Special Report of Certain Policies, Procedures, Controls and Financial Activity Regarding Medicaid Managed Care

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Table of Contents

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July 31, 2013

Audrey Haynes, Secretary
Lawrence Kissner, Medicaid Commissioner
Cabinet for Health and Family Services

RE: Special Report on Medicaid Managed Care

We have completed our Special Report on Medicaid managed care. The enclosed report provides both a historical perspective of our work over the past 16 months and current recommendations related to the Cabinet for Health and Family Service's oversight of the Medicaid managed care program.

Procedures included site visits with the three Managed Care Organizations - CoventryCares of Kentucky, Kentucky Spirit Health Plan, and WellCare of Kentucky - as well as meetings with Cabinet for Health and Family Services (Cabinet) management and staff, and discussions with various health care providers. Also, procedures included a review of a significant volume of documentation, and included other procedures required for the annual financial and compliance audit for Medicaid. Unless otherwise specified, this report covers an examination of records for the first year of the Medicaid managed care program, a period November 1, 2011 through October 31, 2012, with additional analysis and inquiries made through the date of this report.

Detailed findings and recommendations along with the Cabinet's planned corrective actions communicated during the managed care implementation period and during the annual audit are presented in this report to provide background information of the foundation of our report, as well as additional analysis. Additional concerns and recommendations not previously communicated are also included for the Cabinet's consideration. If you wish to discuss this report further, please contact Libby Carlin, Assistant State Auditor, or me.

Respectfully submitted,

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Medicaid Accountability and Transparency Unit
Executive Summary
July 31, 2013

Special Report of Certain Policies, Procedures, Controls, and Financial Activity Regarding Medicaid Managed Care.

Objectives

On February 3, 2012, after hearing widespread complaints from various sources regarding the Cabinet for Health and Family Services' (Cabinet) and managed care organizations' (MCO) implementation of the Medicaid managed care program, the Auditor of Public Accounts (APA) announced the creation of the Medicaid Accountability and Transparency Unit (MATU). The objective of the MATU is to address a broad scope of Medicaid issues, to propose ways to increase the oversight of the Kentucky Medicaid program, to evaluate the Cabinet's effectiveness of administering the managed care program, to obtain an understanding of managed care system as it has been established for the Kentucky Medicaid program, and to perform data analysis to determine risk for misuse, abuse, or fraud within the program. The MATU was tasked with performing a review of the Medicaid managed care program since its implementation date, November 1, 2011, to the current report date.

Background

The Medicaid program is a federal entitlement program that pays for medical assistance for certain individuals and families with low income and resources. Medicaid is jointly funded by the state and federal government and is administered by the state. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States, serving nearly 60 million people (or 1 in 5 Americans). As of 2010, approximately 787,000 Kentuckians were enrolled in the Medicaid program, which was approximately 18% of the state's total population.

Managed Care Contracts

On July 7, 2011, Governor Steve Beshear announced the state entered into contracts with three MCOs. The MCOs announced were CoventryCares of Kentucky (Coventry), Kentucky Spirit Health Plan (KY Spirit), and WellCare of Kentucky (WellCare). The contracts with KY Spirit, Coventry, and WellCare for all Kentucky regions except Region 3 were set to expire July 6, 2014, although as noted within this report, KY Spirit terminated its contract with the Commonwealth early.

The capitation rates, which are upfront payments to the MCOs based on the number of members enrolled, were negotiated between the individual MCOs and the Cabinet. These rates are therefore unique for each MCO and may vary significantly for any single member class or covered region.

Contract Differences: A comparison of the three MCO contracts was performed, with major differences amongst the three vendors being noted. Although differences in the contracts of the three MCOs are expected due to the nature of negotiations, it is important for Cabinet employees to be aware of these differences when overseeing and monitoring the contracts.

Findings and Recommendations Made To The Cabinet February 2012 Through March 2013

Recommendations Based On Information Requested From MCOs Due to the number and egregious nature of complaints received concerning Coventry, KY Spirit, and WellCare during the first few months of the managed care program, State Auditor Adam Edelen requested data from each of the MCOs on February 29, 2012 to determine how quickly claims were being processed and paid.

Based on the information received and analyzed, Auditor Edelen issued ten recommendations to the MCOs and the Cabinet. The Cabinet responded initially on August 20, 2012 and provided an additional status response on September 21, 2012. These recommendations and the Cabinet's responses are presented in their entirety in Appendix 8.

Recommendations Based On MCO Site Visits In May 2012 and June 2012 the MATU met with corporate representatives from Coventry, KY Spirit, and WellCare at their Kentucky offices. The auditors were seeking to gain an understanding of how the administration of the Medicaid program changed under the newly introduced managed care system.

Based on our site visits and discussion with the MCOs, we met with the Cabinet management and staff to discuss the concerns gathered during this process. These meetings resulted in a set of recommendations to the Cabinet. The Cabinet responded on September 21, 2012. The full text of these recommendations and the Cabinet's response are presented in Appendix 9.

Findings and Recommendations Based On The Fiscal Year 2012 Annual Audit The APA audits Medicaid annually as part of the audits of the Kentucky Comprehensive Annual Financial Report (CAFR) and the Statewide Single Audit of Kentucky (SSWAK). The audit procedures include testing certain activities of the Cabinet for compliance and internal controls over financial reporting and over requirements applicable to Medicaid.

As part of these audits, the APA reports findings and recommendations to the Cabinet for internal control and compliance matters relevant to the scope of the audit. During the course of our Medicaid audit for fiscal year 2012 we noted 13 findings. These findings are presented in their entirety in Appendix 10.

Continuing Challenges with Managed Care Transition and Additional Recommendations

Quick Implementation of Expanded Managed Care Since the implementation of the Kentucky Medicaid managed care system many challenges have been faced by the Cabinet, MCOs, provider, and members. Many of the issues were specifically identified as a result of the quick transition from Kentucky's FFS to managed care. These include contract issues, marketing issues, and elicited concerns from providers.

Hospitals On November 2, 2012 the KHA and several hospital representatives met with the MATU to discuss their concerns. Many of the issues were similar among the different providers, which indicated potential systemic concerns. One of the most significant and troubling concerns centered on whether Kentucky's rural hospitals could continue to afford to "float" Medicaid related costs. Hospital representatives indicated that rural hospitals are not equipped for the sudden financial stress put upon them by the managed care program. The matters brought to our attention include increasing accounts receivable impacting the hospitals' cash flow, increased administrative burden for hospitals in trying to file claims to MCOs, below cost reimbursements related to emergency department triage fee policies, and reporting difficulties due to a lack of information available from MCOs.

Provider Availability Since the implementation of the Kentucky Medicaid managed care system concerns have been expressed alleging that providers are going to stop serving Medicaid members if provider concerns are not resolved. Auditors analyzed the changes in providers since the implementation of managed care in Kentucky, and noted an overall 8 percent decline in all provider types. Most troubling was a 57% decline in general hospitals participating in the Medicaid managed care program.

Overall, the reduction in the number of providers under the managed care program is troubling, especially in light of the more than 300,000 new Medicaid members estimated to join the program when the Commonwealth implements the Medicaid expansion portion of the Affordable Care Act (ACA). We further analyzed this information by provider type and presented a table of variance by provider type in Appendix 7.

Network Adequacy A major issue which surfaced during Kentucky's switch to a managed care environment for the Medicaid program was the adequacy of each MCO's provider network. A provider network is the collection of hospitals, physicians, dentists, and various other healthcare providers contracted with an MCO to provide services to Medicaid members. An inadequate network would make it difficult for Medicaid members to receive proper treatment and healthcare.

Based on reports generated using member/provider data, at the time of auditor inquiry in July 2012, the Cabinet determined the majority of contractual requirements for provider network requirements were being met by all MCOs. The reports indicated 100% of members in both urban and rural areas had access to both hospitals and PCPs. Further, the majority of members had access to specialty physicians, local health departments, FQHCs, and CMHCs. However, concerns remain about how contractual requirements in certain rural areas are met given the challenging geography in many parts of the state. Cabinet staff clarified that the MCO contracts permit miles to be measured by straight-line distance instead of driving distance. The network adequacy reports are based on these straight-line calculations meaning that although the MCOs may meet network adequacy guidelines, some members may struggle with adequate access to care.

Local Health Departments Since the implementation of the Kentucky Medicaid managed care system, we have received numerous complaints from Local Health Departments (LHD) concerned with the outstanding and denied claims from the MCOs. The LHDs were already struggling financially due to several other challenges, such as cuts in funding and the Cabinet's change in how the Medicaid match requirement is met, which placed a greater burden on the LHDs. These challenges, along with the transition to managed care have created a financial hardship for these entities.

MCO Subcontracts We identified a concern with one of the MCO's vendor for dental claim processing. This MCO changed vendors and indicated it was not able to provide dental claims paid/denied prior to September 2012. We extended the deadline for this information to February 2013 and still were unable to obtain the requested information. The MCO indicated that it did not have the information from its previous vendor and was not able to obtain it. It is unclear how the MCO or the Cabinet is able to meet federal requirements without access to all claims received/paid; therefore this is a serious concern. Also, this raises questions as to whether the Cabinet should have greater involvement in approving MCO subcontracts or vendors when those third parties maintain or administer programmatic functions.

KY Spirit Cancels Contract On October 17, 2012, the Commonwealth acknowledged KY Spirit's intent to cancel its contract one year

early in July 2013 due to lost profits under the managed care structure. KY Spirit ultimately made the decision to end its contract with the Commonwealth as of midnight on July 5, 2013, and the Cabinet implemented a plan to have all KY Spirit members transferred to other MCOs.

Cost Savings To Commonwealth
Implementation of managed care was estimated to save the state $375 million over a three year period. The Cabinet's methodology does not appear to consider factors related to the cost of implementation, such as the payment for its contract with Public Consulting Group (PCG) to review the Cabinet and make recommendations to improve oversight. Also, the calculation does not include the Cabinet's administrative costs, costs associated with reorganization, or the effects of the 7 percent increase in capitation rates given to two of the MCO's beginning January 1, 2013.

Recommendations

- Consider establishing a formal advisory panel comprised of members of all stakeholder parties.
- With contract expirations approaching, the Cabinet should already be in the planning stage for the next contract term.
- Establish a requirement within the contracts that all claim related data, whether maintained by the MCO or a subcontractor, will be available to the Cabinet and auditors for a period no shorter than the Cabinet's own record retention policy.
- Establish an approval process by the Cabinet for all subcontracts used by MCOs for fulfilling contractual requirements in Kentucky, including third party providers for dental, vision, behavioral health, etc.
- Improve monitoring and follow up related to MCOs' accounts payable to providers and prompt pay concerns.
- Establish a methodology for estimating cost savings to the Commonwealth based on the full cost of implementing and administering the Medicaid managed care program, as well as an ongoing process for analyzing the savings actually realized.

Moving Forward

Ultimately, the information gathered since the implementation of the Medicaid managed care program, as well as our consideration of future challenges for the program, highlights two significant concerns that will test the strength of the program and its impact on the Commonwealth in the future. One is the long-term viability of rural hospitals in Kentucky, which poses serious consequences for a large number of Kentuckians who utilize these hospitals for medical care, regardless of their participation in the Medicaid program. It is questionable as to whether these hospitals have access to resources necessary to handle the financial and administrative burdens discussed in this report for a long period of time.

The second concern relates to the system's readiness for Medicaid expansion. The expansion is estimated to extend coverage to more than 300,000 Kentuckians. Kentucky should ensure all necessary planning is in place to meet the challenges brought by this expansion. A separate report by Deloitte Consulting released May 22, 2013 indicated Kentucky needs approximately 3,790 additional physicians, 612 additional dentists, 5,635 additional registered nurses, 296 additional physician assistants, and 269 additional optometrists to adequately meet the current demand for the Medicaid program. Therefore, even more resources will be needed to provide adequate care for members under the Medicaid expansion.

Chapter 1
Overview

Objectives

On February 3, 2012, after hearing widespread complaints from various sources regarding the Cabinet for Health and Family Services' (Cabinet) and managed care organizations' (MCO) implementation of the Medicaid managed care program, the Auditor of Public Accounts (APA) announced the creation of the Medicaid Accountability and Transparency Unit (MATU). The objective of the MATU is to address a broad scope of Medicaid issues, to propose ways to increase the oversight of the Kentucky Medicaid program, to evaluate the Cabinet of Health and Family Services' (Cabinet) effectiveness of administering the managed care program, to obtain an understanding of managed care system as it has been established for the Kentucky Medicaid program, and to perform data analysis to determine risk for misuse, abuse, or fraud within the program.

Scope

The MATU was tasked with performing a review of the Medicaid managed care program since its implementation date, November 1, 2011, to the current report date. During the reporting time frame, the APA requested information from the MCOs to analyze data on two separate occasions in response to complaints and as a monitoring procedure to gauge the progress of the MCOs in carrying out their responsibilities. The auditors also performed site visits to each of the new MCOs to obtain an understanding of their processes, as well as the challenges they were facing with the newly implemented state-wide system. In addition, auditors met with staff and management at the Cabinet on several occasions to discuss issues regarding managed care and obtain an understanding of their ongoing challenges with the newly implemented system.

Report Format

This report contains a summary of work performed over a 16 month period. It is important to note that MATU auditors worked in real time during the first year of implementation of the Medicaid managed care program instead of performing a traditional audit which typically occurs after the end of a fiscal period. Because of this methodology, as findings and concerns were identified, they were reported to the Cabinet's management throughout the process. As a result, significant recommendations were made to the Cabinet during the period, and the Cabinet has responded to those recommendations.

This first chapter of the report gives a chronological perspective of the work of the MATU. Chapter 2 of this report provides an overview of the differences in the MCO contracts, followed by explanations of previously communicated findings and recommendations in Chapter 3. Chapter 4 presents areas of concern not previously communicated to the Cabinet's management, and Chapter 5 summarizes upcoming actions planned for Kentucky's Medicaid program.

Chapter 1
Overview

Background

Medicaid in Kentucky

The Medicaid program is a federal entitlement program that pays for medical assistance for certain individuals and families with low income and resources. Medicaid is jointly funded by the state and federal government and is administered by the state. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States, serving nearly 60 million people (or 1 in 5 Americans). As of 2010, approximately 787,000 Kentuckians were enrolled in the Medicaid program, which was approximately 18% of the state's total population. Between 2008 and 2011, Kentucky's Medicaid spending grew by an average of 6 percent per year while the growth in state revenue was approximately 8 percent during the same timeframe. This increase in Medicaid spending amounted to more than $300 million, during a time when concerns arose that health care costs would continue to rise significantly nationwide.

In 2010, Kentucky's per capita income was $32,076 per year. This is 80% of the national average ranking Kentucky 47th among the states. Since eligibility for Medicaid is based in part on income, Kentucky heavily relies on Medicaid for its healthcare needs.

Prior to November 2011, Kentucky's Medicaid program operated on a fee-for-service (FFS) basis with the exception of Region 3, which includes Jefferson County and the 15 surrounding counties and was exclusively covered through the managed care vendor United Health Care (doing business as Passport). The FFS basis required providers to submit a claim to the State for each service provided in order to receive reimbursement for the eligible Medicaid member.

The continuous growth of Medicaid expenditures was concerning, especially with the pending implementation of the Affordable Care Act (ACA). Estimates indicate that when Kentucky adopts the ACA's Medicaid expansion option for uninsured adults, the state could add more than 300,000 members.

What is Managed Care?

Kentucky chose to move to a managed care model statewide with the goal of improving the health of Medicaid members while reducing cost. Kentucky contracted with three new companies to manage health care for most Medicaid members beginning in November 2011 for a period of three years.

Chapter 1
Overview

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services in the United States through an arrangement between a state Medicaid agency and managed care organizations that accept a set payment - "capitation" - for these services.

Implementation of Medicaid Managed Care in Kentucky

The Commonwealth's objective for expanding managed care was to provide consistent, comprehensive care to patients, in order to ensure vulnerable families would continue to receive the quality medical services necessary while reducing costs for the state's Medicaid program. Additionally, it was estimated that significant savings could be realized by transitioning the Medicaid program from a FFS system to a managed care system. In addition, this move was expected to prevent unnecessary cuts to Medicaid providers and other areas of state government.

On July 7, 2011, Governor Steve Beshear announced the state entered into contracts with three MCOs. The MCOs announced were CoventryCares of Kentucky (Coventry), Kentucky Spirit Health Plan (KY Spirit), and WellCare of Kentucky (WellCare). Governor Beshear also announced that the state expansion of managed care within the Medicaid program was expected to save taxpayers $375 million in the General Fund and $1.3 billion in all funds over the course of the new three-year contracts.

On September 8, 2011, the U.S. Centers for Medicaid and Medicare Services (CMS) approved the waiver to allow Kentucky to implement a mandatory managed care program for Medicaid recipients outside of Region 3, which operated under a separate CMS waiver. The waiver approval is effective from October 1, 2011 through September 30, 2013.

On September 19, 2011, the Cabinet granted an extension to November 1, 2011 for the managed care implementation date. The implementation date was originally targeted for October 1, 2011; however, the short implementation time-frame of three months was a significant concern of the hospitals. The Kentucky Hospital Association (KHA) requested an extension to allow adequate time to sign contracts with the MCOs and prepare for implementation.

On November 1, 2011, Kentucky's expansion of Medicaid managed care was implemented. The new MCOs were tasked with coordinating health care to Medicaid recipients across the state, except for recipients receiving long term care and waiver services, which remained part of the FFS system. As of December 2011, the new MCOs enrolled more than 519,000 recipients and operated in all regions of the state except Region 3 (see Appendix 1 for Managed Care Regions).

A more detailed timeline for implementation is shown in Appendix 2 - Timeline for Managed Care Implementation.

Chapter 2
Contracts and Review

Managed Care Contracts

As noted above, on July 7, 2011, contracts were issued to KY Spirit, Coventry, and Wellcare, which were selected through the competitive bid process established by the Kentucky Finance and Administration Cabinet (FAC). MATU auditors met with representatives from FAC to discuss the bid process and contract negotiations with the three MCOs. Within these discussions, FAC did not note any issues with the procurement, and indicated the process went smoothly. At the time, Region 3 was exclusively served by Passport; however, effective January 1, 2013, Passport can no longer *exclusively* serve this region. Therefore, new contracts for Region 3 were competitively bid and issued on October 24, 2012 to Coventry, WellCare, Humana Health Plan, Inc., and Passport. Due to these four new contracts for Region 3 being outside the timeframe of this report, the details of the new contracts are not covered by this report.

Issuance of Contracts

Capitation Rates

The contracts with KY Spirit, Coventry, and WellCare for all Kentucky regions except Region 3 were set to expire July 6, 2014, although as noted within this report KY Spirit terminated its contract with the Commonwealth early. As the contracts are based on capitation payment rates by covered region, member, and month, there are no total costs calculated for these contracts. [See Appendix 3 for schedules of the original Approved Capitation Payment Rates through the first year for all three MCOs.] The capitation rates, which are upfront payments to the MCOs based on the number of members enrolled, were negotiated between the individual MCOs and Cabinet. These rates are therefore unique for each MCO and may vary significantly for any single member class or covered region.

Since the inception of the managed care program, the capitation rates have been formally adjusted once by the Cabinet. This adjustment increased the original Capitation Rates for contract years 2 and 3 effective January 1, 2013 by 7 percent for WellCare and Coventry. The Cabinet formally amended the contracts to document this change in February 2013. This rate increase was not effective for KY Spirit. Per the Cabinet, this capitation increase was offered by the Cabinet to seek indemnity for "any issues which had or could have been raised concerning the interpretation or implementation of the contracts in exchange for the 7% increase." KY Spirit was offered the same consideration, but declined.

Membership

In November 2011, a total of 519,740 members were moved from the Medicaid FFS system to one of the three new MCOs. There were 127,332 members enrolled with WellCare (24.5 percent), 221,339 members enrolled with Coventry (42.6 percent), and 171,069 members enrolled within KY Spirit (32.9 percent). As of December 1, 2011, 130,009 Medicaid recipients were determined ineligible to participate in the managed care structure and would remain within Medicaid FFS.

Total Payments to MCOs as of June 30, 2013

As of June 30, 2013, the following total payments have been made by CHFS to the three MCOs since the managed care system was implemented November 1, 2011.

MCO	Total Paid
KY Spirit	$915,544,192
WellCare	1,296,715,062
Coventry	1,518,829,879
Grand Total Paid	**$3,731,089,133**

A detailed listing of payments by MCO can be seen in Appendix 4.

Contract Terms

The three contracts with the MCOs are very similar in nature as they appear to have been created from the same template. The contracts cover terms such as member services, subcontracts, provider services, provider network, program integrity, reporting, monitoring, etc. As noted in the *Major Contract Differences* section below, there are some differences in the granular terms of the contracts.

Major Contract Differences

A comparison of the three MCO contracts was performed, with major differences amongst the three vendors being noted. The significant discrepancies related to contract terms are as follows:

- In Section 7.1, "Provider Indemnity," of the WellCare contract, there is a statement not included in the other two contracts requiring WellCare to provide its proposed form of Provider contracts to DMS for review and approval prior to use.
- In Section 7.3, "Disclosure of Certain Delegated Subcontractor's Subcontracts," of the WellCare contract states its subcontractors that provide covered services can exclude amounts paid to their contracted providers for the provision of covered services to members.
- In Section 8.1, "Term," the KY Spirit contract calls for proposal of rates 180 days before expiration of the current term while the other two contracts call for 90 days. This possibly provides for a longer negotiation period.
- Section 14.4, "Advances, Distributions, and Loans," in the KY Spirit contract contains an additional clause allowing KY Spirit to make advances under a contract previously approved by DMS or the Department of Insurance (DOI).
- Section 17.1, "Encounter Data Submission," of the WellCare contract states if there is a change to the threshold edits, the contractor will be given 60 days notice. The other two contracts state 30 days notice will be given. Discussions with DMS staff indicated DMS gives all three MCOs 60 days notice in order to treat the MCOs fairly.

- Section 29.2, "Payment to Out-of-Network Providers," of the KY Spirit and WellCare contracts states covered services will be reimbursed at "no less" than 100 percent of the Medicaid fee schedule/rate until January 1, 2012 and after January 1, 2012, no less than 90% of the Medicaid fee schedule/rate. The Coventry contract replaced "no less" with "at."
- Section 39.13, "Termination by Contractor," of the WellCare and Coventry contracts state they can terminate their contract with notice given at least 6 months but no more than 7 months prior to the end of the initial term. KY Spirit can terminate after at least 6 months but no more than 12 months. This effectively gives a six-month window for KY Spirit and one-month window for Coventry and WellCare to terminate the contract.
- Section 39.17, "Funding Out Provision," is only present in the KY Spirit contract. This section states the Commonwealth can terminate the contract with 30 days notice if funds are not appropriated to DMS or are not available.
- Section 40.17 is "Review of Distributions." All three contracts differ in this section. KY Spirit has a schedule of sharing pretax earnings while the other two vendors do not. KY Spirit and WellCare can provide notice to DMS at the same time of submission of a request for approval to the DOI of any distribution of capital and surplus that are subject to the provision of the Commonwealth's Insurance Code [KRS Chapter 304], while Coventry must seek approval prior to submitting the request.

Although differences in the contracts of the three MCOs are expected due to the nature of negotiations, it is important for Cabinet employees to be aware of these differences when overseeing and monitoring the contracts. Certain differences cited above, such as the amount of required notification for specific aspects of the program from the MCO to the Cabinet, could easily be synchronized going forward. However, we recognize other differences may be important points of negotiation that the Cabinet cannot easily synchronize.

