Act

Kentucky does not have a state false claims statute. As a result, it is likely that the state is paying fraudulent Medicaid claims that appear legitimate. Because perpetrators of fraud attempt to hide their actions and reportedly submit claims that often appear cleaner than those of their legitimate counterparts, the only effective means of detection is a whistle-blower, a person with inside knowledge.

The federal False Claims Act says that a private whistle-blower, called a “relator,” may file a civil lawsuit on behalf of the United States government (31 USC 3729 to 3733). The government has the option of intervening in the action. Whether or not the government intervenes, the relator may receive a portion of an award or settlement under the Act. Relators receive 15 percent to 30 percent of the proceeds, depending on whether the government intervened and the extent to which the relator substantially contributed to the prosecution. The Act also has provisions to protect relators from retaliation by their employers.

The Act covers false claims made to federal programs, including Medicaid. Under the Act, a plaintiff has only to prove that someone knowingly made a false claim or presented false information to obtain a payment from Medicaid. However, awards under the Act represent only federal Medicaid funds. The national organization of state Medicaid fraud control units usually attempts to negotiate a separate settlement to recover state funds, but there is no guarantee that all the state losses will be recovered. Also, the relator receives nothing from a state settlement.

The federal share is calculated according to the federal medical assistance percentage (FMAP). FMAP varies by state and over time; in addition, the federal stimulus law temporarily increased FMAP in 2009 and 2010. A typical Kentucky FMAP without the stimulus is 70 percent, meaning about 70 percent of a Medicaid claim is paid with federal funds and 30 percent with state funds. In a federal false claims case, Kentucky would attempt to negotiate a 30 percent settlement.

The Deficit Reduction Act of 2005 provided a financial incentive for states to enact false claims acts that apply to a state’s Medicaid program. The incentive is an increase of 10 percentage points in the state’s share of recoveries (42 USC 1396h). If, for example, Kentucky had a state false claims act that met federal criteria, then it would be entitled to 40 percent of the recoveries under the state act.

A state false claims statute would permit relators and state prosecutors to file lawsuits in state courts. When the state filing corresponded to a federal filing, the federal court would handle both. The relator would then receive a portion of both the federal and state shares. Based on various reports, relators’ fees seem to average 16 percent to 19 percent. To be conservative, Program Review staff used 20 percent to illustrate a relator’s fee. Accounting for the state incentive and the relator’s fee, Kentucky would recover 32 percent compared with 30 percent without a state act.

According to reports from other states, the most significant effect of a state false claims act would be the increase in cases opened. Some cases would involve providers operating primarily in Kentucky; most would be filed in conjunction with federal cases. Of the state-only cases,

some would not otherwise come to the attention of Medicaid authorities and the entire recovery would be a gain for the state.

A state with an FMAP of less than 60 percent might recover less in federal cases than it would without a false claims act. There is not enough information to determine whether the recoveries from additional state-only cases would offset the lower recoveries in federal cases for such a state.

Based on these findings, the 2006 and 2007 Program Review reports recommended:

The Office of the Attorney General's Medicaid Fraud and Abuse Control Division and the Cabinet for Health and Family Services' Office of Inspector General should work together to explore the feasibility of implementing a false claims statute in Kentucky. Issues to be considered include required staffing of all agencies, required monetary resources, and a cost-benefit analysis of implementing such a statute. The two agencies should present a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, the Health and Welfare Committee, and the Judiciary Committee (IS 96).

If it is the intent of the General Assembly to provide the most effective tools for recovering losses caused by Medicaid fraud, then after receiving input from the Office of the Attorney General and other interested parties, the General Assembly may wish to consider passage of a state false claims act that meets the requirements outlined in the Deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud (Rx 17).

In response to the 2007 recommendation, both the cabinet and the Office of the Attorney General noted that state false claims bills consistent with provisions of the Deficit Reduction Act of 2005 were filed in 2006, 2007, and 2008 but were not enacted.

Current Findings

In 2008, a letter from the Centers for Medicare and Medicaid Services clarified the return of FMAP in state-only false claims act cases. It asserted that states must repay the FMAP before deducting the relator's fee and must calculate the repayment on the total recovery, including multiple damages, penalties, and fines. CMS also suggested that states could submit a relator's fee that was directly attributable to Medicaid recoveries as an expense for federal reimbursement at the administrative rate (US. Centers. *SHO*). The administrative reimbursement rate is 50 percent.

The effect of the CMS letter is in doubt. Alabama immediately challenged the letter in court, and a federal district court decided that the letter was not enforceable because CMS did not follow the proper procedure for making a new rule (Alabama). CMS has appealed the decision. In the interim, some states have used other formulas for calculating the FMAP repayment. At least one state deducts the relator's fee first and then computes the FMAP, which is the same as the distribution illustrated above for joint federal-state cases.

Using the CMS model in a state-only case, Kentucky would begin with 40 percent of the total recovery. A relator would receive on average about 20 percent of the total recovery, but that would come entirely from Kentucky's share, reducing it to 20 percent. After submitting the relator's fee for federal reimbursement, the net state recovery would be 30 percent of the total, or the same as the state's original FMAP share. In other words, the federal incentive would exactly cancel the relator's fee. For a relator's fee under 20 percent, Kentucky would recover a greater amount; for a greater relator's fee, Kentucky would recover a lesser amount.

A state with a lower FMAP share would fare better by using the CMS model than by deducting the relator's fee from the total gross recovery. A state like Kentucky, with a higher FMAP share, would fare better using the latter approach. Appendix D illustrates this and other repayment scenarios.

When determining the value of a state act, another factor is that the relator's fee is taxable. A state could recover a portion of the fee as tax revenue, improving the return even for states with lower FMAP shares.

By the end of 2010, 27 states and the District of Columbia had false claims acts. Of these, 14 qualified for the federal Medicaid incentive. New York City and Chicago also had local false claims acts.

Congress made changes to the federal Act in 2009 and 2010.^c The Department of Health and Human Services Office of Inspector General, which determines whether state acts qualify for the incentive, has not yet determined whether the criteria for the incentive have changed. While awaiting that determination, no new state acts have been certified compliant.

Program Review staff determined that no Kentucky false claims bill was filed in 2009 or 2010. The Department for Medicaid Services and the Office of Inspector General, in response to questions from Program Review staff in 2010, said that they continued to support the implementation of a state false claims act.

In addition, the Office of the Attorney General suggested that the General Assembly may wish to fully explore whether a state false claims act should be limited to Medicaid fraud claims alone or whether it should include all expenditures of state funds. The office also asserted that any false claims act should provide for a recovery of litigation expenses, attorney fees, and penalties.

The Office of the Attorney General pointed out that a state Medicaid false claims act probably would lead to a significant number of national cases' being filed in Kentucky in parallel with filings in other states. This would permit direct access to evidence and direct recovery of Kentucky's state share. Another benefit of a state Medicaid false claims act would be the ability to pursue smaller cases that affect only Kentucky or states in the region.

Both the cabinet and the Office of the Attorney General indicated that if a state Medicaid false claims act were passed, the state would need to add sufficient staffing and funding for the two

^c Changes were made via the Fraud Enforcement and Recovery Act of 2009, the Wall Street Reform and Consumer Protection Act of 2009, and the Affordable Care Act of 2010.

entities to handle the influx of new cases. The federal government would cover 50 percent of the cost of additional cabinet staff and 75 percent for additional staff in the Office of the Attorney General. The office estimated that its fraud control unit would need to add at least

- four attorneys,
- two investigators,
- one auditor,
- one paralegal, and
- one administrative assistant.

The total cost of the fraud control unit additions was estimated to be \$700,000 per year, of which the state would pay \$175,000.

Program Review staff find the following:

- The General Assembly may still wish to consider passage of a state false claims act that meets the requirements outlined in the Deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud.
- The General Assembly may wish to fully explore whether a state false claims act should cover only Medicaid or all expenditures of state funds.
- If a state false claims act were passed,
 - the cabinet might need additional funding to support investigation of new cases, and
 - the Office of the Attorney General’s Medicaid fraud control unit might need additional staff at a cost of \$175,000 or more to the state per year.

Program Integrity Plan

The process of minimizing Medicaid fraud, abuse, and agency error is called “program integrity.” In Kentucky, several agencies and many private vendors are involved in this endeavor. However, Program Review reports in 2006 and 2007 found inadequacies in how well these various entities were coordinating their efforts.

The 2006 report noted that Medicaid fraud and abuse could happen at many different levels. As such, it was recommended that a strong fraud control strategy should be in place. Specifically, the report recommended that

The Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General should work with Medicaid contractors to develop a plan for controlling fraud against Kentucky’s Medicaid program. The plan should consider the roles of the Department for Medicaid Services, the Office of Inspector General, the Office of the Attorney General, and each relevant contractor, and should provide a timeline for implementing a cohesive fraud control strategy. The Department for Medicaid Services should report the plan to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (IS 94).

The cabinet had no formal response to this recommendation, but the Office of the Attorney General replied that it had been working with various entities to control fraud and would continue to do so. In particular, the office noted that its Division of Medicaid Fraud and Abuse

Control had worked with Office of Inspector General and Department for Medicaid Services personnel to close various loopholes in the Medicaid claims review process.

Program Review's 2007 evaluation of Kentucky Medicaid found that planning for program integrity was fragmented, in large part because there was no comprehensive written plan to help guide Kentucky Medicaid's program integrity efforts. Therefore, the 2007 Program Review report recommended that

The Department for Medicaid Services, in consultation with all involved agencies and vendors, should ensure that a comprehensive Medicaid program integrity plan is developed, maintained, and followed. The plan should delineate responsibility for all aspects of program integrity: prevention, detection, and recovery of fraud, abuse, and other overpayments related to recipients, providers, Medicaid contracts, state employees, and pharmaceutical and other medical supply manufacturers. The plan should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers (Rx 43).

The cabinet agreed with this recommendation and said that DMS and the Office of Inspector General were working on developing a more comprehensive program integrity plan. The cabinet noted that a new program integrity vendor was hired in April 2008 and would be responsible for helping agency staff develop and implement the plan.

The Office of the Attorney General also responded to the recommendation, requesting that its Medicaid fraud control unit be included in the development and implementation of the new program integrity plan.

Current Findings

The Medicaid program integrity operation was transferred from the Office of Inspector General to the Department for Medicaid Services in 2008. OIG continued to be responsible for operating the fraud and abuse hotline and investigating all allegations of fraud and abuse.

In 2010, the department provided Program Review staff with copies of current memoranda of understanding between DMS and various state agencies and of contracts between the department and private vendors involved in program integrity. These documents show well-defined relationships between DMS and the various entities involved, including lists of tasks for which each entity is responsible. A federal review commended the relationship among the agencies (US. Centers. *Kentucky* 3, 4). As described elsewhere, DMS monitors its contracts and agreements for performance.

DMS also provided the FY 2011 work plan for its Division of Program Integrity. The work plan described some of the context and the division's goals but did not constitute an overall plan. Program Review staff believe DMS would benefit from pulling these individual memoranda of understanding, contracts, and work plans into a single comprehensive program integrity plan. The plan should spell out the department's overarching goals and the role that each entity should play in achieving those goals. Such a plan and progress reports on it could be included in the cabinet's strategic planning process under KRS 48.810.

Program Review staff find the following:

- Relationships between the Department for Medicaid Services and other state agencies and private vendors involved in program integrity are well documented in agreements and contracts.
- The department regularly conducts reviews of agreements and contracts, increasing accountability.
- The department does not have a single comprehensive program integrity plan. The department should follow previous Program Review recommendations on such planning.

Program Integrity Activities

Program integrity activities are to ensure that all providers have the proper credentials, all recipients are eligible, all services are appropriate and necessary, and all claims have correct information and represent legitimate services. In Kentucky, the Department for Medicaid Services' Division of Program Integrity is responsible for these activities and for coordinating Medicaid policies that could improve care and contain costs. Previous Program Review reports focused primarily on the process of determining whether claims are correct and legitimate. Prepayment and postpayment reviews are the two methods of doing so.

Prepayment Review

The Department for Medicaid Services has several measures in place to avoid paying improper claims. All claims are subject to two types of automated checks before being paid: edits and audits. An edit uses predefined rules to verify that each claim has all the required information and that the information is valid. An audit also uses predefined rules but checks the claim for consistency with previous claims.

Edits and audits occur at different times in the adjudication process depending on the claim type. Most pharmacy claims are checked at the point of sale and are paid or denied on the spot. Most nonpharmacy claims are adjudicated in batches, sometimes days after the claim was filed, and can be paid, denied, or suspended. Suspended claims may be manually reviewed to determine whether they should be paid.

Point-of-sale and batch processing with manual review each have advantages and disadvantages. Manual review provides the most accurate assessment but can sacrifice timely processing and is expensive. Point-of-sale or point-of-service edits and audits provide immediate adjudication but with a greater potential for paying an improper claim. The 2006 Program Review report made the following recommendation, to which the agency offered no response.

The Department for Medicaid Services and the Office of Inspector General should take as aggressive a stance as possible to implement effective edits and audits and prevent improper payments. Both organizations should evaluate the benefits and disadvantages of point-of-sale claims processing versus traditional batch processing, including manual review of suspended claims (IS 53).

The 2007 Program Review report also mentioned predictive analytics, a form of fraud detection used for credit card transactions and more recently adapted for health care claims. This report made a similar recommendation; here, “concurrent detection” refers to prepayment methods, including edits, audits, and predictive analytics.

As part of its overall program integrity plan, the Department for Medicaid Services should explore ways to implement concurrent fraud, abuse, and overpayment detection within the pharmacy point-of-sale system as well as the medical-claims processing system (Rx 44).

The cabinet responded that some concurrent detection already existed in the pharmacy point-of-sale system and that Medicaid was working with the pharmacy benefit administrator to enhance reporting and detection. The cabinet also stated that the next PBA procurement would “aggressively explore” concurrent fraud and abuse detection and that a new program integrity vendor, described later in this section, would fully address the issue (Rx 188-189).

Periodically, DMS must ask the vendor in charge of the computerized claims processing system to disable an edit or audit to troubleshoot a specific problem. During this time, there is an increased chance that improper claims will not be caught. Therefore, it is essential that all claims paid while an edit or audit is disabled be flagged for reprocessing later. Given the increased potential for improper payment when an edit or audit is disabled, the 2006 Program Review report made the following recommendation, to which the agency had no response.

The Department for Medicaid Services should document and follow edit/audit management procedures that require high-level management control over any request to change or disable an edit/audit, that require immediate corrective action to reactivate the edit/audit, and that require prompt review of all affected payments and prompt recovery of all resulting improper payments (IS 53).

Postpayment Review

Although it is best to catch improper claims before they are paid, Kentucky Medicaid uses a process called surveillance and utilization review (SUR) to detect erroneously paid claims. Several vendors and agency units are involved in this process, including the

- Division of Program Integrity,
- pharmacy benefit administrator,
- Drug Management Review Advisory Board,
- Medicaid management information system (MMIS) vendor,
- SUR vendor,
- Office of Inspector General, and
- managed care organization.

The SUR process analyzes Medicaid datasets, including provider enrollment, recipient eligibility, benefit plan coverage rules, prior service authorizations, and service claims for health care. Reports produced from these analyses flag claims that might have been improperly paid and help identify providers and recipients who might be abusing or defrauding the program.

Two important parts of the SUR process are the SUR subsystem of the MMIS and the enterprise data warehouse. The SUR subsystem is designed to create reports listing providers and recipients whose services or claims are unusual. The data warehouse combines information from several information systems for detailed analysis. At the time of Program Review's 2006 report, the cabinet was in the process of overhauling the entire Medicaid program, including replacement of the existing MMIS. Because it is important that the SUR process have a broad range of data from which analysts can draw, the Program Review report recommended that,

For surveillance and utilization review, the Kentucky Medicaid administrative agent, pharmacy benefit administrator, related vendors, and the Office of Inspector General should include and analyze all available data from the MMIS and pharmacy benefit and managed care systems (IS 55).

Program Integrity Vendors

Kentucky Medicaid did not retain adequate staff to perform SUR functions and conduct overpayment recovery and collections, so the cabinet has contracted for vendors who performed these activities and provided SUR expertise. In addition to a larger number of support staff, the cabinet would have needed relatively expensive technical and clinical staff.

During the overhaul, there was an extended period during which a new vendor operated the old MMIS and the new MMIS was under construction. Even after the new MMIS began processing claims, its SUR subsystem was not functional, making the program integrity task much more difficult. Even so, there was a program integrity vendor through June 2006. The cabinet allowed the contract to lapse without a replacement vendor and did not issue another request for proposals (RFP) until October 2006. Hiring of the new vendor was delayed in part to coincide with the implementation of the new MMIS, but new federal program integrity requirements led the cabinet to cancel the RFP in October 2007 to bring it into compliance with the new rules. Therefore, the 2007 Program Review report recommended that,

As part of its overall program integrity plan, the Department for Medicaid Services should reissue a program integrity request for proposals substantially similar to the one canceled in October 2007 and award a contract as soon as it is prudent to do so. The new vendor and program integrity staff should implement as soon as possible a review of all Medicaid claims, with special priority on prescription claims submitted since June 2003 (Rx 103).

Current Findings

In 2009, the Centers for Medicare and Medicaid Services conducted a review of Kentucky's program integrity efforts. The review found several effective and innovative practices along with a few areas of noncompliance and one vulnerability (US. Centers. *Kentucky*). Some of the findings are mentioned in the following discussion.

Prepayment Review. DMS appears to be considering the importance of concurrent improper payment detection. Health Care Excel, the program integrity vendor in 2008 and 2009, drafted regulatory language for a provider prepayment review program. Although not yet in place, the program would target providers who have billing inaccuracies, which might include billing

incorrectly to maximize reimbursement, submitting claims with errors that show a lack of knowledge of DMS policies, or repeatedly violating DMS billing rules. Once flagged, providers would be placed in the program for an indefinite period and their claims would be suspended for up to 60 days for detailed review before payment.

Program integrity vendors, the Office of Inspector General, and the Office of the Attorney General have the knowledge and experience to propose improved prepayment rules. The Division of Program Integrity stated that it uses feedback from these sources to improve edits and audits. The division provided a listing of the changes proposed by various sources for FY 2010 and examples of changes being implemented.

The 2010 program integrity contract encourages the feedback process. The new vendor may propose edits and audits or other improvements to avoid costs. If DMS implements a proposal and determines that it has avoided costs, the vendor receives a contingency fee of 12.5 percent of the calculated avoidance. The vendor receives this same percentage for postpayment recovery. The cabinet stated that the fee is near the middle of a range that federal authorities have permitted.

Program Review staff question whether the fee is appropriate for cost avoidance. The vendor incurs significant staff and material costs for postpayment recovery but virtually no costs for prepayment cost avoidance. Prepayment interventions do reduce the vendor's postpayment recovery opportunities, but the vendor saves the cost of seeking those postpayment recoveries. Therefore, it seems more equitable to offset just the vendor's estimated lost profits. However, the contract appears to have safeguards to ensure that the cabinet can accurately measure the savings and can terminate the program if it is not cost effective.

Medicaid officials have told Program Review staff since 2004 that aggressive edits and audits must be balanced against the displeasure of providers. If providers perceive that too many claims are denied or that it is too difficult to meet the rules for claims payment, they sometimes threaten to withdraw from Medicaid. In addition, the Centers for Medicare and Medicaid Services has criticized Kentucky Medicaid for denying too many claims. Program Review staff have no way to evaluate the aggressiveness of DMS's efforts. However, the cabinet did provide examples of new edits and audits; these and the proposed concurrent reviews described above make a case that the cabinet is working to tighten improper payment detection.

DMS reported that its research indicated some providers were billing for more visits than permitted under a Medicaid program rule; the department implemented an edit to stop the practice. Because the MMIS was not originally programmed to enforce this rule, it is possible that there are other program rules that the MMIS does not enforce. To the extent possible, the MMIS and the PBA system should enforce all Medicaid program rules.

Program Review staff asked about concurrent fraud and abuse detection in the pharmacy point-of-sale system. The cabinet did not describe methods for prepayment detection but did assert that existing pharmacy claims edits help prevent fraud and abuse. The drug use review report for 2009 indicated avoided costs of almost \$136 million, but it was unclear what portion would be considered fraud or abuse. The cabinet indicated that it is planning to convert some of the

pharmacist messages into “hard edits” that the pharmacist cannot override; this should increase cost avoidance.

KRS 205.6316, created in 1994, requires the cabinet to include information about the patient’s medical claims history in the pharmacy point-of-sale system so that the PBA can perform a prepayment review of claims. In its response to the 2004 PBA request for proposals, First Health—now Magellan—proposed a prepayment review, but the medical information would not come from the medical claims system. Rather, the PBA system would attempt to deduce the patient’s medical conditions from the prescriptions already presented. In 2010, the cabinet stated that the PBA system still does not obtain actual medical information and that any attempt to interface MMIS data with the current PBA system would require a significant capital investment. Pharmacists can access medical claims using another online system, KyHealthNet. However, it seems unlikely that busy pharmacists would routinely use a separate system to verify a patient’s medical history.

The cabinet did not mention predictive analytics among the methods of concurrent detection being considered. Predictive analytics could build on the cabinet’s proposed prepayment review because it suspends claims based on patterns that might indicate fraud and abuse. The Small Business Jobs Act of 2010 requires states to implement predictive analytics for prepayment review of claims by 2015, including a waiver of prompt payment rules if needed (P.L. 111-240 sec. 4241).^d The 2010 program integrity contract mentions prepayment predictive modeling as an option the cabinet might choose.

DMS provided Program Review staff with written internal procedures for documenting and tracking changes to edits and audits. The written procedures were inadequate because they presented only the perspective of the MMIS vendor, did not address PBA changes, and did not adequately describe the responsibility and role of DMS management. The cabinet asserted that all changes are approved by the appropriate division director.

The cabinet stated that if an MMIS edit or audit has to be disabled, it can be set to suspend claims temporarily or to “pay and report,” meaning that the claims are paid but tracked. Any overpayments that result can be recovered by recycling them through the claims system after the edit or audit is reinstated. The cabinet stated that the PBA monitors all changes in its edits and audits and would take action to recover any overpayments from its system.

Provider enrollment is an important process for preventing fraud and abuse. The 2009 federal review found commendable both the DMS provider enrollment verification process and the DMS match between provider applications and outstanding provider overpayments. The federal report noted that in addition to providers, DMS requires billing agents and payees to sign an agreement acknowledging that they are subject to sanctions for knowingly preparing or assisting in submission of false claims. The federal review also complimented the provider agreement and regulation that permit DMS to terminate providers at will (US. Centers. *Kentucky* 4, 5).

DMS is to be commended for its efforts to improve concurrent fraud and abuse detection. The department has addressed many of the elements of previous Program Review recommendations.

^d The law gives the secretary of Health and Human Services discretion to delay implementation until 2016.

Program Review staff find that:

- The cabinet’s efforts and plans for prepayment fraud and abuse detection are commendable.
- The cabinet is considering enhanced prepayment detection of improper payments, including more aggressive edits and audits.
 - The cabinet should implement its proposed provider prepayment review program as soon as possible.
 - The cabinet has demonstrated that it receives and uses feedback from relevant sources on improving policy, edits, and audits.
 - The cabinet should ensure that the claims processing systems enforce all Medicaid program rules.
- The 2010 program integrity contract gives the vendor a percentage of costs that the cabinet determines were avoided if the cabinet adopts prepayment edits and audits proposed by the vendor. The contract appears to have some safeguards, but the percentage may be unnecessarily high.
- The provider prepayment review program recognizes that claims processing should include an option to suspend claims for manual review. Predictive analytics also requires manual prepayment review.
- The cabinet should attempt to create means for manual prepayment review in the processing of all types of claims, including point-of-sale pharmacy claims. Point-of-service adjudication should not be used for other providers unless it includes robust prepayment review.
- The cabinet reported almost \$136 million in avoided costs related to pharmacy point-of-sale processing in 2009, but it was unclear how much represented fraud or abuse.
- The cabinet is planning to prevent some pharmacy improper payments by creating edits that pharmacists cannot override, which is commendable.
- The cabinet should carry out KRS 205.6316 by creating a direct link between the pharmacy point-of-sale system and the medical claims system and requiring the pharmacy benefit administrator to include the medical claims in its prepayment drug utilization review. If such changes are not feasible, the cabinet should include these requirements in the next PBA procurement.
- Federal law requires state Medicaid programs to implement prepayment predictive analytics by 2015. In the 2010 program integrity contract, the cabinet has the option of a “predictive modeling” system that might meet the requirement.
- The Department for Medicaid Services has procedures in place for changing edits and audits that involve division-level management review and approval. The department should develop internal documentation of the change management procedure from its own perspective that covers all claims processing systems and clearly describes the responsibility and role of department management.
- The department appears to have a means to track and recover any overpayments that result from disabling or changing edits and audits.