The APA's approach for the MATU was different than the approach used for typical audits. State Auditor Edelen recognized that frustrations voiced by providers had real impact, not only on the livelihoods of those providers but also on the health care of Medicaid members. Therefore, the MATU's objective was to provide recommendations for improvement to the Cabinet or MCOs on an as-needed basis and not limit the timeframe or scope of communications to the confines of an annual audit report. Because of this approach, the APA made formal recommendations to the Cabinet on three separate occasions over the past 16 months including the recommendations made during the annual audit. The impetus and content of these communications are described below.

MCO Data Requested by Auditor

Due to the number and egregious nature of complaints received concerning Coventry, KY Spirit, and WellCare during the first few months of the managed care program, State Auditor Adam Edelen requested data from each of the MCOs on February 29, 2012 to determine how quickly claims were being processed and paid. Complaints from health care providers included claims for reimbursement being inappropriately rejected, delayed, or simply ignored since the state implemented the managed care program on November 1, 2011. The complaints from various doctors, pharmacists, hospitals, dentists, hospice care, and other health care providers asserted that the three MCOs were months behind in payments and had a cumbersome and lengthy pre-approval process for medical procedures thereby causing many providers financial hardship. Although no complaints were received specifically against Passport this organization was also included in the request for information by Auditor Edelen related to claims.

The information requested from all four MCO's included the number of provider claims filed, dollar value of provider claims filed, number of provider claims paid, dollar value of provider claims paid, number of provider claims rejected, dollar value of provider claims rejected, and the number of members served.

Based on the information received and analyzed, Auditor Edelen issued ten recommendations to the MCOs and the Cabinet. The Cabinet responded initially on August 20, 2012 and provided an additional status response on September 21, 2012. These recommendations and the Cabinet's responses are presented in their entirety in Appendix 8.

Chapter 3
Findings and Recommendations Communicated February 2012 Through March 2013

MCO Site Visits

In May 2012 and June 2012 the MATU met with corporate representatives from Coventry, KY Spirit, and WellCare at their Kentucky offices. The auditors were seeking to gain an understanding of how the administration of the Medicaid program changed under the newly introduced managed care system. Each MCO explained their role with managed care in Kentucky. In addition, they shared their expectations and challenges both with the implementation and ongoing operations of the Medicaid program.

The explanation given for much of the confusion was an unusually rushed implementation and miscommunication following the launch of the managed care program on November 1, 2011. There were misunderstandings by both the MCOs and the Cabinet due to inadequate time allotted for preparation between the Request For Proposal (RFP) approval and the go-live date. This aggressive time schedule caused certain intricacies specific to Kentucky Medicaid not to be disclosed to or fully understood by the MCOs, which led to inappropriately denied claims, delayed payments, and general administrative issues.

Another area of misunderstanding related to the 'data book,' the documentation generated by a third party accounting firm and provided by the State to the MCOs during the RFP process. The third party provider compiled prior year information from the Cabinet's Medicaid database and organized and segmented this information in order to determine trends, utilization, and cost. The data book is vital to the managed care process because the MCOs and Cabinet use this information to negotiate mutually acceptable capitation rates. In the months following the launch, the MCOs noticed unexpected claim volume which did not coincide with their prior review of the data book. As a result, the MCOs indicated their monthly capitation payments received from the state were not sufficient to cover the cost of the claims they were paying. As will be discussed further in Chapter 4, this issue was noted as one of the factors leading to KY Spirit's announcement that it would be ending its contract with the State a year early.

The MCOs expressed concerns with the speed of decision making by the Cabinet. On some requests, after waiting extensively for a response from the Cabinet to approve or deny a business action, the MCOs proceeded in the manner they deemed most appropriate and based future actions on the Cabinet's reaction. Although this situation initially caused problems, the MCOs commended the efforts of Cabinet Secretary Haynes, who was appointed as Secretary of the Cabinet for Health and Family Services on April 16, 2012, in improving the communication and responsiveness of the Cabinet.

A strong desire to advise the Cabinet in reforming aspects of Kentucky Medicaid to improve healthcare and cut costs was also expressed by the MCOs. The most significant and urgent concern was the much needed expansion of options for intermediate behavioral healthcare. A lack of such options resulted in high rates of readmission into inpatient behavioral healthcare facilities because members had difficulties during the window between inpatient care ending and outpatient care beginning. In later meetings with the auditors, the Cabinet recognized this need and stated they were working with the MCOs and the provider community to improve intermediate behavioral healthcare availability and utilization.

Differences in the negotiation and contracts, as noted in Chapter 2, between the MCOs led to fairness concerns especially as the companies' losses increased. Incentives for the state, the interpretation of network adequacy, and the timing of capitation rate increases differed amongst the contracts with the MCOs. As a result, the appearance of favoritism and penalizing tradeoffs unnecessarily impaired the discussion between the MCOs and the Cabinet when decisions that affected all parties were required. To avoid similar problems in the future, the Cabinet indicated that contracts for MCOs bidding on Region 3 would be identical with the exception of the capitation rates.

Throughout the site visits with each MCO, management reiterated their commitment to creating a sustainable managed care system in Kentucky. They stressed it was possible, despite the challenging launch and subsequent difficulties, to improve the health of Kentucky Medicaid members and reduce the total cost of the program. Although KY Spirit terminated its contract early, both WellCare and Coventry are both honoring their contracts and were chosen to expand into Region 3 beginning in January of 2013.

Based on our site visits and discussion with the MCOs, we met with the Cabinet management and staff to discuss the concerns gathered during this process. These meetings resulted in a set of recommendations to the Cabinet. The Cabinet responded on September 21, 2012. The full text of these recommendations and the Cabinet's response are presented in Appendix 9.

Fiscal Year 2012 Annual Audit

The APA audits Medicaid annually as part of the audits of the Kentucky Comprehensive Annual Financial Report (CAFR) and the Statewide Single Audit of Kentucky (SSWAK). The audit procedures include testing certain activities of the Cabinet for compliance and internal controls over financial reporting and over requirements applicable to Medicaid.

Chapter 3

Findings and Recommendations Communicated February 2012 Through March 2013

In the audit of the CAFR, the Cabinet's process and transactions related to material financial accounts are tested to determine whether the financial information is fairly stated in accordance with accounting principles generally accepted in the United States. Also, the audit includes tests of internal controls that may have a material impact on financial reporting. Although Medicaid is not the sole objective of this audit of the Cabinet, it is heavily tested due to its magnitude. In the SSWAK audit, auditors are required to identify the Commonwealth's major federal programs. Those major federal programs are then audited for compliance with their significant federal compliance requirements. Due to its size and high risk, the Medicaid program is part of this annual audit.

As part of these audits, the APA reports findings and recommendations to the Cabinet for internal control and compliance matters relevant to the scope of the audit. During the course of our Medicaid audit for fiscal year 2012 we noted 13 findings. These findings are presented in their entirety in Appendix 10.

Chapter 4
Continuing Challenges with Managed Care Transition and Additional Recommendations

Numerous concerns were reported to or identified by the MATU since Kentucky expanded Medicaid managed care. MATU auditors were able to interview various stakeholders, review additional documentation, and perform additional analysis outside the scope of the typical financial or compliance review to assess whether these concerns could be contributing to the problems widely reported related to the program. As noted in Chapter 3, a significant number of recommendations were reported to the Cabinet over the last 16 months as a proactive approach to pass along information in a timelier manner than feasible with the traditional annual audit. In addition to those recommendations previously communicated, additional concerns have been identified and assessed by the MATU as contributing to difficulties in the administration and oversight of the Medicaid program. The most significant of these concerns are presented below.

Quick Implementation of Expanded Managed Care

Since the implementation of the Kentucky Medicaid managed care system, many challenges have been faced by the Cabinet, MCOs, provider, and members. Many of the issues were specifically identified as a result of the quick transition from Kentucky's FFS to managed care.

The MCOs initially had three months to establish operations in Kentucky. They were required to prepare for the transition; establish a Kentucky local office; adapt to the Kentucky laws and environment; recruit and train staff; prepare their system for Kentucky data; contract with local providers and educate them on managed care; and market to potential Medicaid managed care enrollees.

Contract Issues

At the request of the KHA, the Cabinet did grant one additional month for the transition. This extension was allowed mostly due to concerns from the providers, especially the hospitals, that the implementation time constraints were a hindrance in solidifying contracts with the MCOs.

To meet this aggressive time schedule the MCOs signed a Letter of Intent (LOI) instead of a contract with many provider networks. The LOI was not a legally binding contract, but a document stating the MCO was intending to establish a contract. This resulted in confusion and disagreements between the MCOs, hospitals, and providers. In a few situations, the LOI did not lead to a contract.

Marketing Issues

The Cabinet automatically assigned the members to an MCO based on a complex algorithm. Each member was notified at least twice prior to the implementation date to contact the Cabinet to join the MCO of their choice rather than be automatically assigned. The member had an open enrollment period of 90 days, during which they had the option to try their MCO and switch to another if they were dissatisfied.

The MCOs are paid a capitation rate, which means they are paid based on the number of members assigned to them. It was alleged that the Cabinet automatically assigned more members to KY Spirit than the other two MCOs because KY Spirit had a lower overall capitation rate.

To obtain more members in the quick implementation period, Coventry took an aggressive approach in marketing to Medicaid members. To provide an incentive to potential members, Coventry did not require any copays for services. This marketing resulted in a large number of patients with more severe health problems to switch to Coventry. However, this approach did not fare well for Coventry because the payments to the providers for these members exceeded the capitation rate, which caused Coventry to lose money.

Providers

Since the implementation of the Kentucky Medicaid managed care system many providers contacted the APA for assistance regarding their struggles with managed care. We discussed the issues with them, met with providers, and assisted them by addressing their concerns directly with the Cabinet or the MCOs.

One of the most significant concerns we noted during this process was that the Cabinet's management continually stated it did not want to be involved in the MCO and Provider contractual relationship. While this may be a practical business approach, we were concerned about the passive approach taken by the Cabinet in these matters at a time when leadership was vital to resolving problems. During the implementation phase, the Cabinet should have exhibited a commitment to ensuring the provider community was educated and treated fairly amongst the MCOs, and that the transition was handled smoothly. We recognize that the Cabinet worked hard during the transition and in some cases the problems were not anticipated. However, it appears that planning time was not sufficient to avoid these problems.

Hospitals

On November 2, 2012 the KHA and several hospital representatives met with the MATU to discuss their concerns. Many of the issues were similar among the different providers, which indicated potential systemic concerns. One of the most significant and troubling concerns centered on whether Kentucky's rural hospitals could continue to afford to "float" Medicaid related costs. Hospital representatives indicated that rural hospitals are not equipped for the sudden financial stress put upon them by the managed care program. The matters brought to our attention are summarized below, and include concerns such as significant increases in accounts receivable related to outstanding claims from the MCOs and also problematic increases in the administrative burden of the hospital to meet the various requirements of the MCOs for claims submissions. Hospital names have been removed from examples to avoid inadvertent disclosure of proprietary information.

Accounts Receivable

The hospital representatives indicated their hospitals were experiencing significant increases in their accounts receivable, or outstanding claim payments, from the MCOs. The table below depicts a few examples provided to the auditors of the change in accounts receivable.

	A/R as of 10/31/2012	A/R as of 10/31/2011	Increase ($)	Increase (%)
Hospital A	1,104,839.49	763,894.63	340,944.86	44.63%
Hospital B	651,188.50	163,868.69	487,319.81	297.38%
Hospital C	6,966,814.00	4,070,123.00	2,896,691.00	71.17%

Hospitals indicate these increases in accounts receivable have been due to errors in claim processing, lack of clarity with certain MCO policies, contradictory communication with the MCOs, or problems with claim coding. These examples show a significant impact on the hospital operations during the one year period reviewed, and hospital administrators reported these issues to be primarily due to the problems with the implementation of managed care. Increases in accounts receivable cause problems for operations because of the resulting cash flow limitations. Cash flow problems then create a strain on finances, making it difficult for the hospitals to meet their obligations to pay employees, vendors and others. Furthermore, negative cash flow analysis may also impact the hospital's debt capacity and/or debt rating, making it more expensive for the hospital to acquire financing.

However, it is also important to note that auditors were unable to verify that these reported accounts receivable numbers represent actual amounts owed by the MCOs. Accounts receivable estimates based on claims submitted may not be reported at the MCOs agreed upon rate since the claim has not yet been accepted. In the hospital provided data reported above, information is not available to determine whether these amounts were based on actual accounts receivable from approved claims or estimated accounts receivable based on claims submitted.

Increased Administrative Burden

Hospitals reported various problems caused by the implementation of managed care that put a strain on its administrative functions. Examples of these issues include:

- Denial of claims - one small hospital indicated that it did not have the case management staff necessary to meet some of the requirements enforced by the MCOs, such as prior authorizations and specifically related to MCO requirements that each day of service be authorized separately.
- MCO Support Problems - Hospital staff experienced problems being put on hold during inquiry calls for lengthy periods, up to 45 minutes. However, hospital staff indicated if they needed to put one MCO on hold, they were given only two minutes. Also, one hospital indicated that it was given different answers to questions by two different employees at the same MCO. This caused confusion, frustration, and an increased administrative burden to the hospital.
- Medicare crossover claims were an automated process in the past, but with the implementation of managed care, it became a manual process that takes a significant amount of time. A crossover claim is one in which a Medicare patient is admitted to a hospital without Medicare Part A coverage, which

is required for inpatient services. Medicare is billed for certain charges paid under Medicare Part B coverage, and the unpaid portion "crosses over" and is electronically billed to the MCO. The MCO should pay the rest of the claim; however, hospitals are receiving denials.

- Hospitals reported that newborn babies were initially assigned to the wrong MCOs. Instead of being assigned to the MCO associated with their current provider, the Cabinet automatically assigned them to their mother's MCO. Providers were told to resubmit the claims to the appropriate MCO. This resulted in a recoupment by the MCO for all paid claims and turned into excess administrative costs and a disruption of cash flow, further burdening the hospitals.
- Hospitals indicated they are experiencing challenges in the credentialing of providers. It was stated by the hospitals that the process was to pick one MCO and submit credentialing information. The MCO then forwards the application to the Cabinet - Department of Medicaid Serves (DMS) for approval. Once approved by DMS, the provider/facility notifies all MCO's they have been approved. In one instance noted by a hospital it took seven months with this new process to credential a provider.

ED Triage Fee

Hospitals reported that MCOs implemented an Emergency Department (ED) triage fee, and that if the MCO does not agree with a procedure performed as being an emergency, the MCO will only pay a $50 fee. However, the MCO does not notify the provider of this until after the procedure has been performed. One hospital is concerned that the triage fee is a violation of 42 CFR 438.114. The CFR states "…The following entities are responsible for coverage and payment of emergency services and post stabilization care services. 1) The MCO, PHIP, or PAHP…The entities identified in this section must cover and pay for emergency services regardless of whether the provider that furnishes these services has a contract with the MCO, PIHP, PAHP, or PCCM; and may not deny payment for treatment obtained under each of the following circumstances: A) an enrollee has an emergency medical condition…"

Hospital representatives indicated that MCOs will not provide hospitals with a copy of the criteria they use to determine which patients are being classified as emergency versus non-emergency. Disagreements as to whether emergency services provided resulted from actual emergency medical conditions or from conditions subject to a lower cost treatment alternative are unavoidable unless providers are clear as to MCO's guidelines related to emergency services. It does appear that the CFR and the MCOs' policy related to triage fees puts all the risk on the hospitals since the hospital must perform an assessment of the patient to determine "with reasonable clinical confidence" whether the patient has an emergency condition. This assessment includes running appropriate tests to assist the physicians in their assessment. Hospital representatives further indicate that reimbursement rates for emergency services are already less than cost, but the financial burden created by this policy is unsustainable.

Chapter 4
Continuing Challenges with Managed Care Transition and Additional Recommendations

One of the cost savings concepts to managed care is for member health care to be managed in a way that leads to the most effective, but lowest cost, treatment provided. However, it appears that in the rush of implementation of the Medicaid managed care program, policies were implemented before providers were ready or understood the potential impact. Also, policies such as the implementation of this ED triage fee appear to place a great deal of the burden and risk on the provider before the managed care system has had an opportunity to transition patients and providers toward better health care management practices. One such practice would involve incentivizing members to manage their care in a way that requires fewer trips to the emergency room in favor of increasing visits to physician offices and clinics. In order to create programs and incentives to encourage members toward this type of approach, and also to help providers understand the impact of providing high cost treatment alternatives under new payment policies, additional education would be necessary for both members and providers. However, at least in the case of triage fees, it appears that policies were implemented with unprepared providers with little or no transition.

Reporting

Multiple hospitals described problems with receiving year-end reports or paid claims listings from the MCOs. These reports are important to the hospitals, because they are used to perform year-end calculations required by the state. The reports are also used for their year-end audit process, as auditors request the paid claims listing in order to reconcile contractual adjustments and cost reports.

It is evident that hospitals are still experiencing many issues with regard to MCO implementation. Hospital representatives acknowledged there have been meetings involving hospital representatives, MCO representatives and the Cabinet, in which provider concerns were expressed, but that additional leadership is needed from the Cabinet in order to come to a concrete and fair resolution of the concerns.

Provider Availability

Since the implementation of the Kentucky Medicaid managed care system concerns have been expressed alleging that providers are going to stop serving Medicaid members if provider concerns are not resolved. Providers believe they are being required to cover the difference between the cost of services and the reimbursement rates under the new program and cannot stay in business if they are not paid fairly and timely for their services.

To determine whether this concern was already impacting the Medicaid program, we performed an analysis on the number of providers that were active at the beginning of the managed care system on November 1, 2011 compared to the number of active providers on February 28, 2013. The following changes were identified in the number of providers by region:

Region	Active Providers on 11/1/2011	Active Providers on 2/28/2013	Change in Providers	% Change
1	1,521	1491	(30)	-2%
2	2,238	2,125	(113)	-5%
3	7,397	7,199	(198)	-3%
4	2,802	2,689	(113)	-4%
5	5,942	5,751	(191)	-3%
6	1,624	1,558	(66)	-4%
7	1,796	1,709	(87)	-5%
8	3,485	3,377	(108)	-3%
9*	12,674	10,350	(2,324)	-18%
Total	**39,479**	**36,249**	**(3,230)**	**-8%**

Source: KYMMIS
* Region 9 is out of state providers

As noted above, overall there was an 8% reduction in providers. According to the breakdown by provider type presented in Appendix 7, the most significant change was related to general hospitals, which saw a reduction of 586 providers, or 57% since the inception of the managed care program through February 28, 2013. Because of the magnitude of this change, auditors inquired about the change with the Cabinet which indicated a large portion of this change is attributed to out-of-state hospitals. A proportionately higher percentage of changes related to out-of-state hospitals could impact members living in or around border counties. Appendix 7b identifies the change in the number of general hospitals by state between November 1, 2011 and February 28, 2013.

Auditors made additional inquiries after noting that many out-of-state hospitals listed as providers prior to the implementation of managed care were not in contiguous states. The Cabinet indicated that, under the FFS program, members traveling outside of Kentucky may require care while out of state. Also, members may have needed an out-of-state specialist for care. Under managed care, MCOs are responsible for contracting with their own providers as long as the MCO meets the requirements for proper network adequacy, which is discussed in the next section.

Overall, the reduction in the number of providers under the managed care program is troubling, especially in light of the more than 300,000 new Medicaid members estimated to join the program when the Commonwealth implements the Medicaid expansion portion of the Affordable Care Act (ACA). We further analyzed this information by provider type and presented a table of variance by provider type in Appendix 7.

Network Adequacy

A major issue which surfaced during Kentucky's switch to a managed care environment for the Medicaid program was the adequacy of each MCO's provider network. A provider network is the collection of hospitals, physicians, dentists, and various other healthcare providers contracted with an MCO to provide services

to Medicaid members. An inadequate network would make it difficult for Medicaid members to receive proper treatment and healthcare.

Providers voiced concerns and frustration for months related to the implementation of managed care, which produced numerous state legislature hearings. Of these concerns, network adequacy became a key issue in a lawsuit filed in U.S. District Court in Lexington by Medicaid provider Appalachian Regional Hospital (ARH) against Coventry. This lawsuit was in response to Coventry's decision to drop ARH from its network. Coventry's position was that all MCOs were not required by the Cabinet to contract with ARH and this lead to Coventry receiving an unfair share of high-risk members. Coventry also held that its provider network without ARH still met all contractual obligations and that it would still be able to deliver all services required. This lawsuit is currently ongoing.

All MCO contracts contain requirements used to determine whether MCO provider networks afford sufficient access to healthcare for Medicaid members. MCO provider networks must meet the following guidelines:

Contract Stipulations

- Primary Care Providers (PCP) which are no more than 30 miles or 30 minutes from members in urban areas and 45 miles or 45 minutes in non-urban areas; also, the member-to-PCP ratio is not to exceed 1500:1;
- Access to hospital care for which travel time does not exceed 30 minutes in urban areas and 60 minutes in non-urban areas;
- Access to general dental, general vision, laboratory, and radiology services for which travel time does not exceed 60 minutes;
- Access to pharmacy services for which travel time shall not exceed 60 minutes and the location shall not be further than 50 miles from the member's residence; and
- Access to specialty services proportionate to designated subpopulations

MCO contracts also contain other requirements to ensure that distance is not the only criteria used in determining network adequacy. Networks must attempt to enroll various other providers including teaching hospitals, at least one Federally Qualified Health Centers (FQHCs) in each region, public health departments, and Community Mental Health Centers (CMHCs). There are also stipulations regarding appointment wait times which must be met in order for members to receive timely healthcare.

Procedures

To gain a better understanding of how provider network adequacy is addressed and monitored by the Cabinet, auditors met with Cabinet personnel to review the network adequacy process.

The Cabinet receives a monthly provider network file from each MCO. This file contains a listing of all providers contracted with the MCO to provide services to Medicaid members and includes GPS coordinates for the physical address of the provider. Provider network files, along with member GPS data from the Medicaid Management Information System (MMIS), are loaded into mapping software used for network adequacy purposes.

Network adequacy is determined on a member-by-member basis based on MCO provider data and on member addresses in KYMMIS, the Cabinet's database for member claim information. This information is loaded into the Cabinet's Environmental Systems Research Institute (ESRI) database to generate the network adequacy report. Each member is assigned to the closest available provider for that particular provider type and the distance between the coordinates for the provider physical address and member physical address is calculated. This is done for all Medicaid provider types and Medicaid members. Statistics on the number of members within certain distance increments from providers are kept for each provider type and these metrics are used to help determine if each MCO is meeting the requirements of the contract for network adequacy. The provider file also allows the Cabinet to determine if other network adequacy criteria are met, such as enrollment of FQHCs and CMHCs.

Based on reports generated using member/provider data, at the time of auditor inquiry in July 2012, the Cabinet determined the majority of contractual requirements for provider network requirements were being met by all MCOs. The reports indicated 100% of members in both urban and rural areas had access to both hospitals and PCPs. Further, the majority of members had access to specialty physicians, local health departments, FQHCs, and CMHCs. However, concerns remain about how contractual requirements in certain rural areas are met given the challenging geography in many parts of the state. Cabinet staff clarified that the MCO contracts permit miles to be measured by straight-line distance instead of driving distance. The network adequacy reports are based on these straight-line calculations meaning that although the MCOs may meet network adequacy guidelines, some members may struggle with adequate access to care.

Due to its role in recent litigation, as well as the recent decline in providers under managed care, as noted above, network adequacy will remain a key issue in the future of the Kentucky Medicaid program. As with other facets of the Medicaid program, improvement is needed to ensure all members have adequate access to Medicaid services, and the Cabinet must ensure its monitoring process is sufficient to determine that this critical requirement is met.

Local Health Departments

Since the implementation of the Kentucky Medicaid managed care system, we have received numerous complaints from Local Health Departments (LHD) concerned with the outstanding and denied claims from the MCOs. The LHDs were already struggling financially due to several other challenges, such as cuts in funding and the Cabinet's change in how the Medicaid match requirement is met,

which placed a greater burden on the LHDs. These challenges, along with the transition to managed care have created a financial hardship for these entities.

Impact

The impact noted by LHDs is the additional financial burdens related to managed care. LHDs have announced layoffs, furloughs, and the shutdown of certain programs. Although LHDs serve to fill in the health care gap for many lower income individuals, including many children, the result is fewer services are being delivered.

The open accounts receivable by Medicaid payer for all LHDs as of April 3, 2013 are as follows:

Medicaid Payer	A/R Amount
KY pre-managed care claims	$ 1,420,845
Passport	255,172
Coventry	1,888,001
Well Care	2,660,545
Humana	1,372
KY Spirit*	16,319,931
Total	$22,545,866

Source: CHFS DPH

*KY Spirit did issue "bridge" payments in April and May 2012 in the amount of $6,731,270, which would reduce this accounts receivable amount to $9,588,661. However, for reporting purposes, it should be noted that the "bridge" payment was an advancement of funds and not the result of claims adjudicated. Therefore, the "bridge" payment was not tied to a patient's claim and not credited/posted to the patients accounts receivable.

A detailed report is presented in Appendix 6.

MCO Subcontracts

A year after managed care implementation, concerns and complaints regarding timely payments and outstanding accounts receivable were still being received by the APA. To determine the progress being made to address these issues, we requested data from the MCOs on October 31, 2012. The information requested was to include the period from date of implementation (November 1, 2011) through October 31, 2012. The information would provide us a picture of their progress in a one year time-frame.

Based on the information requested, we identified a concern with one of the MCO's vendor for dental claim processing. This MCO changed vendors and indicated it was not able to provide dental claims paid/denied prior to September 2012. We extended the deadline for this information to February 2013 and still were unable to obtain the requested information. The MCO indicated that it did not have the information from its previous vendor and was not able to obtain it. It is unclear how the MCO or the Cabinet is able to meet federal requirements without

access to all claims received/paid, and therefore this is a serious concern. Also, this raises questions as to whether the Cabinet should have greater involvement in approving MCO subcontracts or vendors when those third parties maintain or administer programmatic functions.

KY Spirit Cancels Contract

On October 17, 2012, the Commonwealth acknowledged KY Spirit's intent to cancel its contract one year early in July 2013 due to lost profits under the managed care structure. Leading up to the implementation of managed care, KY Spirit had offered the lowest bid in response to the Cabinet's RFP for MCO contracts.

Section 39.13, "Termination by Contractor", of KY Spirit's contract states, "The Contractor may terminate this Contract with notice given in accordance with the requirements of Section 40.13 at least six (6) months but not more than twelve (12) months prior to the end of the initial term of this Contract or any renewal terms." With the end of the initial term being July 2014, KY Spirit's announcement to terminate the contract was more than twelve months prior to the end of the initial term. Since terminating its contract early would result in damages paid by KY Spirit to the Commonwealth, KY Spirit is suing the Commonwealth, alleging Gov. Steve Beshear's administration rushed to privatize Medicaid managed care and, as a result, provided incorrect cost information to the bidders in the data book during the Requests for Proposal process. KY Spirit claims their reliance on the purported inaccurate data led them to offer a lower bid than was reasonable.

On May 31, 2013, Judge Thomas Wingate ruled that KY Spirit's contract provisions do not give it the right to back out of its contract with the Commonwealth early. KY Spirit ultimately made the decision to end its contract with the Commonwealth as of midnight on July 5, 2013, and the Cabinet implemented a plan to have all KY Spirit members transferred to other MCOs.

Cost Savings to the Commonwealth

Uncertainties exist related to the Cabinet's methodology for calculating the cost savings for the Commonwealth resulting from the implementation of managed care. Implementation of managed care was estimated to save the state $375 million over a three year period. Auditors requested information regarding the Cabinet's total cost savings and the methodology used for calculating it. The Cabinet's formula for the estimate was :

Projected Members x Projected Rates (w/out managed care) x 32 months
- Projected Members x Projected Rates (w/ managed care) x 32 months
= Total Projected Savings

The Cabinet further indicates that its enacted budget was based on achieving these savings; therefore, the savings have already been captured by the state. However, the Cabinet's methodology does not appear to consider factors related to the cost of implementation, such as the payment for its contract with Public Consulting Group (PCG) to review the Cabinet and make recommendations to improve oversight.

Also, the calculation does not include the Cabinet's administrative costs, costs associated with reorganization, or the effects of the 7 percent increase in capitation rates given to two of the MCO's beginning January 1, 2013.

There is no question that the claims related estimates used in the Cabinet's projected savings calculation are the largest expenditures of the program, and that ultimately the Commonwealth should realize some cost savings under this transition to managed care. The concern is whether the estimated cost savings considers all factors, is realistic, and whether the Cabinet has a mechanism in place to calculate and monitor actual savings to the Commonwealth. It appears there is a need for the Cabinet to further develop projections that include a full picture associated with the Medicaid program, and also develop a process to analyze the actual savings to the Commonwealth.

Recommendations

Based on the additional concerns lingering in the managed care system reported in this section, we have the following recommendations to the Cabinet:

- Consider establishing a formal advisory panel comprised of members of all stakeholder parties. This panel should have the ability to study the details of concerns brought to it from MCOs or providers, and make recommendations related to policy, education, or communications to the Cabinet.
- With contract expirations approaching, the Cabinet should already be in the planning stage for the next contract term. The Cabinet should analyze concerns, findings, and recommendations made from all sources in constructing the new contracts. Specifically, the Cabinet should consider enhancements to the contract to detail more meaningful reporting requirements, improved Cabinet monitoring capabilities, subcontract approval procedures, improve network adequacy requirements, etc. The Cabinet should also identify contract terms not subject to negotiation in order to improve the consistency of certain terms, which will also help improve the Cabinet's ability to hold the MCOs to the same requirements.
- Establish a requirement within the contracts that all claim related data, whether maintained by the MCO or a subcontractor, will be available to the Cabinet and auditors for a period no shorter than the Cabinet's own record retention policy. Failure to maintain sufficient claim data should result in a penalty.
- Establish an approval process by the Cabinet for all subcontracts used by MCOs for fulfilling contractual requirements in Kentucky, including third party providers for dental, vision, behavioral health, etc.

- Improve monitoring and follow up related to MCOs accounts payable to providers and prompt pay concerns. This monitoring should be routine, and should involve at least a sampling of case reviews to determine whether the MCOs are meeting contractual and programmatic requirements.
- Establish a methodology for estimating cost savings to the Commonwealth based on the full cost of implementing and administering the Medicaid managed care program, as well as an ongoing process for analyzing the savings actually realized.

Chapter 5
Moving Forward

Although it is evident that concerns are still outstanding related to Kentucky's managed care system, the system continues to evolve, as does the Cabinet's approach to overseeing the program. However, given the litigation currently on-going, and contract terms set to expire in just over one year, the system is at a critical stage. This will require the Cabinet's full attention to ensure the system makes it through this period intact.

All three MCOs indicated during the period they were struggling financially under their contracts with Kentucky. KY Spirit, who has done business in numerous other states, as part of its suit against the Commonwealth stated managed care will not succeed in Kentucky in the direction it is going. Provider complaints continued into the second year of the program, by and large due to the financial stress and administrative burden the program has placed on them. Ultimately, the Cabinet is responsible for ensuring this is a viable program that will succeed in meeting its primary objective of providing improved health care to Medicaid members and reduce costs to the Commonwealth.

As noted above, the Cabinet's Department of Medicaid Services (Department) contracted with PCG to review the Department and make recommendations for managed care oversight. One of the recommendations was for the Department to undergo a reorganization to more efficiently administer and oversee the Medicaid program in the new environment. The Department has indicated it has accepted this recommendation and is undergoing reorganization.

Also, on April 5, 2013, Governor Beshear announced his veto of House Bill 5, legislation introduced in the 2013 Regular Session and supported by the Auditor of Public Accounts, which introduced additional measures to assist providers in resolving prompt pay disputes with MCOs. With this veto, the Governor also announced a plan to help address the payment concerns without interfering with contractual relations between providers and MCOs. The plan announced the following:

- Prompt pay disputes are to be reviewed by the Kentucky Department of Insurance instead of the Cabinet's Department of Medicaid Services, keeping with the intent of House Bill 5.
- MCOs are to meet with every hospital in the state to reconcile accounts receivable.
- The Kentucky Department of Insurance will perform targeted audits of each statewide MCO.
- Enhanced education through education forums sponsored by the Cabinet in each of the eight Medicaid regions to allow providers, MCO representatives and Department of Insurance representatives to meet face-to-face to discuss concerns about proper billing, appeals process, and any other specific regional issues related to managed care.
- A specific education component focused on efficient and effective emergency room management that meets community needs without an ER operating as a primary care office.

In addition to the multi-point plan announced, the press release also detailed statistics identifying improvements resulting from the implementation of Medicaid managed care. The information indicated that the improvements reflect an emphasis on wellness and preventative care, such as a 33% increase in preventative flu vaccinations for children, a 14% increase in Human Papillomavirus (HPV) vaccinations, and an almost 1,100% increase in documentation of diagnostic screenings, such as blood pressure, diabetes, cervical cancer, mammograms, and colonoscopies. While these statistics depict a few examples of positive measures, there is still a great deal of momentum needed to accomplish the objectives of this program. The statistics must be measured against other troubling trends, some of which are addressed in this report. For instance, it is unclear what impact the decline in services, staffing, and funding to local health departments and the increasing burden on providers will have on these areas going forward. The Governor's plan for addressing ongoing managed care and MCO concerns needs time to work, and will be the subject of further reviews by the Medicaid Accountability and Transparency Unit.

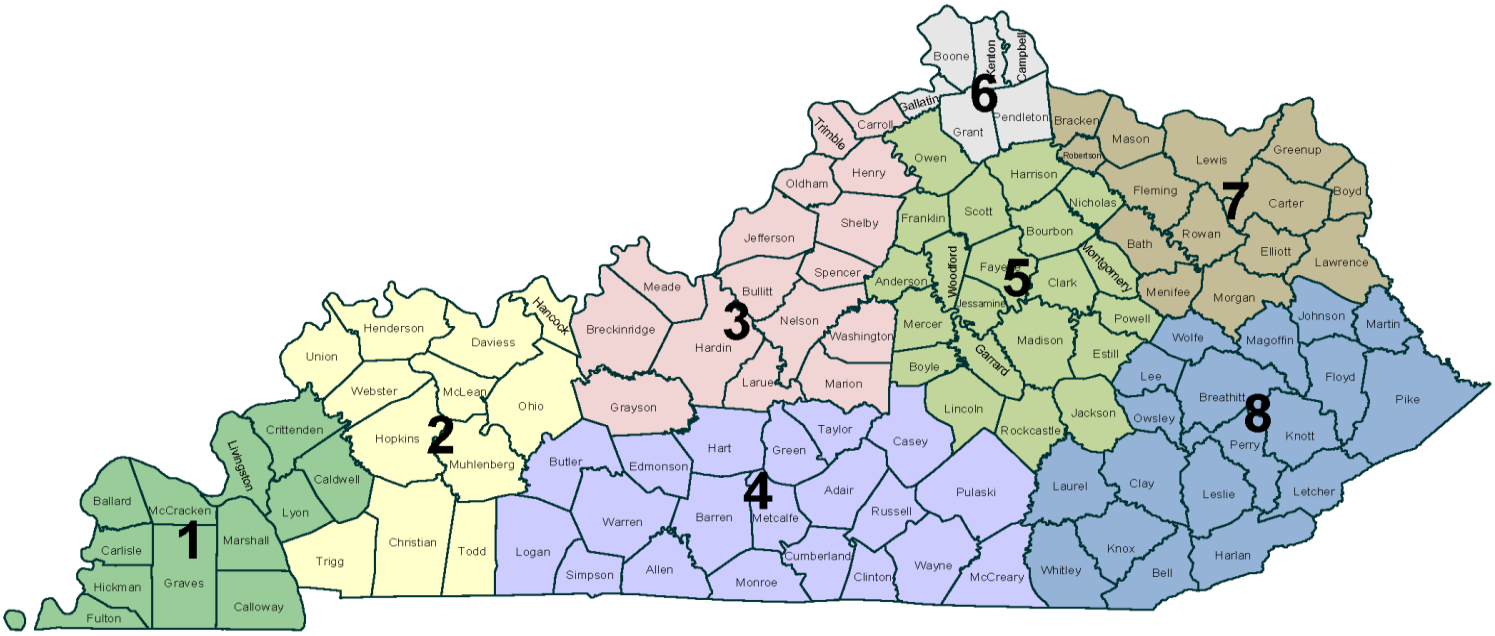
Ultimately, the information gathered since the implementation of the Medicaid managed care program, as well as our consideration of future challenges for the program, highlights two significant concerns that will test the strength of the program and its impact on the Commonwealth in the future. One is the long-term viability of rural hospitals in Kentucky, which poses serious consequences for a large number of Kentuckians who utilize these hospitals for medical care, regardless of their participation in the Medicaid program. It is questionable as to whether these hospitals have access to resources necessary to handle the financial and administrative burdens discussed in this report for a long period of time.

The second concern looking ahead for the Medicaid program relates to the system's readiness for Medicaid expansion. Governor Beshear announced in May 2013 that Kentucky will expand Medicaid coverage as permitted by the ACA. The expansion is estimated to extend coverage to more than 300,000 Kentuckians. A Price Waterhouse Coopers report indicated the expansion could create 17,000 new jobs in Kentucky and add $15.6 billion to the state economy through 2021.

However, Kentucky should ensure all necessary planning is in place to meet the challenges brought by this expansion. A separate report titled, "Health Care Workforce Capacity Report" by Deloitte Consulting released May 22, 2013 indicated Kentucky needs approximately 3,790 additional physicians, 612 additional dentists, 5,635 additional registered nurses, 296 additional physician assistants, and 269 additional optometrists to adequately meet the current demand on the Medicaid program. Therefore, even more resources will be needed to provide adequate care for members under the Medicaid expansion. This information highlights the critical need for the state to improve stakeholder concerns in order to make Medicaid expansion successful.

Managed Care Regions
Appendix 1

Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) Regions



Timeline for Managed Care Implementation
Appendix 2

Date	Description
4/7/2011	Request For Proposal is released
5/25/2011	Bids are due
7/7/2011	Contracts are finalized
7/22/2011	First notification letter sent to providers
8/12/2011	Second notification letter sent to providers
8/18/2011	First notification to members
9/8/2011	Approval from CMS
9/19/2011	Cabinet extended implementation to November 1, 2011
9/21/2011	Second notification to members
11/1/2011	Open enrollment begins
1/31/2012	Open enrollment ends

Approved Capitation Payment Rates

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

YEAR 1 - OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

	Year 1							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	540.85	530.73		582.49	597.07	539.77	577.07	576.37
Child (age 1 through 5)	120.14	117.88		129.39	132.61	119.87	128.16	128.02
Child (age 6 through 12)	144.75	142.06		155.90	159.84	144.52	154.49	154.27
Child (age 13 through 18) - Female	249.33	244.59		268.49	275.11	248.65	265.88	265.64
Child (age 13 through 18) - Male	185.37	181.96		199.67	204.77	185.16	197.92	197.60
Adult (age 19 through 24) - Female	539.10	528.01		580.15	593.17	535.56	573.14	573.59
Adult (age 19 through 24) - Male	193.97	190.89		209.15	215.23	194.94	208.10	207.21
Adult (age 25 through 39) - Female	474.05	464.57		510.27	522.12	471.60	504.54	504.63
Adult (age 25 through 39) - Male	333.29	328.07		359.40	369.95	335.14	357.71	356.10
Adult (age 40 or older) - Female	521.97	512.61		562.33	577.05	521.94	557.77	556.62
Adult (age 40 or older) - Male	512.28	503.73		552.18	567.59	513.81	548.73	546.87
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	522.36	512.97		507.26	570.19	582.31	543.53	538.52
Adult (age 19 through 24) - Male	395.15	388.05		383.73	431.33	440.50	411.17	407.37
Adult (age 25 through 44) - Female	709.16	696.42		688.66	774.09	790.56	737.91	731.10
Adult (age 25 through 44) - Male	564.57	554.44		548.26	616.27	629.38	587.46	582.05
Adult (age 45 or older) - Female	950.14	933.07		922.68	1,037.14	1,059.19	988.66	979.54
Adult (age 45 or older) - Male	868.01	852.42		842.93	947.49	967.64	903.20	894.87
Waiver Option								
Dual Eligible								
All Ages - Female	102.42	122.07		123.45	138.99	142.58	139.49	144.47
All Ages - Male	90.21	107.51		108.73	122.42	125.58	122.85	127.24
SSI Children								
Infant (age under 1)	4,242.23	5,039.36		5,522.82	5,878.51	4,829.08	4,583.58	3,995.12
Child (age 1 through 5)	577.25	685.72		751.51	799.91	657.11	623.70	543.63
Child (age 6 through 18)	476.88	566.49		620.84	660.82	542.85	515.26	449.11
Foster Care								
Infant (age under 1)	1,209.50	1,379.19		1,358.59	1,393.59	1,100.29	1,127.05	1,389.74
Child (age 1 through 5)	223.26	254.59		250.78	257.24	203.10	208.04	256.53
Child (age 6 through 12)	439.38	501.02		493.54	506.25	399.71	409.43	504.85
Child (age 13 or older) - Female	678.77	774.01		762.45	782.08	617.49	632.50	779.92
Child (age 13 or older) - Male	640.55	730.43		719.52	738.05	582.72	596.89	736.01

Approved Capitation Payment Rates

KENTUCKY SPIRIT HEALTH PLAN, INC.

YEAR 1 - OCTOBER 1, 2011 THROUGH JUNE 30, 2012

	Year 1							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	334.27	340.06		359.14	410.37	326.33	424.66	423.84
Child (age 1 through 5)	116.34	101.92		127.97	136.43	104.09	129.66	152.86
Child (age 6 through 12)	131.86	145.97		167.99	156.31	132.57	150.34	166.17
Child (age 13 through 18) - Female	240.25	241.12		256.22	267.12	226.04	225.74	252.04
Child (age 13 through 18) - Male	191.51	229.54		216.59	217.04	173.79	159.56	176.74
Adult (age 19 through 24) - Female	533.82	472.16		488.70	543.15	496.16	492.31	496.91
Adult (age 19 through 24) - Male	172.19	144.61		188.96	200.27	193.71	191.73	168.83
Adult (age 25 through 39) - Female	467.48	413.27		444.40	491.07	467.91	418.49	421.54
Adult (age 25 through 39) - Male	433.27	305.40		347.15	358.48	351.86	271.89	296.02
Adult (age 40 or older) - Female	500.43	416.49		502.07	534.56	493.94	547.50	467.94
Adult (age 40 or older) - Male	568.50	512.55		465.82	599.82	594.67	473.15	416.09
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	563.86	560.63		597.40	525.90	513.59	549.09	506.23
Adult (age 19 through 24) - Male	475.97	355.37		324.98	436.95	524.99	421.44	346.72
Adult (age 25 through 44) - Female	733.94	652.22		707.82	739.25	750.35	768.14	674.01
Adult (age 25 through 44) - Male	476.03	499.40		547.05	656.73	649.12	520.16	540.73
Adult (age 45 or older) - Female	890.57	935.36		895.65	960.19	948.33	926.40	924.77
Adult (age 45 or older) - Male	816.14	858.44		771.16	936.59	971.95	751.90	762.22
Waiver Option								
Dual Eligible								
All Ages - Female	116.96	141.58		143.93	161.41	157.46	156.32	163.33
All Ages - Male	104.85	120.30		126.91	134.50	150.14	141.21	140.34
SSI Children								
Infant (age under 1)	3,177.99	2,983.31		4,121.55	5,643.79	4,272.65	4,529.93	3,819.84
Child (age 1 through 5)	447.02	510.66		598.05	957.40	976.76	606.79	609.28
Child (age 6 through 18)	505.72	608.15		662.98	627.05	479.66	487.10	420.16
Foster Care								
Infant (age under 1)	771.05	460.03		714.09	1,500.06	633.34	1,080.50	1,961.72
Child (age 1 through 5)	221.07	251.18		242.08	334.45	215.85	268.19	276.24
Child (age 6 through 12)	404.25	521.39		510.44	464.97	336.59	404.02	402.02
Child (age 13 or older) - Female	484.55	702.52		784.14	861.75	700.02	572.29	839.60
Child (age 13 or older) - Male	918.60	934.73		709.02	688.57	703.20	560.55	697.03

Approved Capitation Payment Rates

WellCare of Kentucky, Inc.