Postpayment Review. The claims processing software and data section of this report points out that most claims information is available in a centralized data warehouse, but many important pieces of information reside elsewhere. The additional information could be important for SUR analyses. It is possible that program integrity efforts have included these data elements, but the cabinet’s reports suggest that the improper payment identification algorithms were more conventional.

It also appears that the Division of Program Integrity and its vendors have not generated a significant number of suspected fraud cases. The Office of the Attorney General indicated that it had not needed to increase its Medicaid fraud staff because of the low number of referrals. The office suggested that fraud control units in other states received a greater volume of fraud referrals from their Medicaid agencies.

Previous cabinet officials have noted that the typical methods of postpayment review were not targeted at fraud but rather at easily identified overpayments. The federal Department of Health and Human Services' Office of Inspector General noted that although Medicare recovery audit contractors had identified more than \$1 billion in overpayments, they had referred only two cases of potential fraud. The office suggested that the incentives for recovery vendors discouraged reporting of fraud. The Centers for Medicare and Medicaid Services has proposed that states require vendors to report suspicions of fraud (US. Centers. "Medicaid" 69040-69041).

Another contributing factor may be the lack of a program integrity vendor for most of the past 4 years. In addition, there were delays in the development of the new SUR subsystem of the MMIS. The old Unisys SUR subsystem was available until May 2007 but it was considered inadequate. The new SUR subsystem began operation at that time but it did not have pharmacy and managed care data included until sometime in 2008. It has since been upgraded to make it more effective.

The SUR process appears to use targeted claims reviews based on predefined indicators of suspected fraud and abuse. However, it is important that some portion of postpayment reviews be conducted on randomly selected claims because the predefined indicators may not reveal significant improper payments. Analysis of random claims can discover new indicators for use in future targeted reviews.

The PBA conducts some postpayment reviews of pharmacy claims. The PBA does have other health service claims in its data warehouse and could use them in its postpayment reviews. However, the focus of the reviews is not to identify fraud and abuse but to find patterns of drug prescribing and dispensing that could be improved through provider education.

The federal review found commendable the cabinet's data match between the MMIS and the date of death from the Office of Vital Statistics. By matching the date of death against service claims, DMS can recover and sometimes prevent improper payments for recipients after their deaths. DMS also can recover improper payments made to deceased providers. In addition, the review commended the cabinet on its use of the Kentucky All Schedule Prescription Electronic Reporting system in Medicaid program integrity (US. Centers. *Kentucky* 3-5).

Program Review staff find that:

- The surveillance and utilization review process appears not to have used all the available information from the enterprise data warehouse and other sources.
- The cabinet should ensure that the Division of Program Integrity and all other agency units and vendors that conduct postpayment reviews attempt to take full advantage of all available information related to claims and the claims submission process to identify fraud and abuse.

- The cabinet should ensure that program integrity vendors have adequate incentives to identify and refer instances of possible fraud.
- The postpayment surveillance and utilization review process should include some random claims reviews.

Vendors And Work Plan. In January 2008, the cabinet issued an RFP similar to the one for a program integrity vendor canceled in October 2007. Health Care Excel (HCE) won the contract and began work in April 2008. Kentucky Medicaid had been without such a vendor for 21 months. According to the DMS evaluation of HCE, the vendor performed well after some initial problems and was awarded an extension through December 2009.

Again, the cabinet allowed the contract to lapse without a replacement vendor. The cabinet issued a program integrity RFP in December 2009 but had to withdraw it for technical reasons. It issued another RFP in March 2010. This RFP was similar to the previous two. Ingenix, the only responding vendor, was awarded the contract in October 2010, 9 months after HCE ceased work.

The 2007 Program Review report pointed out that Kentucky Medicaid had never conducted a comprehensive review of all claims for all types of providers. This remains true. Instead, the cabinet has asked its vendors to focus on one or two types of providers at a time. Because providers are required to keep documentation for their claims for only 5 years, every provider type must be reviewed at least every 5 years to avoid losing some overpayments (907 KAR 1:672). This was especially an issue for prescription claims because they had last been reviewed in June 2003.

DMS provided a list of HCE's major provider recovery initiatives, none of which were directed at pharmacies. It appears that the cabinet did not carry out that aspect of the recommendation. Some older overpayments to pharmacies began to expire in July 2008 and continue to do so. Older overpayments are expiring for any provider group that Medicaid has not examined since 2005.

The actual recoveries reported based on HCE's work in FY 2010 were \$3.7 million. This number includes only 6 months of activity by HCE and is far below the target that the cabinet has set for Ingenix. The Ingenix benchmark is 1 percent of total Medicaid expenditures. Based on FY 2009 numbers, the target would be about \$32 million before paying the contingency fee. A higher 1.5 percent benchmark, which Utah uses, would yield a target of about \$48 million.

The target also assumes that the vendor will be able to address all major types of Medicaid service providers each year. Medicaid's complexity and the variety of providers make this a challenging task, but it is a commendable goal. If Ingenix is able to carry out such a comprehensive program, the cabinet should consider increasing the 1 percent benchmark.

Calculating return on investment is difficult because Medicaid operates on a complex blend of state and federal funds. Overall, Kentucky stands to gain \$8 for each \$1 spent on the Ingenix contingency fee for postpayment recoveries. However, assuming roughly 30 percent state funds, as will be the case after June 2011, the return on state dollars will be only \$4.80 per \$1 of state funds spent. Neither of these calculations considers any costs of the cabinet from coordinating

with the vendor, approving recoveries, processing appeals, and monitoring the contract. In addition to the total recovery benchmark, it might be useful for the cabinet to use a benchmark for program integrity contracts that measures the return based on state dollars only. Iowa does this and expects \$3.50 per \$1 of state funds, but achieved only about \$2.50 in FY 2007 (Iowa. Dept. Medicaid. *IME Performance* 47).

If it is possible to recover 1 percent of the spending on direct Medicaid services annually, then since 2006, the cabinet should have been able to recover \$20 million to \$30 million per year. Instead, the cabinet has been unable to review all provider types and, in some years, has been unable to conduct a comprehensive review of any. Because the cabinet may look for recoveries at least 5 years old, these numbers do not represent actual losses. However, they do illustrate the urgency of implementing a comprehensive SUR program. The cabinet's staffing for program integrity remains inadequate to conduct a comprehensive SUR program on its own, so it is important that program integrity vendors be retained continuously, perhaps overlapping when vendors change so that the new vendor can be productive as soon as the previous contract ends.

Cabinet staff devoted to recipient fraud and abuse exceed those allocated to provider fraud and abuse. Although vendors will furnish most of the effort on provider fraud and abuse, the cabinet might want to consider whether this is the most effective use of resources.

The Division of Program Integrity's FY 2011 work plan included the following items.

- Hiring additional staff, consisting of another nurse, an auditor who can mine data, and two staff for third-party liability work
- Encouraging the use of health information technology toward implementing federal mandates
- Noting the numerous changes to Medicaid and new program integrity requirements in the Affordable Care Act
- Carrying out cost savings measures, primarily related to third-party liability and unlikely combinations of services
- Moving the lock-in program to the division in order to increase scrutiny of recipients' benefit utilization
- With the Office of Inspector General, conducting unscheduled on-site visits of high-risk provider types such as durable medical equipment, home health, and possibly others

The work plan is commendable on several points. The division is taking appropriate steps to improve staffing. The plan accounts for upcoming changes in federal programs and rules. It also includes cost savings initiatives that have a sound basis.

Program Review staff find that:

- As recommended, in January 2008 the cabinet reissued a request for proposals for a program integrity vendor that was similar to the one it suspended in October 2007.
- The cabinet was without a program integrity vendor for 30 of the 54 months from July 2006 to December 2010.
- The Ingenix program integrity vendor contract is commendable. If Ingenix is able to achieve the 1 percent postpayment recovery goal, the cabinet should consider increasing the benchmark to at least 1.5 percent.

- The cabinet might consider an additional vendor performance benchmark based on the return of state funds rather than the total of state and federal funds. Using such a calculation, the current contract appears commendable.
- The cabinet should take steps to ensure that future program integrity procurements are initiated early enough that there are no gaps and a new vendor can be fully productive by the time the previous contract ends.
- Some overpayments to pharmacies and probably to other providers have become unrecoverable because they have aged past 5 years. The cabinet should ask Ingenix to conduct a historical review of all Medicaid service types immediately.
- The cabinet should ensure that the pharmacy benefit administrator and the program integrity vendor coordinate their claims review activities and that at least one of the vendors conducts a thorough ongoing review of pharmacy claims for fraud and abuse.
- The cabinet might consider the relative effort and return on investment for recipient versus provider fraud and abuse.
- The Division of Program Integrity's FY 2011 work plan is commendable.

Audits Of Pharmacies And Other Providers

In a 2007 Program Review report, staff interviews suggested that Kentucky and several other state Medicaid programs conducted few if any pharmacy audits. First Health, the pharmacy benefit administrator, did not bill for any audits, and it appeared that the Department for Medicaid Services had not requested any for several years. However, it is a usual and customary business practice for a commercial PBA to conduct regular pharmacy audits. In fact, officials of Passport Health Plan told staff that it conducted routine desk audits of 20 to 25 percent of its member pharmacies each year plus field audits of targeted pharmacies.

The report stated that the department should determine whether the Office of Inspector General or the PBA or both should conduct pharmacy audits. The report recommended a pharmacy audit program similar to that of Passport and commercial insurers.

The 2007 Program Review report recommended that

As part of its overall program integrity plan, the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and develop an ongoing cost-benefit analysis of the program. The department should modify the program over time to optimize costs and benefits (Rx 105).

The cabinet responded that it would modify the PBA contract if needed and would implement an audit program. The audit program would be included in the program integrity plan and would become part of the new program integrity vendor's responsibilities (Rx 196).

The Office of the Attorney General responded that the department should conduct its own audits of pharmacy claims, presumably meaning desk audits. The office appeared to imply that more aggressive auditing would find more fraud and abuse (Rx 208).

Current Findings

In June 2009, the cabinet began a pharmacy audit program. By early October 2010, the cabinet reported conducting 44 field audits and no desk audits. DMS currently requires audits of 13 to 15 point-of-sale in-state pharmacies each quarter.

The PBA is responsible for ensuring that audits are conducted and has subcontracted the task to Integrated Pharmacy Solutions. This vendor uses proprietary algorithms run against pharmacy claims data to determine which pharmacies will be audited. As of October 2010, the cabinet reported payments of \$124,960 to the PBA, approximately \$27,000 in state staff costs, and a preliminary estimate of recoveries of \$794,000, which results in a potential return on investment of nearly \$5.40 for each \$1 spent.^c Besides monetary recoveries, audits help educate pharmacies on best practices, statutes, and regulations; audits also deter fraud and abuse by other providers.

In addition to pharmacy audits, the cabinet reported 55 audits of hospitals, primary care centers, rural health clinics, and other types of medical clinics and providers conducted in the past year. These audits were performed on providers that were considered beyond the norm of their peers. Outside referrals and hotline tips can also trigger audits of providers. The department had contracts for these audits with the Office of Inspector General and Health Care Excel, a surveillance and utilization review vendor. The contract with Health Care Excel expired in December 2009. The new surveillance and utilization review contract that began in October 2010 requires the vendor, Ingenix, to perform a minimum of 30 on-site audits and 50 desk audits each year, presumably of nonpharmacy providers.

The Division of Program Integrity's work plan for FY 2011 included unscheduled on-site visits to high-risk provider types such as durable medical equipment, home health, and possibly others. It was not clear whether these visits were in addition to the audits described above.

Program Review staff find that:

- The cabinet has instituted a program of on-site audits of targeted pharmacies having unusual claims patterns. The program appears to have a significant positive return on investment.
- The cabinet should expand the program to include some random or routine rotating desk audits of pharmacies not targeted by the current program.
- The cabinet has conducted desk and on-site audits of targeted nonpharmacy providers having unusual claims patterns or named in outside referrals or hotline tips.
- The cabinet should expand the nonpharmacy audit program to include some random desk and possibly field audits of providers not targeted by the current program.
- The cabinet should develop ongoing cost-benefit analyses of both audit programs and should modify the programs over time to optimize costs and benefits.

^c Program Review staff estimated staff costs based on the cabinet's estimate of 20 staff hours per audit and \$60,000 as the annual cost of a department employee including benefits.

Phone-In Prescriptions

In 2007, Program Review staff surveyed Kentucky physicians and pharmacists about Medicaid prescription drug fraud. Among other issues, respondents reported that a common problem was recipients' pretending to be physicians and phoning in fake prescriptions for themselves. Based on this finding, the Program Review report recommended that

The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine whether fair and reasonable limitations could be placed on filling phone-in prescriptions (Rx 79).

In response to the recommendation, the cabinet agreed that fraudulent phone-in prescriptions were a problem. The cabinet noted that in 2007 the Office of Inspector General had incorporated examples of such prescriptions into the training materials for users of the Kentucky All Schedule Prescription Electronic Reporting system in an attempt to increase awareness of the issue. Furthermore, the cabinet suggested that the General Assembly might want to consider creating a task force to study the problem. However, the cabinet also cautioned that restricting phone-in prescriptions might result in undue hardship for critically ill patients and those with limited mobility (Rx 193).

Current Findings

Effective July 1, 2010, the cabinet amended 907 KAR 1:019 so that Medicaid prescribers phoning in a prescription must fax a copy to the pharmacy within 48 hours. The new regulation also states that Medicaid will reimburse a pharmacy for a prescription only if the prescriber is a Medicaid provider. According to the cabinet, the PBA system will deny a controlled substance claim if the prescriber is not enrolled in Medicaid; this restriction eventually will extend to all prescriptions. The cabinet noted that it is too early to estimate the impact these changes might have on fraudulent phone-in prescriptions.

Program Review staff find the following:

- The cabinet has taken measures to combat fraudulent phone-in prescriptions for Medicaid.
- It is too soon to tell how effective these new measures will be at stopping fraudulent phone-in prescriptions.
- The cabinet should design and implement an ongoing evaluation of this intervention.

Eligibility Procedures And Fraud And Abuse

In the 2007 Program Review report, staff observed that some Department for Community Based Services caseworkers appeared to accept the information provided them by applicants without conducting independent verification.

The Quality Control Branch focused on adult Medicaid cases because the recipients typically use more expensive services than other recipients do. The branch targeted only institutionalized adult Medicaid recipients who have enough assets to be responsible for some of the costs of care. The

branch reported for federal fiscal year 2006 that 21.9 percent of these adult Medicaid cases had some kind of error. Most were agency errors, but 9 percent of all cases had applicant errors. For approximately 40 percent of the cases with applicant errors, the recipient would have been denied eligibility had the application been filled out correctly. These errors may have represented fraud or abuse.

It also appeared that some caseworkers and claims workers failed to refer cases of suspected fraud to the Office of Inspector General as required. OIG reported that few if any adult Medicaid fraud cases were referred to the office for investigation. Interviews with DCBS staff suggested that many of the workers were unaware of the procedure for referring suspected fraud cases.

Based on these findings, the 2007 Program Review report recommended:

The Department for Medicaid Services should review Medicaid eligibility procedures, and the Department for Community Based Services should ensure that all caseworkers understand and follow the procedures for verifying an applicant's statements. The Department for Medicaid Services should consider whether it is desirable that caseworkers ask adult Medicaid applicants for information about expenses and attempt to balance income, resources, and expenses. If so, the departments together should develop such a procedure and incorporate it into caseworker training (Rx 54).

The Department for Community Based Services should ensure that referrals for suspected fraud in adult Medicaid cases are being made correctly to the Office of Inspector General. The department should implement procedures to reduce the error rate in adult Medicaid cases (Rx 61).

In response, the cabinet stated that verification of income and resources for all adult Medicaid cases was required. Caseworkers were required to obtain information from the applicant regarding his or her personal situation and verify the information using available means. Failure to provide required information resulted in denial of the application. DCBS planned to expand caseworker training to reinforce agency policy as well as create an interview guide to remind staff of interviewing procedures. DMS and DCBS developed a corrective action plan in an effort to reduce Medicaid errors.

The cabinet also explained that DCBS staff are only required to refer intentional Medicaid program violations to OIG. In 2007, DCBS workers were referring about 380 Medicaid cases to OIG per year. The cabinet did not indicate how many of these were adult Medicaid cases. The operation manual was updated in 2006, and it detailed how to prevent and identify fraud and abuse, as well as how to refer suspected cases to OIG. DCBS planned to issue correspondence reiterating the policy as well as to ensure the issue was covered during training.

Current Findings

In its 2010 response to Program Review staff, DMS reported that there is no system that counts the applicants for whom caseworkers discovered unreported income or resources, and there is no method to estimate them. The Social Security Administration's electronic asset verification system reported detection of undisclosed assets in 20 percent of all requests it received. The

Supplemental Appropriations Act of 2008 required states to implement an asset verification system but provided no funding. DMS is drafting a request for proposals for such a system.

Although fixed-income benefits are easily identifiable, it remains possible, perhaps likely, that some applicants have unreported income and resources, such as rental property, spousal support, and other sources, along with unreported resources. It seems unlikely that any asset verification system could successfully identify all income and resources, especially for applicants who may forget or choose to hide some of them. It appears that reconciling expenses with income and resources would help caseworkers find unreported income and resources. DMS explained that an adult Medicaid applicant with a noninstitutionalized spouse does have to provide information about expenses, but other adult Medicaid applicants do not.

DMS pointed out that the American Recovery and Reinvestment Act probably would prohibit such a change in methodology until enhanced federal assistance ends. In addition, the Affordable Care Act included similar language effective until the end of 2013. Looking ahead to that time, the department did not explain why the application should not ask about expenses for all adult Medicaid recipients. The cabinet also did not offer evidence that DCBS caseworkers reconcile available expense information with income and resources.

The contract between DMS and DCBS was renegotiated in 2007 and incorporated corrective actions needed to address the error rate for the targeted institutionalized adult Medicaid recipients. The quality control program has continued to conduct annual adult Medicaid case reviews. In federal fiscal year 2009, Kentucky reported an eligibility error rate of 10 percent. This is an increase of 2.5 percentage points since federal fiscal year 2004. The total adult Medicaid error rate also has increased each year since federal fiscal year 2006.

These increases in the error rates suggest that efforts to reduce adult Medicaid errors have not been effective so far. However, the DCBS Division of Family Support reported that the sampling method used in previous years included both old and new cases, which would have been less reflective of recent improvements. At the same time, the overall adult Medicaid error rate increased from 22 percent in 2006 to 29 percent in 2009, and it seems unlikely that old cases alone would account for the difference.^f For the 2010 fiscal year, the method was revised to include new cases only. Unfortunately, that means the 2010 error rates will not be comparable with previous rates and it will require several years to establish a trend.

Beginning in September 2010, DCBS intensified the case review process in an attempt to reduce the adult Medicaid error rate. Counties identified as having high error rates or having awarded benefits to applicants erroneously will be chosen for heightened review. Upon completion of the review, a corrective action plan will be developed to address deficiencies.

DCBS pointed out that adult Medicaid eligibility is extremely difficult to determine because of the many benefit categories and the many ways older adults have invested their resources. In addition, more adult Medicaid applicants now engage attorneys or financial planners to reduce or shelter assets and income. DCBS also mentioned that adult Medicaid applicants are a small

^f The overall error rate includes both eligibility errors and errors in calculating the level of benefit.

fraction of all Medicaid applicants. The group targeted for quality control is about 2.7 percent of all Medicaid recipients and 9.8 percent of adult Medicaid recipients.

For comparison, the federal Payment Error Rate Measurement program measures each state's overall eligibility-related errors every 3 years. In 2007, Kentucky had an overall eligibility error rate below 1 percent, suggesting that eligibility-related errors are much lower for applicants other than the targeted adults. Results from the 2010 review are not yet available.

DCBS reported that in 2009, its caseworkers referred 525 cases of suspected fraud to OIG. The department did not indicate how many of these were adult Medicaid cases. The Division of Family Support reported implementing several measures to improve identification and referral of suspected fraud cases. These efforts included publishing a memo reminding staff of appropriate policies and procedures; rewriting portions of the operations manual; and including information about Determining Eligibility Through Extensive Review, the OIG's applicant investigation program, in presentations to field staff.

DMS reported that DCBS staff appear to be referring suspected cases of fraud when appropriate. The number of referrals is part of the DMS contract monitoring process. DMS stated that it has encouraged DCBS to make referrals for certain case situations that are suggestive of fraud.

Program Review staff find the following:

- There is no mechanism to record unreported income and resources discovered by caseworker verification, and there is no method to estimate them.
- Adult Medicaid recipients who fall into the disabled or aged categories typically use more expensive services.
- The Affordable Care Act probably prohibits the cabinet from increasing requirements for adult Medicaid applicants to report and reconcile expenses until the end of 2013.
- The cabinet should explain why, after 2013, all adult Medicaid applicants should not report their expenses and caseworkers should not reconcile expenses with income and resources in order to find unreported income and resources.
- Adult Medicaid eligibility error rates have grown in Kentucky from 7.5 percent to 10 percent in the last five years. In September 2010, the cabinet changed its sampling method and intensified its case review process in order to reduce the error rates.
- The overall Medicaid eligibility error rate in 2007 was less than 1 percent.
- Eligibility caseworkers referred approximately 380 cases of suspected fraud in 2007 and 525 such cases in 2009 to the Office of Inspector General. The cabinet should report how many in each year were for adult Medicaid applicants.

Preeligibility Fraud

From 1986 until 2003, the Cabinet for Health and Family Services Office of Inspector General operated the Cooperative Review of Eligibility (CORE) program. CORE performed field investigations of public assistance applicants within 15 days of the application to prevent them from fraudulently obtaining benefits. The program covered applicants for the Kentucky Transitional Assistance Program, Food Stamps, Medicaid, and other benefits.

A 1996 Program Review report recommended expanding investigative programs like CORE (Kentucky. Legislative. Program. *Department*). At the time, CORE operated in 10 counties, but it was discontinued in 2003.

The 2004 Program Review report on the Transitional Assistance Program recommended that the agency consider reviving CORE or a similar program, depending on the results of a cost-benefit analysis (Kentucky. Legislative. Program. *Improving*). The cabinet provided evidence of a return in the range of \$4 to \$5 for each \$1 spent on CORE (UR 130-131). Based on this finding, the 2004 Program Review report on uncollected revenues repeated the recommendation.

The Cabinet for Health and Family Services should review the feasibility of establishing a field-based investigation unit such as the Cooperative Review of Eligibility program. The review should include a cost-benefit analysis. The results of the analysis and any actions taken to expand the capability of the Office of Inspector General to conduct field investigations should be reported to the Program Review and Investigations Committee before the 2005 session of the General Assembly (UR 35).

In March 2005, OIG initiated a program similar to CORE called Determining Eligibility Through Extensive Review (DETER). First implemented in Louisville, DETER expanded to 16 counties by November 2007.

The creation of the DETER program was commendable. Program Review staff obtained costs and projected benefits and calculated an overall return on investment of \$2.60 per \$1 spent from March 2005 to April 2007. Although the returns declined during that period as the program expanded, staff expected the return to increase as new investigators became more productive.

Expansion of the DETER program would require adequate funding from Department for Community Based Services, Medicaid, and OIG's general fund appropriation. Expansion also would depend on having both local space for investigators and acceptance by local DCBS offices. In counties without DETER, regional DCBS claims workers handled suspicions of eligibility fraud. DETER expansion would have to occur in coordination with claims workers.