YEAR 1 - OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

	Year 1							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	530.52	591.85		626.52	750.48	614.59	767.50	718.17
Child (age 1 through 5)	120.78	107.22		134.78	138.98	110.19	138.82	162.09
Child (age 6 through 12)	142.91	157.75		183.41	169.33	146.64	166.27	183.96
Child (age 13 through 18) - Female	259.40	260.69		281.86	290.16	251.15	253.93	280.68
Child (age 13 through 18) - Male	198.33	234.32		229.85	226.83	185.80	175.45	195.96
Adult (age 19 through 24) - Female	586.92	530.21		534.88	615.68	569.32	563.17	562.65
Adult (age 19 through 24) - Male	206.12	206.12		206.12	206.12	206.12	206.12	206.12
Adult (age 25 through 39) - Female	514.71	462.28		488.77	553.05	534.62	477.19	485.77
Adult (age 25 through 39) - Male	461.83	331.65		370.30	390.30	390.04	303.99	338.13
Adult (age 40 or older) - Female	549.61	468.42		564.84	610.56	571.42	643.55	561.12
Adult (age 40 or older) - Male	601.88	567.30		506.25	666.02	684.37	554.68	485.86
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	564.34	570.45		628.28	549.54	517.94	578.39	551.72
Adult (age 19 through 24) - Male	479.38	375.10		334.75	439.66	643.30	448.39	386.09
Adult (age 25 through 44) - Female	757.51	684.81		738.39	782.84	791.88	823.10	753.97
Adult (age 25 through 44) - Male	485.87	517.03		559.44	673.97	651.29	548.25	590.72
Adult (age 45 or older) - Female	935.76	990.67		965.78	1,033.15	1,014.44	1,026.77	1,061.82
Adult (age 45 or older) - Male	861.60	886.59		818.06	965.61	989.97	816.28	859.56
Waiver Option								
Dual Eligible								
All Ages - Female	106.80	130.71		131.04	150.24	148.15	150.01	155.69
All Ages - Male	95.60	111.82		116.68	127.96	142.58	135.00	136.30
SSI Children								
Infant (age under 1)	5,650.40	5,650.40		5,650.40	5,650.40	5,650.40	5,650.40	5,650.40
Child (age 1 through 5)	468.56	518.72		625.89	888.00	945.34	642.41	631.04
Child (age 6 through 18)	565.57	677.53		738.47	681.69	536.24	560.09	472.71
Foster Care								
Infant (age under 1)	1,474.72	1,474.72		1,474.72	1,474.72	1,474.72	1,474.72	1,474.72
Child (age 1 through 5)	232.16	273.77		271.94	328.50	229.08	277.89	296.40
Child (age 6 through 12)	453.14	611.61		611.64	525.51	401.00	468.02	466.74
Child (age 13 or older) - Female	549.26	779.22		873.00	906.28	769.84	635.18	902.79
Child (age 13 or older) - Male	1,083.40	1,031.39		782.42	733.69	760.85	605.29	771.03

Total Payments to MCOs As Of June 30, 2013
Appendix 4

Vendor Name	Date	Payment Amount
Coventry Health and Life Insurance Company	11/3/2011	$ 63,634,632.38
	12/7/2011	73,515,576.13
	1/5/2012	78,889,172.76
	2/7/2012	79,896,858.50
	3/7/2012	79,640,636.15
	4/5/2012	80,924,975.86
	5/7/2012	80,941,898.39
	6/8/2012	81,500,461.91
	6/22/2012	16,177.92
	7/5/2012	85,566,584.34
	8/6/2012	84,143,269.09
	9/6/2012	83,052,391.74
	10/4/2012	87,693,333.09
	10/25/2012	424.07
	11/7/2012	73,804,603.67
	11/9/2012	2,225.51
	12/4/2012	72,793,660.51
	1/4/2013	80,445,276.71
	2/7/2013	75,736,774.40
	3/5/2013	79,829,894.21
	4/4/2013	85,717,772.55
	5/2/2013	1,972,124.74
	5/6/2013	83,296,601.32
	5/8/2013	214,880.21
	6/6/2013	5,599,672.68
Coventry Health and Life Insurance Company Total		**$ 1,518,829,878.84**
Kentucky Spirit Health Plan, Inc.	11/3/2011	$ 66,837,141.76
	12/7/2011	57,565,691.29
	12/8/2011	2,810.48
	12/15/2011	176.40
	12/16/2011	9,100.40
	12/19/2011	4,625.70
	1/5/2012	52,607,469.53
	2/7/2012	47,717,234.55
	3/7/2012	48,045,019.36
	4/5/2012	48,804,569.24
	5/7/2012	47,230,690.56
	6/7/2012	44,606,364.14
	7/5/2012	44,767,572.73
	8/6/2012	44,278,921.76
	9/6/2012	49,142,941.81
	10/4/2012	44,288,171.09
	10/25/2012	276.65

Total Payments to MCOs As Of June 30, 2013
Appendix 4

Vendor Name	Date	Payment Amount
Kentucky Spirit Health Plan, Inc. (Continued)	11/7/2012	41,540,845.29
	12/4/2012	41,862,081.71
	1/4/2013	40,875,155.92
	2/7/2013	41,146,054.88
	3/5/2013	33,302,492.32
	3/25/2013	332.33
	4/4/2013	40,492,266.16
	5/2/2013	1,710,708.33
	5/6/2013	39,114,855.03
	5/8/2013	53,468.07
	6/6/2013	39,537,154.97
Kentucky Spirit Health Plan, Inc. Total		**$ 915,544,192.46**
WellCare Health Insurance of Illinois, Inc.	11/3/2011	$ 39,697,635.27
	12/7/2011	45,319,290.32
	12/19/2011	62,983.44
	12/20/2011	18,398.80
	1/5/2012	49,467,625.82
	2/7/2012	53,072,532.05
	3/7/2012	53,743,761.84
	4/5/2012	54,899,499.12
	5/7/2012	54,600,313.82
	6/8/2012	55,124,138.18
	7/5/2012	57,420,871.93
	8/6/2012	57,262,085.18
	9/6/2012	59,217,920.30
	10/4/2012	61,892,428.35
	10/25/2012	229.73
	11/7/2012	79,991,355.76
	12/4/2012	80,181,141.52
	1/4/2013	91,992,996.96
	2/7/2013	95,248,279.28
	2/15/2013	127.44
	3/5/2013	100,659,809.98
	4/4/2013	102,340,850.88
	5/2/2013	164,094.13
	5/6/2013	99,167,986.13
	6/6/2013	5,168,705.26
WellCare Health Insurance of Illinois, Inc. Total		**$ 1,296,715,061.49**
Grand Total Of Payments Made To All Three MCOs As Of June 30, 2013		**$ 3,731,089,132.79**

Required MCO Reports
Appendix 5

Report #	Report Name	Status	Action	Frequency
1	NAIC Annual Financial Statement	Active	Added	Annual
2	Audit/Internal Control	Active	Added	Annual
3	NAIC Quarterly Financial Statement	Active	Added	Annual
4	Executive Summary	Active	Added	Quarterly
6	Member Requested Change in PCP Assignment	Active	Added	Quarterly
6	Member Requested Change in PCP Assignment (Annual)	Inactive		
7	PCP Requested Change in Member Assignment	Active	Added	Quarterly
7	PCP Requested Change in Member Assignment (Annual)	Inactive		
8	MCO Initiated Change in PCP Assignment	Active	Added	Quarterly
8	MCO Initiated Change in PCP Assignment (Annual)	Inactive		
9	PCPs with Panel Changes Greater than 50 or 10%	Active	Added	Quarterly
9	PCPs with Panel Changes Greater than 50 or 10% (Annual)	Inactive		
10	Narrative for MCO Report #s 6-8	Active	Added	Quarterly
11	Call Center	Active	Added	Monthly
12	Provider Network File Layout	Active	Added	Monthly
12A	Geo Access Network Reports and Maps	Active	Added	Annual
13	Access and Delivery Network Narrative	Active	Added	Quarterly
14	Denial of MCO Participation (Quarterly)	Inactive		
15	Subcontractor Monitoring	Active	Added	Quarterly
16	Summary of Quality Improvement Actives	Active	Added	Quarterly
17	Quality Assessment and Performance Improvement Work Plan	Active	Added	Quarterly
18	Monitoring Indicators, Benchmarks and Outcomes	Active	Added	Quarterly
19	Performance Improvement Projects	Active	Added	Quarterly
20	Utilization of Subpopulations and Individuals with Special Healthcare Needs	Active	Added	Quarterly
21	MCO Committee Activity	Active	Added	Quarterly
22	Satisfaction Survey(s)	Active	Added	Quarterly
23	Evidence Based Guidelines for Practitioners	Active	Added	Quarterly
24	Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Active	Added	Quarterly
25	Overview of Activities	Inactive		

26	Credentialing and Re-credentialing Activities During the Quarter	Inactive		
27	Grievance Activity	Active	Added	Quarterly
28	Appeal Activity	Active	Added	Quarterly
29	Grievances and Appeals Narrative	Active	Added	Quarterly
30	Quarterly Budget Issues	Active	Added	Quarterly
31	Potential or Anticipated Fiscal Problems	Active	Added	Quarterly
32	Enrollment Summary	Active	Added	Quarterly
33	Utilization of Ambulatory Care by Age Breakdown	Inactive		
34	Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission	Inactive		
35	Emergency Care by ICD-9 Diagnosis	Inactive		
36	Home Health Utilization	Inactive		
37	Utilization of Ambulatory Care by Provider Type and Category of Aid	Inactive		
38	EPSDT Special Services	Inactive		
39	Monthly Formulary Management Report	Active	Added	Monthly
40A	Top 50 Psych Drugs by Quantity Reimbursed	Active	Added	Annual
40B	Top 50 Psych Drugs by Reimbursement	Active	Added	Annual
41	Top 50 OTC Drugs by Reimbursement	Active	Added	Annual
42A	Top 50 Prescribers by Reimbursement	Active	Added	Quarterly
42B	Top 50 Prescribers of Controlled Drugs by Reimbursement	Active	Added	Quarterly
42C	Top 50 BH Prescribers by Reimbursement	Active	Added	Quarterly
43	Top 50 Controlled Drugs by Quantity Reimbursed	Active	Added	Quarterly
44	Top 50 Drugs by MCO Reimbursement	Active	Added	Quarterly
45A	Top 50 Drugs by Quantity	Active	Added	Quarterly
45B	Top 50 Non PDL Drugs by Reimbursement	Active	Added	Quarterly
46	Systems Development and Encounter Data	Active	Added	Quarterly
47	Claims Processing Timeliness/Encounter Data Processing	Inactive		
48	Organizational Changes	Active	Added	Quarterly
49	Administrative Changes	Active	Added	Quarterly
50	Innovations and Solutions	Inactive		
51	Operational Changes	Active	Added	Quarterly
52	Expenditures Related to MCO's Operations	Active	Added	Quarterly
53	Prompt Payment	Active	Added	Quarterly
54	COB Savings	Active	Added	Monthly
55	Medicare Cost Avoidance	Active	Added	Monthly

56	Non-Medicare Cost Avoidance	Active	Added	Monthly
57	Potential Subrogation	Active	Added	Monthly
58	Original Claims Processed	Active	Added	Monthly
59	Prior Authorizations	Active	Added	Monthly
60	Original Claims Payment Activity	Active	Added	Monthly
61	Denied Claims Activity	Active	Added	Monthly
62	Suspended Claims Activity	Active	Added	Monthly
63	Claims Inventory	Active	Added	Quarterly
64	Encounter Data	Inactive		
65	Foster Care	Active	Added	Monthly
66	Guardianship	Active	Added	Monthly
67	Provider Credentialing Activity	Active	Added	Monthly
68	Provider Enrollment	Inactive		
69	Termination from MCO Participation	Active	Added	Monthly
70	Denial of MCO Participation	Active	Added	Monthly
71	Provider Outstanding Accounts Receivable	Active	Added	Monthly
72	Medicaid Program Violation Letters and Collections	Active	Added	Monthly
73	Explanation of Member Benefits (EOMB)	Active	Added	Monthly
74A	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Active	Added	Monthly
74B	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Active	Added	Quarterly
74C	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Active	Added	Monthly
75	SUR Algorithms	Active	Added	Monthly
76	Provider Fraud Waste and Abuse	Active	Added	Quarterly
77	Member Fraud Waste and Abuse	Active	Added	Quarterly
78	Quarterly Benefits Payment	Active	Added	Quarterly
79	Health Risk Assessments	Active	Added	Quarterly
80	Provider Changes in Network	Active	Added	Quarterly
81	Par and Non-Par Provider Participation	Active	Added	Quarterly
82	Status of all Subcontractors	Inactive		
83	Member TPL Resource Information	Inactive		
84	Quality Assessment and Performance Improvement Project Description	Active	Added	Annual
85	Quality Improvement Plan and Evaluation	Active	Added	Annual
86	Annual Outreach Plan	Active	Added	Annual
87	DMS Copied on Report to Management of any Changes in Member Services Function to Improve the Quality of Care Provided or Method of Delivery	Inactive		

88	Absent Parent Canceled Court Order Information	Inactive		
89	List of Members Participating with the Quality Member Access Advisory Committee	Inactive		
90	Performance Improvement Projects Proposal	Active	Added	Quarterly
91	Abortion Procedures	Active	Added	Quarterly
92	Performance Improvement Projects Measurement	Active	Added	Annual
93	EPSDT CMS - 416	Active	Added	Annual
94	Member Surveys	Active	Added	Annual
95	Provider Surveys	Active	Added	Annual
96	Audited HEDIS Reports	Active	Added	Annual
97	Behavioral Health Adults and Children	Active	Added	Monthly
98	Behavioral Health Pregnant and Postpartum	Active	Added	Monthly
99	Behavioral Health Intravenous Drug Users	Inactive		
100	EPSDT for Behavioral Health Populations	Active	Added	Monthly
101	Adults SMI Receiving Evidence Based Practices	Active	Added	Monthly
101A	Behavioral Health and Wellness	Active	Added	Annual
102	Behavioral Health and Chronic Physical Health	Active	Added	Monthly
103	PRTF Residential Inpatient Readmission	Active		
104	Behavioral Health Expenses PMPM	Active	Added	Monthly
105	Unduplicated Number of Adults and Children/Youth Received Services under 907 KAR 3:110	Inactive		
106	Behavioral Health Pharmacy for all MCO Members - Adults and Children	Active	Added	Monthly
107	Behavioral Health Capacity	Active	Added	Monthly
108	Unduplicated Number of Adults and Children/Youth Received PRTF - Level I and Level II	Inactive		
109	Unduplicated Number and Percentage of Adults and Children/Youth Readmitted to PRTF	Inactive		
110	Behavioral Health Services by Procedure	Active	Added	Monthly
111	Unduplicated Number and Percentage of Adults with SMI	Inactive		

112	Unduplicated Number and Percentage of Adults with SMI and Children/Youth with SED Received with Co-occurring Mental Health Abuse Disorders	Inactive		
113	Unduplicated Number and Percentage of Children/Youth with SED Therapy or Family Functional Therapy	Inactive		
114	Unduplicated Number and Percentage of Children/Youth with SED who were assessed for Trauma History	Inactive		
115	Unduplicated Number of Adults and Children/Youth of their Caregivers Received Peer Support Service	Inactive		
116	Unduplicated Number and Percentage of Pregnant and Post-partum women with Substance use Disorders Received First Treatment within 48 hours	Inactive		
117	Unduplicated Number and Percentage of Children/Youth Discharged from PRTF	Inactive		
118	Behavioral Health Outcome Summary	Active	Added	Monthly
119	Behavioral Health Statistics Improvement Project Adult Survey	Active	Added	Annual
120	Behavioral Health Statistics Improvement Project Child Survey	Active	Added	Annual
121	Unduplicated Number of Adults and Children/Youth with Behavioral Health Diagnosis' with PCP	Inactive		
122	Unduplicated Number of Children/Youth with Behavioral Health Diagnoses Received Annual Wellness Check/Health Exam	Inactive		
123	Unduplicated Number of Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis	Inactive		
124	Unduplicated Number of Adults and Children/Youth with Regular use of Tobacco Products	Inactive		
125	Unduplicated Number of Adults and Children/Youth Screened for Substance Use Disorder in Physical Care Setting	Inactive		
200-260	Attestation for Enrollment, Capitation and Claim Reconciliation Reports	Active	Added	As Needed
200	Ineligible Assignment	Active	Added	Daily

205	Assignment Inquiry	Active	Added	Daily
210	Duplicate Member	Active	Added	Daily
220	Newborn	Active	Added	Monthly
230	Capitation Payment Request	Active	Added	Monthly
240	Capitation Duplicate Payment	Active	Added	Monthly
250	Capitation Adjustment Requests	Active	Added	Monthly
260	MCO Claims Paid for Voided Members	Active	Added	Monthly

Source: CHFS

Local Health Department Accounts Receivable
Appendix 6
Inception of MCOs to April 3, 2013

KY Local Health Departments
Open Accounts Receivable by Medicaid Payor and LHD
Inception of Payor Programs through April 3, 2013

	Clinic	KY Prev. Medicaid	Passport	Coventry	Well Care	Humana	Ky Spirit (Gross Amount)	Ky Spirit Bridge Payment	Ky Spirit (Net Amount)	TOTAL ALL MEDICAID PAYORS
002	ALLEN CO HEALTH DEPT	$ 3,357		$ 23,183	$ 20,475		$ 482,584	$ 187,900	$ 294,684	**$ 341,699**
003	ANDERSON COUNTY HEALTH DEPT	$ 30,540	$ 109	$ 7,958	$ 4,869		$ 148,007	$ 44,931	$ 103,075	**$ 146,552**
007	BELL CO HEALTH CENTER	$ 10,186	$ 160	$ 34,304	$ 334,519		$ 96,132		$ 96,132	**$ 475,302**
009	BOURBON CO HEALTH DEPT	$ 2,387	$ 103	$ 6,116	$ 4,060		$ 50,816	$ 19,602	$ 31,214	**$ 43,880**
010	ASHLAND-BOYD CO HEALTH DEPT	$ 5,090		$ 3,742	$ 12,084		$ 45,928	$ 21,709	$ 24,219	**$ 45,134**
011	BOYLE CO HEALTH DEPT	$ 10,981	$ 495	$ 4,540	$ 37,642		$ 32,086	$ 10,494	$ 21,592	**$ 75,249**
012	BRACKEN CO HEALTH DEPT	$ 5,895		$ 10,386	$ 7,599		$ 87,530	$ 33,596	$ 53,934	**$ 77,814**
013	BREATHITT CO HEALTH DEPT	$ 3,531		$ 1,687	$ 10,090		$ 32,145	$ 12,935	$ 19,211	**$ 34,519**
014	BRECKINRIDGE CO HEALTH DEPT	$ 702	$ 1,929	$ 204	$ 391		$ 223		$ 223	**$ 3,449**
015	BULLITT CO HEALTH DEPT	$ 124	$ 2,790	$ 463	$ 507		$ 37	$ 37		**$ 3,884**
018	CALLOWAY COUNTY HEALTH DEPT	$ 46,765		$ 13,846	$ 15,720		$ 59,687	$ 17,162	$ 42,525	**$ 118,856**
024	CHRISTIAN CO HEALTH DEPT	$ 431		$ 17,577	$ 9,769		$ 199,787	$ 89,987	$ 109,800	**$ 137,576**
025	CLARK CO HEALTH DEPT	$ 1,069		$ 8,516	$ 13,456		$ 320,557	$ 172,674	$ 147,883	**$ 170,924**
033	ESTILL COUNTY H. D.	$ 1,757		$ 5,953	$ 8,501		$ 54,655	$ 16,075	$ 38,580	**$ 54,791**
034	LEXINGTON-FAYETTE CO. H.D.	$ 21,937		$ 21,169	$ 57,247		$ 491,700	$ 245,395	$ 246,305	**$ 346,659**
035	FLEMING COUNTY HEALTH DEPT	$ 3,301		$ 1,602	$ 6,918		$ 58,637	$ 19,350	$ 39,287	**$ 51,108**
036	FLOYD CO HEALTH DEPT	$ 199,760		$ 32,268	$ 51,538		$ 243,476	$ 90,226	$ 153,249	**$ 436,816**
037	FRANKLIN CO HEALTH DEPT	$ 61,826	$ 131	$ 24,637	$ 4,460		$ 248,700	$ 74,179	$ 174,521	**$ 265,575**
040	GARRARD CO HEALTH DEPARTMENT	$ 1,881		$ 1,665	$ 4,486		$ 45,374	$ 8,890	$ 36,484	**$ 44,516**
042	GRAVES COUNTY HEALTH CENTER	$ 1,131	$ 136	$ 6,962	$ 16,030		$ 102,715	$ 40,528	$ 62,186	**$ 86,445**
045	GREENUP COUNTY H. D.	$ 7,461		$ 11,746	$ 18,893		$ 28,078	$ 8,067	$ 20,010	**$ 58,111**
054	HOPKINS CO HEALTH DEPT	$ 570		$ 33,671	$ 36,971		$ 400,035	$ 163,429	$ 236,606	**$ 307,818**
056	LOUISVILLE METRO HEALTH DEPT	$ 117,977	$ 141,348	$ 874	$ 3,675	$ 1,144	$ 794	$ 35	$ 759	**$ 265,777**
057	JESSAMINE CO HEALTH DEPT	$ 4,089	$ 474	$ 3,058	$ 7,220		$ 44,023	$ 14,850	$ 29,173	**$ 44,014**
058	JOHNSON CO HEALTH DEPT	$ 362		$ 14,975	$ 42,541		$ 286,536	$ 116,207	$ 170,329	**$ 228,208**
061	KNOX COUNTY HEALTH DEPARTMENT	$ 26,463	$ 407	$ 72,133	$ 47,979		$ 324,448	$ 184,156	$ 140,292	**$ 287,275**
063	LAUREL COUNTY H. D.	$ 16,356		$ 20,864	$ 66,374		$ 145,505	$ 74,448	$ 71,057	**$ 174,652**
064	LAWRENCE CO HEALTH DEPARTMENT	$ 11,219		$ 17,586	$ 32,437		$ 142,038	$ 47,294	$ 94,744	**$ 155,987**
068	LEWIS CO HEALTH DEPT	$ 37		$ 6,634	$ 10,005		$ 339,069	$ 143,107	$ 195,962	**$ 212,638**
069	LINCOLN CO HEALTH DEPT	$ 11,472	$ 557	$ 7,455	$ 28,846		$ 191,592	$ 83,699	$ 107,892	**$ 156,222**
076	MADISON COUNTY HEALTH DEPT	$ 1,835	$ 450	$ 37,940	$ 49,031		$ 364,960	$ 156,410	$ 208,550	**$ 297,806**
077	MAGOFFIN COUNTY HEALTH DEPT	$ 406		$ 1,920	$ 2,375		$ 18,337	$ 7,183	$ 11,154	**$ 15,855**
079	MARSHALL CO HEALTH DEPT	$ 199		$ 3,895	$ 19,903		$ 107,796	$ 48,342	$ 59,455	**$ 83,452**
080	MARTIN CO HEALTH DEPT	$ 1,265		$ 13,568	$ 28,061		$ 147,025	$ 63,780	$ 83,245	**$ 126,139**
084	MERCER CO HEALTH DEPARTMENT	$ 4,248	$ 393	$ 5,701	$ 12,441		$ 65,255	$ 26,201	$ 39,054	**$ 61,837**
086	MONROE COUNTY HEALTH DEPT.	$ 4,068		$ 3,710	$ 3,529		$ 146,977	$ 55,968	$ 91,009	**$ 102,317**
087	MONTGOMERY COUNTY HEALTH DEPT	$ 142		$ 6,437	$ 15,552		$ 100,640	$ 55,672	$ 44,968	**$ 67,099**
089	MUHLENBERG CO. HEALTH CENTER	$ 50,633	$ 37	$ 8,499	$ 127,518		$ 278,561	$ 147,303	$ 131,258	**$ 317,945**
093	OLDHAM COUNTY HEALTH DEPT.	$ 3,038	$ 2,607	$ 184	$ 55		$ 18		$ 18	**$ 5,903**
098	PIKE CO HEALTH DEPT	$ 31,969	$ 203	$ 130,154	$ 70,752		$ 686,848	$ 380,413	$ 306,435	**$ 539,513**
099	POWELL CO HEALTH DEPT	$ 1,810		$ 960	$ 5,977		$ 10,696	$ 6,001	$ 4,695	**$ 13,442**
110	TODD COUNTY HEALTH DEPT	$ 7,047		$ 12,481	$ 9,147		$ 53,739	$ 25,781	$ 27,958	**$ 56,634**
118	WHITLEY CO HEALTH DEPT	$ 1,349		$ 28,062	$ 64,078		$ 781,274	$ 435,684	$ 345,589	**$ 439,078**
120	WOODFORD COUNTY HEALTH DEPT.			$ 799	$ 3,101		$ 13,136	$ 6,446	$ 6,690	**$ 10,591**
302	LINCOLN TRAIL DIST HEALTH DEPT	$ 31,280	$ 54,802	$ 4,016	$ 7,297	$ 101	$ 4,404	$ 1,325	$ 3,079	**$ 100,575**
303	BARREN RIVER DISTRICT HD	$ 6,616	$ 592	$ 62,646	$ 131,916		$ 1,416,314	$ 528,638	$ 887,676	**$ 1,089,446**
304	PURCHASE DIST HEALTH DEPT	$ 34,245	$ 64	$ 18,594	$ 80,967		$ 546,185	$ 213,301	$ 332,884	**$ 466,755**
305	NORTH CENTRAL DISTRICT H.D.	$ 8,438	$ 34,673	$ 1,367	$ 2,828		$ 184		$ 184	**$ 47,490**
309	LAKE CUMBERLAND DIST HLTH DEPT	$ 411,449	$ 2,674	$ 527,595	$ 275,480		$ 2,363,266	$ 879,416	$ 1,483,850	**$ 2,701,048**
310	NORTHERN KY DIST HEALTH DEPT	$ 56,462	$ 628	$ 27,296	$ 48,899		$ 347,753	$ 96,764	$ 250,988	**$ 384,273**
311	LITTLE SANDY DIST HLTH DEPT	$ 4,175	$ -	$ 7,431	$ 19,478		$ 52,514	$ 30,331	$ 22,183	**$ 53,267**
312	KENTUCKY RIVER DIST HLTH DEPT	$ 18,173	$ 56	$ 115,030	$ 167,171		$ 604,197	$ 254,858	$ 349,339	**$ 649,769**
313	CUMBERLAND VALLEY DISTRICT H.D	$ 52,921	$ 1,690	$ 207,376	$ 167,955		$ 598,619	$ 24,109	$ 574,509	**$ 1,004,451**
314	GREEN RIVER DISTRICT HEALTH DE	$ 29,769	$ 2,656	$ 81,971	$ 221,894		$ 1,108,485	$ 518,372	$ 590,113	**$ 926,403**
315	WEDCO DISTRICT HEALTH DEPT	$ 1,641		$ 10,123	$ 7,515		$ 62,333	$ 30,009	$ 32,324	**$ 51,603**
316	GATEWAY DISTRICT HEALTH DEPT.	$ 13,622	$ 834	$ 108,057	$ 105,407		$ 424,846	$ 252,654	$ 172,192	**$ 400,112**
317	THREE RIVERS DIST HEALTH DEPT	$ 4,500	$ 4,175	$ 11,601	$ 10,834	$ 126	$ 111,804	$ 32,294	$ 79,510	**$ 110,746**
318	PENNYRILE DISTRICT HEALTH DEPT	$ 1,311		$ 16,273	$ 64,373		$ 842,698	$ 374,154	$ 468,545	**$ 550,501**
321	BUFFALO TRACE DISTRICT H.D.	$ 29,577		$ 18,541	$ 21,709		$ 358,174	$ 138,899	$ 219,275	**$ 289,102**
	Grand Total	**$ 1,420,845**	**$ 255,172**	**$ 1,888,001**	**$ 2,660,545**	**$ 1,372**	**$ 16,319,931**	**$ 6,731,270**	**$ 9,588,661**	**$ 15,814,595**

Source: CHFS

Provider Variance
Appendix 7
Inception of MCOs to February 28, 2013

Provider Type	11/1/2011	2/28/2013	Change	% Change
01 - General hospital	1030	444	-586	-57%
02 - Mental Hospital	13	13	0	0%
04 - Psychiatric Residential Treatment Facility	23	24	1	4%
11 - ICF/MR	14	14	0	0%
12 - Nursing Facility	305	306	1	0%
13 - Specialized Children Service Clinics	16	16	0	0%
14 - MFP Pre-Transition Services	3	3	0	0%
15 - Health Access Nurturing Development Svcs	130	129	-1	-1%
17 - Acquired Brain Injury	47	47	0	0%
20 - Preventive & Remedial Public Health	989	997	8	1%
21 - School Based Health Services	141	146	5	4%
22 - Commission for Handicapped Children	13	13	0	0%
23 - Title V/DSS	2	2	0	0%
24 - First Steps/Early Int.	1	1	0	0%
27 - Adult Targeted Case Management	14	14	0	0%
28 - Children Targeted Case Management	14	14	0	0%
29 - Impact Plus	112	106	-6	-5%
30 - Community Mental Health	16	16	0	0%
31 - Primary Care	147	155	8	5%
33 - Support for Community Living (SCL)	230	239	9	4%
34 - Home Health	104	101	-3	-3%
35 - Rural Health Clinic	143	147	4	3%
36 - Ambulatory Surgical Centers	64	61	-3	-5%
37 - Independent Laboratory	227	213	-14	-6%
39 - Dialysis Clinic	122	122	0	0%
41 - Model Waiver	20	20	0	0%
42 - Home and Community Based Waiver	76	72	-4	-5%
43 - Adult Day Care	123	122	-1	-1%
44 - Hospice	24	24	0	0%
45 - EPSDT Special Services	675	655	-20	-3%
50 - Hearing Aid Dealer	18	13	-5	-28%
52 - Optician (528 - Optical clinic)	32	29	-3	-9%
54 - Pharmacy	1394	1390	-4	0%
55 - Emergency Transportation	275	248	-27	-10%
56 - Non-Emergency Transportation	667	687	20	3%
57 - Net (Capitation)	15	15	0	0%
58 - Net Clinic (Capitation)	1	1	0	0%
60 - Dentist - Individual	1228	1199	-29	-2%
61 - Dental - Group	181	182	1	1%
64 - Physician Individual	18755	16742	-2013	-11%
65 - Physician - Group	2631	2456	-175	-7%
70 - Audiologist	85	87	2	2%
74 - Nurse Anesthetist	1250	1231	-19	-2%
77 - Optometrist - Individual	732	685	-47	-6%
78 - Certified Nurse practitioner	3224	3606	382	12%
80 - Podiatrist	228	213	-15	-7%
82 - Clinical Social Worker	100	88	-12	-12%
85 - Chiropractor	622	546	-76	-12%

Provider Variance
Appendix 7
Inception of MCOs to February 28, 2013

86 - X-Ray / Misc. Supplier	65	46	-19	-29%
87 - Physical Therapist	266	262	-4	-2%
88 - Occupational Therapist	40	34	-6	-15%
89 - Psychologist	127	90	-37	-29%
90 - DME Supplier	1735	1151	-584	-34%
91 - CORF (Comprehensive Out-Patient Rehab Facility)	6	5	-1	-17%
92 - Psychiatric Distinct Part Unit	15	14	-1	-7%
93 - Rehabilitation Distinct Part Unit	12	12	0	0%
95 - Physician Assistant	932	975	43	5%
96 - HMO/PHP	1		-1	-100%
98 - MCO (Managed Care Organization)	3	5	2	67%
99 - Not on File	1	1	0	0%
Grand Total	**78,958**	**72,498**	**-6,460**	**-8%**

Source: KYMMIS

Provider Variance Detail
Appendix 7B
General Hospitals by State
Inception of MCOs to February 28, 2013

State[1]		11/1/2011	Changes 11/1/2011 - 2/28/2013 Additions	Reductions	2/28/2013
ALABAMA	AL	13	1	9	5
ALASKA	AK		1		1
ARIZONA	AZ	26	2	16	12
ARKANSAS	AR	3		2	1
CALIFORNIA	CA	13	3	10	6
COLORADO	CO	9		9	
CONNECTICUT	CT	1		1	
FLORIDA	FL	49	4	43	10
GEORGIA	GA	15	1	12	4
HAWAII	HI	2		1	1
IDAHO	ID	2		2	
ILLINOIS	IL	79		52	27
INDIANA	IN	90	2	48	44
IOWA	IA	5		4	1
KANSAS	KS	5		5	
KENTUCKY	KY	116	3	7	112
LOUISIANA	LA	5		5	
MAINE	ME	1		1	
MARYLAND	MD	4		4	
MASSACHUSETTS	MA	3		2	1
MICHIGAN	MI	40	1	28	13
MINNESOTA	MN	6		5	1
MISOURI	MO	37		22	15
MISSISSIPPI	MS	6		5	1
MONTANA	MT	1		1	
NEBRASKA	NE	2	2	2	2
NEVADA	NV	8		8	
NEW HAMPSHIRE	NH	2		2	
NEW JERSEY	NJ	6		5	1
NEW MEXICO	NM	3		3	
NEW YORK	NY	13	3	8	8
NORTH CAROLINA	NC	28	1	23	6
NORTH DAKOTA	ND	1		1	
OHIO	OH	132	2	89	45
OKLAHOMA	OK	3		1	2
OREGON	OR	7		5	2

Provider Variance Detail
Appendix 7B
General Hospitals by State
Inception of MCOs to February 28, 2013

State[1]		11/1/2011	Changes 11/1/2011 - 2/28/2013 Additions	Reductions	2/28/2013
PENNSYLVANIA	PA	19	1	17	3
RHODE ISLAND	RI	1		1	
SOUTH CAROLINA	SC	12	1	10	3
SOUTH DAKOTA	SD	2		1	1
TENNESSEE	TN	104	2	51	55
TEXAS	TX	42	1	31	12
UTAH	UT	6	1	6	1
VIRGINIA	VA	56	4	34	26
WASHINGTON	WA	7	1	6	2
WASHINGTON DC	DC	1		1	
WEST VIRGINIA	WV	30		14	16
WISCONSIN	WI	11	1	8	4
WYOMING	WY	3		3	
Total Changes - General Hospitals		**1030**	**38**	**624**	**444**

[1] No general hospitals were identified as providers for Kentucky's Medicaid program in Delaware and Vermont.

Recommendation 1: Develop metrics for the claim process

The Cabinet, MCOs and provider community should develop an agreed-upon metric for measuring and reporting the timeliness of provider reimbursements, and implement action plans to resolve identified deficiencies in a timely manner.

The Cabinet, with input from MCOs and the provider community, should specifically identify the information necessary to adequately monitor and provide trend analysis for the claims process. This information should include defined data fields, syntax of the reports, and timelines for reporting. Specific to the data field definitions, the information required from each MCO should be uniform to allow comparisons among the MCOs.

Agency Response

Contracts between the Cabinet and each MCO established specific reports to be used to monitor contract compliance, including the timely payment of claims. The standards for the timeliness of claims payment were based on Medicaid Federal Regulations and State Law for commercial insurers. Each month since implementation, Coventry Cares of Kentucky, Kentucky Spirit, and WellCare submit claim reports, which provide all claims inventory, prior authorization, original (clean) claims paid, claims suspended, and claims denied, respectively. The Department for Medicaid Services has worked with each MCO to determine accuracy, monitor the claims activity, identify areas of concern, and provide guidance to MCOs related to correcting any problems identified. Timeliness of claims payments to providers has improved significantly since the February 29, 2012 letter from the APA.

Recommendation 2: Cabinet monitor and enforce timeliness of billing

The Cabinet should better monitor and enforce the governing MCO contracts, specifically as relates to the timeliness of billing.

The Cabinet should expand the monitoring process in place currently to scrutinize the reporting related to the timeliness of claim payments in order to determine whether there has been improvement since the implementation of the MCO process on November 1, 2011. Should an MCO fall below the requirements set out in the contract or the Cabinet identifies a decrease in their timeliness of claim payments, the Cabinet should use its authority granted in the contract to report this deficiency to the MCO. The MCO should then provide corrective action plans to get claims payment timeframes either within those established with the contract or' back up to those timeframes seen previously.

Agency Response

See above response. The cabinet continues to conduct one-on-one weekly meetings with each MCO to address any and all issues that may arise. Additionally, meetings between the Department, the MCOs and the

hospital association are held every other week; meetings between the Department, the MCOs and community mental health centers are held once a month. Meetings with other provider groups occur as requested. Additionally, a new "dashboard' report has been developed which provides the Department a weekly analysis of MCO compliance with key measures listed in the MCO contracts.

Recommendation 3: Utilize secure modern technology

MCOs and pharmacy benefit managers (PBMs) should use secure, modern technology to process pre-authorizations and reimbursement claims and transmit information to providers and pharmacists.

For pre-authorizations, the optimal process would be an automated system available to the providers and pharmacists to provide pre-authorization responses through a real-time, encrypted transmission.

For reimbursements, MCOs should recommend the use of direct deposit and provide information concerning how to set up this process through their communication efforts to providers and pharmacists. For direct deposit to be useful for the providers and pharmacies, however, there needs to be sufficient information provided to allow the providers and pharmacies to reconcile direct deposits, which normally provide minimal identification information, back to the reimbursement being paid. Unless this type of reconciliation information is provided, it will be difficult for the providers or pharmacists to determine what claims have been paid and are still outstanding

Agency Response

The Cabinet concurs that improved secure automation of the submission process by MCOs would be beneficial and that proper reconciliation information must be provided. All three MCOs currently allow providers to submit requests for pre-authorizations via either telephone or fax transmissions as is consistent with processes utilized by commercial carriers and the Kentucky Medicaid program. The Kentucky Medicaid regulations also permit use of internet technology for prior authorizations. The Cabinet continues to emphasize to MCOs the needs of providers to receive timely and complete information. However, it should be noted that prior authorization issues have declined significantly.

Recommendation 4: Track claims using automated systems

MCOs should train providers and their billing agents to use the automated systems in place to track the submission of claims and their status in real time; providers should utilize those systems to verify claims' status, correct errors, reduce duplicate claim submissions and speed the payment process.

The automated applications to submit and query claims and any other services available to the provider/pharmacist community need to be

specifically communicated to all providers and pharmacists in the MCG networks. The MCG should also provide training on what services are available and how to properly use these services. This training could be through regional live sessions or' through audio-conferences, webinars, or self-study tutorials. The training should be made available to all providers and pharmacists and should be updated as changes in procedure or regulations occur.

Agency Response

The Cabinet concurs that automated systems would be optimal to submit and monitor claims. The Cabinet has directed each MCO to increase efforts to educate and train providers to bill and monitor claims and to conduct site visits at the provider's location. The MCO's have conducted provider training through regional training sessions, webinars, on-site provider training when requested, provider manuals, and instructional web sites for provider review.

Recommendation 5: Properly staff MCO office to process claims

Each MCO should adjust staffing as needed to clear existing backlogs in claims and pre-authorizations and ensure that processing of claims and pre-authorizations adheres to the time frames in the contracts.

It is imperative/or the MCOs to properly staff their Kentucky-based offices, in an on-going basis, to ensure processing of claims and pre-authorizations is performed efficiently and within the contractual response time-frames.

Agency Response

The Department currently monitors prior authorization made by MCOs to assure appropriate use of the prior authorization process. The Cabinet agrees with the Auditor that the MCOs must staff operations in order to meet their contractual obligations. The Cabinet monitors and reviews Prior Authorizations (PA) and claims on a daily basis. The Cabinet has facilitated provider and MCO educational visits, meetings, seminars, and conference calls focused on properly requesting and submitting forms for PA for each MCO and informing and educating providers on proper billing and claims submission to ensure claims payments to providers. As providers have learned MCO processes for prior authorization and claims processing, complaints to the Department have declined significantly.

Recommendation 6: Improve communication on appeals

MCOs and PBMs should better communicate to providers and pharmacists the process for appealing denied claims and, related to specific prescription costs, the process for appealing the maximum allowable cost and dispensing fees.

The MCOs and PBMs should provide information related to the appeal process/or a denied claim or pre-authorization request and the appeal process/or MAC pricing or' dispensing fees in a format and location where it can be easily accessed by providers and pharmacists.

Agency Response

The contracts do not dictate specific reimbursement for pharmacy benefits; however, the MCO must pay a sufficient reimbursement amount to assure access to pharmacy benefits for enrollees. MCOs currently include information regarding the appeals process with any notices of denied claims. The Cabinet will continue to monitor to assure appropriate access to pharmacy benefits.

Recommendation 7: Streamline appeal process

MCOs and PBMs should streamline and expedite the appeal process to reduce the risks to the health and safety of patients.

The appeal process needs to be efficient/or all appeals; however, it should be expedited in those instances where the health or safety of the member is at risk.

Agency Response

The contracts with MCOs already allow for an expedited appeal as provided both in federal and state regulations. Requesting an expedited appeal does not guarantee that the request will be granted, but MCOs should be cognizant of their responsibility to ensure the health and safety of Medicaid enrollees. The cabinet is aware of the issues related to appeals and is currently evaluating the appeals process.

Recommendation 8: Provide explanation when claims are denied

MCOs and PBMs should more diligently review claims to ensure relevant patient information is considered before making final decisions and provide detailed explanations when claims are denied.

MCOs and PBMs should use all pertinent patient medical information provided within a claim to make decisions related to the claim's validity. Further, if a claim is being denied, detailed information should be provided concerning why the decision was made, what alternative(s) are available to the requested procedure or drug, and the appeal process available to the provider or pharmacist.

Agency Response

The Cabinet agrees. MCOs are responsible to ensure all relevant information is utilized in determining whether to pay a claim. As noted previously, this seems to have been largely a start-up issue. As providers have become more familiar with MCO processes, complaints in this area have declined significantly.

Recommendation 9: Consider if behavioral health would be better served under fee-for-service

The Cabinet should study whether behavioral health patients and others who receive specialized medical services would be better served under the Medicaid fee-for-service structure administered by the Cabinet.

There is a growing concern over whether specific classes of members receiving specialized medical services, procedures, and medications are being best served by the MCO model. The Cabinet should study information from the MCOs and PBMs to determine those instances where procedures, resources, and/or drug for members are being systematically denied or pre-authorization is being delayed. Based on this information, the Cabinet should consider whether similar classes of members, such as behavioral health, would be better served under the Medicaid fee-for-service architecture administered by the Cabinet.

Agency Response

As indicated by Secretary Haynes in her meeting with the APA MATU earlier, the Cabinet made a conscious decision to contract for an integrated model of health care delivery in order to promote a holistic approach to care rather than excluding behavioral health. General medical providers need to recognize and address behavioral health conditions. Seamless access to behavioral health providers and services must routinely be provided within health care networks if such integration is to be achieved. The Cabinet believes that this managed care initiative provides an opportunity to facilitate this integration in order to improve overall health care outcomes, both in terms of physical health and behavioral health.

Considerable data exist to support integration of behavioral health and physical health services. Below is an excerpt from a 2009 grant announcement by the federal Substance Abuse and Mental Health Services Administration, which articulates the necessity for such integration:

> *"Physical health conditions among people with serious mental illnesses impact their quality of life and contribute to disproportionate premature death. In 2006, the National Association of State Mental Health Program Directors (NASMHPD) issued a technical report, Morbidity and Mortality in People with Serious Mental Illness, which revealed that people with serious mental illness on the average die 25 years earlier than people without serious mental illness. While several factors contribute to this alarming disparity (including barriers to appropriate care, stigma and the lack of cross-discipline training), empirical findings indicate that early mortality among people with serious mental illnesses is clearly linked to the lack of access to primary care services for this population. People with serious mental illnesses have*

elevated rates of hypertension, diabetes, obesity and cardiovascular disease as compared to people without serious mental illnesses. Many of these health conditions are exacerbated by unhealthy practices like inadequate physical activity, poor nutrition, smoking, substance abuse, and by the side effects of psychotropic medication, including weight gain. Many of these health conditions are preventable through routine health promotion activities, primary care screening, monitoring, treatment and care management/coordination strategies and/or other outreach programs at home or community sites. Because people with serious mental illnesses frequently seek and obtain services from community-based behavioral health providers, these organizations must be able to formulate partnerships to foster integration of primary care services and provide wellness education on site with the goal of improving health outcomes for clients." This excerpt can be found at http://www.samhsa.gov/grants/2009/sm_09_011.aspx

Recommendation 10: Streamline pre-authorization process

MCOs and PBMs should streamline the process for a more timely execution of pre-authorizations.

The MCOs and PBMs need to streamline the pre-authorization process to ensure members are not being placed in a life-threatening position.

In addition, the Cabinet should review each MCO's pre-authorization requirements to ensure the procedures/resources requiring pre-authorization do not put the member at risk and, for the prescriptions being claimed as refills requiring preauthorization, disruption in medication would not cause a life-threatening situation. Further, the Cabinet should monitor the pre-authorization processing time-frames to ensure all pre-authorizations are processed within the 48-hour timeframe. Recommended changes to pre-authorization requirements should be made in writing to the MCOs and a corrective action plan required.

Agency Response

As indicated above, complaints in this area have declined significantly as providers have become more familiar with MCO processes.

Recommendation 1: Responsiveness to Leadership

A common theme among discussions with the MCOs and providers is frustration with the Cabinet regarding problems identified with process and program requirements. We recommend the Cabinet offer guidance and assistance to MCOs and providers in a timely fashion for those issues that impact member services. In addition, the Cabinet should take a more active role between MCOs and providers when there are questions regarding contract obligations, such as network adequacy.

Agency Response

The Cabinet has taken a very active role in working with providers during these early months of managed care start up. In fact, in much of the testimony before legislative committees this past winter and spring, providers repeatedly complimented the responsiveness of the Cabinet in working through MCO issues. Overall, providers have expressed satisfaction to the cabinet for its assistance. That does not mean that all problems and issues have been resolved, but it does demonstrate a commitment to methodically addressing issues as they arise. The Cabinet's contractual agreements are with the MCO's. MCO agreements are between MCOs and the providers within their provider networks. The Cabinet cannot negotiate the agreements between MCOs and their subcontractors.

With respect to MCO frustration with process and program requirements, the Cabinet acknowledges that there have been some delays in responding to some MCO issues, but response time has improved. The issues raised by both providers and MCOs during the transition are not unique. Any state Medicaid program making a transition from fee-for-service to managed care would likely mirror the Kentucky experience. Each of these companies has considerable prior experience (based on the proposals submitted to the Commonwealth in seeking this business) in the area of Medicaid Managed Care and should be familiar with the variable nature of each state with respect to Medicaid process and program requirements.

Nonetheless, in new contractual relationships, it is not unusual for there to be disagreements regarding interpretation of contract language between parties to the contract. With respect to network adequacy, the Cabinet is continually assessing adequacy and has a sophisticated means of examining network adequacy. Additionally, CMS is continually assessing network adequacy of MCOs. The Cabinet has encouraged providers and MCOs to work to reach agreements to enable Medicaid recipients as many provider choices as possible. However, as mentioned above, the Cabinet cannot negotiate those agreements and, this task is a primary contractual responsibility of the MCO vendors. It is important for providers and MCOs to learn to work together to resolve issues and achieve network adequacy. Kentucky's managed care transition is at a point where MCOs and providers can take a greater responsibility for working together to resolve issues. There are still areas where the cabinet will need to initiate dialogue or bring MCOs and their subcontractors together, but these should continue to diminish over time.

Recommendation 2: Communication

The Cabinet should establish a time frame to respond to the MCO issues and inquiries, and dedicate resources to achieve that goal. Through discussion with the MCOs, it was noted the response time by the Cabinet is sluggish. The Cabinet can take months to respond, which causes a disruption to the MCOs' business process and their ability to serve the Medicaid members in a timely fashion. We recommend the Cabinet work toward compliance with CMS standards related to a 30 day response time.

We do acknowledge the importance of Cabinet approval on correspondence to the members. Based on conversations with Cabinet officials some correspondence from the MCOs to the members can be excessive, unnecessary, and confusing. Editing correspondence can be time-consuming. We recommend that the Cabinet communicate to the MCOs acceptable practices to ensure the correspondence to the members is necessary, concise, and relevant.

Agency Response

The Cabinet recognizes that MCO issues can require considerable time to resolve on both sides. The Department has revised its internal procedures for receiving and distributing MCO issues and inquiries for department review and disposition. Guidelines and checklists have also been developed for use by the MCOs that describe MCO expectations, submission requirements and preferred format for submission. Since the procedures were only revised this summer, there has been limited time to determine the effectiveness of the new processes although implementation appears positive thus far.