Based on this finding, the 2007 Program Review report recommended:

The Department for Medicaid Services, the Office of Inspector General, and the Department for Community Based Services should develop a plan to expand the Determining Eligibility Through Extensive Review program to additional local offices. The plan should address local office acceptance of the program, office space, funding, and the role of claims workers (Rx 59).

The cabinet expressed agreement with the recommendation but pointed out the need for additional state funds.

Current Findings

Since the 2007 Program Review report, the DETER program added coverage for one county. The cabinet stated that if additional resources were to become available, coverage would be expanded further. DCBS officials stated that the DETER program was a valuable resource. OIG provided detailed cost and savings information for fiscal years 2007 to 2010. As shown in Table 2.1, the overall return on investment continued to decline after FY 2008, reaching a low of \$1.20 per \$1 spent in FY 2010. The cabinet was unable to explain the decline or the difference between this return and the \$4 to \$5 returns reported for CORE. One reason was that the cabinet no longer could determine how the CORE returns were calculated.

Table 2.1
Determining Eligibility Through Extensive Review
Annualized Overall Returns On Investment
2005 To 2010

	Time Period				
	March 2005- April 2007*	FY 2007	FY 2008	FY 2009	FY 2010
Total cost avoidance	\$677,000	\$749,500	\$770,500	\$362,500	\$286,500
DETER expenses	\$262,500	\$434,500	\$232,000	\$132,500	\$238,500
Return per \$1 spent	\$2.58	\$1.73	\$1.88	\$1.61	\$1.20

Note: Cost avoidance and expenses are rounded to the nearest \$500.

*The savings and expenses for this period are shown as a single-year average for comparison.

Source: Compiled by Program Review staff from information provided by the Office of the Inspector General of the Cabinet for Health and Family Services.

The new OIG information was sufficiently detailed to calculate a return on investment for Medicaid separately. This calculation compared the expenses charged to the Medicaid account against the costs avoided for applicants who would have received Medicaid benefits. Because the Medicaid account and the avoided costs are different mixes of federal and state funds, Program Review staff calculated the return on investment of state funds. Table 2.2 shows the gross return along with the return on state funds assuming either a 70 percent or 80 percent federal match rate for Medicaid costs avoided and a 50 percent match rate for expenses.

Table 2.2
Determining Eligibility Through Extensive Review
Returns On Medicaid Investment
Fiscal Year 2008 To Fiscal Year 2010

	Fiscal Year		
	2008	2009	2010
Medicaid cost avoidance	\$430,000	\$166,000	\$150,000
Medicaid expenses	\$195,000	\$87,000	\$79,000
Gross return per \$1 Medicaid funds	\$2.20	\$1.91	\$1.90
State cost avoidance at 70% federal*	\$129,000	\$50,000	\$45,000
State cost avoidance at 80% federal*	\$86,000	\$33,000	\$30,000
State expenses at 50% federal	\$97,500	\$43,500	\$39,500
Return per \$1 state funds at 70% federal	\$1.32	\$1.15	\$1.14
Return per \$1 state funds at 80% federal	\$0.88	\$0.76	\$0.76

Note: Cost avoidance and expenses are rounded to the nearest \$500.

*The match rates are rounded. The 70 percent federal match rate applied to Medicaid services prior to the federal stimulus and will take effect again in July 2011. The 80 percent federal match rate applied during most of the federal stimulus period. From July 2010 to June 2011, the rate gradually declines from 80 to 70 percent.

Source: Analysis by Program Review staff based on information from the Cabinet for Health and Family Services.

With the conventional 70 percent federal match rate for Medicaid services, the DETER return on the state investment is positive, but barely so. During the federal stimulus period, during which the federal match was 80 percent for services, the state only avoided 20 percent of costs but still had to cover one-half of the expenses of the program.

Program Review staff find the following:

- Determining Eligibility Through Extensive Review has been expanded to cover 17 counties, one more than in 2007.
- The DETER return on investment in FY 2010
 - for all benefit programs combined has fallen to \$1.20 for each \$1 of state and federal funds spent, from \$2.58 between March 2005 and April 2007;
 - for Medicaid was \$1.90 for each \$1 of state and federal funds; and
 - for Medicaid state funds was 76 cents for each \$1 of state funds spent, a negative result, but would have been \$1.14 using the federal match without the stimulus increase.
- The cabinet should analyze the spending and cost avoidance attributable to DETER and attempt to improve the return on investment.
- The cabinet should document the methodology used to determine return on investment for DETER and train additional employees in its calculation so that turnover does not result in additional loss of institutional knowledge.
- DETER may have a deterrent effect that would add value to the program.
- Using return on investment, the cabinet should consider whether to further expand DETER.

Third-Party Liability

By federal law, Medicaid is the payor of last resort and is required to reject claims that may be payable by a third party (42 CFR 433.139(b)(1)). Such third-party liability refers to the legal obligation of third parties to pay all or part of the cost of medical services rendered. Such third-party sources include Medicare, private health insurance, casualty and personal injury insurance, and personal injury damage awards. Thus, third-party liability should be a cost avoidance intervention. The Medicaid system should ascertain ahead of time that another party is required to pay for the medical services and should refrain from paying for those services.

Prepayment information is most readily available for Medicare recipients because the federal government shares Medicare eligibility information with Medicaid programs. The 2004 Program Review report stated that Medicaid did not have the files of all the other insurers serving the state. At that time, the relevant state statute, KRS 205.623, was insufficient to ensure that all insurers complied with Medicaid's requests for electronic eligibility files.

Based on these findings, both the 2004 and 2006 Program Review reports made the same recommendation:

To maximize Medicaid's liability to avoid paying claims that are the responsibility of a liable third party, the General Assembly may wish to consider amending KRS 205.623 to include a penalty for noncompliance (UR 31; IS 85).

In its response to the 2004 report, the cabinet pointed out that third parties who complied with the statute might incur additional health care costs. Therefore, in the absence of a penalty, third parties had no incentive to provide information to Medicaid. In a 2005 follow-up, cabinet officials said that insurance companies generally complied with the statute, but including a penalty for noncompliance would be helpful.

Current Findings

In 2008, provisions were added to KRS 205.623 specifying that private health insurers shall provide information electronically in the format prescribed by the Department for Medicaid Services and designating the purpose for which the department shall use the information. Also in 2008, KRS 304.12-255 was created. This section makes it an unfair or deceptive trade practice to violate KRS 205.623. The penalty is a fine not less than \$100 or twice the amount of the gain from the commission of the violation, whichever is greater; or the possible revocation of certificate of authority or license; or both (KRS 304.99-010).

As of October 2010, the cabinet reported that it has no difficulty obtaining needed information from third-party payors. Through its third-party liability vendor, DMS has access to all major and minor insurance carriers and receives automatic feeds of insurance information. The noncompliance penalty in KRS 304.12-255 has been effective in mandating cooperation by payors.

Program Review staff find the following:

- The statutory changes to KRS 205.623 and 304.12-255 have been effective in helping the Department for Medicaid Services obtain needed information from third-party payors.

Medical Child Support

Federal legislation enacted in 1975 mandates that each state operate a government-administered child support program. The Department for Income Support in the Cabinet for Health and Family Services performs child support enforcement (CSE). Individuals who receive federal benefits, including Medicaid, are required to participate in this program if there is someone who might be obligated to provide child support.

The most common form of medical child support is an order that the noncustodial parent obtain and pay for dependent health insurance coverage from his or her employer. A court also may order the noncustodial parent to pay cash medical support to cover medical bills, either in addition to or instead of health insurance. When the child is eligible for Medicaid, the custodial parent must assign to the state all rights to medical child support (42 CFR 433.146). Insurance benefits are considered the first source of payment for all medical expenses; cash medical support would be the second source; and Medicaid pays any remainder.

The 2004 Program Review report expressed concern that more than 94 percent of medical child support orders for dependent insurance went unenforced in FY 2002. Assuming a similar percentage, this could have caused Medicaid to lose up to \$11 million in state Medicaid funds in FY 2003. The report also questioned whether cash medical support was always requested when appropriate. The report recommended that

The Cabinet for Health and Family Services should determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care. Medical support can include partial or full payment of dependent children's medical bills, partial or full payment of private health insurance coverage accessed by the custodial parent for their dependent children, or reimbursement to Medicaid for the use of Medicaid services (UR 63).

The cabinet expressed general agreement with the recommendation and explained ways that Medicaid and CSE would work together to improve medical support enforcement. These methods included "identifying existing insurance, enforcement of orders for insurance, and targeting cases with a high potential for insurance that require the establishment of a medical insurance order"; cash in lieu of insurance; and health insurance premium assistance for noncustodial parents (UR 136).

However, in its follow-up in 2005, Program Review staff noted that the cabinet did not provide an evaluation of whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance (Kentucky. Legislative. Staff. "Uncollected").

The 2006 Program Review report on Medicaid found that unfulfilled medical support orders for health insurance might have cost up to \$13.8 million in state Medicaid funds in FY 2005. The report updated and reiterated two previous recommendations. In addition to determining the potential value of seeking cash medical support, it recommended a study of further incentives for local child support offices to improve enforcement of all medical support orders.

The Cabinet for Health and Family Services should a) reexamine the costs and benefits of providing greater financial incentives to county child support offices for improving enforcement of medical support orders and b) determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care through the Medicaid program and the Kentucky Children's Health Insurance Program. The cabinet's Department for Medicaid Services and Department for Community Based Services should provide a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (IS 97).

The cabinet did not respond to the 2006 report, nor did it report to the committees as recommended.

Current Findings

In July 2008, federal regulations were issued to require state child support programs to seek medical child support orders for health insurance or cash payments for children who are eligible for Medicaid (45 CFR 303.31). In June 2009, KRS 403.211 was amended to accommodate this federal requirement. In combination with 45 CFR 303.8(d), this regulation appears to obligate CSE to seek cash medical child support orders to reimburse Medicaid. Therefore, the recommendation that the cabinet determine whether cash medical support should be required is moot.

However, cabinet information systems have been unable to transfer cash medical support payments from CSE to Medicaid. For this reason, when the amended KRS 403.211 became effective, CSE instructed county attorneys not to request cash medical support in the form of reimbursement to Medicaid; they do request cash medical support for expenses not covered by Medicaid and other insurance. Although CSE and Medicaid met several times to discuss how to transfer the payments, the systems remain unable to do so.

In June 2010, the US Office of Child Support Enforcement issued a letter regarding possible changes in child support requirements under the Affordable Care Act. The cabinet stated that, based on the letter, it has suspended plans to modify systems to transfer cash medical support payments until federal guidance is finalized. However, the letter also said that "it is important that state IV-D [child support] agencies continue to provide medical child support enforcement services in compliance with all statutory requirements" (US. Dept. Office of Child Support).

The cabinet asserted that CSE is not required to seek, and courts are not required to order, cash medical child support to defray Medicaid's costs. Program Review staff disagree, but the federal regulations are sufficiently ambiguous that clarification from the federal government appears indicated. Even so, KRS 403.211(7)(c)2 appears to impose the same requirement.

The cabinet also expressed concern that cash medical support orders to reimburse Medicaid might deprive the custodial parent and the child of support in other areas. The 2004 Program Review report noted this potential problem, and it was one of the reasons that the report recommended the cabinet assess the value of cash medical child support (UR 61-62).

Kentucky Medicaid implemented a Health Insurance Premium Payment program in the mid-1990s. The cabinet's response in 2004 suggested that the program could be made available to some noncustodial parents. In June 2010, the cabinet requested federal approval of a state plan amendment and promulgated a regulation for a modified program. Although noncustodial parents might technically be eligible, the cabinet expressed doubt that the program should be used to assist noncustodial parents to pay dependent health insurance premiums that the court has ordered the parent to pay. However, requiring noncustodial parents to pay the cost of dependent health insurance could deprive the custodial parent and the child of support in other areas; the cabinet acknowledged this.

Program Review staff also note that the program could be used when the court has determined that the cost of dependent health insurance is not reasonable under KRS 403.211(7)(d). An open question is whether the noncustodial parent could be required to cover a portion of the premium payments.

CSE stated that no incentives are needed for local child support offices because medical child support is part of those offices' contractual obligations, and so no cost-benefit analysis is needed. CSE asserted that all local offices petition the court for medical support and courts appear to be ordering appropriate support.

Program Review staff find the following.

- Current federal and Kentucky laws require child support enforcement to seek dependent health insurance or cash medical support as appropriate. Program Review staff did not determine how often such support was requested or ordered, but the cabinet asserted it was requested in all cases and ordered when appropriate.
- Medicaid has not received cash medical support payments, although federal requirements have been in place since July 2008 and a conforming Kentucky law was effective June 2009.
- CSE instructed local child support offices not to seek cash medical support in the form of reimbursement to Medicaid because the CSE and Medicaid information systems could not transfer the payments.
- As of June 2010, the cabinet put on hold efforts to create a system to transfer cash medical support to Medicaid, based on a letter from the federal Office of Child Support Enforcement. In fact, the letter instructed states to continue to carry out all aspects of the law.
- The cabinet should obtain guidance from the federal Office of Child Support Enforcement and the Centers for Medicare and Medicaid Services on the following questions and report the response to the Program Review and Investigations Committee.
 - May the state child support agency and the courts consider Medicaid coverage as “private health insurance”
 - when determining whether to order such insurance under 45 CFR 303.31(b)(1) or
 - when determining the amount of cash medical support to be ordered under 45 CFR 303.31(b)(2)?

- When a dependent child is covered by Medicaid:
 - Does a state's child support agency have an obligation
 - to ensure that reasonable cash medical child support is ordered when a noncustodial parent does not have access to affordable health insurance and
 - to ensure that such orders are enforced and payments are transferred to reimburse the Medicaid program for the child's medical expenses?
 - If the answer to the preceding question is yes on both counts, what is the effect of Office of Child Support Enforcement Action Transmittal AT-10-02 on carrying out the state's obligation?
 - Is Medicaid obligated to seek reimbursement from cash medical child support under third-party liability rules?
- The cabinet should enforce the cash medical child support law but should report to the appropriate committees of the Legislative Research Commission if such enforcement creates hardships for custodial parents and their children.
- If permitted by federal law, the cabinet
 - should offer health insurance premium assistance to noncustodial parents when it is cost effective and a court has ruled that available dependent health insurance costs are not reasonable,
 - should determine whether to do so in other circumstances, and
 - should determine whether it is permissible and reasonable to require the noncustodial parent to pay some portion of the premium.
- CSE has not carried out the recommended evaluation of incentives for local child support offices to improve enforcement of medical child support orders. CSE asserted that incentives are not necessary because local offices fulfill their contractual obligations to enforce such orders but did not provide data on the portion of orders that are unfulfilled or evidence that local offices take all available actions to enforce those orders.

Claims Processing Software And Data

When Program Review staff examined Medicaid information systems in 2005 for the 2006 report, there were three new contracts, each of which included a major information system.

- Medicaid management information system, awarded to Electronic Data Systems, now HP Enterprise Services
- Pharmacy benefit administrator, awarded to First Health Services Corporation, now Magellan Medicaid Administration
- Kentucky Medicaid administrative agent (KMAA), also awarded to First Health

Each of the three requests for proposal included requirements for information systems to perform at least some of the six functions of a conventional MMIS. The vendor proposals and contracts followed these requirements. The Program Review report questioned the need for each vendor to operate its own information system because the MMIS was required to verify and store all claims and to store all provider and recipient information. Table 2.3 illustrates the overlap.

Table 2.3
Distribution Of Medicaid Information System Functions
Under 2004-2005 Medicaid Modernization

Function	Management Information System	Pharmacy Benefit Administrator	Administrative Agent
Claims processing	Primary	Primary*	—
Provider enrollment and management	Secondary	Secondary	Primary
Recipient eligibility and management**	Secondary	Secondary	Secondary
Outside data needed for reference	Primary	Primary*	Secondary
Management and administrative reporting	Primary	Primary*	Secondary
Surveillance and utilization review	Primary	Primary*	Secondary

*Primary for pharmacy claims only.

**Recipient functions are secondary for all vendors because eligibility information originates in the Department for Community Based Services' information system.

Source: Summary of information from Kentucky. Legislative. Program. *Information*.

In its proposal, EDS stated that its claims system could perform point-of-service interactive claims processing both for pharmacy and nonpharmacy services. The Program Review report suggested that a single system could be used for claims processing even if a separate pharmacy benefit administrator performed the clinical and administrative functions. The urgency to have a PBA in place prior to implementing a new MMIS might have made it necessary to duplicate the systems at that time. Similarly, the KMAA vendor might perform all its responsibilities using MMIS tools, but the new MMIS was not available and perhaps the old MMIS was inadequate.

In addition to these information systems, each request for proposal and resulting contract included a distinct data warehouse and decision support system. Data warehouses typically contain information from multiple information systems or databases. Decision support systems are software tools that provide ways to summarize and analyze the information. The Program Review report questioned the need for each vendor to operate its own data warehouse and decision support system because the purpose of a data warehouse is to consolidate information in one location.

Medicaid modernization involved not only these vendors but also information from the systems listed in Table 2.4. The Program Review report questioned whether all the necessary information from all the systems was transferred in a timely manner and was available in a centralized data warehouse. For example, information from Passport, the managed care organization, is important for utilization review and program integrity, as recipients move in and out of the managed care region. The fraud and abuse literature also indicates that audit trail information about all claims—prior authorizations, denials, resubmissions, adjustments, and so on—is important for detecting and investigating fraud and abuse. These items also help detect efforts on the part of a few unscrupulous providers to probe the claims system for weaknesses.

Table 2.4
Medicaid Data Sources Outside The Primary Information Systems

Owner	Description
Department for Community Based Services	Medicaid recipient eligibility information
AmeriHealth Mercy	Information about services provided to Medicaid recipients in the Passport region
PerformRx	Information about prescriptions provided to Medicaid recipients in the Passport region

Source: Compiled by Program Review staff.

The 2004 Program Review report made the following recommendations.

The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's pharmacy benefit software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the pharmacy benefit administrator should use EDS software to perform their tasks (IS 48).

The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's administrative agent software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the Kentucky Medicaid administrative agent should use EDS software to perform their tasks (IS 50).

The Department for Medicaid Services, the Office of Inspector General, and Medicaid vendors should review the need for multiple data warehouses and decision support systems. When feasible and cost effective, the enterprise data warehouse and decision support system should be used rather than having additional copies of the Medicaid data and additional decision support software (IS 51).

The Department for Medicaid Services should ensure that the MMIS and enterprise data warehouse contain full information about pharmacy and managed care claims, including all claims data fields, attempted claims that were denied, resubmissions, prior authorizations, adjustments, and corrections (IS 46).

The cabinet did not respond to these recommendations.

Current Findings

The recommendations relating to the KMAA information system and data warehouse are no longer relevant. The KMAA contract ended in December 2008 and was not renewed. KMAA responsibilities were given primarily to EDS, now HP Enterprise Services.

Pharmacy benefit administration was rebid in 2009, and the contract was awarded again to First Health, now Magellan Medicaid Administration. The cabinet stated that the request for proposals was for an information system and clinical and benefit administration. There was not an option

for a vendor to use the existing MMIS instead of its own proprietary systems. The cabinet indicated that EDS responded to the procurement with an integrated solution but was not chosen.

In its 2010 response to questions from Program Review staff, the cabinet agreed that there would be some advantages to having the pharmacy claims system integrated into the MMIS. However, the cabinet pointed out that pharmacy claims rules are significantly different from other claims rules. In addition, pharmacy processing requires radically different reference data, including drug information that changes frequently. Federal guidance is pushing states to define modular systems, so placing pharmacy processing in a separate system complies with that guidance.

Program Review staff believe the question remains open. It is unclear from available information that having a separate pharmacy claims processing system is more cost effective overall than having an integrated system that all vendors could use. The MMIS already uses some of the same rules and reference data to validate pharmacy claims after the PBA adjudicates them. Further, an integrated system can be modular; the decision whether to use an entirely separate system should be based on utility and efficiency. There are differences in the requirements for each type of processing, but it is important with each procurement to consider whether a single system would be more efficient than multiple systems.

There appears to be some unnecessary duplication of data warehouse and decision support systems. In particular, the PBA and Passport, the managed care organization, maintain their own data warehouses and decision support systems. Even if this duplication is necessary, the enterprise data warehouse should contain a consolidated copy of data from all the other data warehouses.

Iowa is an example of a state that has a single data warehouse. Moving beyond Medicaid, Iowa's data warehouse also serves its child welfare and public assistance agencies. The system permits information to be linked among these agencies so that, for example, it is possible to analyze how well Medicaid is serving foster children (Iowa. Dept. Medicaid. "IME Bidders").

The cabinet may have an opportunity to obtain federal funds toward a true Medicaid enterprise data warehouse. In November 2010, the Centers for Medicare and Medicaid Services proposed a new rule that would give states a 90 percent match for the costs of replacing or upgrading their Medicaid eligibility systems from 2010 to 2015. The rule also would give states a 75 percent match for the costs of operating the transformed eligibility systems. If the rule is adopted, the cabinet could design and build an expanded data warehouse in conjunction with the federally funded eligibility project. If other non-Medicaid funds were available, the cabinet could go beyond Medicaid and build a cabinet-wide data warehouse including other functions, such as public assistance programs, disability determination, child support enforcement, child protection, public health, and mental health.

The final concern was whether the types of data in the data warehouses were adequate for surveillance, utilization review, and cost analyses. The cabinet stated that the MMIS data warehouse serves as the primary or enterprise data warehouse. However, Table 2.5 shows that several types of information are not held there. There appears to be difficulty bringing together MMIS, PBA, and managed care claims; all the related audit trail information such as prior

authorizations, manual adjudication logs, and point-of-sale dialogs with pharmacists; and the reference data necessary to interpret claims. The cabinet should have a consolidated data warehouse and decision support system, or it should have a routine process that extracts and merges data from the various systems. The cabinet appears to have neither.

Table 2.5
Location Of Medicaid Claims Data

Type Of Information	In Primary Data Warehouse	Originating System
Nonpharmacy claims (paid and denied)	Yes	Management information system
Nonpharmacy claims audit and reference	No	
Pharmacy claims (paid and denied)	Yes	Pharmacy benefit administrator
Pharmacy claims audit and reference	No	
Passport nonpharmacy paid claims	Yes	Managed care organization
Passport nonpharmacy denied claims	No*	
Passport nonpharmacy claims audit and reference	No	
Passport pharmacy paid claims	Yes	
Passport pharmacy denied claims	No*	
Passport pharmacy claims audit and reference	No**	

*The cabinet is testing a process to transfer denied Passport claims into the primary data warehouse.

**The audit trail of Passport pharmacy claims is inaccessible to cabinet staff.

Source: Information provided by Cabinet for Health and Family Services.

Program Review staff find that:

- The Kentucky Medicaid administrative agent contract ended, and the related recommendation is moot.
- The question of whether to process pharmacy claims using a different system from other claims remains open. In future procurements, the cabinet should encourage vendors to propose both integrated and separate systems.
- The current data warehouse configuration appears to be fragmented, and some important types of information are not available in the enterprise data warehouse.
 - In future procurements, the cabinet should minimize the number of data warehouses and decision support systems and consider whether to request a centralized data warehouse and decision support system to serve most of the data needs of Medicaid and its vendors.
 - The cabinet's enterprise data warehouse should have a complete record of all claims, audit trail, and reference data that might be useful for surveillance, utilization review, and cost analyses.
 - In the short term, the cabinet should develop a routine process for extracting audit trail and reference data from the Medicaid management information system, pharmacy benefit administrator, and managed care systems and merging it with the enterprise data warehouse.
- If additional Medicaid and non-Medicaid funding becomes available, the cabinet should consider a cabinet-wide data warehouse that could consolidate information from Medicaid,

public assistance, disability determination, child support enforcement, child protection, public health, mental health, and other cabinet functions.

Method Of Payment In KASPER

The 2006 Program Review report examining Medicaid information systems noted that the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system did not collect information on method of payment as recommended by a 2003 Prescription Drug Abuse Task Force. Such a change would help Medicaid identify its own recipients; in addition, cash transactions are key for identifying abusers (Rx 15).

Office of Inspector General officials said they believed the statute would need to be changed because the original KASPER legislation did not include method of payment in the database. However, KRS 218A.202(4) says that the “data for each controlled substance that is dispensed shall include but *not be limited to* the following ...” [*emphasis added*]. Thus, there is no statutory restriction to including method of payment in the database.

Office of Inspector General officials noted that adding a field could be complicated and involve changes not only to KASPER’s programming but also to the software used by pharmacies that send the data. It was unclear how extensive the changes would be.

Based on these findings, the 2006 Program Review report recommended:

The Cabinet for Health and Family Services’ Office of Inspector General should develop an estimate of the cost and effort involved in adding the method of payment field to KASPER, as recommended by the House Bill 303 Prescription Drug Abuse Task Force. This estimate should include the changes needed by pharmacies that report information to KASPER and should consider any options that might minimize such changes. The Office of Inspector General should report its findings to the Program Review and Investigations Committee and the Health and Welfare Committee (IS 15).

The agency offered no response to the recommendation.

Current Findings

The cabinet reported that KASPER does not currently capture payment information. The cabinet intends to implement a new data system in April 2011 that will capture payment information.

Program Review staff find the following:

- The Kentucky All Schedule Prescription Electronic Reporting system does not currently capture payment information but plans to do so in April 2011.
- The cabinet should ensure the proposed data system captures and provides reports on the method of payment, including cash payments.

Statutes Related To The Office Of Inspector General And The Office Of The Attorney General

Referrals Of Fraud And Abuse Hotline Complaints

In their 2002 and 2003 joint reports, the Office of Inspector General and the Office of the Attorney General's Medicaid fraud control unit (MFCU) asserted that there was a conflict between KRS 205.8483 and federal regulations 42 CFR 455.14 and 455.15. The state statute requires OIG to refer all fraud and abuse hotline calls to MFCU "immediately." The federal regulations require the Medicaid agency—in this case OIG—to conduct a preliminary investigation and then refer the case to MFCU if the findings indicate "reason to believe that an incident of fraud or abuse has occurred" The agencies recommended that the statute be changed to allow OIG to conduct preliminary investigations before referring cases to MFCU.

The 2007 Program Review report recommended that

If it is the intent of the General Assembly that the Kentucky Medicaid fraud hotline statute be consistent with federal regulation 42 CFR 455.14, then the General Assembly may wish to consider amending KRS 205.8483(2) to allow the Office of Inspector General to conduct a preliminary investigation to determine if a sufficient basis exists for a full investigation, prior to referring the case to the Office of the Attorney General (Rx 107).

As part of its overall program integrity plan, the Department for Medicaid Services should work with the Office of Inspector General and Office of the Attorney General to establish protocols for preliminary investigation of all potential provider fraud cases by the Office of Inspector General and for timely referral to the Office of the Attorney General for full investigation, consistent with federal regulations (Rx 107).

In their responses, the agencies concurred with the recommendations, but MFCU strongly urged that there be a statutory definition and time limit for preliminary investigations.

An issue raised by OIG in the 2005 and 2006 OIG-MFCU joint reports was that KRS 205.8483 requires OIG to refer hotline complaints regarding recipient fraud and abuse to MFCU. Federal rules require the state Medicaid agency, not MFCU, to conduct all investigations of recipient fraud and abuse; and MFCU is not permitted to use federal funds for this purpose (42 CFR 455.15 and 1007.19(e)(5)). According to the agencies at the time, OIG forwarded to MFCU a list of all recipient complaints, and MFCU did not act on them. Although this was an inconvenience to OIG, it did not appear to require a recommendation from Program Review.

Enforcement Enhancements For The Office Of Inspector General

The 2006 and 2007 Program Review reports described enforcement authority enhancements that OIG sought. These focused on program abuse. MFCU cannot pursue providers who abuse the Medicaid program but do not commit criminal fraud. Rather, OIG and the Department for Medicaid Services are responsible for recovering the overpayments. These agencies had limited

options, especially if the provider closed or dropped out of Medicaid. The proposed additional authority included

- administrative subpoena power;
- expansion of administrative or civil penalties to cover program abuse;
- administrative enforcement proceedings;
- mandatory reporting of fraud, abuse, and waste; and
- extension of record-keeping requirements to other public assistance programs.

The 2006 and 2007 Program Review reports made the following recommendations.

The General Assembly may wish to consider amending KRS 194A.020(5) to enhance the ability of the Office of Inspector General to pursue administrative actions in allegations of fraud and abuse against the Medicaid program, including the ability to issue administrative subpoenas and impose civil penalties (IS 90).

If it is the intent of the General Assembly to more fully empower the Office of Inspector General to combat Medicaid fraud and abuse, then the General Assembly may wish to consider the changes requested by that office as embodied in Senate Bill 223 of the 2005 Regular Session (Rx 50).

Current Findings

Referrals Of Fraud And Abuse Hotline Complaints. In the 2009 OIG-MFCU joint report, OIG continued to request removal of the word *immediately* from KRS 205.8483(2). However, in 2010, OIG and MFCU indicated general satisfaction with the relationship between the agencies. OIG refers all complaints to MFCU immediately and screens the complaints to determine which ones merit a preliminary investigation. When OIG begins a preliminary investigation, MFCU assigns an investigator as a liaison. If there is sufficient evidence at any point, including initial screening, to believe fraud has occurred, OIG hands the case to MFCU for full investigation. Even if the preliminary investigation does not find sufficient evidence, OIG sends a summary to MFCU.

OIG stated that it no longer sends to MFCU notification of hotline complaints involving only recipient fraud and abuse. MFCU confirmed that it no longer receives these referrals, but OIG tells MFCU how many there were. This decision eliminated a minor task of little practical value but one that is required by existing Kentucky law. An OIG official expressed the opinion that the recipient referral requirement should be removed.

Program Review staff find the following:

- The contracts and agreements among the Department for Medicaid Services, the Office of Inspector General, and the Medicaid fraud control unit clearly describe a division of duties that appears consistent with federal regulations.
- The current working relationship among the agencies appears positive and productive.
- No change in KRS 205.8483 regarding provider complaints is needed. Although OIG must refer complaints to MFCU immediately, MFCU is free to wait until OIG has completed the federally required preliminary investigation. Immediate referral creates an incentive for OIG to complete preliminary investigations in a timely manner.

- OIG should send to MFCU a nominal written description of all hotline complaints involving recipient fraud and abuse as required by KRS 205.8483(2)(a).
- Recognizing that MFCU may not expend federal funds to act on recipient fraud, the General Assembly may wish to consider amending KRS 205.8483(2)(a) to remove reference to recipients.

Enforcement Enhancements For The Office Of Inspector General. Senate Bill 47 of the 2005 Regular Session, which combined the Cabinet for Families and Children with the Cabinet for Health Services, gave the cabinet administrative subpoena power. In 2009, the cabinet promulgated 906 KAR 1:170 to authorize OIG to use this subpoena power. The cabinet has the authority to give the same power to DMS.

Administrative or civil penalties and enforcement proceedings are no longer relevant to OIG because responsibility for recovery of overpayments resulting from abuse and waste was transferred to the Department for Medicaid Services' Division of Program Integrity.

When DMS can demonstrate that a provider has knowingly submitted or caused to be submitted improper claims for Medicaid payment, the department can impose treble damages, penalties, and interest. The department also may bar the provider from Medicaid for a period of time (KRS 205.8467). This constitutes a debt to the agency.

When DMS can demonstrate that a provider has received other improper payments through program abuse or error, the department may demand repayment. This also constitutes a debt to the agency.

If a provider refuses to repay an outstanding debt, DMS can withhold the amounts from future claims payments. However, if the provider no longer participates in the Medicaid program, the cabinet refers the debt to the Department of Revenue for collection and possible civil action by the Office of the Attorney General (KRS 45.237 and 45.238).

According to the cabinet, there has been difficulty achieving full recovery in fraud cases. In these cases, prosecutors often charge the provider with only a few fraudulent claims in order to present the best evidence of criminal conduct. Court-ordered restitution usually is much less than the total value of allegedly fraudulent claims. The cabinet asserted that it has had difficulty litigating the same issues with the same provider. Program Review staff were unable to determine why this should be the case. Simultaneous and sequential criminal and civil suits addressing the same conduct are common in other states. Kentucky law does not appear to prevent DMS from proceeding through the Department of Revenue as described above.

Mandatory reporting of fraud and abuse has been in place since 1994 (KRS 205.8465). This statute explicitly includes fraud, abuse, and misappropriation of Medicaid funds. Program Review staff did not find any readily accessible online information from the cabinet explaining that reporting is mandatory. The statute does not require reporting when a state employee or contractor perpetrates fraud or abuse; the General Assembly may still wish to consider this situation.

Extension of record-keeping requirements has not been enacted. A 5-year record retention requirement has been in place since at least 1996 for Medicaid providers only (907 KAR 1:672 sec. 4(3)).

Program Review staff find that:

- The Cabinet for Health and Family Services has subpoena power and has authorized the Office of Inspector General to use it. The cabinet has the authority to permit the Department for Medicaid Services to issue subpoenas if needed.
- The cabinet should consider mentioning in its public materials that Medicaid fraud and abuse reporting is mandatory.
- Kentucky statutes appear to be adequate for recovering overpayments, but the cabinet should advise the General Assembly regarding specific improvements that would help the cabinet.
- The General Assembly may still wish to consider mandatory reporting of fraud and abuse perpetrated by cabinet employees or contractors.
- Provider record-keeping requirements are in place for Medicaid.

Potential Legal And Contractual Issues With Information Systems

The 2006 Program Review report on Medicaid information systems described issues concerning the funding for, data location and ownership of, and software rights to, the information systems procured by the Medicaid program.

Federal Financial Participation

By 2004, the federal Centers for Medicare and Medicaid Services had broadened the definition of systems that qualified for enhanced federal financial participation. Instead of the 50 percent federal match that the Kentucky pharmacy benefit administrator received at the time, it was possible for certain aspects of system implementation to qualify for a 90 percent match and for aspects of operation to qualify for 75 percent. To qualify for the 90 percent match, the state needed to have rights to the software, but it appeared that the contract did not grant software rights to Kentucky. If not, it seemed likely that none of the design, development, and implementation costs would qualify. However, the cost of the proprietary software systems related directly to Medicaid management information system functions, and the operation of that software, might still have qualified for a 75 percent match.

Similarly, CMS indicated that it would consider enhanced participation in some aspects of the Kentucky Medicaid administrative agent's software and its operation. Performance of tasks that represented MMIS functions might qualify for a 75 percent match.

At the time, Department for Medicaid Services officials stated that no cost distribution plans had been submitted to CMS for pharmacy benefit administrator or administrative agent funding. They stated, however, that the department would submit cost distribution plans in the future. Department officials were confident that CMS would pay any approved enhanced federal financial participation retroactively.

Ownership And Location Of Data

Electronic Data Systems, now HP Enterprise Services, proposed to process and maintain MMIS claims in its regional data center in Florida. First Health, now Magellan, as pharmacy benefit administrator proposed to process and maintain pharmacy claims in Virginia. First Health as Kentucky Medicaid administrative agent proposed to process and maintain data in Arizona and Virginia, although the proposal also mentioned a server location in Louisville. Kentucky Medicaid officials pointed out that telecommunications technology would allow for efficient processing and storage of data in out-of-state locations.

The degree of control over the commonwealth's Medicaid data merited concern. The MMIS contract included provisions requiring EDS to turn over the data and operating software on termination of the contract. The PBA contract required First Health to "cooperate" with a new vendor but was not specific about the transfer of data. The administrative agent contract was even less clear about the transfer of data at the end of the contract.

Software Rights

A Program Review staff attorney suggested that the interpretation of an MMIS contract clause was open to question. As written, it might have been interpreted to mean that EDS retained full rights to all software developed for the commonwealth, including the MMIS itself. However, in order to qualify for 90 percent federal funding, the rights to the MMIS must belong to Kentucky.

Based on these findings, the 2006 Program Review report recommended:

The Department for Medicaid Services should consult with the Centers for Medicare and Medicaid Services about potential enhanced federal financial participation for the development and operational phases of the pharmacy benefit administrator and Kentucky Medicaid administrative agent contracts. If CMS so advises, the department should submit to CMS cost distribution plans for the systems in an effort to obtain enhanced federal financial participation. The department should report the CMS response to the Program Review and Investigations Committee by December 2006 (IS 58).

The Department for Medicaid Services should evaluate whether it would be feasible and desirable to maintain in Kentucky a duplicate copy of Medicaid data stored by vendors outside Kentucky. The department should ensure that adequate contractual obligations are in place for vendors to transfer all Medicaid-related data to the Commonwealth upon termination of the contracts (IS 43).

The Department for Medicaid Services should obtain a legal opinion on the rights of the Commonwealth to MMIS software developed under the MMIS contract, particularly pages 6-7 of the Master Agreement. If necessary, the contract language should be modified to ensure compliance with requirements of the Centers for Medicare and Medicaid Services. The department should report the opinion and any action taken to the Program Review and Investigations Committee by December 2006 (IS 59).

There was no response from the cabinet, and there was no follow-up report to the committee on these recommendations.

Current Findings

Federal Financial Participation. The cabinet informed Program Review staff that the pharmacy benefit administrator contract did not include the costs of developing a system. Kentucky did receive a 90 percent match for implementation tasks and a 75 percent match for certain aspects of operation. Kentucky Medicaid administrative agent systems were included with the MMIS proposal submitted to CMS. A 75 percent match was approved for certain aspects of operation.

Ownership And Location Of Data. The cabinet stated that the fiscal agent, HP Enterprise Services; the pharmacy benefit administrator; the third-party liability vendor, HMS Inc.; and the Passport system all house their databases outside Kentucky. DMS does not maintain a duplicate copy of any of the databases. However, the vendors are obligated to maintain backup copies of their data. Also, when a contract ends, each vendor is contractually obligated to provide a copy of its data.

Software Rights. The cabinet stated that Kentucky Medicaid is satisfied with the language in the contracts. Upon further review of the MMIS contract and request for proposals, Program Review staff agree that it seems likely that the commonwealth has ownership of the software necessary to continue operating the MMIS after termination of the contract.

Program Review staff find that:

- The cabinet appears to have fulfilled the recommendation regarding federal financial participation in the costs of implementing and operating information systems.
- The cabinet should continue to pursue all opportunities for Kentucky Medicaid to receive the maximum allowable percentage of federal financial participation.
- The cabinet appears to have fulfilled the recommendation regarding the location of data.
- The cabinet appears to have fulfilled the recommendation regarding software rights.

Operation Of Advisory Bodies

The 2007 Program Review report found that there were two Medicaid advisory bodies defined in statute that were inactive: the Drug Management Review Advisory Board and the Recipient Utilization Review Committee.

Drug Management Review Advisory Board

Federal law and regulations require each state to create a drug use review (DUR) board (42 USC 1396r-8(g)(3); 42 CFR 456.716). The boards are intended to ensure that state Medicaid programs implement prescription screening procedures that help pharmacists ensure that prescriptions are appropriate, are medically necessary, and are not likely to result in adverse medical results. The boards are also intended to ensure that state Medicaid programs examine pharmacy claims after payment to educate physicians and pharmacists and to identify and reduce

the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care (42 USC 1396r-8(g)(1) to 1396r-8(g)(3)).

In 1998, the General Assembly set up the Drug Management Review Advisory Board (DMRAB) to meet the federal requirements and serve as Kentucky's DUR board (KRS 205.5636 and 205.5638). As of 2007, DMRAB had not met since August 2004. No cabinet officials that staff interviewed were familiar with such a board (Rx 47). There was some discussion of whether the Pharmacy and Therapeutics Committee performed the necessary functions, but it was clear that the committee did not meet the federal criteria for a DUR board.

Based on these findings, the 2007 Program Review report recommended:

The Cabinet for Health and Family Services should reconstitute the Drug Management Review Advisory Board and ensure that it fulfills its duties under federal and Kentucky law. If the cabinet believes that the board's duties and those of the Pharmacy and Therapeutics committee could be combined, it should propose to the General Assembly legislation that is consistent with federal law (Rx 49).

In its response to the recommendation, the cabinet said that the Department for Medicaid Services would pursue reinstating DMRAB. The cabinet asserted that the responsibilities of the Pharmacy and Therapeutics Committee were not the same as those of DMRAB and that the two should not be combined.

Recipient Utilization Review Committee

The Recipient Utilization Review Committee (RURC) was mandated by KRS 205.8455 to be created by July 1994. Its primary objective was to review Medicaid use by recipients who might be abusing or defrauding the program. However, Program Review staff found no evidence that the committee ever existed.

The statute defines the responsibilities of the committee and notes that some of them would require a waiver of federal law. Those provisions would not be effective unless a waiver were obtained.

RURC would comprise multiple entities, including the Department for Public Health, the Department for Medicaid Services, and one or more Medicaid recipients. For benefit abuse, the statute authorizes a lock-in program that restricts such recipients to a single doctor or pharmacist. For suspected benefit fraud, the case would be referred to the Office of Inspector General, and if that office determined that there was recipient fraud, RURC would revoke the recipient's participation in the Medicaid program for a limited period. Such a revocation would require a waiver of federal law.

RURC is also mentioned in KRS 205.8459(2). That statute says the Department for Medicaid Services shall consult with the committee in defining terms related to the provision of emergency services.

The 2007 Program Review report recommended:

Recognizing that the Recipient Utilization Review Committee does not exist, the General Assembly may wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable. If the statute is not so modified, the Department for Medicaid Services should operate the committee as defined in the law (Rx 64).

The cabinet's original response to the recommendation in the 2007 report was that the requirement for an RURC should be deleted from the law. The reasons were twofold:

- The authority given to RURC should be moved to the Department for Medicaid Services.
- Federal Medicaid rules have single state agency requirements. These specify that individuals not employed by or under contract with the state Medicaid agency should not make determinations regarding Medicaid eligible individuals (Rx 193).

Current Findings

Drug Management Review Advisory Board. In 2010, the cabinet reinstated DMRAB and reiterated that the board and the Pharmacy and Therapeutics Committee have different functions and should remain separate entities. The cabinet's action followed introduction of budget language in March, instructing the cabinet to follow the statute. DMRAB held its first meeting in May and met again in August and November; it was scheduled to meet quarterly thenceforward. However, the minutes of the meetings have not been posted on the board's website.

Program Review staff find the following:

- The cabinet has reconstituted the Drug Management Review Advisory Board, and the board appears to be fulfilling its duties under federal and Kentucky law.
- The board's website should include its meeting minutes.

Recipient Utilization Review Committee. In 2010, the statute remains intact but the cabinet has not created the committee. Cabinet officials said that the Department for Medicaid Services' position has not changed since the 2007 study. The cabinet has tried several times to seek repeal of the requirement that such a committee be maintained, and the cabinet still has concerns that the committee as described in Kentucky statute could be in conflict with the federal single state agency requirement. The cabinet also cited possible problems with the Health Insurance Portability and Accountability Act because committee members outside the department would need to review personal health information.

Program Review staff suggest that the Kentucky statute can be interpreted to imply that RURC is an organizational unit within the Department for Medicaid Services, preserving the department as the single state agency. This is similar to the Drug Management Review Advisory Board and the Pharmacy and Therapeutics Committee, both of which have members outside the department.

Staff also note that if RURC is considered an organizational unit of the department, then it should be possible to satisfy federal privacy requirements through confidentiality agreements. If not, then the department could execute a business associate agreement with the committee.

Program Review staff find the following:

- Recognizing that the Recipient Utilization Review Committee does not exist at present, the General Assembly may still wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable.
- If the Kentucky statutes are not so modified, the Department for Medicaid Services should operate RURC as defined in the law, to the extent permitted by federal law.
 - The department should ask the Centers for Medicare and Medicaid Services if RURC and its duties, as currently defined in Kentucky law, would conflict with the single state agency requirements.
 - The department should seek any federal waivers necessary to implement the statute.
 - The department should seek direction from the federal Department of Health and Human Services on ways that RURC as currently defined in Kentucky law could satisfy federal privacy requirements.
 - If there are insurmountable federal obstacles, then the department should inform the relevant committees of the General Assembly, including the Program Review and Investigations Committee.

Federal Drug Use Review Reporting

The 2007 Program Review report described the federal requirements for a drug use review board and noted not only that the Kentucky board did not exist, but that cabinet officials and the pharmacy benefit administrator were unable to locate copies of federally required annual DUR reports.

The 2007 Program Review report recommended

The Department for Medicaid Services should ensure that the annual drug use review report is prepared and sent to the federal government. In addition, the department should provide copies of the last five such annual reports and all future reports to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission (Rx 50).

The cabinet agreed with the recommendation, but copies of the reports have not been provided.

The Office of the Attorney General commented that it would like to have copies of the reports.

Current Findings

In 2010, Program Review staff again requested copies of DUR reports from federal fiscal years 2003 forward. The cabinet provided reports for 2005 to 2009. The reports for 2005 and 2006 contained hundreds of pages of detailed listings, such as individual pharmacy denials and denial overrides; this information was not useful. However, the 2007 to 2009 reports were much shorter and contained useful summaries of prescription drug usage.

In response to an inquiry from Program Review staff, the Centers for Medicare and Medicaid Services wrote that all Kentucky DUR reports were submitted on schedule “to the best of our

knowledge.” The letter also stated, “There is no measure of adequacy that we attach to the report” (Glaze).

The cabinet indicated that it has not provided copies of DUR reports to the Office of the Attorney General.

Program Review staff find the following.

- The Department for Medicaid Services was unable to provide drug use review reports for 2003 and 2004.
- The federal Medicaid agency did not indicate any problems with Kentucky’s DUR report submissions.
- Going forward, DMS should provide a copy of each annual DUR report to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission.
- Going forward, DMS should consult with the Office of the Attorney General and decide whether to provide the office with copies of the annual reports.

KASPER Statutes

The Kentucky All Schedule Prescription Electronic Reporting system is a Web-based system that tracks controlled substance prescriptions for persons and providers. The Drug Enforcement and Professional Practices Branch of the Kentucky Cabinet for Health and Family Services’ Office of Inspector General operates KASPER.

The Medicaid management information system interfaces with KASPER. If Medicaid has identified a recipient as having an unusual usage of controlled substances, it can receive information from KASPER. Medicaid can also ask for KASPER information about prescribers or pharmacists. The interface filters the information so Medicaid receives only prescription information for Medicaid recipients.

In the 2007 Program Review report, six concerns were raised about KRS 218A.202 and one about KRS 218A.240. All concerns involved access by various entities to KASPER data. The report recommended:

If it is the intent of the General Assembly to clarify the permitted and prohibited uses of data in the Kentucky All Schedule Prescription Electronic Reporting system, then the General Assembly may wish to consider amending KRS 218A.202 and KRS 218A.240 to remove possible ambiguities and inconsistencies (Rx 94).

Cabinet officials responded to each of the concerns individually. The concerns and the responses are summarized here.

The first and second concerns had to do with KRS 218A.202(6)(c), which says that the cabinet shall be authorized to provide KASPER data to “a state-operated Medicaid program.” Staff asked whether the statute limited Kentucky’s and other states’ Medicaid programs to data about Medicaid recipients.

The cabinet responded that the provision means that Kentucky's Medicaid program could only access KASPER data for Medicaid recipients and Medicaid providers. Another state Medicaid program would have to complete a KASPER account application process that would place the same limitations on it that were in place for Kentucky.

The third concern was about KRS 218A.202(8)(b), which says,
a representative of the Department for Medicaid Services may share data or reports regarding overutilization by Medicaid recipients with a board designated in subsection (6)(a) of this section, or with a law enforcement officer designated in subsection (6)(b) of this section.

The referenced subsections, KRS 218A.202(6)(a) and (6)(b), say that the cabinet can only provide KASPER data to a "designated representative of a board ... who is involved in a bona fide specific investigation involving a designated person," or a Kentucky or other certified peace officer "who is engaged in a bona fide specific investigation involving a designated person." The report questioned whether the Medicaid program's license to share data about a recipient should be restricted to boards or law enforcement officers involved in a bona fide specific investigation of that recipient.