Recommendation 3: Eligibility

The error rate regarding member eligibility determinations has been excessively high within the Department for Community Based Services (DCBS). DCBS performs eligibility determinations on behalf of the Cabinet for various federal programs, including Medicaid. DCBS performs quality reviews on specific program types; however, they do not perform quality reviews on all programs in which they perform eligibility determinations. Based on reviews obtained by our auditors, the error rate on eligibility determinations by DCBS is unacceptable. We obtained a quality review for Medicaid Long Term Care eligibility determinations and the error rate for FFYIO was 29.9%, and for FFYII it was 38.2%, which is astonishing. Long Term Care is a fee for service arrangement, so the MCOs do not manage Long Term Care members; however, the error rate exhibited by DCBS also raises a concern for the portion of the Medicaid program covered by managed care. Due to the Cabinet providing payments to the MCOs based on a capitated rate per eligible member, eligibility accuracy is key, and it should be the focus of the Cabinet to minimize these errors. We recommend the Cabinet require quality reviews to be performed by DCBS on all Medicaid programs types, and establish a maximum acceptable error rate with consequences for exceeding that rate.

Agency Response

The above statement is misleading with respect to member determinations. Kentucky's overall Medicaid eligibility error rate has consistently been one percent or less according to the Medicaid Payment Error Rate Measurement (PERM) review and, in fact, was one-tenth of one percent in 2010. The PERM is a comprehensive, federally-required review of all Medicaid categories. In addition to PERM (which is conducted by an outside vendor), the Department for Community Based Services (DCBS) Quality Control unit also performs a procedural review of Medicaid recipients in nursing homes or receiving waiver services (Adult Medical Assistance Quality Control or QC report).

The Center for Medicare/Medicaid Services (CMS) provides states the flexibility to determine the scope and categories included ill their QC efforts through a mandatory QC plan approval process. Kentucky has chosen to focus its QC reviews on members in institutional or waiver settings because the policies surrounding these categories are extremely complex and are most prone to procedural error. Kentucky submits its QC plan to CMS for approval each year. The DCBS Adult Medical QC review examines procedural errors of persons who may be eligible for institutional or waiver services and is not limited to payment and eligibility errors. This type of review inflates the overall error rate, but also helps DCBS identify areas where improvements are needed in terms of eligibility worker training and procedures.

The long term care group is a subset of adult medical eligibles who may be eligible for institutional care and numbers about 22,000 or approximately 2.7 percent of all Medicaid eligibles. The sample size for the report was 1160. Typically, this is the group of Medicaid eligibles most likely to have some assets. The APA statement could mistakenly lead the reader to believe that the 38.2% error rate for this small group means that all of those recipients who fell within the 38% were ineligible. This is not the case.

Of the 38.2% figure:

- *Only 6.1 % of the 38.2% were ineligible as noted in the Adult Medical Assistance Quality Control (QC) report. Nearly 50% of the errors for this group occurred due to DCBS field staff not referring documentation to the Department for Medicaid Services (DMS) for review and approval or failure to obtain other documentation from the client prior to approval. Once proper documentation was either submitted to DMS for approval or provided by the applicant, the majority of applicants were found eligible for services. It should be noted that after corrections were made to these cases, only 3.4% were found to be ineligible.*

- *The report also indicates that 22.6% of the total error rate was due to documentation errors primarily consisting of either incomplete or missing forms PA-16, Real Property Verification Request (property check at PVA and court house) and PAFS-18, Liquid Asset Verification and Invoice for Payment (bank asset check). In most cases, the missing documentation was subsequently located. It should be noted that the Department for Community Based Services implemented "documentation errors" as a new quality control item in 2011. Because it was a new item, DCBS expected that error rates attributed to these forms would increase, as the data above indicate. However, implementing this as a QC item allowed DCBS to identity and implement proper corrective action, which it has undertaken since that time. Once those items were corrected, only 3.3% of these cases were in error*
- *The report indicates that 9.5% of the total error rate is attributed to the patient liability calculation. A variance of $5 or more is considered an error. This means that DCBS either overstated or understated what could be considered the client's liability or "deductible" by $5 or more. The average over/under variance was less than $115 in 2011. The Department for Community Based Services has taken steps to address the error rate in this area as well. However, we would point out that a patient liability variance constitutes an error only in calculating patient liability, not an error in client eligibility.*

Recommendation 4: NCCI Coding

The Cabinet should ensure Kentucky uses the National Correct Coding Initiative (NCCI) standards as required. The MCOs are required by contract to use NCCI edits and audits for their Medicaid Management Information System (MMIS). There are instances, however, where coding practices in Kentucky differ from the NCCI standards. We recommend the Cabinet evaluate the coding structure used in Kentucky to ensure it follows the NCCI standards, unless specifically prohibited by law or statute. Further, once completed, the Cabinet and MCOs should provide educational programs and offer assistance as necessary to providers to ensure they follow the approved standards for coding services.

Agency Response

Kentucky coding practices comply with NCCI standards except where Kentucky has CMS-approved exemptions. When NCCI first became a federal requirement, there were a few instances where Kentucky's historical coding practice as set out in Kentucky administrative regulation was in conflict with NCCI. The Department for Medicaid Services submitted a request for exemption of application of those specific NCCI standards to CMS. Kentucky was subsequently granted permission from CMS to continue operation in accordance with its existing administrative regulation. Kentucky providers are generally familiar with DMS coding

requirements, but the MCOs, being new to Kentucky, were not familiar with DMS coding requirements.

Recommendation 5: Task Force

We recommend the Cabinet create a task force to review current Kentucky Medicaid policies in areas where Kentucky policies differ from the nationally accepted coding, reporting, and widely accepted best practices. This task force can also analyze programs, such as Behavioral Health, for cost appropriateness and opportunities for reform. The task force could also perform analysis to determine where the waste and inefficient cost may be occurring.

Agency Response

The Department and the Cabinet already maintain a number of technical advisory committees or TACs, commissions and advisory bodies to advise it on a myriad of Medicaid and Medicaid-related issues. In addition, MCOs routinely provide information to the Kentucky Medicaid program regarding practices used in other states that they deem to be beneficial. In instances where regulation and the contracts with the MCOs permit, the MCOs are free to implement these policies. In various program areas, the Department also utilizes services of nationally recognized firms that work with Medicaid programs throughout the United States. Medicaid and other CHFS program staff that work with Medicaid programs routinely attend national conferences; this fosters discussion with persons in other states' Medicaid programs. Finally, the Department participates in the National Association of State Medicaid Directors. All of these resources offer opportunities to compare practices of the Kentucky Medicaid program to those of other states and applicability of those practices to Kentucky's program.

Recommendation 6: Reporting

The Cabinet should evaluate the reports required by the MCO contracts to determine whether the information gathered is complete and relevant data to effectively monitor and analyze MCO activity at the Cabinet level. The contracts identify over 100 reports is required by the MCOs. MCOs having multi-state contracts indicate Kentucky requires by far the highest number of required reports, and much of the information appears to be redundant. We recommend that the Cabinet work with the MCOs to condense and streamline the reporting process. In an effort to increase the effectiveness of MCO reporting, the Cabinet should meet with the MCOs concurrently to discuss the possibility of combining or eliminating redundant reports. In addition, the Cabinet should analyze the reports provided within an appropriate time frame of receipt to identify trends, areas of improvements, and areas that must be strengthened.

Agency Response

The Department concurs and is addressing this issue. Some reports have been changed to an "inactive" status if the Department has determined that the data is already included on other reports or while the Department is making a determination whether the data is currently needed. The Medicaid Commissioner is personally engaged in the process of reviewing all of the required reports. The reporting requirements were known to the MCOs at the time they signed contracts with the Commonwealth. In fact, some reports were eliminated during the contract negotiations process. Particularly during this first year, having more information from MCOs rather than less is not unreasonable as the Department determines the information that will prove most beneficial in assessing MCO performance. The Department required a more comprehensive set of reports from MCOs in recognition of recommendations by the APA in its audit of the Passport Health Plan and to reinforce the Department's commitment to consumer protection. Until the evaluation process has been fully completed for all reports, MCOs are expected to continue to submit the reports pursuant to contractual requirements unless otherwise specified by the Department.

Recommendation 7: Cost Savings Measure

Managed care was implemented as a cost-savings approach for Kentucky, and a mechanism to monitor and evaluate its efficiency should be in place. We recommend the Cabinet develop metrics for monitoring the cost savings of implementing the MCOs' managed care.

Agency Response

The Cabinet has a mechanism to monitor cost savings related to MCO managed care. That mechanism was developed and in place at the time statewide MCO managed care implementation began on November 1, 2011 and is fairly straightforward, involving a monthly calculation of a plan's eligibles (eligibility file provided by the Cabinet) times the negotiated rate. The product of the three calculations (one for each company) are totaled and compared to estimates. Savings targets were identified and have been presented in public testimony. Costs were monitored continuously throughout FY 2012 and continue to be monitored. Those data collected are the basis for the specialized reports being developed at the request of Commissioner Kissner as referenced in his earlier response to the APA. It should be noted that the savings targets for FY 12 were met.

Recommendation 8: Lock-in Program

To assist recent legislation designed to curb prescription drug abuse, the Cabinet and MCOs should develop and enforce an effective Lock-In program. The MCO contract states a Lock-In program is to be developed with criteria based on 907 KAR 1:677. However, the MCOs have processes in place used in other states to identify potential abusive members sooner than would be identified using the process established in the KAR. We recommend the Cabinet assist the MCOs in establishing a Lock-In program for the Commonwealth. At a minimum, the criteria in 907 KAR 1:677 should be followed; however, we recommend the MCOs be allowed to offer more stringent criteria as long as it is reasonable and consistent among the MCOs.

Agency Response

With respect to Kentucky's Medicaid lock-in program, that process is established in Kentucky Administrative Regulation. That, along with other regulations that the MCOs are expected to abide by were known to the MCOs at the time contracts were signed. The MCOs have a variety of tools at their disposal to manage provider practice and patient care; lock-in is one. Additionally, Kentucky has tools that some other states do not have that can assist pharmacy management and overall patient health care management. For example, Kentucky is on the forefront nationally in its health information exchange and has a robust prescription monitoring program. MCOs can structure their provider incentives to encourage use of tools such as the health information exchange.

If the Department determines that regulatory or contractual changes for this or other aspects of the Medicaid Managed Care program are appropriate for Kentucky and would improve patient care management, changes to the regulation(s) will be initiated and/or contractual modifications will be considered.

Recommendation 9: Impact Plus

The Impact Plus program is a behavioral health program for Medicaid-eligible children who have complex behavioral healthcare needs. Currently, the MCOs pay the Cabinet for all Impact Plus claims and the Cabinet then pays the providers. This process causes a hardship on providers due to the time lag in payment. MCOs question the eligibility of the providers; however, the provider eligibility is determined by the Cabinet. In addition, the MCOs cannot check the status of a provider claim since providers are paid by the Cabinet. We recommend that Impact Plus be solely managed by the MCOs with the specific guidance and requirements provided by the Cabinet. Further, we recommend the MCOs be required to submit reports to the Cabinet to allow the Cabinet to monitor the program for effectiveness.

Agency Response

Impact plus is not available, nor was it designed to be available, to all Medicaid eligible children. It is available to a narrowly targeted group of Medicaid eligible children. In order to effectively manage this program and focus on those children most in need of services and to implement the program within limited funding. Impact Plus was implemented as a Title V Maternal and Child Health Medicaid state plan amendment. Title V Medicaid plan amendments permit the state Medicaid agency to cover provision of certain rehabilitation services to children even though such services may not be available to the general Medicaid population under a state's Medicaid program. In order to closely monitor quality of providers and services, carefully define the eligible population and assure consistent enforcement of program rules and criteria for entry within limited funding, it was necessary for the Department for Public Health as the state's designated MCH grantee to delegate on behalf of Public Health and the state Medicaid agency, the administration of this Title V service for severely emotionally disabled children to the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). The Cabinet is considering whether to permit MCOs to manage this particular program. However, due to the specific nature of the limited benefit under a Title V agreement, care must be taken to evaluate any potential unintended consequences in moving the benefit, specialized provider network and most importantly, the fragile population into a new model.

Recommendation 10: Encounter Data

We acknowledge that the Cabinet has performed corrective action on the Encounter data errors that occurred during the implementation phase; however, we recommend that the Cabinet develop and perform procedures to ensure the Encounter data submitted by the MCOs going forward is complete and accurate. In addition, we recommend the Cabinet perform reconciliation procedures to ensure the reports submitted by the MCOs agree to the Encounter data.

Agency Response

The Department has developed and continues to develop procedures to ensure completeness and accuracy of encounter data submitted by the MCOs. Processes were completed in August to ensure that all of the previously submitted encounter data from MCOs was complete and correct (including resubmission of all encounters previously rejected). This has resulted in a significant increase in encounters accepted by the Department ("accepted" means the encounters passed edits and were loaded into the MMIS). Modifications were also implemented to simplify and expedite the process for MCOs to identify and correct rejected encounters. Now that the Department is satisfied the volumes of the encounters arc largely correct, processes are being initiated to ensure accurate and timely encounter submission going forward, as well as

continued review of encounter data submitted to assure accuracy, and that encounter data in the MMIS is reflective of the data seen on the MCO reports.

Recommendation 11: Intermediate Behavioral Health Care

Kentucky has a need for behavioral heath transitional care programs throughout the Commonwealth to prevent the costly readmission for members who have relapses before their outpatient care begins. The Cabinet should continue its leadership in implementing Intermediate Behavioral Health Care in *all* regions of the state to benefit the members of Kentucky.

Agency Response

The Cabinet agrees that there is a need for behavioral health transitional care and appreciates the acknowledgement of its leadership role.

Recommendation 12: Suboxone

The Cabinet should establish a policy to clarify the prescribing of Suboxone and other similar drugs used to treat addiction. It is our understanding the drug Suboxone is intended to be used in conjunction with a supplemental outpatient program. Based on provider and clinical guideline information, there are circumstances that can result in lifetime use for this drug; however, the ideal treatment is to taper off the use of the drug slowly and appropriately while psychosocial services are continued. It is the responsibility of the Cabinet to set a policy regarding Suboxone and other similar drugs, and the responsibility of the MCOs to ensure these drugs are prescribed according to the policy established by the Cabinet. We recommend the Cabinet establish and clarify practices for prescribing Suboxone related to the maintenance of outpatient care. The Cabinet should ensure best practices are being followed.

Agency Response

The Cabinet has a policy regarding prescribing of Suboxone. That policy was clarified with MCOs.

Recommendation 13: Prior Authorization

We recommend the Cabinet closely monitor the prior authorizations made by the MCOs to ensure the denial for service or treatment was made appropriately. The contract requires prior authorizations to be made within 48 hours. MCOs should ensure sufficient and competent personnel are available to follow up with providers, when necessary, on requests for prior authorization within the contractually required timeframe. Further, the MCOs should educate the provider on the necessary information or criteria needed by the MCOs to make informed decisions on prior authorizations and payments on claims. Each MCO has a web portal that the providers could utilize to determine the status of claims and prior authorizations. We also recommend the Cabinet encourage providers to use the MCOs web provider portals to review the prior authorization status, and process of claims.

Agency Response

The Department currently monitors prior authorization made by MCOs to assure appropriate use of the prior authorization process. The Cabinet concurs with the APA recommendations to MCOs. With respect to use of MCO provider portals, it is the responsibility of the MCO to educate and encourage their enrolled providers to use their available resources including their MCO provider portals. This is one of the responsibilities for which the Cabinet pays the MCO vendors. This issue seems to have been primarily a start-up issue. As providers have learned MCO processes for prior authorization, complaints to the Department have declined significantly.

Recommendation 14: State Fair Hearing

The Cabinet's policy of permitting members, or providers representing members, to go directly to a State Fair Hearing without first attempting to go through the individual MCO's grievance/appeal process has had unintended consequences. Through discussions with MCOs, members or providers have begun to submit a request for a State Fair Hearing without first contacting the MCO about the issue. The MCOs indicate the number of hearings is increasing, and the cost associated with each meeting has increased due to the Cabinet's requirement that legal staff from the MCOs be present at each meeting. We recommend the Cabinet evaluate the current State Fair Hearing process for the MCOs to ensure it is in the best interest of the Commonwealth. The Cabinet should encourage members and those providers representing members to exhaust the MCO grievance and appeal options prior to requesting a State Fair Hearing.

Agency Response

The Cabinet agrees that what was intended to be a consumer protection measure may have had unintended consequences. The Cabinet is already evaluating this process.

Finding 1: The Cabinet For Health And Family Services' Department For Medicaid Services Did Not Ensure All System Audits And Edits Are Accurately Configured For The Kentucky Medicaid Management Information System And Up To Date Documentation Was Retained

As noted in the prior year audit, our fiscal year (FY) 2012 audit of the Cabinet for Health and Family Services (CHFS) Kentucky Medicaid Management Information System (KYMMIS) revealed the Department for Medicaid Services (DMS) did not maintain updated documentation of all programmed audits and edits performed during KYMMIS system processing. System edits ensure the data within a transaction is complete, accurate, and formatted correctly; whereas, system audits provide a check against historical transactions to ensure the current claim is valid and allowable. Multiple instances of inactive system audits or edits continued to be identified as active, whereas multiple active audits and edits were omitted from the associated documentation. In addition, several audits and edits were incorrectly configured.

DMS uses audits and edits within the KYMMIS application for quality assurance purposes. This process ensures data input is accurate and complies with Medicaid eligibility guidelines. DMS created two manuals to document the available KYMMIS audits, which are the KYMMIS Audit Manual and the KYMMIS Claim Check Manual. In addition, DMS created the KYMMIS Edit Manual to document KYMMIS edits.

We sampled five audits and seven edits reporting no failed claims for the current fiscal year. Three of the five audits sampled, or 60 percent, failed the test criteria. Specifically,

- One audit had a defect identified when DMS tested its functionality.
- Two audits were identified as active by DMS; however, when DMS attempted to test the audit, it was determined the audits are not applicable or could not generate an exception due to other audits activated earlier in the review process.

Of the seven sampled edits, four edits, or 57.1 percent, failed the test criteria. Specifically,

- Two edits had defects identified when DMS tested their functionality.
- Two edits were identified as active by DMS; however, when DMS attempted to test the edit, it was determined the edits were not applicable or could not generate an exception due to other edits activated earlier in the review process

We are aware DMS has submitted a request to the vendor to update the documents to address these concerns. Further, the issues involving the audits and edits specifically identified as not performing as expected have been submitted to the vendor as defects for correction.

Failure to accurately document system audits and edits increased the risk that agency staff will be unfamiliar with audit and edit criteria. In addition, outdated documentation could also be a reflection of inaccuracies within the KYMMIS audit or edit configurations, which could lead to erroneous claims being processed or valid claims being denied. Inaccurate audit and edit configurations could allow excessive, inaccurate, or non-compliant claims to be processed.

Updated documentation of all system audits and edits should be retained for quality assurance purposes. Documentation should be distributed to all responsible personnel. In addition, all system audits and edits should be configured according to the agreed upon and approved criteria.

Recommendations

We recommend DMS work with the vendor to correct all audits and edits identified as defects. Additionally, DMS should work with the vendor to research any audits and edits where questions remain regarding the appropriateness of the logic or whether an audit or edit was active. Further, DMS should institute periodic reviews of active audits and edits to ensure they are accurately configured to flag claims matching the documented criteria. Any audits or edits identified as being configured incorrectly should be modified to ensure they function as required for business purposes. Documentation of this process should be maintained for audit purposes.

Finally, we recommend DMS continue to work with the vendor to update the KYMMIS audit and edit manuals. Any active audits and edits omitted from the associated documentation should be added along with the associated descriptions and criteria. With regard to inactive audits and edits, a notation should be made in the documentation to reflect an inactive status. DMS should also ensure all audit and edit numbers are recorded correctly in the documentation. Once updated, the audit and edit manuals should be distributed to all responsible personnel.

Management's Response and Corrective Action Plan

In response to these findings, DMS has appointed staff to work/monitor these issues:

- *Implement a process for tracking and analyzing current system logic and applicable program policy compared to current documentation which will increase DMS ability to identify noncompliance. DMS will develop a process with a 10/1/2012 completing and initiating implementation of that process.*
- *Work with vendor and appropriate programmatic DMS staff to correct defects and perform updates, when necessary, as identified during the initial and subsequent reviews. This is an ongoing process, but DMS will commit to a date of July 1, 2014 to complete its initial review and correction of MMIS edits and audits.*

- *Implement a process for tracking any defect or change orders initiated as a result of review to ensure completion; this process will be developed by 10/1/2012.*
- *Take a proactive approach to documentation maintenance by implementing a process for monitoring systematic and/or programmatic changes which may impact the functionality of applicable audits/edits; more rigorous enforcement of current procedures involving the update of system documentation will begin by July 1, 2012.*
- *Work with vendor to modify the current structure of audit/edit manuals to include notation for inactive or end dated status and the inactive or end dated date. Modifications to the structure of the manuals has already begun. All new edits and audits will contain this information, and modification of all edit and audit documentation will be complete by November 30, 2013.*

DMS has begun work on creating a database to track and review current system logic compared to current documentation. Once complete, this phase will aid in identifying appropriate program policy staff who will review both system logic and documentation. Policy staff review will ensure the functionality is in accordance to current program policy; reporting any inaccuracies found in the functionality or documentation to project lead. In addition, this phase will aid in identifying inconsistencies with system logic compared to current documentation. The mission is to have accuracy and consistency among system logic, program policy (where applicable) and documentation

During the initial and subsequent reviews DMS will work with vendor to ensure the most current manuals are electronically available to users. As defects or updates are identified, necessary defect or change orders will be submitted instructing the vendor on necessary changes or updates

DMS will immediately begin work on creating a process for tracking defect and change orders initiated as a result of review findings.

DMS will immediately begin discussion with the vendor to modify the current structure of audit/edit manuals to include notation for inactive or end dated status and the inactive or end dated date. This feature will aid in users easily and clearly identifying the appropriateness of audit/edit.

These efforts are in addition to last year's efforts, which included:

The Department for Medicaid Services (DMS) opened a non-billable Change Order on April 14, 2011 with the KYMMIS vendor to address this issue. This will be an ongoing effort with the vendor until all discrepancies are resolved. DMS' approach is to:

- *Request edit or audit pages policy staff suspect or know currently aren't correct*
- *Review the edit and audit pages*
- *Identify what is not current within the pages in the manual according to DMS policy*
- *Communicate what has been identified to the appropriate party to update/correct*
- *Update/correct the pages*
- *Add status (active/inactive) to the header of the manual pages*
- *Send the page(s) back to DMS staff for final review and sign off*
- *Work with the vendor to maintain a process to ensure the pages remain up to date ongoing within the documentation*
- *Test edits/audits that are not hitting any claims*

Finding 2: The Cabinet For Health And Family Services Was Inconsistent In Their Determination of Advanced Payments To Impact Plus Providers And Did Not Maintain Proper Support For Reimbursement Of Advance Payments

During the fiscal year 2012 audit of the Cabinet for Health and Family Services (CHFS) we tested a sample of transactions to verify the expenditure was recorded appropriately and had adequate support. Four of these transactions consisted of payments to two different providers in the Impact Plus program. While reviewing these transactions the auditors noted they were advanced payments paid to the providers to aid them during the transition from a Fee for Service model to the Managed Care Organizations (MCOs). The transition from a Fee for Service model to the MCO's resulted in payment of claims not being made timely. These advancements were requested by Legislators and the Impact Plus provider community because they could not continue to provide services and meet their payroll obligations without payment from the MCOs. Based on accounting records, a total of $2,869,832.88 was advanced to Impact Plus providers as of June 30th, 2012. As of that date, $463,000 had been repaid by the Impact Plus providers to CHFS. Although CHFS maintained records of the advanced amounts based on estimates, year-end summary data provided to the auditors omitted interim payments from the Impact Plus providers which were based on claims in the system. CHFS did not maintain proper support of reimbursement from the advancement. The auditors utilized the State accounting system, eMARS, to determine the amount of reimbursement from the advancement.