The cabinet responded that Medicaid may share KASPER data or reports only with a licensure board or law enforcement officer when that entity is engaged in an investigation of the persons being reported. Further, if Medicaid staff suspected potential controlled substance abuse, Medicaid staff did not release KASPER information. Instead, it referred the situation to the Drug Enforcement and Professional Practices Branch in the Office of Inspector General (Rx 195).

The fourth concern was whether KRS 218A.202(8)(b) should explicitly address sharing KASPER information about Medicaid providers with investigating entities. The cabinet's response did not address the question.

The fifth concern was about KRS 218A.202(8)(c), which says "the Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B." The report questioned whether the statute should explicitly limit the Department for Medicaid Services' use of KASPER data to administrative hearings related to Medicaid.

The cabinet responded that it would not be opposed to modifying the statute to clarify that Medicaid may only provide KASPER data to Medicaid hearings (Rx 196).

The sixth concern was about KRS 218A.202(12), which says "obtaining information under this section not relating to a bona fide specific investigation, shall be a Class D felony for the first offense." The report asked whether the statute should explicitly reference the exception for Medicaid to obtain KASPER data for purposes other than a bona fide specific investigation.

The cabinet responded that
Medicaid access to KASPER data is enumerated in KRS 218A.202(6)-(8), and the exception for using KASPER data in a Medicaid administrative hearing is referenced in

KRS 218A.202(10) If the General Assembly believes it is needed, a reference to the exception in paragraph 10 could be added to KRS 218.202(12) to provide further clarification (Rx 196).

The seventh concern was about KRS 218A.240(7)(a), which states that the cabinet shall use KASPER data “for investigations ... and shall proactively identify trends in controlled substance usage and other potential problem areas.” The section further says that the cabinet shall notify a board responsible for the licensure, regulation, or discipline of each practitioner, pharmacist, or other person who is authorized to prescribe, administer or dispense controlled substances, if a report or analysis conducted under this subsection indicates that further investigation about inappropriate or unlawful prescribing or dispensing may be necessary by the board.

A question was whether this paragraph gives cabinet personnel the authority to look for patterns in KASPER data, without prior suspicion of specific persons, in order to identify and investigate possible criminal activity.

The cabinet responded that

the General Assembly may wish to modify this paragraph to clarify whether the cabinet has authorization to proactively research KASPER data for investigative purposes to identify specific controlled substance drug abusers or diverters (Rx 196).

Current Findings

The concerns raised in the Program Review report still seem relevant. Regarding the seventh concern, the cabinet currently asserts that no cabinet personnel, except those in the Department for Medicaid Services, search KASPER data to identify prescribers, dispensers, or patients engaging in possible criminal behavior and that doing so would violate the statutes.

Program Review staff find the following.

- The General Assembly may still wish to consider amending KRS 218A.202 to remove possible ambiguities and inconsistencies regarding access to data in the Kentucky All Schedule Prescription Electronic Reporting system.
- The cabinet currently interprets the statutes as prohibiting cabinet personnel from looking for patterns in KASPER data under KRS 218A.240(7) in order to identify and investigate possible criminal activity of any individuals without prior suspicion. The General Assembly may still wish to clarify the intent of this statute.

Controlled Substance Laws

The federal Controlled Substances Act of 1970 establishes five classes of controlled substances based on a drug’s potential for abuse, accepted medical use, and accepted safety under medical supervision. Schedule I has the highest potential for abuse, and Schedule V has the lowest (21 USC 812).

Some states, including Kentucky, codify their own schedules of controlled substances. Kentucky codified its initial schedule, which generally corresponded to the federal schedule, at KRS 218A.030 to 218A.130. In Kentucky, the substance classifications can be changed in two ways: by statute or by administrative regulation. KRS 218A.020 authorizes the Cabinet for Health and Family Services to promulgate regulations to change the classification of any drug that is not available over the counter.

Cabinet officials stated that the federal controlled substance schedule takes precedence if more restrictive than the state schedule. However, Kentucky can make its schedule more restrictive than the federal schedule. For example, Kentucky classifies carisoprodol (Soma), which is not scheduled in the federal classification, as a Schedule IV controlled substance.

The 2007 Program Review report noted that Kentucky's controlled substance statute might need to be clarified. Because the General Assembly wrote the original drug schedule into statute, "granting administrative authority to the cabinet to alter a statutory schedule may raise concerns about the delegation of law-making power to this executive branch agency" (Rx 82). Physicians and pharmacists were asked to list noncontrolled substances that should be scheduled and controlled substances that should be rescheduled. Seventy-nine percent of the pharmacists indicated that tramadol (Ultram) should be a scheduled drug.

Based on these findings, the 2007 Program Review report made two recommendations:

The General Assembly may wish to consider options to remove potential conflicts among KRS 218A.020-130, related administrative regulations, and the federal controlled substance schedule (Rx 83).

The Cabinet for Health and Family Services should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling (Rx 83).

In response to the first recommendation, cabinet officials recommended that KRS 218A.070 to 218A.130 be modified to incorporate the corresponding federal schedules by reference. The cabinet would then need to modify Kentucky regulations only to specify additional Kentucky controlled substance restrictions. In response to the second recommendation, the cabinet reported that it had filed a regulation to classify tramadol as a schedule IV controlled substance.

Current Findings

The rescheduling of tramadol in 902 KAR 55:030 became effective in 2008.

In 2010, cabinet officials said that it continued to support modifying KRS Chapter 218A to incorporate the corresponding federal controlled substance schedules. Tramadol is the only substance the cabinet has scheduled or rescheduled since 2007. The cabinet is not currently considering any other changes to the controlled substance schedule.

Program Review staff find the following:

- The General Assembly may still wish to consider options to remove potential conflicts among KRS 218A.020 to 218A.130, related administrative regulations, and the federal controlled substance schedule, perhaps by incorporating the federal schedules by reference.
- Tramadol (Ultram) was scheduled as recommended.
- The cabinet should continue to review other drugs for more restrictive scheduling as needed.

Medicaid Fraud Control Unit's Federal Funding

Most state Medicaid fraud control units, including Kentucky's, are housed in the state's Office of the Attorney General. They are reimbursed by the federal government for 75 percent of their costs, capped at one-fourth of one percent of the state's total Medicaid expenditures or \$500,000 annually, whichever is greater. The actual amount received may be less, based on the matching state funds. Under this formula, Kentucky could have received more than \$11.4 million in FY 2006, but the state allocated only enough matching funds to receive just more than \$2.2 million, forgoing about \$9.2 million, or 80 percent, of available funding.

From FY 2000 to FY 2004, the federal reimbursement forgone increased steadily to 88 percent, indicating that Kentucky was spending fewer state dollars on its Medicaid fraud control program relative to total Medicaid expenditures, even though state MFCU spending increased during the period. In fiscal years 2005 and 2006, state spending for MFCU increased and the portion of forgone federal funds returned to 80 percent.

The federal government will approve incremental increases in funding with proper justification. To qualify for additional federal funding, MFCU need only demonstrate that state matching funds are available. At the time of the 2007 Program Review report, Kentucky's MFCU had experienced an increase in workload. Because a MFCU is responsible for handling allegations of patient abuse and neglect in health care facilities, several extensive cases of patient abuse in the past several years had stretched Kentucky's MFCU staff.

The report noted that staffing issues could become highly significant in subsequent years as well, because several changes had taken place. The federal Medicaid Integrity Plan audits and Payment Error Rate Measurement project had the potential to generate some fraud referrals. Perhaps more significantly, the Kentucky Department for Medicaid Services hired a program integrity vendor to implement a modern and comprehensive program integrity function. From these new initiatives, MFCU could have received a large increase in referrals.

MFCU officials pointed out that when prosecuting Medicaid criminal fraud cases, return on investment is not always a consideration. There may be cases in which prosecution costs more than the amount recovered through restitution. Although MFCU had recovered more than it had spent in several previous fiscal years, there was no guarantee of a positive return in the future.

Based on these findings, the 2006 and 2007 Program Review reports recommended:

The Office of the Attorney General should consider requesting additional state funding from the General Assembly to more fully access the federal funds to operate its Medicaid

Fraud and Abuse Control Division. The office should allocate state appropriations to the division in amounts necessary to maximize access to the federal funds. If at any time the office believes additional state funds are necessary to access federal matching funds for operation of the Medicaid Fraud and Abuse Control Division, an emergency appropriation increase should be requested for the division utilizing unused or discretionary funds from other budget units within the Office of the Attorney General. This action by the office should be utilized to the greatest extent possible without significantly impairing other legal, investigative, and administrative functions. When requesting additional funds from the General Assembly during the budget process, the Office of the Attorney General should present a comprehensive plan with the request outlining how the new funds will be used and the expected results from the increased expenditures (IS 75).

The General Assembly should consider appropriating additional state funds to the Office of the Attorney General for the specific purpose of accessing a larger amount of federal funds to operate its Medicaid Fraud and Abuse Control Division only after the office has shown that appropriation increases provided through fund transfers from other budget units within the office are insufficient to obtain the specified goals of the Medicaid Fraud and Abuse Control Division. Additional funding by the General Assembly should be made as a specific line-item appropriation for the purpose of accessing larger amounts of federal funds to operate the Medicaid Fraud and Abuse Control Division. Specified appropriations by the General Assembly should be contingent upon demonstrating, to an appropriate legislative committee, by the Office of the Attorney General actual results produced by the Medicaid Fraud and Abuse Control Division and obtaining a determination by the General Assembly that the results warrant the additional funding requested (IS 75.)

The Office of the Attorney General should develop a budget request for state funding necessary to cover the costs of investigating and prosecuting all the anticipated criminal Medicaid fraud cases referred as well as performing the other duties for the Medicaid fraud control unit. The attorney general should provide a justification for the funding request and a range of estimated recoveries (Rx 110).

The Office of the Attorney General responded to the 2006 report:

The Office of the Attorney General regularly requests additional general funds for the Medicaid Fraud program to make full use of available federal funds This office plans to continue our requests for additional funds to maximize federal funds whenever possible The mission of the Medicaid Fraud and Abuse Control Division is prosecutorial in nature. Investigating fraud perpetrated against the Medicaid program and crimes committed against vulnerable adults in health care facilities are the Division's main focus. Often, providers who are convicted of fraud against the Medicaid program are ordered to make full restitution as part of their sentences. The Medicaid Fraud and Abuse Control Division always seeks such an order (IS 125-126).

The office also pointed out that new employees require 18-24 months on the job before they are independently functional, which can bring case recovery statistics down; and that Kentucky's

unit, unlike those of some states, does not have civil authority and so the burden of proof is always the highest (IS 126-127).

Current Findings

MFCU in Kentucky is now the Office of Medicaid Fraud and Abuse Control of the Office of the Attorney General.

In 2010, the Office of the Attorney General stated that MFCU processes all complaints received from any source regarding criminal Medicaid provider fraud. The unit also pursues average wholesale price cases against various pharmaceutical companies and pursues other civil claims through the National Association of Medicaid Fraud and Abuse Control Units.

MFCU provided the budget figures shown in Table 2.6. The amount of available federal funding forgone is around 85 percent. The funding level is slightly less than it was in 2006.

Table 2.6
Kentucky Medicaid Fraud Control Unit Budget And Use of Federal Funds
Fiscal Year 2010 To Fiscal Year 2012

State Fiscal Year	State Funds	Federal Funds		% Of Federal Funds Forgone
		Used	Available	
2010 Actual	\$709,000	\$2,127,000	\$13,662,000*	84.4%*
2011 Budget	725,700	2,177,000	14,054,000	84.5
2012 Budget	745,400	2,236,000	15,575,000	85.6

Note: Dollar amounts are rounded to the nearest \$1,000. Fiscal years are state fiscal years.

*Based on the 2008-2010 Medicaid budget; the actual amount may differ slightly.

Source: Information from Office of the Attorney General and budget legislation.

MFCU provided financial information for October 2008 to September 2010. The return on investment per dollar spent was \$19.65 based on expenditures of \$5.7 million and recoveries and awards of nearly \$112.1 million. Because of the variable nature of recoveries and awards, it is likely that future returns would be different.

In response to questions from Program Review staff in 2010, the Office of the Attorney General stated,

Since [state fiscal year 2008], the office’s general fund budget has been cut by over 32%. In spite of that, the office continues to maintain and/or increase the budget for the MFCU each fiscal year To increase general fund support to the maximum federally permitted level for the Office of Medicaid Fraud and Abuse without additional general fund appropriations would decimate many other programs in the [Office of the Attorney General] (Denham).

MFCU indicated that it was able to handle the current workload with its current budget and staff. The unit depends on referrals from the Department for Medicaid Services and other sources because it is not permitted to spend federal funds to search Medicaid claims data for potential

fraud. It appears that MFCU has not received the expected increase in fraud referrals from the enhanced program integrity efforts of the Department for Medicaid Services.

However, there should be more fraud referrals in the coming years because of the continued federal audit programs, the steadily increasing federal emphasis on fraud and abuse detection, and the new Medicaid program integrity vendor. If a new federal rule proposed in March 2011 is adopted, MFCUs will be permitted to search Medicaid claims data directly (US. Dept. Office of Inspector General). In addition, if the General Assembly were to pass a state false claims act, MFCU probably would see a large increase in its workload.

Program Review staff find the following:

- It appears that the Office of the Attorney General has been making the fullest use of its state funds for the Medicaid fraud control unit.
- The unit's current staffing appears to be adequately handling the cases that come before it. There is no need for General Assembly action at this time.
- The Office of the Attorney General should be prepared to request additional funds in the future if workload increases because of new federal regulations, greater effectiveness of the Medicaid program integrity effort, or the passage of a state false claims act.

Relief From Federal Recoupment Of Overpayments

Prior to 2010, federal rules required states to repay the federal share of all overpayments 60 days after the overpayments were discovered. State Medicaid programs often were unable to recover overpayments within the 60-day period and so lost the federal funds as well as their own until able to complete the recoveries. For cases in which recovery was impossible, such as bankruptcy and death, there was a federal process for writing off the debt and recouping the federal share (42 USC 1396b(d)(2)).

In addition, the Centers for Medicare and Medicaid Services implemented several programs to audit state claims. States were required to recover any overpayments the audits discovered, and the overpayments were subject to the same 60-day recovery window. State Medicaid programs expressed concern that if those audits discovered large numbers of overpayments, the states could become liable for large repayments to the federal government before being able to complete the recoveries.

The 2007 Program Review report recommended

If it is the intent of the General Assembly to assist the Kentucky Medicaid program in seeking more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs, the General Assembly may wish to consider a resolution asking Congress to provide such relief (Rx 46).

Current Findings

In 2010, the Affordable Care Act extended the period for repaying the federal share of overpayments to 1 year. It also created an exception so that if the overpayment is a result of

fraud, and there is an administrative or judicial process under way, the repayment is not required until 30 days after final judgment (P.L. 111-148 sec. 6506).

According to the cabinet, the CMS audit programs so far have not resulted in a significant increase in discovery of overpayments. This may be a result of the limited intensity of the audits. However, CMS plans to increase the scope and intensity of the audits, and the state might need to increase its recovery staff in the future. The state should experience a positive return on this investment. With the change in the overpayment recovery window, it seems much less likely that the state would face a significant repayment of federal funds based on these audits.

Program Review staff find the following:

- Because the overpayment recovery window was widened to 1 year, that issue is moot.
- If the scope and intensity of federal audits are expanded, it is possible that state Medicaid programs will have to expand their recovery staffs; however, there should be a positive return on this investment.
- The cabinet should advise the General Assembly regarding any resolutions to Congress that might support helpful changes to federal laws.

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Appendix A

Status Of Program Review And Investigations Committee Recommendations

Recommendations from the three Program Review reports covered in this follow-up are listed in the order in which they originally appeared, with an indication of status and the page number on which they appear in this report.

Statuses are the following:

- Complete: No further work is needed.
- Ongoing: The recommendation was completed, and subsequent work is ongoing as expected.
- Partial: Some progress was made, but additional work is needed.
- Remaining: All or most of the recommendation remains to be done.
- Added items: Updated or additional recommendations were made in the follow-up.
- Moot: The recommendation is no longer relevant.

Recommendations From Report *Uncollected Revenues and Improper Payments Cost Kentucky Millions of Dollars a Year (2004)*

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
3.1: To maximize Medicaid’s liability to avoid paying claims that are the responsibility of a liable third party, the General Assembly may wish to consider amending KRS 205.623 to include a penalty for noncompliance (31; <i>Information Systems</i> 85).	Complete	50
3.2: The Cabinet for Health and Family Services should review the feasibility of establishing a field-based investigation unit such as the Cooperative Review of Eligibility program. The review should include a cost-benefit analysis. The results of the analysis and any actions taken to expand the capability of the Office of Inspector General to conduct field investigations should be reported to the Program Review and Investigations Committee before the 2005 session of the General Assembly (35).	Complete	47
3.3: The CHFS Inspector General should implement the planned expansion of audit and investigative functions and ensure the financial integrity of public benefit programs administered by the cabinet. The Inspector General should develop a method to report the results of audits and investigations. The Office of Inspector General should report to the Program Review and Investigations Committee before the 2005 session of the General Assembly all actions taken to strengthen the audit and investigative functions of the cabinet (37).	Partial	19

(continued)

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
3.4: Medicaid should actively try to collect all drug rebates and interest owed by all pharmaceutical companies, including current and backlogged amounts (40).	Ongoing	25
3.5: Medicaid should monitor interest charges on all invoices to drug manufacturers. When an invoice remains unpaid, interest charges should be assessed on the outstanding balance from the due date (40).	Ongoing	25
3.6: Medicaid should resolve disputed amounts in the backlog of drug rebate receivables. If the backlogged amounts are not collectible, they should be removed from the receivable balance to enable Medicaid to concentrate on collectible amounts due (40).	Partial	25
4.3: The Cabinet for Health and Family Services should determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care. Medical support can include partial or full payment of dependent children's medical bills, partial or full payment of private health insurance coverage accessed by the custodial parent for their dependent children, or reimbursement to Medicaid for the use of Medicaid services (63).	Moot, Added items	51

Recommendations From Report *Information Systems Can Help Prevent, but Not Eliminate, Health Care Fraud and Abuse (2006)*

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
2.1: The Cabinet for Health and Family Services’ Office of Inspector General should develop an estimate of the cost and effort involved in adding the method of payment field to KASPER, as recommended by the House Bill 303 Prescription Drug Abuse Task Force. This estimate should include the changes needed by pharmacies that report information to KASPER and should consider any options that might minimize such changes. The Office of Inspector General should report its findings to the Program Review and Investigations Committee and the Health and Welfare Committee (15).	Partial, Added items	59
3.1: The Department for Medicaid Services should evaluate whether it would be feasible and desirable to maintain in Kentucky a duplicate copy of Medicaid data stored by vendors outside Kentucky. The department should ensure that adequate contractual obligations are in place for vendors to transfer all Medicaid-related data to the Commonwealth upon termination of the contracts (43).	Ongoing	64
3.2: The Department for Medicaid Services should ensure that the MMIS and enterprise data warehouse contain full information about pharmacy and managed care claims, including all claims data fields, attempted claims that were denied, resubmissions, prior authorizations, adjustments, and corrections (46).	Partial, Added items	56
3.3: The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health’s pharmacy benefit software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the pharmacy benefit administrator should use EDS software to perform their tasks (48).	Remaining	56
3.4: The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health’s administrative agent software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the Kentucky Medicaid administrative agent should use EDS software to perform their tasks (50).	Moot	56

(continued)

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
3.5: The Department for Medicaid Services, the Office of Inspector General, and Medicaid vendors should review the need for multiple data warehouses and decision support systems. When feasible and cost effective, the enterprise data warehouse and decision support system should be used rather than having additional copies of the Medicaid data and additional decision support software (51).	Remaining	56
3.6: The Department for Medicaid Services and the Office of Inspector General should take as aggressive a stance as possible to implement effective edits and audits and prevent improper payments. Both organizations should evaluate the benefits and disadvantages of point-of-sale claims processing versus traditional batch processing, including manual review of suspended claims (53).	Partial	32
3.7: The Department for Medicaid Services should document and follow edit/audit management procedures that require high-level management control over any request to change or disable an edit/audit, that require immediate corrective action to reactivate the edit/audit, and that require prompt review of all affected payments and prompt recovery of all resulting improper payments (53).	Partial	33
3.8: For surveillance and utilization review, the Kentucky Medicaid administrative agent, pharmacy benefit administrator, related vendors, and the Office of Inspector General should include and analyze all available data from the MMIS and pharmacy benefit and managed care systems (55).	Partial	34
3.9: The Department for Medicaid Services should report the following information to the Program Review and Investigations Committee by December 2006:		14
<ul style="list-style-type: none"> • What measurements will be used to determine the health improvements and cost effectiveness of the pharmacy benefit administrator? Who will conduct the assessment and when will it be done? • What measurements will be used to determine the health improvements and cost effectiveness of the Kentucky Medicaid administrative agent? Who will conduct the assessment and when will it be done? • What measurements will be used to determine the health improvements and cost-effectiveness of the KyHealth Choices program? Who will conduct the assessment and when will the assessment be done (55-56)? 	<ul style="list-style-type: none"> • Partial • Moot • Partial 	

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
3.10: The Department for Medicaid Services should consult with the Centers for Medicare and Medicaid Services about potential enhanced federal financial participation for the development and operational phases of the pharmacy benefit administrator and Kentucky Medicaid administrative agent contracts. If CMS so advises, the department should submit to CMS cost distribution plans for the systems in an effort to obtain enhanced federal financial participation. The department should report the CMS response to the Program Review and Investigations Committee by December 2006 (58).	Ongoing	64
3.11: The Department for Medicaid Services should obtain a legal opinion on the rights of the Commonwealth to MMIS software developed under the MMIS contract, particularly pages 6-7 of the Master Agreement. If necessary, the contract language should be modified to ensure compliance with requirements of the Centers for Medicare and Medicaid Services. The department should report the opinion and any action taken to the Program Review and Investigations Committee by December 2006 (59).	Complete	64
4.1: The Office of the Attorney General should consider requesting additional state funding from the General Assembly to more fully access the federal funds to operate its Medicaid Fraud and Abuse Control Division. The office should allocate state appropriations to the division in amounts necessary to maximize access to the federal funds. If at any time the office believes additional state funds are necessary to access federal matching funds for operation of the Medicaid Fraud and Abuse Control Division, an emergency appropriation increase should be requested for the division utilizing unused or discretionary funds from other budget units within the Office of the Attorney General. This action by the office should be utilized to the greatest extent possible without significantly impairing other legal, investigative, and administrative functions. When requesting additional funds from the General Assembly during the budget process, the Office of the Attorney General should present a comprehensive plan with the request outlining how the new funds will be used and the expected results from the increased expenditures (75).	Ongoing	73

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
4.2: The General Assembly should consider appropriating additional state funds to the Office of the Attorney General for the specific purpose of accessing a larger amount of federal funds to operate its Medicaid Fraud and Abuse Control Division only after the office has shown that appropriation increases provided through fund transfers from other budget units within the office are insufficient to obtain the specified goals of the Medicaid Fraud and Abuse Control Division. Additional funding by the General Assembly should be made as a specific line-item appropriation for the purpose of accessing larger amounts of federal funds to operate the Medicaid Fraud and Abuse Control Division. Specified appropriations by the General Assembly should be contingent upon demonstrating, to an appropriate legislative committee, by the Office of the Attorney General actual results produced by the Medicaid Fraud and Abuse Control Division and obtaining a determination by the General Assembly that the results warrant the additional funding requested (75).	Ongoing	74
4.3: To maximize Medicaid's liability to avoid paying claims that are the responsibility of a liable third party, the General Assembly may wish to consider amending KRS 205.623 to include a penalty for noncompliance (85; <i>Uncollected Revenues</i> 31).	Complete	50
4.4: The General Assembly may wish to consider amending KRS 194A.020(5) to enhance the ability of the Office of Inspector General to pursue administrative actions in allegations of fraud and abuse against the Medicaid program, including the ability to issue administrative subpoenas and impose civil penalties (90).	Moot	61
4.5: The Office of Inspector General should conduct a cost-benefit analysis of the initiatives of its Division of Special Investigations and its Division of Audits and Detection and report the results to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (91).	Remaining	20
4.6: The Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General should work with Medicaid contractors to develop a plan for controlling fraud against Kentucky's Medicaid program. The plan should consider the roles of the Department for Medicaid Services, the Office of Inspector General, the Office of the Attorney General, and each relevant contractor, and should provide a timeline for implementing a cohesive fraud control strategy. The Department for Medicaid Services should report the plan to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (94).	Partial	30