In addition, the methodology in determining advancement amounts was inconsistent among Impact Plus providers. CHFS based a portion of the advancement on actual claims that had not properly processed in either the State of MCO Medicaid Management Information System (MMIS). The other portion of the advancement to the providers was based on internal estimates made by CHFS. Rather than using a methodology the auditors could recalculate, confirm, and apply to all of the providers, CHFS based the advancement estimates partly on historical data and partly on intangible internal assessment.

Furthermore, the outstanding balances of the advancements from the providers were not properly accounted for at fiscal year end. The amount due to CHFS should have been considered accounts receivable at fiscal year end. CHFS did not recognize the outstanding balance as a part of their account receivable.

Ordinarily CHFS pays the MCOs a per member, per month capitation fee. Providers submit Medicaid claims to the MCOs, wait for the claims to process, and are then paid by the MCOs for the services rendered. The Impact Plus program, however, adds a step to the payment process. Rather than the MCOs directly paying the Impact Plus providers, the MCOs pay CHFS for processed claims. CHFS then pays the providers. Ineffective communication and improper planning regarding the specificities of the Impact Plus program led to payment issues during the transition to an MCO environment.

Impact Plus provider claims are handled differently than other providers in the Medicaid Program. Impact Plus providers are paid by CHFS and the MCO's did not properly plan for the timely payment of the Impact Plus claims through the transition from the Fee for Service to MCO environment.

It is understood these advanced payments were vital in order to sustain the Impact Plus program. Nevertheless, the inconsistent methodology in determining the advancement amounts and the lack of controls on tracking the reimbursement are both problematic. Because of the inconsistent nature of the internal assessments, the process could face accusations of bias or unfairness toward certain providers based on the amounts of the advancement.

Although CHFS did base a portion of the loans on actual claims that had not properly processed in either the State or MCO Medicaid Management Information System (MMIS), the current standing of a portion of these claims is unknown and is being reviewed by CHFS. The Impact Plus providers were expected to pay CHFS back once they had received payment for processed claims. Because many of the claims are not processing as expected CHFS is not being repaid for these advancement in a timely fashion.

While this may be an unusual circumstance, it is necessary for CHFS to properly account for advancements at year end. By not including these advancements on year-end summary data, regardless of whether CHFS personnel are aware of their existence, CHFS could erroneously report or misstate receivable balances

Poor planning and communication between CHFS and the MCOs created an environment in which Impact Plus providers suffered severe hardship to the point of, in some cases, potentially not meeting payroll obligations. Had CHFS and the MCOs been better prepared for the transition, neither CHFS nor the Impact Plus providers would have been in a situation where such substantial advancement were necessary. Furthermore, these circumstances could lead to a breach of trust between the Medicaid provider community and CHFS. If the providers are not compensated, their ability to deliver healthcare services to Medicaid members could be compromised.

42 CFR 447.45(d)(2,3,4) states, "The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. The agency must pay all other claims within 12 months of the date of receipt…"

42 CFR 447.46(c)(1) states, "A contract with an MCO must provide that the organization will meet the requirements of §§774.45(d)(2) and (d)(3)…".

Proper internal controls dictate that policies and procedures should be created and documented to provide direction to staff in regards to advance payments to providers. These policies and procedures should guide staff in determining the amount of advancement estimated to providers. . If loans are based on provider hardship, such policies should dictate what factors will be considered in assessing the magnitude or severity of said hardship.

In 1993, The Program Review and Investigations Committee authorized a study of the Medicaid program (LRC Research Report No. 274). The goal of that report was to identify problems in the administration of the program. The report contained several recommendations related to financial accountability. Two of the report's recommendations were particularly relevant to the issues noted during the 2012 audit. Those recommendations were numbers 6 and 7: (6) [CHFS] should determine the legality of making advance payments and discharging overpayments and (7) [CHFS] should develop policies to define hardship. These recommendations highlighted the lack of policies and procedures governing interim loans disbursed to providers and the determination of loan amounts based on hardship. The methodology for advance payments per the Department of Medicaid Services at that time - 75% of pending claims or the previous month/ prior year monthly average - was not followed in this instance and reveals inconsistencies in how CHFS determines short term loan amounts to providers.

Recommendation

We recommend CHFS:

- Create a method for accurately tracking payments from Impact Plus providers to CHFS to ensure full reimbursement on the advancement
- Determine a methodology in determining advancement amounts which only include those claims for which existence has been confirmed and adjudication is reasonably certain. In addition, if estimates must be used as the basis for short term loans, base the amounts on clearly defined measurements
- Ensure proper accounting of accounts receivable is performed to account for outstanding balances of advancements
- Document the issues faced during this transition and apply that information to the State's current and future efforts in the expansion of Managed Care to avoid similar pr Develop policies to define hardship which would result in advance payments. In addition, define clear parameters for determining future advancement amounts if CHFS determines hardship is evident.
- Improve communication between CHFS and the Impact Plus provider community to be more transparent so providers can prepare for potential funding issues.

Management's Response and Corrective Action Plan

DBHDID has accounted for all advance payments to Impact Plus subcontractors. Detail of reimbursement from the advancement utilizing a spreadsheet that was created during fiscal year 2012 specifically for this purpose. Each sub-contractor that received funds is listed along with the amount each received. As reimbursements are received, those amounts are entered onto the spreadsheet. The current balance due from each sub-contractor is available at any time. Payments received are applied to each Impact Plus sub-contractor's outstanding balance. During the current fiscal year all Impact Plus sub-contractors with outstanding balances were sent communication requesting full payment by the end of FY13.

Issues were raised concerning the rationale for developing two different methods for making interim payments. Theoretically, we agree with the auditor's comment that: "advancement amounts which only include those claims for which existence has been confirmed and adjudication is reasonably certain. In addition, if estimates must be used as the basis for short term loans, base the amounts on clearly defined measurements." Our initial attempts to determine a reasonable and equitable basis was based on requesting pending claims from each MCO. It was soon discovered that a large number of providers (because of the use of third party billing/processing agents used by some providers as well as MCOs) were having difficulty successfully submitting claims; therefore, the pending claims data did not provide a reasonable or equitable basis for making advance payments. To compensate for the lack of accurate data, DBHDID devised a methodology that based future interim payments on a two month estimate of Impact Plus payments prior to the implementation of managed care. DBHDID feels that basing interim payments on two months of most recent payments history provided the best estimate to ensure fairness to Impact Plus subcontractors, given the time sensitive nature of the payment issue.

As indicated above, all repayments are applied to each sub-contractor's outstanding balance. Existing funds were utilized to make advance payments and did not result in additional revenues to DBHDID. When payments are received they are applied as a reduction to expenditures.

With the expansion of managed care for behavioral health services in Region 3 it is the expectation of DBHDID for the Managed Care Organizations to meet the Impact Plus payment and service obligations. As the Impact Plus Provider, DBHDID recognizes the importance of maintaining our sub-contractor network

Two of the current MCOs will be participating in the expansion of Managed Care. DBHDID staff are working with the new MCOs to develop processes prior to the go live implementation of the new Region 3 MCOs scheduled for January 2013. In addition, DBHDID Impact Plus staff is reaching out to sub-contractors in region 3 to ensure a smoother transition.

If it should become necessary to make advance payments, DBHDID will require each sub-contractor to formally request assistance. Sub-contractors will be required to demonstrate a financial hardship before DBHDID will issue an interim payment. The parameters to determine financial hardship will be developed and implemented by January 31st 2013. DBHDID will base any future interim payments on a two month average of Impact Plus payments.

Four provider trainings were held by DBHDID during the week of December 3rd in order to prepare the sub-contractors for the second phase of Managed Care Implementation in Region 3. Each training was facilitated by one of the MCOs and provided the sub-contractors with detailed information about their clinical processes as well as claims and billing procedures. DBHDID is available to sub-contractors on a daily basis for technical assistance and to serve as a liaison between the IMPACT Plus Sub-contractors and the MCOs. Conference calls have been coordinated between each MCO and the IMPACT Plus Sub-contractors during which provider questions can be answered and concerns addressed. DBHDID has daily communication with the MCO regarding the processing of payment and hosts frequent Department level meetings with each MCO in which sub-contractor issues are shared. IMPACT Plus Central Office staff are also invited to and participate regularly in multiple provider forums statewide including Regional Provider Meetings, Children's Alliance Meetings, etc. These forums provide the sub-contractors the opportunity to ask questions, express concerns, and troubleshoot problems with Department staff.

In order to further facilitate communication between the IMPACT Plus Sub-contractors and the MCOs, DBHDID hosted two full days of meetings between the sub-contractors and all three MCOs in January 2012. Sub-contractors were given the opportunity to schedule a one on one appointment with each MCO to address any claims submission, billing, prior authorization, or payment issues they were experiencing. DBHDID issued a follow up survey to solicit sub-contractor feedback related to usefulness of these forums and gauge interest for future meetings facilitated by DBHDID. Based on the feedback received, we anticipate that a similar meeting will be held in February as part of the second phase of Managed Care implementation in Region 3. DBHDID has shown and continues to be committed to ensuring its sub-contractors are receiving payment and can continue to provide uninterrupted, high quality services to the children of the Commonwealth.

Finding 3: The Cabinet For Health And Family Services Did Not Properly Authorize Or Maintain Support For Expenditures, Nor Ensure Appropriate Cited Authority Was Used For Procured Expenditures

During the fiscal year 2012 audit of the Cabinet for Health and Family Services (CHFS) we tested a sample of expenditures to verify controls were in place and to ensure the expenditure was accurate and complete. The testing revealed that CHFS did not properly authorize and maintain support for expenditures. In addition, they also did not ensure that the appropriate Cited Authority was being used for procured expenditures. The details of the testing are noted below:

- Three expenditures for non-emergency medical transportation; one did not have sufficient supporting documentation and two did not have any supporting documentation, such as invoices or receipts.
- Eight out of the nine expenditures related to non-emergency medical transportation was not procured using the proper Cited Authority.
- Five requests for wire transfers related to the Medicaid managed care organization payments were missing authorization signatures.
- One request for a wire transfer related to Medicaid pharmacy benefits was missing an authorization signature.
- One expenditure for the First Steps Program lacked supporting documentation for a portion of the cost report.

We will note that CHFS did correct the improper Cited Authority to non-emergency medical transportation when they noticed it was incorrect in the accounting system; however, they did not notice the error until fiscal year 2013.

CHFS did not exercise strong internal controls on expenditures. When expenditures are being paid without obtaining proper authorization it creates a risk that improper payment can occur. Furthermore, when payment documents are created in eMARS a Cited Authority is required to ensure compliance with statutory, regulatory or policy citation. When an improper Cited Authority is used there is a risk that the expenditure was not procured correctly and in accordance with policy. In addition, supporting documentation is a necessity to ensure the expenditure is accurate and complete. If supporting documentation is not provided for a transaction or not complete, the reasonableness or necessity of the expense cannot be confirmed. For the First Steps Program CHFS did not substantiate, through supporting documentation, the existence of expenditures reported by the grant recipient. By not substantiating the cost report, CHFS imposes a risk of grant recipients having the opportunity of inflating or falsifying their request for payment.

According to the General Procurement Guide for eMARS Course 601 :

> In order for a purchase to be legally processed, the Commonwealth of Kentucky requires a Cited Authority to be associated with each award and each payment document. This Cited Authority contains statutory, regulatory or policy citations for a purchase. This information is required when creating award and payment documents.

Proper completion of the Cited Authority field is required for the Commonwealth of Kentucky to comply with agency's pre-audit delegation agreement resulting from FAP 120-13-00 (Decentralization of the Pre-Audit Function).

Cited Authority represents the statutory, regulatory or policy citation - for example, "FAP 111-55-00".

Cited Authority is required on Award Documents and Payment Requests where there is no reference or only a memo reference to an award. Cited Authority is not required on Requisition or Solicitation documents.

The validation of the Cited Authority's minimum and maximum amount will occur at the document header level - the document amount and NOT the line amounts. The determination of which Cited Authorities are available to be selected is based on business rules set up in eMARS.

Good internal controls dictate that supporting documentation to justify expenditures be maintained on file at least through the agency's record retention policy date. Strong internal controls also require all expenditures to be properly authorized and reviewed to ensure accuracy

Recommendations

We recommend CHFS:

- Maintain supporting documentation through the agency's record retention policy date to justify expenditures.
- Ensure all documents are properly authorized with original signatures.
- Ensure that the appropriate Cited Authority is being referenced for procured expenditures.
- Require grant recipients to attach support for all expenditures, particularly ambiguously categorized expenses.

Management's Response and Corrective Action Plan

Management Response and Corrective Action Plan (Division of General Accounting):

- *Of three expenditures for non-emergency medical transportation; one did not have sufficient supporting documentation and two did not have any supporting documentation, such as invoices or receipts.*

Response: In October 2012, the Division of General Accounting moved responsibility for payment of these items from the Grants Branch to the Payables Branch. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions. The new process ensures that all backup documentation will be attained before payment is made.

- *Eight out of the nine expenditures related to non-emergency medical transportation was not procured using the proper Cited Authority.*

Response: CHFS discovered an incorrect cited authority was used in FY 2012 and corrected the cited authority for all FY 2013 payments. In addition, in October 2012 the Division of General Accounting moved these payments from the Grants Branch to the Payables Branch to ensure proper cited authority is always selected. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

- *Five requests for wire transfers related to the Medicaid managed care organization payments were missing authorization signatures*

Response: The lack of authorized signatures on the SAS 62 form was an oversight and will be reviewed closely in the future. It is noted that these wire transfers were approved electronically in eMARS by CHFS. As indicated above, in October 2012, responsibility for these payments was moved from the Grants Branch to the Payables Branch to ensure a more detailed document review. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

- *One request for a wire transfer related to Medicaid pharmacy benefits was missing an authorization signature.*

Responsibility: The lack of authorized signatures on the SAS 62 form was an oversight and will be reviewed closely in the future. It is noted that this wire transfer was approved electronically in eMARS by CHFS. In October 2012, responsibility for these payments was moved from the Grants Branch to the Payables Branch to ensure a more detailed document review. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

Management Response and Corrective Action Plan (Department of Public Health):

The Department for Public Health agrees with the finding. The 2012 invoice form has been updated to ensure all supporting documentation is attached to the invoice. The Point of Entry contractors are now required to submit the documentation of expenditures with the billing each month. Additionally each Point of Entry has a formal, independent financial audit done annually that we can review.

Finding 4: The Department For Medicaid Services (DMS) Does Not Have The Proper Tools Or Controls In Place To Monitor Federal Compliance Of Utilization Control And Program Integrity

The Department for Medicaid Services (DMS) does not have the proper tools or controls in place to monitor federal compliance of utilization control and program integrity.

During the FY 2012 audit of the Cabinet for Health and Family Services (CHFS), we reviewed the Managed Care Organizations (MCO) program integrity plans as well as their reporting requirements for appeals and grievances approved by the Commonwealth. The Department for Medicaid Services (DMS) requires all of the MCOs, including Passport, to submit quarterly reports to the DMS Managed Care Oversight Branch (MCOB) concerning appeals and grievances for members and providers. We requested the quarterly reports submitted by the MCOs. Due to the lack of detail in these reports we could not ensure federal compliance requirements were met. Furthermore, the MCOs are required by the Commonwealth to resolve grievances within a thirty day time period. The reports required from the MCOs do not provide sufficient information for DMS to ensure the grievances were handled in a timely manner.

In addition, the Office of the Inspector General (OIG) receives complaints via their hotline and a variety of other sources. If a complaint is in relation to a MCO, OIG refer that complaint to the MCOB. The MCOB then forwards the complaint on to the MCO for their investigation. It becomes the responsibility of the MCOB to ensure the MCO follows up on the complaint and to update OIG on the status of these cases. During our review of the OIG complaints, we reviewed five cases that were referred to the MCOB and we could not determine the status of the investigation. The MCOB did not properly monitor these cases and failed to communicate the status of the investigation to the OIG.

The MCOs do not submit sufficient reports to DMS for monitoring the program integrity activity of the MCO. Without proper tools for monitoring program integrity, DMS cannot ensure the Commonwealth is meeting federal compliance requirements. In addition, if the MCOB does not properly track and monitor the complaints forwarded to the MCOs, grievances could go unresolved and potential fraudulent activity could be undetected.

42 CFR 455.13 states the Medicaid agency must have - (a) Methods and criteria for identifying suspected fraud cases; (b) Methods for investigating these cases that (1) Do not infringe on the legal rights of persons involved; and (2) Afford due process of law; and (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

Per agreement between the Commonwealth and MCOs, section 24.1: Grievance Process, the investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant."

Per section 27.8 Provider Grievance and Appeals, provider grievances or appeals shall be resolved within thirty (30) calendar days.

Per section 37.8 Grievance and Appeals Reporting Requirements, the Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information:

A. Number of Grievances and Appeals, including expedited appeal requests;
B. Nature of Grievances and Appeals;
C. Resolution;
D. Timeframe for resolution; and
E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.

The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected fraud or abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.

Good internal controls dictate that any complaint forwarded to the MCOB should be tracked to ensure that it is resolved.

Recommendations

We recommend the structure of the grievances report be re-evaluated to ensure contractual compliance with the MCO grievance process for both member and provider grievances. The report should include at a minimum, the type of grievance, the date of receipt, the date of resolution, type of resolution, and referral if necessary. We also recommend a tracking system be developed and implemented at the MCOB to ensure all grievances referred to the MCOs be followed up on and communicated back to the OIG.

Management's Response and Corrective Action Plan

The Department has recently completed an on-site audit of each Managed Care Organization's policies and procedures regarding the grievance and appeals process. It was determined that each MCO did adequately track the date that each grievance or appeal was received and the date that each was resolved or action on the grievance or appeal was completed; however, it was determined that there were differences in the definition of a grievance used by each MCO which limits the ability of the Department to compare one MCO to another. It was also noted that more details needed to be maintained, tracked, and reported by each MCO regarding the outcome of each grievance. The Managed Care Oversight Branch has drafted guidelines for the revised Grievance and Appeal process. The finalized guidelines will be transmitted and explained to the MCOs so that greater consistency between each MCO's process can be achieved, as well as establishing a standard definition of a grievance that is understood by all parties.

In addition to the Department's monitoring of the Grievance and Appeals process, two of the Department's contracted vendors; will conduct or have conducted reviews of the Grievance and Appeals process with a slightly different focus. One vendor performs Market Conduct Reviews of each MCO and will focus on the effectiveness of each plan's internal policies and procedures related to Grievances and Appeals. The Department's certified External Quality Review Organization (EQRO) conducts the Department's federally mandated External Quality Review of each MCO. As part of that review, they will sample specific Grievances and Appeals and analyze those cases and the result for the member to help ensure that the MCO is providing quality health care. As a result of these reviews, DMS will develop and document a defined review process and tracking system. Any inadequacies in the Grievance and Appeal process identified by the Department, through its ongoing review process, or its two external vendor reviews will be presented to each MCO for correction. In addition, the MCOB will periodically update DMS management regarding the status and disposition of appeals and grievances. MCOB will recommend, as appropriate, any further changes to process/procedure or contractual provisions. Failure on the Part of the MCOs to make necessary adjustments would result in an Official Corrective Action Plan notice to the offending MCO.

Finding 5: The Department For Community Based Services Did Not Maintain Supporting Documentation Required To

During the FY 2012 audit of the Cabinet for Health and Family (CHFS) we tested member eligibility for the Kentucky Children's Health Insurance Program (K-CHIP) and the Medical Assistance Program (MAP). The Department for Community Based Services (DCBS) determines eligibility for these programs.

To ensure compliance of member eligibility for these programs was

Determine Member Eligibility For Medicaid

sufficiently performed we reviewed 63 case files for K-CHIP and 63 case files for MAP in seventeen counties. During our testing we noted CHFS was not in compliance with federal regulations regarding member eligibility. Case files were not available for review and documentation was not maintained at the local DCBS office and/or Electronic Case File (ECF) system to give the assurance that proper eligibility determinations were performed by DCBS personnel. We noted the following exceptions:

K-CHIP

We tested 63 case files and 13 exceptions were noted:

- Six case files were not available for review (five case files in Jefferson County and one case file in Nicholas County)
- Two case files did not have any documentation available in file for member in question (one case file in Bracken County and one case file in Jefferson County)
- Five case files had insufficient documentation available for review in case files (one case file in Fayette County, one case file in Garrard County, one case file in Owsley County, one case file in Pendleton County, and one case file in Wolfe County)

MAP

We tested 63 case files and 14 exceptions were noted.

- Eight case files not being available for review (one case file in Bracken County, one case file in Fayette County, four case files in Jefferson County, one case file in Nicholas County, and one case file in Pendleton County)
- Six case files had insufficient documentation available for review in case files (two case files in Fayette County, one case file in Garrard County, one case file in Lewis County, one case file in Owsley County, and one case file in Wolfe County)

Proper documentation was not maintained at the local DCBS offices and/or Electronic Case File (ECF) system; thus no assurance can be achieved as to the adherence to proper eligibility determination procedures by DCBS personnel. Inadequate case documentation and improper eligibility determination procedures lead to an increased risk that benefits are being issued to ineligible recipients. CHFS is not in compliance with Federal regulations regarding member eligibility.

OMB Circular A-133 Part 6 states, "The A-102 Common Rule and OMB Circular A-110 require that non-Federal entities receiving Federal awards (i.e., agency management) establish and maintain internal control designed to reasonably ensure compliance with Federal laws, regulations, and program compliance requirements."

Per DCBS Operation Manual Volume IV:

MS 1250* CASE RECORD CONTENT - All case records represent a continuing documentation of eligibility for assistance. The case record contains sufficient material to substantiate validity of all authorized assistance.
Per DCBS Operation Manual Volume IV-A:

MS 1372 (B)(2)(c) "Explain the potential for prosecution for committing fraud, and have the individual sign form MA-2, Medicaid Penalty Warning;"

MS 1890 (A) "Form MA-34 MUST be completed for ALL Long Term Care (LTC) or waiver resource assessments, applications, and recertifications, whether or not the individual has an annuity."

Recommendations

We recommend CHFS DCBS properly train staff to ensure eligibility determinations for Medicaid members are verified by adequate supporting documentation. Furthermore, DCBS offices shall maintain appropriate documentation to support member eligibility determinations in accordance with Federal regulations.

Management's Response and Corrective Action Plan

DCBS works on a continual basis to identify and implement solutions to assure and improve management of cases, including case documentation. Effective June 2012, Kentucky's Electronic Case File (ECF) management system became operational statewide. ECF is a paperless system that permits workers to scan documents at their desks and attach the scanned documents to an electronic case file. Once the electronic case file is originated and documents are attached, the possibility of a total loss of files is virtually eliminated. As the state moved forward with the phased roll out of the system, certain issues were brought to light that hindered implementation in certain areas. For example, Jefferson County did not have the appropriate bandwidth to handle the volume of documents to be scanned and attached into ECF. This created a backlog of documents to be scanned and attached in the system until the issue was corrected. The issue has been resolved as of this date and Jefferson County has been working to have all documents scanned and attached to the appropriate case file.