(continued)

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
<p>4.7: The Office of the Attorney General’s Medicaid Fraud and Abuse Control Division and the Cabinet for Health and Family Services’ Office of Inspector General should work together to explore the feasibility of implementing a false claims statute in Kentucky. Issues to be considered include required staffing of all agencies, required monetary resources, and a cost-benefit analysis of implementing such a statute. The two agencies should present a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, the Health and Welfare Committee, and the Judiciary Committee (96).</p>	Partial	28
<p>4.8: The Cabinet for Health and Family Services should a) reexamine the costs and benefits of providing greater financial incentives to county child support offices for improving enforcement of medical support orders and b) determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care through the Medicaid program and the Kentucky Children’s Health Insurance Program. The cabinet’s Department for Medicaid Services and Department for Community Based Services should provide a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee (97).</p>	Partial, Added items	52

Recommendations From Report *Medicaid Prescription Drug Benefit Fraud, Abuse, and Cost Management (2007)*

Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
1.1: If it is the intent of the General Assembly to provide the most effective tools for recovering losses caused by Medicaid fraud, then after receiving input from the Office of the Attorney General and other interested parties, the General Assembly may wish to consider passage of a state false claims act that meets the requirements outlined in the Deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud (17).	Remaining, Added items	28
1.2: The Department for Medicaid Services should develop a process to ensure that the documentation of policies and procedures is comprehensive and kept up to date. The department should work with all vendors, both governmental and private, to ensure that they also maintain comprehensive and up-to-date documentation of their policies and procedures (33).	Partial	12
1.3: The Department for Medicaid Services should ensure that an adequate staffing resource plan is developed and maintained. To the extent possible, such planning also should be implemented by the department's vendors, both governmental and private. The Cabinet for Health and Family Services should present an adequate staffing plan in its budget proposals to the governor and the General Assembly (36).	Partial	11
1.4: The Department for Medicaid Services, in consultation with all involved agencies and vendors, should ensure that a comprehensive Medicaid program integrity plan is developed, maintained, and followed. The plan should delineate responsibility for all aspects of program integrity: prevention, detection, and recovery of fraud, abuse, and other overpayments related to recipients, providers, Medicaid contracts, state employees, and pharmaceutical and other medical supply manufacturers. The plan should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers (43).	Partial	31
1.5: As part of its overall program integrity plan, the Department for Medicaid Services should explore ways to implement concurrent fraud, abuse, and overpayment detection within the pharmacy point-of-sale system as well as the medical-claims processing system (44).	Partial, Added items	33

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
1.6: If it is the intent of the General Assembly to assist the Kentucky Medicaid program in seeking more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs, the General Assembly may wish to consider a resolution asking Congress to provide such relief (46).	Moot, Added items	76
1.7: The Department for Medicaid Services should implement a comprehensive program to evaluate the performance and outcomes of Medicaid as a whole and of each vendor and each benefit program. To the extent possible, the program should attempt to measure the outcomes and calculate a return on investment for each agency and vendor activity and each benefit plan change and innovation (47).	Partial, Added items	15
1.8: The Cabinet for Health and Family Services should reconstitute the Drug Management Review Advisory Board and ensure that it fulfills its duties under federal and Kentucky law. If the cabinet believes that the board’s duties and those of the Pharmacy and Therapeutics committee could be combined, it should propose to the General Assembly legislation that is consistent with federal law (49).	Ongoing, Added items	66
1.9: The Department for Medicaid Services should ensure that the annual drug use review report is prepared and sent to the federal government. In addition, the department should provide copies of the last five such annual reports and all future reports to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission (50).	Ongoing, Added items	68
1.10: If it is the intent of the General Assembly to more fully empower the Office of Inspector General to combat Medicaid fraud and abuse, then the General Assembly may wish to consider the changes requested by that office as embodied in Senate Bill 223 of the 2005 Regular Session (50).	Partial	61
2.1: The Department for Medicaid Services should review Medicaid eligibility procedures, and the Department for Community Based Services should ensure that all caseworkers understand and follow the procedures for verifying an applicant’s statements. The Department for Medicaid Services should consider whether it is desirable that caseworkers ask adult Medicaid applicants for information about expenses and attempt to balance income, resources, and expenses. If so, the departments together should develop such a procedure and incorporate it into caseworker training (54).	Partial	44

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
2.2: The Department for Medicaid Services, the Office of Inspector General, and the Department for Community Based Services should develop a plan to expand the Determining Eligibility Through Extensive Review program to additional local offices. The plan should address local office acceptance of the program, office space, funding, and the role of claims workers (59).	Partial, Added items	47
2.3: The Department for Community Based Services should ensure that referrals for suspected fraud in adult Medicaid cases are being made correctly to the Office of Inspector General. The department should implement procedures to reduce the error rate in adult Medicaid cases (61).	Partial, Added items	44
2.4: The Department for Community Based Services should determine a staffing level adequate to ensure quality results in the Division of Family Support. The department should develop a staff retention plan to reduce turnover. To the extent that either an adequate staffing level or a retention plan requires additional positions or funding, the department should include the needed resources in its budget requests (61).	Partial	11
3.1: Recognizing that the Recipient Utilization Review Committee does not exist, the General Assembly may wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable. If the statute is not so modified, the Department for Medicaid Services should operate the committee as defined in the law (64).	Remaining, Added items	67
3.2: The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine whether fair and reasonable limitations could be placed on filling phone-in prescriptions (79).	Ongoing, Added items	43
3.3: The General Assembly may wish to consider options to remove potential conflicts among KRS 218A.020-130, related administrative regulations, and the federal controlled substance schedule (83).	Remaining	72
3.4: The Cabinet for Health and Family Services should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling (83).	Ongoing	72

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
3.5: If it is the intent of the General Assembly to clarify the permitted and prohibited uses of data in the Kentucky All Schedule Prescription Electronic Reporting system, then the General Assembly may wish to consider amending KRS 218A.202 and KRS 218A.240 to remove possible ambiguities and inconsistencies (94).	Remaining	69
3.6: As part of its overall program integrity plan, the Department for Medicaid Services should reissue a program integrity request for proposals substantially similar to the one canceled in October 2007 and award a contract as soon as it is prudent to do so. The new vendor and program integrity staff should implement as soon as possible a review of all Medicaid claims, with special priority on prescription claims submitted since June 2003 (103).	Partial, Added items	34
3.7: As part of its overall program integrity plan, the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and develop an ongoing cost-benefit analysis of the program. The department should modify the program over time to optimize costs and benefits (105).	Ongoing, Added items	41
3.8: If it is the intent of the General Assembly that the Kentucky Medicaid fraud hotline statute be consistent with federal regulation 42 CFR 455.14, then the General Assembly may wish to consider amending KRS 205.8483(2) to allow the Office of Inspector General to conduct a preliminary investigation to determine if a sufficient basis exists for a full investigation, prior to referring the case to the Office of the Attorney General (107).	Moot, Added items	60
3.9: As part of its overall program integrity plan, the Department for Medicaid Services should work with the Office of Inspector General and Office of the Attorney General to establish protocols for preliminary investigation of all potential provider fraud cases by the Office of Inspector General and for timely referral to the Office of the Attorney General for full investigation, consistent with federal regulations (107).	Ongoing, Added items	60
3.10: The Office of the Attorney General should develop a budget request for state funding necessary to cover the costs of investigating and prosecuting all the anticipated criminal Medicaid fraud cases referred as well as performing the other duties for the Medicaid fraud control unit. The attorney general should provide a justification for the funding request and a range of estimated recoveries (110).	Ongoing	74

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Recommendation Number, Text Of Recommendation (Page In Original Report)	Status	Page In This Report
4.1: The Department for Medicaid Services should estimate the amount by which the Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual eligible recipients if they were still in the Medicaid prescription drug benefit. The department should report their estimate to the Program Review and Investigations Committee by September 2008 (115).	Remaining	24
4.2: When measuring the performance of the Medicaid prescription drug program, the Department for Medicaid Services and all its vendors should consider the effects of Medicare Part D and the clawback. When presenting any performance information to the public, and particularly to the General Assembly, the department should explain these effects (116).	Partial	23
4.3: The Department for Medicaid Services should conduct a complete cost-benefit analysis of the behavioral health drug use review program, including historical trend data by drug class and the effect of the agreement on the preferred drug list and supplemental rebates. The department should ensure that a tracking system is in place to monitor the results of the program and should compare actual with expected results. The department should report to the Program Review and Investigations Committee: <ul style="list-style-type: none"> • the cost-benefit analysis by September 2008 and • the results after the 2-year program (127). 	Partial, Moot	15
4.4: The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine effective and acceptable education regarding best practices for prescribing and dispensing (127).	Ongoing	22
4.5: The Department for Medicaid Services should consider whether to implement counter-detailing to provide unbiased prescribing information to physicians and other prescribers. The department also should consider Medication Therapy Management by pharmacists as a means of improving care and reducing costs. If either program appears to be effective and feasible, the department should request any necessary enabling legislation and should implement the program (129).	Remaining	22

Appendix B

Medicaid Agencies And Vendors

The following list includes most of the Kentucky agencies and vendors involved in this follow-up, along with some that were included in earlier Program Review staff reports.

- Cabinet for Health and Family Services
 - Department for Medicaid Services (DMS)—the single state agency responsible for all Medicaid operations in Kentucky except the fraud control unit
 - Division of Program Integrity—responsible for surveillance, utilization review, and benefit policy coordination
 - Office of Inspector General (OIG)—performing preliminary investigations of recipient and provider fraud allegations
 - Department for Community Based Services, Division of Family Services (DCBS)—responsible for Medicaid eligibility determination and eligibility quality control
 - Department for Public Health (DPH)—performing diabetes care management
 - Department for Income Support
 - Disability Determination Services—related to Medicaid eligibility determination
 - Child Support Enforcement—related to medical support orders and enforcement
 - Office for Human Resource Management—related to Medicaid fraud by state employees
- Office of the Attorney General, Office of Medicaid Fraud and Abuse Control—Kentucky’s Medicaid fraud control unit (MFCU)
- Kentucky Board of Pharmacy
- Kentucky Board of Medical Licensure
- Hewlett Packard (HP), formerly Electronic Data Systems (EDS)—the primary Medicaid management information system vendor; also responsible for most of the former Kentucky Medicaid Administrative Agent’s operations, including provider enrollment; also responsible for Ky Health Card
- Magellan Medicaid Administration, formerly First Health Services Corporation—the Pharmacy Benefit Administrator (PBA) vendor
- Myers and Stauffer—former program integrity vendor
- Health Care Excel—former program integrity vendor
- Ingenix—current program integrity vendor
- HMS—the third-party liability vendor
- Accenture—former Kentucky Medicaid Operational Support Services vendor
- Comprehensive NeuroScience—the former vendor paid by Eli Lilly to implement the Behavioral Pharmacy Management Program
- University Health Care Inc., operator of Passport Health Plan—the Medicaid managed care organization in Jefferson and surrounding counties
 - AmeriHealth Mercy—the Passport benefit administrator
 - PerformRx—the Passport pharmacy benefit administrator
 - IPRO—the external quality review organization that conducts quality reviews of Passport to ensure proper operation and access to care.

Appendix C

Selected Kentucky Laws And Regulations Related To Medicaid Cost Containment

This appendix identifies state statutes that relate primarily to cost containment or expenditure reduction, including program integrity and recovery of overpayments. It was drafted by Pam Thomas, staff administrator of the Appropriations and Revenue Committee, with modifications by Program Review staff.

Cost Containment Measures Included In The 1994 Kentucky Health Care Reform Bill

Most of the statutes directly related to Medicaid cost containment were enacted as part of the omnibus health care reform bill passed by the General Assembly in the 1994 Regular Session, House Bill 250 (1994 Ky. Acts 512). The bill had 12 provisions relating to cost containment and fraud and abuse detection and prevention, as well as a requirement that cost savings attributable to the cost containment measures be certified to the Legislative Research Commission on a quarterly basis. All but one of these provisions remain in statute. They generally require the Cabinet for Health and Family Services to establish systems, conduct reviews, and promulgate regulations relating to specific components of the Medicaid program. The statutes, with some related regulations, are listed below.

- Establishment of a system to reduce unnecessary emergency room utilization (KRS 205.6310)
 - 907 KAR 1:014 Outpatient hospital services (amended Nov. 5, 2010)
 - 907 KAR 1:015 Payments for outpatient hospital services (amended Nov. 9, 2010)
 - 907 KAR 1:677 Medicaid recipient lock-in program (amended Nov. 9, 2010)
- Imposition of copayments in some circumstances (KRS 205.6312)
 - 907 KAR 1:604 Recipient cost sharing
- Review of the rates paid to emergency transportation providers (KRS 205.6314)
 - 907 KAR 1:060 Ambulance transportation
 - 907 KAR 1:061 Payments for ambulance transportation
- Requirements for private peer review organizations reviewing levels of care (KRS 205.6315)
 - 907 KAR 1:755 Preadmission screening and resident review program
- Review of the procedures for reimbursement of pharmacists (KRS 205.6316)
 - 907 KAR 1:018 Reimbursement for drugs
 - 907 KAR 1:019 Outpatient pharmacy program (amended Nov. 9, 2010)
- Review of available technology to determine which technology is best suited to enhance program service operation, monitoring ability, and fraud and abuse detection (KRS 205.6318)
 - 907 KAR 1:671 Conditions of Medicaid provider participation; withholding overpayments; administrative appeals process and sanctions
 - 907 KAR 1:677 Medicaid recipient lock-in (amended Nov. 9, 2010)

- Strengthening of primary care case management and establishment of standards for managed care (KRS 205.6320)
 - 907 KAR 1:320 Kentucky Patient Access and Care System (KenPAC)
 - 907 KAR 1:705 Demonstration project: Services provided through regional managed care partnerships (1115 Waiver)
- A directive to the cabinet to prohibit the sheltering of assets in long-term-care cases (KRS 205.6322)
 - 907 KAR 1:650 Trust and transferred resources requirement for Medicaid
- Review of the Medicaid reimbursement systems for appropriateness and cost effectiveness, and implementation of standardized patient assessment and consistent quality-of-care mandates for long-term-care services (KRS 205.6326)
 - 907 KAR 1:755 Preadmission screening and resident review program
 - 907 KAR 3:090 Acquired brain injury waiver services (amended Nov. 9, 2010)
- Development of a system for monitoring the use of Medicaid services by recipients using appropriate technology in conjunction with an identification card (KRS 205.6332)
 - 907 KAR 1:675 Program integrity
- Quarterly certification of general fund savings realized from all cost saving initiatives, including those listed above, from the secretary of the Finance and Administration Cabinet after consulting with the secretary of the Cabinet for Health and Family Services (KRS 205.6336)

Third-Party Liability

States are required to ensure that Medicaid is the payor of last resort. The following statutes implement this requirement:

- KRS 205.593 Prohibition against health insurer's considering individual's eligibility for or receipt of medical assistance in enrollment or payment of benefits—Application of claims payment requirements to Medicaid services
- KRS 205.622 Billing of third party by vendor for medical services
- KRS 205.623 Information on claims paid for insurance policyholders and dependents—Use of data—Confidentiality of information—Prohibited fees
- KRS 205.624 Assignment to cabinet by recipient of rights to third-party payments—Right of recovery by cabinet
- KRS 205.626 Time assignment becomes enforceable—Payment to cabinet—Attorney's fees
- KRS 205.628 Liability of recipient
- KRS 205.629 Notification of cabinet in actions seeking recovery for recipient
- KRS 304.12-255 Refusal to provide requested Medicaid information as unfair or deceptive trade practice for health insurer or administrator
- KRS 304.99-010 General penalties
- KRS 411.188 Notification of parties holding subrogation rights—Collateral source payments and subrogation rights admissible

Regulations related to these statutes include

- 806 KAR 17:081 Minimum standards for long-term-care insurance policies
- 806 KAR 17:570 Minimum standards for Medicare supplement insurance policies and certificates
- 907 KAR 1:018 Reimbursement for drugs
- 907 KAR 1:671 Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions

Medical Child Support

States are required to seek medical child support orders whenever appropriate for children who receive Medicaid benefits.

- KRS 205.594 Health coverage for child under medical child support order—Duties of health insurers
- KRS 205.595 Health coverage for child under medical child support order—Duties of employers
- KRS 205.596 Prohibition against health insurer's imposing requirements on state agency assigned rights of individual eligible for medical assistance that are different from those applicable to agent or assignee of other covered individual
- KRS 205.597 Health coverage through insurer of noncustodial parent of child under medical child support order
- KRS 205.598 Withholding of income and state tax refund of person required by court to provide cost of child's health service—Priority of claims for child support over costs of reimbursement of child medical support
- KRS 403.211 Action to establish or enforce child support—Rebuttable presumption for award—Allocation of child-care costs and health care expenses—Order for payment of health insurance coverage—Noncustodial parent's health plan—Attachment of income—Credit for disability payments

Regulations related to these statutes include

- 921 KAR 1:001 Definitions
- 921 KAR 1:380 Child Support Program application and interstate process
- 921 KAR 1:400 Establishment, review, and modification of child support and medical support orders
- 921 KAR 1:410 Child support collection and enforcement

Fraud And Abuse Detection And Prevention

KRS Chapter 205 also contains statutes related to controlling fraud and abuse in the Medicaid program (KRS 205.8451 to 205.8483). These statutes were originally enacted in 1994 and require the cabinet and the Department for Medicaid Services to control fraud and abuse in the Medicaid system by

- providing information about proper utilization,

- establishing appropriate checks and audits,
- sharing information and reports with other relevant agencies, and
- taking other steps to control fraud and abuse (KRS 205.8453).

KRS 205.8455 requires the commissioner of the Department for Medicaid Services to establish a Recipient Utilization Review Committee. The committee is charged with reviewing suspected recipient abuse, and if appropriate federal waivers are obtained, the committee has the authority to restrict or revoke recipient participation in the Medicaid program, and it may institute actions to recover the value of benefits received by a recipient related to fraudulent or abusive activities.

The fraud provisions also include penalties and fines for recipients and providers who engage in fraudulent practices.

Regulations related to these statutes include

- 907 KAR 1:671 Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions
- 907 KAR 1:672 Provider enrollment, disclosure, and documentation for Medicaid participation
- 907 KAR 1:675 Program integrity

Other Statutory Requirements Related To Cost Containment

Long-Term Or Institutional Care

KRS 205.558 mandates the implementation of a statewide prescreening admissions review system, including the imposition of a resource means test, for all long-term-care facilities and beds, acute-care, hospital-based, skilled-nursing or intermediate-care beds regardless of payment status of the resident upon admission.

A regulation related to this statute is 907 KAR 1:755 Preadmission Screening and Resident Review Program.

Prescription Drug Benefit

KRS 205.561 requires the cabinet to report on the dispensing of prescription medications every 3 years beginning October 31, 2003; subsequent report dates would be in 2006 and 2009. The report must be reviewed by the Drug Management Review Advisory Board created under KRS 205.5636.

KRS 205.5632, related to prior authorization for prescription drugs, is a cost containment measure and protects recipients' health.

Regulations related to this statute include

- 907 KAR 1:018 Reimbursement for drugs
- 907 KAR 1:019 Outpatient Pharmacy Program

KRS 205.5634 to 205.5639 establish the Drug Management Review Advisory Board, which is charged with providing advice regarding drug standards and drug therapies, including standards for identifying suspected fraud and abuse. The board is required to submit an annual report.

A regulation related to this statute is

- 907 KAR 1:019 Outpatient Pharmacy Program.

KRS 205.564 establishes the Pharmacy and Therapeutics Committee, which advises the cabinet on the preferred drug list and prior authorization rules. These activities directly affect Medicaid's ability to negotiate supplemental drug rebates and to manage the costs of prescription drugs by preferring some drugs over others.

A regulation related to this statute is

- 907 KAR 1:019 Outpatient Pharmacy Program.

Increased Reimbursement For Providers

KRS 205.621 established an annual indexed formula to increase reimbursement to Medicaid physicians and dentists.

Collection Of Outstanding Provider Debts

In addition to the actual amounts of overpayments, KRS 205.8467 authorizes the cabinet to assess additional penalties if the overpayments were intentional. If a provider refuses to repay an outstanding debt, and the provider no longer participates in the Medicaid program, the cabinet refers the debt to the Department of Revenue under KRS 45.237 and 45.238 for collection and possible civil action by the Office of the Attorney General under KRS 15.060.

Regulations related to these statutes include

- 907 KAR 1:671 Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions
- 103 KAR 1:070 Uniform collection procedures

Advisory Council For Medical Assistance

This council of provider and recipient representatives was created in 1960 to advise Medicaid on health and medical care services, Medicaid policy and administration, and furtherance of participation by recipients in development of policy and administration (KRS 205.540 and 205.550).

There appear to be no regulations related to these statutes.

Budget Language

The biennial budget also typically includes provisions directed at Medicaid cost containment or the reporting of information that will allow tracking of Medicaid expenditures. HB 1, enacted in 2010 Extraordinary Session 1, included the following directives for the 2011-2012 biennium.

- Medicaid may charge any copayments permitted by federal law, notwithstanding the provisions of KRS 205.6312 that might limit the application of copayments.
- Notwithstanding KRS 205.6312(4), a Medicaid pharmacy shall not be required to serve an eligible recipient if the recipient does not make the required copayment at the time of service, except under certain conditions of potential harm to the recipient.
- The cabinet shall develop a plan for evaluating Medicaid benefits and efficiencies, including a cost and savings analysis; shall evaluate enumerated areas as well as others; and shall report the evaluations to specified legislative committees by December 1, 2010.
- If permitted by federal rules, the cabinet shall renew the University Health Care contract to operate the Passport health plan under the section 1115 waiver.
- The cabinet shall take steps to increase the use of generic drugs and increase accepted practices to eliminate excess prescriptions in order to deter Medicaid recipients from obtaining multiple prescriptions from different physicians for the same drug.
- The Department for Medicaid Services shall meet the following reporting requirements.
 - Actual statewide Medicaid expenditure data by all categories of Medicaid services, including mandated and optional Medicaid services, special expenditures/offsets, and Disproportionate Share Hospital payments by type of hospital, shall be compiled by the Department for Medicaid Services for all Medicaid providers and forwarded to the Interim Joint Committee on Appropriations and Revenue on a quarterly basis. Projections of Medicaid expenditures by categories of Medicaid services shall be provided to the Interim Joint Committee on Appropriations and Revenue upon request (2010 (1st Extra. Sess.) Ky. Acts ch. 1, Part I, G.3.a(2)).
 - The Department for Medicaid Services shall submit a quarterly budget analysis report to the Interim Joint Committee on Appropriations and Revenue. The report shall provide monthly detail of actual expenditures, eligibles, and average monthly cost per eligible by eligibility category along with current trailing 12-month averages for each of these figures. The report shall also provide actual figures for all categories of noneligible-specific expenditures such as Supplemental Medical Insurance premiums, Kentucky Patient Access to Care, nonemergency transportation, drug rebates, cost settlements, and Disproportionate Share Hospital payments by type of hospital. The report shall compare the actual expenditure experience with those underlying the enacted or revised enacted budget and explain any significant variances which may occur (2010 (1st Extra. Sess.) Ky. Acts ch. 1, Part I, G.3.b(9)).
- The cabinet shall operate the Drug Management Review Advisory Board as described in statute.

Appendix D

State False Claims Act Comparative Recoveries

This appendix presents two basic scenarios for Medicaid false claims. The first is a state without its own false claims act. The second is a state with a false claims act that complies with the Deficit Reduction Act of 2005. It is possible that a state could have a false claims act that does not comply; that scenario is not analyzed here.

The information presented permits an estimate of whether it would be to a state's advantage to adopt a compliant false claims act. In each section of each table, if the state's percent net recovery is greater than the original federal medical assistance percentage (FMAP), then the state gains in that scenario. The tables represent states with FMAPs of 70, 60, or 50 percent, with a relator's fee of 15, 20, or 25 percent. Most sources indicated that relators' fees would average between 16 and 19 percent, but it is possible for a relator's fee to reach 30 percent under certain conditions.

Kentucky has had an FMAP near 70 percent. As the tables illustrate, a state with an FMAP of at least 60 percent is likely to benefit from a state false claims act in most scenarios.

A state with an FMAP of less than 60 percent might recover less in federal cases than it would without a false claims act. However, a state false claims act would likely uncover some state-only fraud that the state would not discover otherwise. There is not enough information to determine whether the recoveries from additional cases would offset the lower recoveries in federal cases.

These scenarios also do not consider the additional revenue from taxes on the relator's fee. If a state has an income tax or other tax that would apply to the relator's fee, the effective size of the fee would decrease and the net recovery to the state would increase.

Returns Without A State Act

When a state does not have a false claims act, there may be federal false claims cases that include Medicaid claims from that state. In such cases, the state would attempt to negotiate a settlement to recover the state's losses. The following tables assume that the state would be able to negotiate a level of damages, interest, and penalties equivalent to the federal recovery.

False Claims Act Recoveries Without State Act

FMAP	Party	Gross Recovery	Relator's Fee	Net Recovery	% Of Net Recovery
70% federal, 30% state	Relator @ 15%		\$10.50	\$10.50	10.5%
	Federal	\$70	10.50	59.50	59.5
	State	30		30.00	30.0
	Relator @ 20%		14.00	14.00	14.0
	Federal	70	14.00	56.00	56.0
	State	30		30.00	30.0
	Relator @ 25%		17.50	17.50	17.5
	Federal	70	17.50	52.50	52.5
	State	30		30.00	30.0
60% federal, 40% state	Relator @ 15%		9.00	9.00	9.0
	Federal	60	9.00	51.00	51.0
	State	40		40.00	40.0
	Relator @ 20%		12.00	12.00	12.0
	Federal	60	12.00	48.00	48.0
	State	40		40.00	40.0
	Relator @ 25%		15.00	15.00	15.0
	Federal	60	15.00	45.00	45.0
	State	40		40.00	40.0
50% federal, 50% state	Relator @ 15%		7.50	7.50	7.5
	Federal	50	7.50	42.50	42.5
	State	50		50.00	50.0
	Relator @ 20%		10.00	10.00	10.0
	Federal	50	10.00	40.00	40.0
	State	50		50.00	50.0
	Relator @ 25%		12.50	12.50	12.5
	Federal	50	12.50	37.50	37.5
	State	50		50.00	50.0

Notes FMAP is the federal medical assistance percentage. Dollar amounts are based on a \$100 total gross recovery.
Source: Program Review staff compilation.

Returns With A State Act

When a state has a compliant false claims act, the state's share of recoveries increases by 10 percentage points. Two situations can arise. According to most sources, the majority of state cases will be filed in both state and federal court; the federal court assumes control of both federal and state interests in these cases. Some cases will be filed in state court only. In the following table, the levels of damages, interest, and penalties are assumed to be the same for the federal and state shares.

False Claims Act Recoveries: Joint Federal-State Cases

FMAP	Party	Gross Recovery	Relator's Fee	Net Recovery	% Of Net Recovery	
70% federal, 30% state	Relator @ 15%		\$15.00	\$15.00	15.0%	
	Federal	\$60	9.00	51.00	51.0	
	State	40	6.00	34.00	34.0	
	Relator @ 20%		20.00	20.00	20.0	
	Federal	60	12.00	48.00	48.0	
	State	40	8.00	32.00	32.0	
	Relator @ 25%			25.00	25.00	25.0
	Federal	60	15.00	45.00	45.0	
	State	40	10.00	30.00	30.0	
	60% federal, 40% state	Relator @ 15%		15.00	15.00	15.0
		Federal	50	7.50	42.50	42.5
		State	50	7.50	42.50	42.5
Relator @ 20%			20.00	20.00	20.0	
Federal		50	10.00	40.00	40.0	
State		50	10.00	40.00	40.0	
Relator @ 25%				25.00	25.00	25.0
Federal		50	12.50	37.50	37.5	
State		50	12.50	37.50	37.5	
50% federal, 50% state		Relator @ 15%		15.00	15.00	15.0
		Federal	40	6.00	34.00	34.0
		State	60	9.00	51.00	51.0
	Relator @ 20%		20.00	20.00	20.0	
	Federal	40	8.00	32.00	32.0	
	State	60	12.00	48.00	48.0	
	Relator @ 25%			25.00	25.00	25.0
	Federal	40	10.00	30.00	30.0	
	State	60	15.00	45.00	45.0	

Note: FMAP is the federal medical assistance percentage. Dollar amounts are based on a \$100 total gross recovery.
 Source: Program Review staff compilation.

State-Only Cases Using 2008 Federal Repayment Model

In 2008, the Centers for Medicare and Medicaid Services presented a model for states to use when calculating repayment of the federal FMAP share of state-only recoveries. A federal court decided that the CMS letter describing the model was invalid but only on the technical grounds that CMS did not follow the proper procedure for making a new rule (Alabama). CMS is appealing the decision. The model is presented here as the preferred federal approach. Under the CMS model, a state calculates the FMAP share on the gross recovery before deducting the relator's fee. The relator's fee is calculated on the gross recovery but is taken out of the state's share only. Then the state submits the relator's fee for reimbursement as an administrative expense at 50 percent.

The most likely alternative to this model is that the state would deduct the relator's fee from the gross recovery first and then would calculate the federal FMAP share of the remainder. This alternative is equivalent to the distribution for joint federal-state cases above. The CMS model results in a better return for a state with a lower FMAP share and a lower return for a state with a higher FMAP share, such as Kentucky.

Some state-only false claims cases would not otherwise come to the attention of Medicaid authorities. In such cases, the state recovery without a false claims act would be zero and any false claims repayment model would provide a gain to the state.

False Claims Act Recoveries: State-Only Cases Using CMS Repayment Model

FMAP	Party	Gross Recovery	Relator's Fee	Federal Financial Participation	Net Recovery	% Of Net Recovery
70% federal, 30% state	Relator @ 15%		\$15		\$15.00	15.0%
	Federal	\$60		\$(7.50)	52.50	52.5
	State	40	15	7.50	32.50	32.5
	Relator @ 20%		20		20.00	20.0
	Federal	60		(10.00)	50.00	50.0
	State	40	20	10.00	30.00	30.0
	Relator @ 25%			25	25.00	25.0
	Federal	60		(12.50)	47.50	47.5
	State	40	25	12.50	27.50	27.5
60% federal, 40% state	Relator @ 15%		15		15.00	15.0
	Federal	50		(7.50)	42.50	42.5
	State	50	15	7.50	42.50	42.5
	Relator @ 20%		20		20.00	20.0
	Federal	50		(10.00)	40.00	40.0
	State	50	20	10.00	40.00	40.0
	Relator @ 25%			25	25.00	25.0
	Federal	50		(12.50)	37.50	37.5
	State	50	25	12.50	37.50	37.5
50% federal, 50% state	Relator @ 15%		15		15.00	15.0
	Federal	40		(7.50)	32.50	32.5
	State	60	15	7.50	52.50	52.5
	Relator @ 20%		20		20.00	20.0
	Federal	40		(10.00)	30.00	30.0
	State	60	20	10.00	50.00	50.0
	Relator @ 25%			25	25.00	25.0
	Federal	40		(12.50)	27.50	27.5
	State	60	25	12.50	47.50	47.5

Note: FMAP is the federal medical assistance percentage. Dollar amounts are based on a \$100 total gross recovery.
 Source: Program Review staff compilation.

Appendix E

Response From The Cabinet For Health And Family Services

The cabinet issued a written response to the findings of the May 2011 draft of this report. Findings for which the cabinet indicated that “no response is necessary” are not included in this appendix. For each finding for which there was a response, the text of the finding (and the page number in the report on which it appears) and the cabinet’s verbatim response are below. There is a reply from Program Review staff for some responses.

Medicaid Administration

Finding: The Department for Medicaid Services (DMS) has made efforts to determine its staffing needs but should have a narrative explanation of its staffing proposals. The department should have a formal staffing plan that it can use as a basis for budget requests (12).

Response: As part of the FY 10-12 biennial budget request, the Department for Medicaid Services submitted an additional funding request with plans to increase staffing by 22 positions, including additional positions in the Program Integrity area. That request was not funded.

We would note that for certain state classifications, state pay grades have not kept pace with the private sector and state employees have gotten small or no annual salary increments, complicating efforts to: a) hire and maintain staff; or, b) hire persons with very specialized skill sets. This has necessitated use of contract staff, to the extent funding permits. The use of contract staff has been unavoidable in securing certain specialized skill sets not readily available to state government due to salary and recruiting restrictions, but it does not lend itself to continuity within the agency.

The state’s economic situation in recent years has hampered recruitment and retention efforts, as evidenced by appropriations as compared to agency budget requests. The agency operates within the funding levels provided by the General Assembly.

Finally, we would note that based on the outcome of the current Medicaid Managed Care RFPs, the types of additional staff recruited by the Department in the future may very well change.

Finding: The cabinet remains unable to fill all needed positions in the Department for Medicaid Services and Office of Inspector General (OIG). The cabinet should present an adequate staffing plan in its budget requests to the General Assembly (12).

Response: For Medicaid, see above. With respect to the Office of Inspector General, the agency’s baseline budget request for the FY 10-12 biennium was not fully funded. Since the baseline request is based on the number of filled positions at the time the personnel snapshot is taken, this means no vacancies are funded unless the agency’s additional budget request is funded. As indicated, neither the agency’s baseline request was fully funded, nor any expansion

items. With the current budgetary constraints, all agency managers are faced with the difficult challenge of maintaining services while facing continued budget reductions. Of necessity, the OIG's priority given the current budgetary constraints has been filling front line positions in its health care and child day care licensing areas which directly impact health and safety of patients and children.

Finding: The Department for Community Based Services (DCBS) does not have a formal staffing resource plan. The department should have a plan that it can use as a basis for budget requests (13).

Response: DCBS prepares its budget request for all program activities based on historical expenditures, trend analysis and projected utilization within the parameters of the budget preparation instructions issued by the Commonwealth. Caseload and staffing reports provide the framework for staffing patterns. The cabinet has submitted budget requests that would support necessary staffing both in types and numbers; however, the state's budgetary constraints have hampered these efforts.

DCBS has implemented a number of efforts to recruit and retain staff. Even with the current budget constraints, these efforts continue. There is a career ladder that allows movement from the entry level position to higher classifications within a local office to supervisory positions, subject matter expert positions, regional management and Central Office administration. DCBS continues to recognize exemplary work by staff via certificates and messages of appreciation. The department continues to promote a positive work environment by using technology to streamline operations.

Notwithstanding the above efforts, as the state's budgetary situation has worsened, the department has been forced to curtail other recruitment and retention activities (such as educational assistance). Additionally, state pay grades have not kept pace with the private sector in many instances and state employees have gotten small or no annual salary increments, complicating efforts to: a) hire and maintain staff; or, b) hire persons with specialized skill sets. The cabinet does not control the state classification system or funding that would be necessary to upgrade certain high demand classifications and provide increments to retain existing staff.

It should be noted that since the beginning of FY 2009, DCBS' General Fund base has declined by \$36 million, slightly more than 10% at a time when the agency has experienced unprecedented caseload growth due to the downturn in the economy. The department believes it has managed its funding and staffing levels prudently within the funding levels appropriated by the General Assembly.

Finding: The department has taken steps to streamline the application process and to make caseworkers more efficient, including improvements in technology (13).

Response: In addition to those efforts identified in the report, the cabinet's recently submitted six-year capital plan identifies projects to further improve the application process, using information technology as a major tool in accomplishing this. Additionally, the department is

pursuing several grant opportunities to enhance the application process and make that process more efficient.

Findings: The department should have a formal staff retention plan.

Staff retention efforts continue at a reduced level. Additional incentives may be needed (13).

Response: See response to the first DCBS finding.

Finding: The Department for Medicaid Services should have a formal policy or standard for creation and maintenance of written internal procedures, including a method of determining which internal procedures need to be documented (13).

Response: Program Review staff conceded that “there are written internal procedures in some cases and that the department is working to document its internal procedures more thoroughly based on the relative importance of each program and operation. The cabinet pointed out that many of Medicaid’s policies and operating rules are part of federal and Kentucky regulations and the State Medicaid Plan” (page 13 of report). The department believes that processes are in place for creation and maintenance of regulations and procedures. The department further notes that while policies and procedures are documented, continuous changes in federal and state law and regulations require constant updates and iterations. As changes are needed and made, division staff works with the department’s administrative regulation writer to coordinate changes with divisions in the department, as well as other agencies outside the Department, i.e. the Office of the Inspector General, Department for Community Based Services. Each regulatory change is sent to all division directors within the department for review and approval. Regulatory changes are disseminated outside the department to other Cabinet agencies. The department regulation writer maintains documentation of changes and actions taken within and outside the cabinet, going back several years.

Finding: The department does not have documentation for all internal procedures, but most of the examples reviewed were acceptable. Examples of vendors’ documentation of their own internal procedures were commendable (13).

Response: The majority of the department’s policies and procedures are directly outlined in regulations, manuals, and State Plan. Within each division, specific internal procedures have been developed and implemented by the division director through written communications and directives.

Finding: The department should have documentation for all internal procedures adequate for a new employee to perform the primary duties of the position (14).

Response: The department agrees that outlining specific job duties for new employees would be helpful and will consider undertaking development of these.

Finding: The department should have a central repository or index of internal procedure documentation that tracks the location and status of those documents and can report on them (14).

Response: The department has a central repository for all regulatory changes as addressed above. With regard to the recommendation of Program Review staff regarding other internal procedures documentation, the department will consider developing this information.

Measuring Cost Containment

Finding: It appears that the cabinet did not develop a formal evaluation plan for the behavioral health drug use review program. The cabinet's documents were inadequate to demonstrate the value or effectiveness of the program (18).

Response: The department's Medical Director collected data on this matter and the results appeared to have been positive, particularly the provision allowing access to peer-to-peer consultations. The findings were supplied in the initial response to Program Review staff. However, staff would note that CMS [Centers for Medicare and Medicaid Services] ultimately determined that a partnership between a private entity and the state agency posed a potential conflict of interest.

Program Review Staff Reply: At the request of Program Review staff, the cabinet provided a program evaluation document, but the document did not quantify any benefits of the program. Although it showed a reduction in the number of originally targeted prescribers who continued to meet the selection criteria, Program Review staff question whether those reductions were a result of the intervention. The program conducted a phone survey of targeted prescribers in July 2009. Staff analysis of the responses indicated that on average they reported being not very likely to consider changing their prescribing practices as a result of the program. (The average score among 18 respondents who had received and read the advisory letter was 1.9 out of 5, with 1 being unlikely and 5 being likely.) The shortened life cycle of the program could have prevented it from achieving its goals, but the design of the cabinet's evaluation was insufficient to measure its effects within any time frame.

Finding: The cabinet has conducted a cost-benefit analysis or calculated a return on investment for only a few of its contracts and cost-containment interventions (18).

Response: Agree. However, certain contracts are procured for the purpose of meeting the federal program requirements. The procurement process itself is designed to determine the best value to the Commonwealth. The re-bidding process helps the agency determine if there are other arrangements that could result in improved services and greater savings. Regarding cost containment interventions, all activities may not have a formal ROI report, but staff routinely reviews experience of other states in determining whether certain activities can be expected to produce savings sufficient to offset the costs of implementation. Because a formal report does not exist does not mean that no analysis was performed.

Finding: The cabinet should design and implement evaluations of the effectiveness of every intervention intended to reduce costs, increase efficiency, or improve quality.

- Each evaluation should provide the best practical measurement of outcomes and return on investment, taking into account indirect and unintended consequences where possible.
- Evaluation of an intervention should continue as long as the intervention continues, because the effectiveness can change with different circumstances (19).

Response: Some interventions that are implemented are federally required; others are elective. However, staff routinely reviews experience of other states in determining whether certain activities can be expected to produce savings sufficient to offset the costs of implementation.

Program Review Staff Reply: Program Review staff and the Auditor of Public Accounts recommended consistently that the cabinet should conduct ongoing cost-benefit analyses for Medicaid program policies and contracts. It is not sufficient to use the experience of other states in order to assume that an activity will produce the same results in Kentucky or that it will continue to produce the same results as time passes.

Finding: The cabinet's cost-containment reports under KRS 205.6336 could be improved by including all interventions and, for each intervention, the calculations and assumptions for determining the amount saved (19).

Response: The agency provides information within quarterly reports in accordance with the provisions of HB 1 and previous executive budget acts. It should be noted that the cost containment provisions of KRS 205.6336 appear to presume that the enacted budget reflects the projected expenditures as contained in the department's biennial budget request and there are "savings" that can be deposited into a trust account. This might be accurate if the agency was appropriated the amount of funding required to meet the budget request. The request reflects a true estimate of expected expenditures based on policies and laws in effect at the time of submission. However, the appropriations to the department are generally considerably less than the budget submission and savings must be achieved simply to live within enacted appropriations.

Finding: The cabinet should fulfill the planning and reporting requirements of HB 1 of the 2010 Extraordinary Session (19).

Response: The department continues to provide quarterly reports pursuant to HB 1. Additionally, Acting Commissioner Wise provided an oral update on cost containment measures as well as the recipient photo ID concept to the Interim Joint Committee on Appropriations and Revenue.

Program Review Staff Reply: KRS 205.6336 states that the reports are to describe all the specific procedures used to achieve savings and are to explain the calculations and assumptions for each. The reports submitted by the cabinet have not met either of these criteria. In particular, the reports have not explained the assumptions and actual calculations by which savings were determined. This was also a finding of the Auditor of Public Accounts.

House Bill 1 of the 2010 Extraordinary Session, Part I G.3.b(24) specified cost and savings analyses that are consistent with KRS 205.6336. Program Review staff are not aware of any reports that present such analyses or a plan for conducting them. According to LRC staff, there was an oral report to the Interim Joint Committee on Appropriations and Revenue on December 2, 2010. The report was not in writing and did not appear to meet the requirements of the bill.

Finding: The cabinet should examine outcomes and return on investment routinely in order to determine whether to continue, modify, or drop each intervention (19).

Response: Some outcomes produce readily documentable savings, others simply avoid costs. Those that are cost avoidance measures are more difficult to quantify. However, these usually show up as increases being less than would be otherwise be expected based on historical expenditure and use patterns. That being said, expenditure patterns are also impacted by any number of factors external to the Medicaid program (economic downturns, changes in federal and state policies, prevalence of particular medical conditions, etc). Therefore, the effect of the cost avoidance measure is more difficult to quantify.

Program Review Staff Reply: On page 18 of this report, (“Methods of Measuring Cost Containment”), staff acknowledged some of the difficulties and proposed some solutions. While it is difficult, it is possible to conduct reasonable measurements. The cabinet would need adequate staffing to do so.

Finding: The cabinet should keep its strategic plan and progress reports under KRS 48.810 up to date and should have a more detailed strategic plan for Medicaid, including related agencies (19).

Response: The cabinet has undertaken update of its strategic plan for FY 12 - FY 14, and each department has assigned a plan liaison to work with the cabinet’s strategic planning coordinator.

Internal Audits And Controls

Finding: Medicaid is subject to audits by a variety of outside agencies, including federal agencies, the auditor of public accounts, and legislative committees, but there remain situations that require internal audits or reviews (21).

Response: Internal audits and reviews do occur. Several recommendations for policy improvements and edit changes have been submitted for review and implementation by department staff. These were previously provided to Program Review staff. The department is always open to opportunities for improvement and will work both internally and other agencies toward that end.

Finding: The Office of Inspector General should conduct targeted compliance audits of vendors when appropriate (21).

Response: The OIG does not currently have sufficient staff to conduct compliance audits on a routine basis. As mentioned previously, the OIG’s baseline budget request for the FY 10- 12

biennium was not fully funded. Since the baseline request is based on the number of filled positions at the time the personnel snapshot is taken, this means no vacancies are funded unless the agency's additional budget request is funded. As indicated, neither the agency's baseline request was funded, nor any expansion items. Since the budget was enacted, agencies have experienced additional budget reductions. With the current budgetary constraints, all agency managers are faced with the difficult challenge of maintaining services throughout their organization while facing continued budget reductions. Of necessity, the OIG's priority given the current budgetary constraints has been filling front line positions in its health care and child day care licensing areas as these directly impact health and safety of patients and children on a daily basis.

Findings: OIG should conduct targeted performance audits of Medicaid itself when appropriate.

OIG should conduct internal audits and reviews, in addition to those requested by Medicaid, when appropriate (21).

Response: See OIG response above.

Finding: Cabinet agencies should calculate a return on investment for audit and control activities (21).

Response: Agree. While all such activities may not have a formal ROI report, staff routinely review experience of other states in determining whether certain activities have produced savings sufficient to offset the costs of implementation. Because a formal report does not exist does not mean that no calculation was performed.

Prescription Cost Containment

Finding: It appears that cabinet efforts have not resulted in new continuing education requirements for prescribers or dispensers (23).

Response: Continuing education requirements are specified by the respective licensure boards, not the cabinet.

Finding: The cabinet has not implemented counter-detailing or a medication therapy management program (23).

Finding: The cabinet should continue to assess whether the return on investment would make counter-detailing or medication therapy management worthwhile (23).

Response: Implementation of this service has been discussed, and the pharmacy RFI [request for information] issued this spring lists this as a requirement. Subsequently, the department issued an RFP for managed care organizations to provide services to a select group of Medicaid eligibles. This solicitation included requests for programs on medication management therapy and other innovative approaches.

Medicaid And Medicare Part D

Finding: The cabinet did not demonstrate having placed appropriate notations on its reports regarding the effect of Medicare Part D and clawback on cost comparisons (25).

Response: It is only necessary to denote this on reports when comparing time periods prior to January 1, 2006 to time periods subsequent to that. We generally have remembered to place such notations on documents, but very well may have missed some.

Finding: The cabinet did not determine whether Kentucky has paid more in clawback than it would have paid for prescription drug coverage of dual eligibles in the absence of Part D (25).

Response: Clawback was a key provision of the Bush administration's Part D legislation in order to make the legislation more affordable to the Federal government. As indicated earlier, since clawback is a federal requirement, it is immaterial whether Kentucky would have paid more. Such determination would not change Kentucky's Medicaid expenditures (past or future) under the rules and regulations that have been imposed by the federal government with respect to clawback.

Prescription Drug Rebates

Finding: The cabinet should continue to attempt to recover the older disputed amounts unless they are not recoverable or the cost of recovery would exceed the amount recovered, at which point the cabinet should write them off (26).

Response: Agree, the cabinet will continue to do so.

State False Claims Act

Finding: If a state false claims act were passed,

- the cabinet might need additional funding to support investigation of new cases, and
- the Office of the Attorney General's Medicaid fraud control unit might need additional staff at a cost of \$175,000 or more to the state per year (30).

Response: Agree.

Program Integrity Plan

Finding: The department does not have a single comprehensive program integrity plan. The department should follow previous Program Review recommendations on such planning (32).

Response: The recommendations of Program Review staff essentially include combining the Program Integrity Plan with several other existing documents to create one comprehensive document. The department will consider consolidating those documents.

Program Integrity Activities

Finding: The cabinet should implement its proposed provider prepayment review program as soon as possible (37).

Response: The department is in the process of developing the provider prepayment review program and will file administrative regulations as appropriate once the program design has been completed.

Finding: The cabinet should ensure that the claims processing systems enforce all Medicaid program rules (37).

Response: As the department identifies issues with claims processing, they are addressed with policy staff and input and approval is sought from division directors.

Finding: The 2010 program integrity contract gives the vendor a percentage of costs that the cabinet determines were avoided if the cabinet adopts prepayment edits and audits proposed by the vendor. The contract appears to have some safeguards, but the percentage may be unnecessarily high (37).

Response: CMS approved this contractual arrangement. Additionally, as indicated by program review staff above, “the contract appears to have safeguards to ensure that the cabinet can accurately measure the savings and can terminate the program if it is not cost effective.”

Finding: The provider prepayment review program recognizes that claims processing should include an option to suspend claims for manual review. Predictive analytics also requires manual prepayment review (37).

Response: Any manual process will be staff and time intensive resulting in higher administrative costs. Given current budgetary constraints, the department seeks to manage its resources as effectively as possible. This approach is unlikely to offer a high return on investment.

Finding: The cabinet should attempt to create means for manual prepayment review in the processing of all types of claims, including point-of-sale pharmacy claims. Point-of-service adjudication should not be used for other providers unless it includes robust prepayment review (37).

Response: The department has plans to implement pre-payment review for all claims types where feasible. The prior authorization process is a form of pre-payment review that has been used for many years.

Finding: The cabinet reported almost \$136 million in avoided costs related to pharmacy point-of-sale processing in 2009, but it was unclear how much represented fraud or abuse (37).

Response: One of the department's ongoing savings initiatives is point-of-sale denials. There are many reasons to deny prescriptions at the point-of-sale, including drug interactions, early refill as well as cost avoidance. Any medication that is not appropriate to dispense is better stopped at the point-of-sale rather than through post-payment review. However, because these are point-of-sale denials, there is no way to determine which may be fraud versus abuse. While the pharmacy benefit administrator (PBA) does have the ability to report specific reasons a prescription was not filled and those reports are maintained by the department, it would require very specific algorithms and interrogation of data to determine if there was fraud or abuse involved in the denial. Since the department has already prevented the transaction and saved the money, this additional effort and expense would not seem to be the most cost effective use of limited dollars.

However, we would point out that cases are referred for further investigation any time the Department suspects fraud.

Finding: The cabinet should carry out KRS 205.6316 by creating a direct link between the pharmacy point-of-sale system and the medical claims system and requiring the pharmacy benefit administrator to include the medical claims in its prepayment drug utilization review. If such changes are not feasible, the cabinet should include these requirements in the next PBA procurement (37).

Response: The department's PBA, Magellan, currently does have access to medical claims. Magellan utilizes that information in its prepayment drug utilization review for some of the medications on the current PDL (for example: most of the atypical antipsychotics require diagnosis codes). Further, Kentucky Health Information Exchange (KHIE) is moving the state in the direction of interoperability and exchange of health information for which the department plays an integral role. If feasible and reasonable, the department will consider including this requirement in the next procurement.

Finding: Federal law requires state Medicaid programs to implement prepayment predictive analytics by 2015. In the 2010 program integrity contract, the cabinet has the option of a "predictive modeling" system that might meet the requirement (37).

Response: According to CMS and the Medicaid Integrity Group, the predictive modeling outlined in the department's existing SUR/RAC contract meets the federal requirements.

Finding: The Department for Medicaid Services has procedures in place for changing edits and audits that involve division-level management review and approval. The department should develop internal documentation of the change management procedure from its own perspective that covers all claims processing systems and clearly describes the responsibility and role of department management (37).

Response: The department previously addressed this issue with Program Review staff. The department believes there is a well-defined change control system already in place. The

department has a robust Project Workbook (PWB) that logs, tracks, and assists with implementation changes. Information Systems staff are assigned to each division and follow the requested change orders for edit and audit updates from start to finish, working with policy and systems staff throughout.

Program Review Staff Reply: The cabinet provided Program Review staff with written internal procedures for documenting and tracking changes to edits and audits. The written procedures were inadequate because they presented only the perspective of the vendor, did not address pharmacy benefit rule changes, and did not adequately describe the responsibility and role of Medicaid management. The cabinet asserted that all changes are approved by the appropriate division director. Program Review staff reiterate the finding that the documentation of the procedure is inadequate.

Finding: The cabinet was without a program integrity vendor for 30 of the 54 months from July 2006 to December 2010 (40).

Response: As indicated in the information provided, the Department for Medicaid Services signed a contract with a new program integrity vendor October 4, 2010. During the months of January 2010-October 2010, while the department was without a SUR vendor, the Division of Program Integrity continued initiatives begun by the former SUR vendor as well as identifying other areas of fraud and abuse. During that nine month period Program Integrity collected over \$4 million.

Finding: The Ingenix program integrity vendor contract is commendable. If Ingenix is able to achieve the 1 percent postpayment recovery goal, the cabinet should consider increasing the benchmark to at least 1.5 percent. (40).

Response: In surveying several states, KY Medicaid staff determined that states generally recover far less than 1 percent. The Director of Program Integrity in Utah observed that a 1.5% goal was considered quite ambitious for that state and most other states. However, New York has recently set a benchmark of 1.5 percent as their goal for 2012. If the current vendor is able to achieve the 1 percent postpayment recovery goal, the cabinet will consider increasing the benchmark to 1.5 percent or higher.

Finding: The cabinet might consider an additional vendor performance benchmark based on the return of state funds rather than the total of state and federal funds. Using such a calculation, the current contract appears commendable (41).

Response: The Cabinet will consider an additional performance benchmark.

Finding: The cabinet should take steps to ensure that future program integrity procurements are initiated early enough that there are no gaps and a new vendor can be fully productive by the time the previous contract ends (41).

Response: Agree.

Finding: Some overpayments to pharmacies and probably to other providers have become unrecoverable because they have aged past 5 years. The cabinet should ask Ingenix to conduct a historical review of all Medicaid service types immediately (41).

Response: The current vendor is already reviewing claims, including those which are five years old.

Finding: The cabinet should ensure that the pharmacy benefit administrator and the program integrity vendor coordinate their claims review activities and that at least one of the vendors conducts a thorough ongoing review of pharmacy claims for fraud and abuse (41).

Response: All program integrity activities are coordinated with vendors and outside agencies. The current contractor has received pharmacy data and is in the process of developing those algorithms. If fraudulent activities are identified, referrals will be made to law enforcement.

Finding: The cabinet might consider the relative effort and return on investment for recipient versus provider fraud and abuse (41).

Response: The department routinely considers level of effort as compared to probable return on investment in determining priorities for program integrity efforts. Recipient fraud is investigated by the Office of the Inspector General, who also assist with the prosecutions through the county or Commonwealth Attorneys. It should be noted that the return on investment is not only measured by monetary means, but also through the deterrent factor and the investigations and prosecutions yield. While the same is true for provider fraud, one algorithm can yield hundreds of thousands of dollars in recoupments with little effort or time on the part of the vendor or department staff.

Audits Of Pharmacies And Other Providers

Finding: The cabinet should expand the program [on-site audits of targeted pharmacies having unusual claims patterns] to include some random or routine rotating desk audits of pharmacies not targeted by the current program (42).

Response: Given the existing staffing and budget constraints, resources must be used in a manner which yields the best results. As staffing and budget constraints are resolved the Department agrees that random desk audits would be beneficial.

Finding: The cabinet should expand the nonpharmacy audit program to include some random desk and possibly field audits of providers not targeted by the current program (42).

Response: Given the existing staffing and budget constraints, resources must be used in a manner which yields the best results. As staffing and budget constraints are resolved the Department agrees that random desk audits would be beneficial.

Finding: The cabinet should develop ongoing cost-benefit analyses of both audit programs and should modify the programs over time to optimize costs and benefits (42).

Response: The Cabinet agrees with this recommendation and will consider development of ongoing cost-benefit analyses within available resources.

Phone-In Prescriptions

The cabinet should design and implement an ongoing evaluation of this intervention [measures to combat fraudulent phone-in prescriptions for Medicaid] (43).

Response: Agree.

Eligibility Procedures And Fraud and Abuse

Finding: There is no mechanism to record unreported income and resources discovered by caseworker verification, and there is no method to estimate them (46).

Response: The Department for Medicaid Services has no means to differentiate between information discovered by the caseworker and that which is reported to the agency, other than documentation that exists in case comments.

Finding: Adult Medicaid recipients typically use more expensive services than other recipients do (46).

Response: This finding should be clarified to read: “Adult Medicaid recipients who fall into the disabled or aged categories typically use more expensive services.”

Program Review Staff Reply: Staff agree that the cabinet’s description is correct. The report has been revised accordingly.

Finding: The cabinet should explain why, after 2013, all adult Medicaid applicants should not report their expenses and caseworkers should not reconcile expenses with income and resources in order to find unreported income and resources (46).

Response: There is no current federal requirement to perform reconciliation at this time. Currently DCBS must depend on applicants providing any financial records beyond those that are captured by the existing Income and Eligibility System and other federal benefit data matches. While DCBS can request copies of bank statements and other financial documents, DCBS does not currently have direct access to the personal banking and financial records of applicants. We would note that the Affordable Care Act requires States to establish an Asset Verification Program by September 30, 2013 in order to verify the financial resources of Medicaid applicants and recipients by direct contact with financial institutions.

Currently staff can request additional verification as far back as five years if, during the interview, there appears to have been a misuse of resources. Staff routinely performs this five-year “look back”.

Under federal rules, a Medicaid applicant who is in an institutional setting is not required to provide all expenses—only shelter expenses if the institutionalized spouse agrees to allow the community spouse to retain part of the institutionalized spouse’s income in order to continue to reside in the homestead. Those adult Medicaid recipients who represent the highest cost to the agency are also the most likely population to have low household expenses, so proof of those costs would not provide sufficient information to be particularly useful.

There is an existing Income and Eligibility Verification System match performed monthly, which includes income and resources identified by the IRS, which has proved successful in finding unreported income.

Finding: Adult Medicaid eligibility error rates have grown in Kentucky from 7.5 percent to 10 percent in the last five years. In September 2010, the cabinet changed its sampling method and intensified its case review process in order to reduce the error rates (46).

Response: As indicated above, the cabinet has refined its sampling method and intensified the case review process.

Finding: Eligibility caseworkers referred approximately 380 cases of fraud in 2007 and 525 such cases in 2009 to the Office of Inspector General. The cabinet should report how many in each year were for adult Medicaid applicants (46).

Response: It would require a hand count to determine how many of the OIG referrals by eligibility caseworkers were for adult Medicaid applicants and this would involve reviewing the case program codes as this information is not automatically captured at this time. The number will not be high simply due to the low percentage of the overall caseload these cases comprise. However, the Department for Community Based Services, Division of Family Support will begin tracking this information from this point forward. The Department for Community Based Services is unable to indicate how many referrals are actually “fraud” because that determination is not made until OIG and law enforcement have investigated and made that declaration.

Preeligibility Fraud

Finding: The cabinet should analyze the spending and cost avoidance attributable to DETER [Determining Eligibility Through Extensive Review] and attempt to improve the return on investment (49).

Response: The cabinet will analyze spending and cost avoidance related to DETER to determine if the return on investment can be improved.

Finding: The cabinet should document the methodology used to determine return on investment for DETER and train additional employees in its calculation so that turnover does not result in additional loss of institutional knowledge (49).

Response: Return on investment for the DETER program is calculated by dividing the total annual cost avoidance amount for the specifically identified program by the total cost of personnel assigned to DETER investigations.

Annual cost avoidance is calculated by determining the amount of benefits that would have been received if certified under original statements and verifications and subtracting any amount of benefits they were determined eligible to receive after a DETER investigation is completed. Medicaid cost avoidance benefits are calculated based upon an average monthly utilization amount provided by DMS multiplied by the number of adults and children in the household.

Total cost of personnel is calculated using the specific budget codes allocated for each program, calculating the amounts expended for personnel costs (funds expended under object type 1) for each specific budget code.

Finding: DETER may have a deterrent effect that would add value to the program (49).

Response: Additional benefits when employing DETER investigations rather than postpayment investigations include:

- No costs imposed upon the criminal justice system;
- No personnel spending time in court assisting with prosecution; and,
- No administrative costs for collection and accounting of re-payments.

The cabinet has not included those costs when determining return on investment. These additional benefits would be difficult to quantify.

Finding: Using return on investment, the cabinet should consider whether to further expand DETER (49).

Response: The cabinet will consider whether to expand DETER further. The fact that the state is not permitted to retain the federal share of funds has hindered efforts to make DETER budget neutral. As indicated above, the state share of recoveries is currently not sufficient to cover all costs associated with the program.

Medical Child Support

Findings: Current federal and Kentucky laws require child support enforcement (CSE) to seek dependent health insurance or cash medical support as appropriate. Program Review staff did not determine how often such support was requested or ordered, but the cabinet asserted it was requested in all cases and ordered when appropriate.

Medicaid has not received cash medical support payments, although federal requirements have been in place since July 2008 and a conforming Kentucky law was effective June 2009.

CSE instructed local child support offices not to seek cash medical support in the form of reimbursement to Medicaid because the CSE and Medicaid information systems could not transfer the payments.

As of June 2010, the cabinet put on hold efforts to create a system to transfer cash medical support to Medicaid, based on a letter from the federal Office of Child Support Enforcement. In fact, the letter instructed states to continue to carry out all aspects of the law.

The cabinet should obtain guidance from the federal Office of Child Support Enforcement and the Centers for Medicare and Medicaid Services on the following questions and report the response to the Program Review and Investigations Committee.

- May the state child support agency and the courts consider Medicaid coverage as “private health insurance”
 - when determining whether to order such insurance under 45 CFR 303.31(b)(1) or
 - when determining the amount of cash medical support to be ordered under 45 CFR 303.31(b)(2)?
- When a dependent child is covered by Medicaid:
 - Does a state’s child support agency have an obligation
 - to ensure that reasonable cash medical child support is ordered when a noncustodial parent does not have access to affordable health insurance and
 - to ensure that such orders are enforced and payments are transferred to reimburse the Medicaid program for the child’s medical expenses?
 - If the answer to the preceding question is yes on both counts, what is the effect of Office of Child Support Enforcement Action Transmittal AT-10-02 on carrying out the state’s obligation?
 - Is Medicaid obligated to seek reimbursement from cash medical child support under third-party liability rules (53-54)?

Response: In a conference call with Federal officials on February 18, 2011, Kentucky Child Support Enforcement staff requested any updated information or guidance regarding medical support since issuance of OCSE-AT-10-02 that suspended state requirements to develop new procedures and interfaces to comply with the medical support Federal rule. Federal officials advised there was no updated information or guidance since issuance of the Action Transmittal 10-02. On May 16, 2011, CSE staff again contacted Federal officials and were told there were no updates to AT-10-02.

Kentucky’s child support enforcement program is in compliance with KRS 403.211 (7)(c)2 by including cash medical support in all new orders and in existing orders when modified.

Additionally, included in the cabinet’s proposed capital plan for 2012-2018 is the development and implementation of a new Medicaid eligibility system, which, if approved, could make possible the exchange of data and payments for cash medical between the Medicaid and Child Support programs.

Finding: The cabinet should enforce the cash medical child support law but should report to the appropriate committees of the Legislative Research Commission if such enforcement creates hardships for custodial parents and their children (54).

Response: The Child Support Program will report to appropriate committees if there is indication that hardships for custodial parents and their children that are prevalent.

Finding: If permitted by federal law, the cabinet

- should offer health insurance premium assistance to noncustodial parents when it is cost effective and a court has ruled that available dependent health insurance costs are not reasonable,
- should determine whether to do so in other circumstances, and
- should determine whether it is permissible and reasonable to require the noncustodial parent to pay some portion of the premium (54)

Response: Because the non-custodial parent is court-ordered to pay for insurance, the cabinet feels it would be in violation of the court order to pay health insurance premiums. The cabinet has surveyed other states and none of those that responded (California, Oregon, Louisiana, Virginia, Idaho, North Carolina, Kansas, Nevada, and Pennsylvania) offer health insurance premium assistance to noncustodial parents.

Program Review Staff Reply: The finding does not apply to noncustodial parents who have been ordered to pay for insurance. It applies only when the court has found that it would be unreasonable to issue such an order.

Finding: CSE has not carried out the recommended evaluation of incentives for local child support offices to improve enforcement of medical child support orders. CSE asserted that incentives are not necessary because local offices fulfill their contractual obligations to enforce such orders but did not provide data on the portion of orders that are unfulfilled or evidence that local offices take all available actions to enforce those orders (54).

Response: Evidence of success of enforcement efforts by county officials is found in Kentucky continues to meet its performance targets, resulting in earning child support incentive funding awards from the federal government. If additional state incentives were to be considered, additional appropriations would be necessary from the General Assembly.

Claims Processing Software And Data

Finding: The question of whether to process pharmacy claims using a different system from other claims remains open. In future procurements, the cabinet should encourage vendors to propose both integrated and separate systems (58).

Response: While the cabinet is moving toward a more integrated reconciliation of data with the institution of the Kentucky Health Information Exchange, we respectfully disagree with Program Review staff as indicated by responses to Program Review staff. The object of issuing

procurements is to obtain the best value, both in terms of quality and cost. While integration is an objective, it is a single consideration among many. In recent years, CMS has advocated the Medicaid Information Technology Architecture (MITA), which features a modular approach to the MMIS as opposed to a large, single system approach.

Finding: The current data warehouse configuration appears to be fragmented, and some important types of information are not available in the enterprise data warehouse.

- In future procurements, the cabinet should minimize the number of data warehouses and decision support systems and consider whether to request a centralized data warehouse and decision support system to serve most of the data needs of Medicaid and its vendors.
- The cabinet's enterprise data warehouse should have a complete record of all claims, audit trail, and reference data that might be useful for surveillance, utilization review, and cost analyses.
- In the short term, the cabinet should develop a routine process for extracting audit trail and reference data from the Medicaid management information system, pharmacy benefit administrator, and managed care systems and merging it with the enterprise data warehouse (58).

Response: While there is always room for improvement, the cabinet disagrees that the data warehouse is fragmented. Efforts continue to include additional data and create interfaces in support of consolidation. Future planning includes the addition of data from KY Health Information Exchange and the development of an "All Claims Payer Database."

If the Cabinet finds that it is in the best interest of the Department for Medicaid Services and it is consistent with CMS MITA, it will consider such an integration.

Data, such as audit trails, utilization review data, and reference data is maintained in the System of source, MMIS. The data from all systems can be extracted and used in a cohesive manner toward the objective that is required. The MMIS and the data warehouse interface and interact, therefore the department believes it has a complete record.

Program Review Staff Reply: The purpose of a data warehouse is to contain all relevant information in a single location. Having to extract additional data from a source system makes it more difficult to use the data. These types of data were identified because they can be important to identifying fraud and abuse, so their ease of use is important.

Finding: If additional Medicaid and non-Medicaid funding becomes available, the cabinet should consider a cabinet-wide data warehouse that could consolidate information from Medicaid, public assistance, disability determination, child support enforcement, child protection, public health, mental health, and other cabinet functions (58-59).

Response: If such funding were to become available, the cabinet would consider a cabinetwide data warehouse.

Method Of Payment In KASPER

Finding: The Kentucky All Schedule Prescription Electronic Reporting system does not currently capture payment information but plans to do so in April 2011 (59).

Response: The OIG is currently working with its data collection vendor to transition to a new platform that includes new standards to capture method of payment. This requires working with dispensers statewide and modifying current technologies. The current estimated completion of this conversion is by end of calendar year 2011.

Finding: The cabinet should ensure the proposed data system captures and provides reports on the method of payment, including cash payments (59).

Response: As method of payment relates to Medicaid, Program Integrity staff within the department currently has a complete picture of a Medicaid recipient's controlled substance history. Per statute, Medicaid has access to any Medicaid recipient's KASPER report that includes all of the controlled substances dispensed to that recipient regardless of payment type. In addition, Medicaid staff has pharmacy claims data for the recipient; therefore, staff can determine which controlled substances were paid by Medicaid and which were paid by cash.

Program Review Staff Reply: The finding was not strictly related to Medicaid. The original recommendations applied to KASPER generally, not just to its use by Medicaid.

Statutes Related To The Office Of Inspector General And The Office Of The Attorney General

Finding: OIG should send to MFCU [Medicaid fraud control unit] a nominal written description of all hotline complaints involving recipient fraud and abuse as required by KRS 205.8483(2)(a) (62).

Response: The OIG has discussed the issue of recipient fraud and abuse hotline complaints with the MFCU and since they do not have jurisdiction over recipient fraud, they have requested to not receive the raw hotline complaints pertaining to those allegations.

Finding: The cabinet should consider mentioning in its public materials that Medicaid fraud and abuse reporting is mandatory (63).

Response: The cabinet will consider mentioning in its public materials that Medicaid fraud and abuse reporting is mandatory. Note that the cabinet posts the Medicaid Fraud and Abuse hotline on its website and the Department for Medicaid Services distributes OIG Medicaid Fraud and Abuse posters at meetings with outside agencies. Additionally, in February 2011, the Department for Medicaid Services mailed letters to various boards and associations alerting them to the federal requirement to return any identified overpayments.

Finding: Kentucky statutes appear to be adequate for recovering overpayments, but the cabinet should advise the General Assembly regarding specific improvements that would help the cabinet (63).

Response: Agree.

Potential Legal And Contractual Issues With Information Systems

Finding: The cabinet should continue to pursue all opportunities for Kentucky Medicaid to receive the maximum allowable percentage of federal financial participation (65).

Response: Agree; the cabinet will continue to do so.

Operation Of Advisory Bodies

Finding: The [Drug Management Review Advisory] board's website should include its meeting minutes (67).

Response: Minutes are posted after the Board approves the minutes by vote at the next meeting.

Findings: Recognizing that the Recipient Utilization Review Committee does not exist at present, the General Assembly may still wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable.

If the Kentucky statutes are not so modified, the Department for Medicaid Services should operate RURC as defined in the law, to the extent permitted by federal law.

- The department should ask the Centers for Medicare and Medicaid Services if RURC and its duties, as currently defined in Kentucky law, would conflict with the single state agency requirements.
- The department should seek any federal waivers necessary to implement the statute.
- The department should seek direction from the federal Department of Health and Human Services on ways that RURC as currently defined in Kentucky law could satisfy federal privacy requirements.
- If there are insurmountable federal obstacles, then the department should inform the relevant committees of the General Assembly, including the Program Review and Investigations Committee (68).

Response: While the department believes its concerns are valid, the department will consult with CMS regarding this issue.

Federal Drug Use Review Reporting

Finding: The Department for Medicaid Services was unable to provide drug use review (DUR) reports for 2003 and 2004 (69).

Response: Agree.

Finding: Going forward, DMS should provide a copy of each annual DUR report to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission (69).

Response: Copies of the annual DUR report have been provided to LRC since 2005 and the department was complimented on the format of the report.

Program Review Staff Reply: In 2007, the cabinet was unable to provide copies of any annual DUR reports. LRC Health and Welfare Committee staff reported that they did not have copies.

In 2010, the cabinet did provide Program Review staff with copies of all DUR reports starting with 2005. However, LRC Health and Welfare Committee staff reported that they still did not have copies.

Finding: Going forward, DMS should consult with the Office of the Attorney General and decide whether to provide the office with copies of the annual reports (69).

Response: The department will share the reports with the Office of the Attorney General.

Controlled Substance Laws

Finding: The cabinet should continue to review other drugs for more restrictive scheduling as needed (73).

Response: Cabinet staff, specifically the OIG, will continue to meet regularly with all of the licensure boards as well as other stakeholders such as law enforcement, Office of Drug Control Policy and groups involved in the field of addiction treatment to determine if there are other prescription drugs that may need to be scheduled or rescheduled to be more restrictive.

Relief From Federal Recoupment Of Overpayments

Finding: Because the overpayment recovery window was widened to 1 year, that issue is moot (77).

Response: Agree.

Finding: If the scope and intensity of federal audits are expanded, it is possible that state Medicaid programs will have to expand their recovery staffs; however, there should be a positive return on this investment (77).

Response: There should be a positive return on investment if there are sufficient state monetary resources to support such expanded efforts so that resources are not redirected away from other Medicaid administrative priorities.

Finding: The cabinet should advise the General Assembly regarding any resolutions to Congress that might support helpful changes to federal laws (77).

Response: The cabinet comments on all legislation proposed by the General Assembly as requested by LRC staff.

Program Review Staff Reply: The finding requests that the cabinet proactively advise the General Assembly if the General Assembly can support helpful changes to federal laws.