Having ECF operational statewide has provided the Department of Community Based Services (DCBS) the opportunity to reevaluate current practices and procedures within field offices in terms of how resources are managed. Additionally, rising caseloads and the future implementation of the Kentucky Health Benefit Exchange has necessitated a need for change in how cases are processed and how work is allocated among field staff. As a result, DCBS has initiated and is piloting a business process redesign project. Under this business process redesign, office resources are organized based on function and activities rather than a 1:1 case worker to client model.

Through the business redesign project, field staff is organized into four groups: client intake; call services; eligibility and enrollment; and support services. Each group performs a defined set of functions. For example, eligibility and enrollment teams conduct application and recertification interviews, while support services teams are responsible for processing pending applications and recertifications upon receipt of verification documentation and will also process any changes made to a case. Under this model, no one worker is responsible for all actions on a case. Many workers are responsible for processing and maintaining a case, establishing an informal review process. Each time a worker touches a case, the case must be reviewed to ensure the last action was worked correctly and the necessary documentation is present. Additionally, for this model to be successful, scanning and attaching documentation is essential, as the documentation drives many of the functions to be performed.

To reinforce the importance of maintaining proper case files, the Division of Service Regions is addressing this issue in the next Service Region Administrators' meeting to be held March 12, 2013. Additionally, the Division of Family Support (DFS) will place a news message on the Kentucky Automated Management Eligibility System (KAMES) regarding the importance of maintaining proper case files. KAMES is the automated system field staff uses to conduct eligibility determination for benefits. Placing news messages on KAMES is a tool used to communicate reminders and important information to field staff as the messages must be reviewed the first time a user logs on each day. This will be completed by April 1, 2013. As recommended, DFS will also meet with training staff to strategize ways in which the importance of maintaining proper case files can be emphasized when conducting program training. This meeting will take place prior to May 1, 2013.

Missing case documentation is a significant concern to DCBS. In addition to the actions above, a review of the actual cases with findings has been conducted by DCBS staff. Documentation for many of the cases

has been identified and scanned into the ECF case file since the time this audit was conducted. DCBS will continue to work with its field offices to ensure all required and mandatory documentation is included in the appropriate case files

Finding 6: The Department For Medicaid Services Did Not Maintain All Documentation Required To Determine Provider Eligibility For The Medicaid Program

The Department for Medicaid Services (DMS) is required to maintain case files on each eligible Medicaid provider in accordance with state and federal regulations. The provider eligibility case files are scanned into the OnBase application located within the Medicaid Management Information System (MMIS). DMS is also required to recredential providers every three (3) years to ensure providers maintain their status as an eligible Medicaid provider. Currently, this process consists of verifying updated licensure.

For the FY 2012 Medicaid audit, we tested a sample of 60 provider case files in the OnBase application for compliance with Medicaid Provider Eligibility requirements set forth in the State Plan and noted the following:

- Four providers did not have an Annual Disclosure of Ownership on file.
- One provider did not have a provider agreement on file.
- One provider did not have an updated license on file.
- One provider did not have an Annual Disclosure of Ownership and an updated license on file.

The required documentation was not obtained and scanned into the OnBase application at the time of eligibility determination and/or annually as required. Upon receiving notification of exceptions discovered during the audit, DMS stated that providers would be contacted to obtain all missing documentation; however, we cannot verify that this documentation was obtained and considered during eligibility determination/re-determination. Consequently, the risk exists that providers receiving Medicaid payments were not eligible to participate in the program and any such payments would be considered unallowable program expenditures.

907 KAR 1:672 states:
Section 2 Enrollment Process for Provider Participation in Medicaid:
(2) To apply for enrollment in the Medicaid Program as a noncredentialed provider, an individual or entity shall:

(a) Complete, and submit to the department, the noncredentialed provider section of a MAP-811, Provider Application; and

(b) Submit of a valid professional license, registration, or certificate that allows the:

1. Individual to provide services within the individual's scope of practice; or

2. Entity to operate or provide services within the entity's scope of practice.

(3) To apply for enrollment in the Medicaid Program as a credentialed provider, an individual shall:

(a) Complete, and submit to the department, the individual provider application section of a MAP-811, Provider Application;

(b) Submit proof of a valid professional license, registration, or certificate that allows the individual to provide services within the individual's scope of practice; and

(c)1. Except for a dentist, submit either:

a. A completed KAPER-1, Kentucky Application for Provider Evaluation and Reevaluation; or

b. Pursuant to 806 KAR 17:480, Section 2(4), the provider application form of the Council for Affordable Quality Healthcare; or

2. If licensed to practice as a dentist, submit a completed Dental Credentialing Form.

(9) Recredentialing. A credentialed provider currently enrolled in the Medicaid Program shall submit to the department's recredentialing process three (3) years from the date of the provider's initial evaluation or last reevaluation.

Section 3. Required Provider Disclosure:

(1) A provider shall comply with the disclosure of information requirements contained in 42 C.F.R. 455.100 through 455.106 and KRS 205.8477.

(2) Time and manner of disclosure. Information disclosed in accordance with 42 C.F.R. 455.100 through 455.106 shall be provided:

(a) Upon application for enrollment;

(b) Annually thereafter; and

(c) Within thirty-five (35) days of a written request by the department or the United States Department of Health and Human Services.

(3) If a provider fails to disclose information required by 42 C.F.R. 455,.100 through 455.106 within thirty-five (35) days of the department's written request, the department shall terminate the provider's participation in the Medicaid Program in accordance with 907 KAR 1:671, Section 6, on the day following the last day for submittal of the required information.

Recommendations

We recommend CHFS:

- Ensure all documentation required to support provider eligibility is obtained and scanned into the OnBase application.
- Establish more formal policies and procedures for the recredentialing of providers to include a more thorough review of provider eligibility documentation.

Management Response and Corrective Action Plan

Recommendation*: Ensure all documentation required to support provider eligibility is updated and scanned into the On-Base system.*

Response*: DMS will ensure that all providers within the system have an end date reflective of their most recent license renewal and also ensure that the Annual Disclosure of Ownership (ADO) process operates more smoothly from a system standpoint. DMS is developing an electronic ADO process to assist in streamlining the process. DMS will be running system reports to identify suspect providers and resolve issues accordingly.*

Recommendation: *Establish more formal policies and procedures for the recredentialing of providers to include a more thorough review of provider eligibility documentation.*

Response*: The Department has a formal process for recredentialinging in place as specified in 907 KAR 1:672. The DMS re-credentialing process consists of verifying licensure (in most instances more than every three years) and verifying sanctions. DMS receives a monthly Medicare Exclusion Database file from CMS and SAM (System for Award Management) to identify if enrolled providers have been sanctioned. This file is compared to the existing providers to identify any providers that may have received a sanction during the prior month. DMS verifies these two elements for re-credentialing because these two elements indicate the greatest risk of impacting provider status. The provider licensure boards verify education and other re-credentialing elements as a condition of licensure; therefore, it is not necessary for DMS to duplicate those efforts. The Department has considered clarifying 907 KAR 1:672 regarding re-credentialing. However, this regulation is currently under review*

Finding 7: The Department For Medicaid Services Does Not Have Adequate Controls In Place To Prevent Ineligible Members From Receiving Targeted Case Management Services

The Kentucky Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) does not have adequate controls in place to prevent ineligible members from receiving Targeted Case Management (TCM) services. While comparing Medicaid member diagnosis information to legal and regulatory guidelines governing TCM the auditor noted two members in a sample of sixty who did not qualify for TCM services. Yet during fiscal year 2012 TCM claims were submitted by providers and successfully processed in the Medicaid Management Information System (MMIS) for these members. This system, MMIS, serves as a control against improper payments but failed in that capacity in these instances. As a result, known questioned costs totaled $557. Additionally, through projecting the error rate from our sample to the entire case management member population, likely questioned costs totaled $701,694.

DMS personnel voluntarily researched these claims after the auditor brought the issue to their attention. Their research confirmed both members were ineligible for TCM services.

The MMIS, a crucial safeguard and control against improper payments, failed to alert DMS staff of a potentially ineligible member receiving benefits. System edits and audits are relied on heavily to ensure the integrity and correctness of claims processed in the MMIS. An error in the design of these edits and audits allowed an improper claim to process.

If system edits and audits are not identifying improper claims, the DMS could be remitting payment for services not covered by Medicaid and not allowable under federal guidelines. Preventing improper payments is much more cost effective than attempting to recover improper payments already remitted; a necessary step if the control system is not functioning correctly. If an opportunity exists due to an inadequacy in the MMIS, providers could abuse or defraud the Medicaid program by knowingly providing services to ineligible members.

907 KAR 1:550. Incorporation by reference of the Targeted Case Management Services Audits Manual.

Section 1."Incorporation by Reference. The cabinet incorporates by reference the Targeted Case Management Services Adults Manual revised September 1, 1992 used in the implementation of this component of the Kentucky Medicaid Program. This manual contains the policies and procedures issued by the cabinet for the implementation of this program element including benefit descriptions and operating instructions used by agency staff and participating providers."

Per DMS Targeted Case Management Services Adult Manual, Section III, Part D Client Qualifications,

> "Targeted case management services for adults with chronic mental illness shall be limited to Medicaid-eligible adults age 18 and over who meet the following criteria:
>
> 1) As defined in KRS 210.005, "chronic" (mental illness) means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently and significantly impaired in his ability to function socially or occupationally or both; and
> 2) Have a diagnosis of a major mental disorder (other than substance abuse or mental retardation as the sole diagnosis) as included in the DSM-IIIR classification under Schizophrenic Disorder, Psychotic Disorders, Mood Disorder, Organic Mental Disorders or Delusional (paranoid) Disorders. Personality disorders shall be considered only when information and history depict that the individual exhibits persistent disability and significant impairment in major areas of community living.

Good internal controls dictate a central level review of the processing should be in place to ensure proper system edits and audits are in effect to be assured proper claim payments are made.

Recommendations

We recommend MMIS edits and audits related to TCM services be reevaluated and redesigned by DMS staff in order to prevent future improper payments. Also, the eligibility determination and redetermination process for case management services should be examined and redesigned in order to avoid current and future improper payments.

Management Response and Corrective Action Plan

The Department for Medicaid Services (DMS) appreciates the due diligence by the auditors in bringing this issue to our attention. DMS reviewed the documentation related to the two (2) members that received benefits through the Behavioral Health Targeted Case Management (TCM) program and determined that the provider failed to document that the two met the diagnostic criteria for the program. In reviewing earlier documentation, it appears that one member would likely have been eligible under program criteria had the appropriate documentation been provided; the other individual did not meet program criteria. DMS will draft a letter to the two (2) provider agencies responsible for the improper billing requesting they submit a plan of correction. Date of completion is 4/22/2013.

The MMIS edits and audits related to TCM services have been reevaluated and found to be working as designed; however, DMS has determined there is a need for further redesign of some of the edits and audits in order to improve provider coding and avoid similar issues in the future. DMS is working with MMIS staff at Hewlett Packard (HP) to on redesign the TCM program audits and edits to include ICD-9 diagnosis codes and age restrictions. DMS is confident these measures will decrease or eliminate such occurrences in the future. Projected date of completion is 4/22/2013.

During next and all future quarterly TCM provider training sessions DMS will ensure provider agencies receive in-depth training regarding the eligibility determination and redetermination process for case management services as defined in KAR1:515 and KAR1:525. Date of completion is 4/22/2013.

Finding 8: The Department For Medicaid Services Is Not Sufficiently Monitoring Drug Rebates

The Kentucky Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) is not sufficiently monitoring Drug Rebates. Pharmaceutical companies are not remitting their drug rebate payments to CHFS within the federally mandated time frame.

In a sample of ten pharmaceutical companies, two remitted payments had not been made at all and two remitted payments were made months after the allowable deadline. We also noted where two remitted payments were made two weeks after the deadline. These two were not deemed significant due to the possibly of a deposit in transit issue; however, these deposits did exceed the deadline. If the companies do not remit payment before the deadline the companies are required to provide CHFS with a written explanation of their dispute with the invoice. A written explanation was not on file for any of the missing or significant late payments.

An oversight on the part of the pharmaceutical companies resulted in late payments. If payments are not made in a timely manner, and especially if payments are never made, the Commonwealth is not receiving funds to which they are entitled by law. If invoice disputes are not reported to the Commonwealth, accounts receivable balances could be overstated due to uncollectible amounts being reported as collectible by CHFS. This would distort the Cabinet's financial reports; compromising both internal decision making and external assessment.

The Social Security Act Section 1927(b)(1)(A) states: "A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this title, a rebate for a rebate period in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs."

Recommendations

We recommend CHFS and their third party Pharmacy Benefits Administrator Magellan inform the pharmaceutical companies of the legal definition of rebate payment timeliness and the potential penalties for non-compliance.

Management's Response and Corrective Action Plan

The Department for Medicaid Services (DMS) agrees with the auditor's recommendation that CHFS and the third party Pharmacy Benefits Administrator (PBA) that pharmaceutical companies should be advised of the legal definition of rebate payment timeliness and the potential penalties for non-compliance. Accordingly, the PBA currently mails a cover letter along with the quarterly invoice to the Labeler (pharmaceutical company). The cover letter states that "The rebate is to be paid to the State within 38 days from receipt of the postmark indicated on the envelope to avoid interest charges". The Summary Page consists of the quarterly invoice list, in addition to the Current Quarter Balance, the Prior Period Balance due and the Interest Balance due. The quarterly invoice Summary Page also addresses the manufacturer's responsibility for calculating and paying interest on all outstanding balances not postmarked within 38 days from the invoice mailing postmark date. The PBA will continue to notify the labeler each quarter of the timeline and, if applicable, the prior period and interest balance due.

DMS will schedule quarterly conference calls with the PBA to discuss pharmacy compliance with rebate requirements and will work in conjunction with the PBA to effectively monitor and follow up on any outstanding drug rebate issues. Conference calls will be scheduled in May, August, November, and February.

Finding 9: The Cabinet For Health and Family Services, And Relevant Third Parties, Are Not Performing Desk

The Cabinet for Health and Family Services (CHFS), and relevant third parties, are not performing desk reviews on Inpatient Hospital and Long-term Care cost reports in a timely manner. Cost reports are completed by the Hospital or Long-term Care Facility or an accounting firm contracted by the Hospital and Long-term Care Facility and is vital to the settlement

Reviews On Inpatient Hospital And Long-Term Care Cost Reports In A Timely Manner

of funds between the facilities and the Department of Medicaid Services (DMS). The desk reviews of the cost reports include checking for mathematical accuracy and other procedures to determine the sufficiency of the settlement amount.

We tested a sample of 15 Hospitals and 15 Long Term Care Facilities to ensure the cost reports were completed and desk reviews were performed as required. Our testing reflected the audits of all 15 Hospital cost reports have not been completed. And the desk audits have not been performed on 7 of the 15 Long Term Care Facilities selected for testing.

In addition, cost reports are required to be submitted to DMS within five (5) months after the close of the Hospital's fiscal year. DMS extended the cost report submission period for ten of the fifteen Inpatient Hospitals tested. The extension was given for an additional three months for all Hospitals due to the Managed Care Organization (MCO) implementation. According to State regulation a 30 day extension may be granted if a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence). The circumstances for submitting and extension surrounding the MCO implementation are not compatible with current State regulation.

DMS relies on the Centers for Medicare and Medicaid Services (CMS) to provide for the audits of the hospitals. Currently these audits are being held by CMS pending review at the Federal level. Until the audits are released DMS will rely on unaudited cost reports.

If desk reviews are not performed on cost reports timely, improper provider accounting or practices could go unnoticed and if not corrected could lead to skewed reporting, poor service to members, or incorrect Medicaid settlement amounts between CHFS and the providers. While the MCO implementation was an arduous process for all involved, allowing providers an extension for non-catastrophic events - as provided for in the KAR - could set a precedent providers could use to request additional extensions. Given the current backlog of cost reports, further delays in cost report submission could worsen the situation.

42 CFR 455.253(g) Audit requirements states, "The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers."

907 KAR 10:015 Section 6(a)2 states: "A cost report shall be submitted within five (5) months after the close of the hospital's fiscal year."

907 KAR 10:015 Section 6 (b)1&2 states:

1) "The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare, it shall simultaneously submit a copy of the cost report to the department.
2) If a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence), the department shall grant a thirty (30) day extension."

Recommendation

We recommend CHFS, and relevant third parties, continue to diligently work through the backlog of cost reports with the goal of completely eliminating the backlog and perform desk reviews for Inpatient Hospital and Long-term Care Facilities in a timely manner.

We also recommend, if circumstances so warrant, that extensions granted to providers are in accordance with the definition in current State regulation.

Management's Response and Corrective Action Plan:

Condition Clarifications:

- *The auditor noted in the Condition section that the Long-term Care cost reports completed are "vital to the settlement of funds between the facilities and the Department…" Long-term Care cost reports for Skilled Nursing Facility providers (14 of the 15 facilities selected in the LTC sample) are utilized for informational and analytical purposes for the year in review (2011 cost reports). These files do not include any settlement of funds between the cabinet and the providers and have no impact on Long-term Care reimbursement given the rates are established prices.*
- *The auditor references the term "Inpatient" related to hospital cost reporting. The inpatient portion of the submitted cost report is reviewed for informational purposes only for Acute Care or Critical Access facilities, not reimbursement purposes only the "Outpatient" portion of the cost report is reviewed for reimbursement purpose.*
- *Of the 7 Long Term Care files noted as being open, 4 have been mailed*
- *Of the 15 Inpatient files noted as being open, 1 has been mailed.*

The auditor noted that DMS granted cost report extensions for 10 of the 15 sampled providers. DMS did not grant an extension for the Medicaid cost report or Medicaid supplemental schedule filing, which is regulated in 907 KAR 10:015. Rather, DMS granted an extension for the provider

to file supplemental MCO schedules to be used by DMS for informational purposes only. Please note it requires the provider to submit the cost report timely, and allows an extension for the MCO schedules only.

Outpatient Hospital
The Department's outpatient reimbursement methodology was changed effective January 5, 2009. This change request was timely submitted to the Centers for Medicare and Medicaid Services (CMS); however, CMS approval was not granted until in October 2011. This two year period created a delay and subsequent backlog for the Department's processing.

The Department understands the regulation allows for an extension only for a catastrophic event or a Medicare granted extension. The Department did not grant providers an extension for filing Medicaid cost report or schedules; the Department granted an extension related to supplemental MCO schedules the Department had requested for informational purposes. Due to the implementation of managed care, providers were unable to obtain needed information from the MCOs in time to submit the data with their cost report filings. As a result, DMS allowed providers to submit their cost reports without such data and permitted providers to submit the additional information based on the extended timeframe. Therefore, the Department deemed it appropriate and reasonable to grant extensions related to these supplemental schedules. The Department believes the extension given for the supplemental informational schedules is appropriate and does conflict with administrative regulation 907 KAR 10:015.

Long Term Care
As noted above, long term care cost reports are reviewed for informational and analytical purposes for the 2011 cost reporting period. As noted in the administrative regulation, the rebasing year's cost reports are utilized for prospective rate setting. Also noted above, 4 files noted by the auditor as being open have been finalized and are considered closed.

One of the sampled long term care files is for an Intermediate Care Facility for Mental Retardation (ICF/MR). In order to process this file, a paid claims listing with a run date of at least 14 months after the provider fiscal year end is needed. Therefore, for the file selected (Wendell Foster), the needed paid claims listing became available in January of 2013. This file, along with other ICF/MR 2011 files, is in the review process and is consistent with timely processing based on the established procedures for this provider type.

With regard to Outpatient Hospital:

- *Hospital fiscal year 2011 settlements will be completed and mailed within the next 4 months*
- *The Department will continue to require hospitals to submit the Medicaid cost report and Medicaid supplemental schedules not impacted by MCO information to DMS within the regulation deadline.*

With regard to Long Term Care:

- *The remaining 2011 skilled nursing facility cost report reviews will be completed and mailed by the end of March 2013.*
- *The 2011 ICF/MR files are currently in the desk review process and anticipated to be completed by the end of May 2013.*

Auditor Reply

The cost settlement implications noted in the finding were included by the auditor as an additional consequence of cost reports not being received timely. The potential impairments to the administration of the Medicaid program caused by the untimely receipt of cost reports, regardless of the provider type, is a liability. Even in cases where payment rates are determined independently of the cost reports this information, as noted by DMS, is used for analytical and informational purposes.

DMS responded that five of the sample items have been mailed. Although this indicates the cost reports are proceeding through the desk review/audit process the auditor did not consider them finalized based on reviewing tracking documentation maintained by DMS and inquiry during testing. In addition, the auditor was not made aware that DMS considered 4 of the files finalized and closed until the management response. Documentation provided to the auditor during the audit period indicated closure letters had not been sent to the LTC providers included in the finding.

Although DMS required providers to submit their cost reports within the legally acceptable timeframe these submissions were incomplete. Given the importance and relevance of data related to claims adjudication between the providers and MCOs these schedules are essential in assessing the status of managed care in Kentucky. If the issue was an inability on the part of the MCOs to supply information timely, as indicated in DMS's response, the threat of establishing a harmful precedent for reporting extensions still applies.

We do appreciate DMS providing clarification regarding the utilization of Long-term Care cost reports. In future audit periods we will take into account the varying reporting periods for provider types such as ICF/MR. The auditor was not made aware of this distinction during the audit despite inquiring about missing or late cost reports.

Finding 10: The Cabinet For Health And Family Services Did Not Have An Adequate Process For Refunding Escheated Checks

During the FY 2012 audit of the Cabinet for Health and Family Services (CHFS), the treatment of uncashed (escheated) checks was reviewed to determine compliance with applicable Federal laws. Escheated checks are checks issued to Medicaid providers which remain uncashed after one year from the date of issue. At the end of this time period, the checks are deemed unallowable program expenditures and the funds are returned to the Commonwealth within 180 days.

Expenditures made by the Medicaid program are subject to Federal Financial Participation (FFP) in which the Federal government pays for a portion of the expenditure. To refund the amount of FFP received for escheated checks, CHFS adjusts the amount of money drawn down from the Federal government for the Medicaid program. The adjustment amount is calculated by applying the Federal Medical Assistance Percentage (FMAP) applicable for the period in which the check is issued to the check amount to determine the portion due back to the Federal government.

Supporting documentation reviewed during testing confirmed the refund of FFP for checks escheated during FY 2012 was not made until January 2013 which exceeds the 180 day requirement. Furthermore, CHFS was required to report the refund on the CMS-64 Quarterly Statement of Expenditures for the Medical Assistance Program. This report was not updated during FY 2012 to reflect the checks which had been escheated.

Further testing of the FMAPs used in calculating the refund also showed an incorrect FMAP was used for one quarter covered in the escheated checks transaction. It was noted CHFS applied an incorrect FMAP for American Recovery and Reinvestment Act (ARRA) portion of federal funds. The difference was not material and CHFS stated a correction would be made by the Finance and Administration Cabinet.

The procedure for the treatment of escheated checks was not developed until FY 2012 including the refunding of FFP. The lack of procedures established for handling escheated checks resulted in CHFS not being in compliance with Federal regulation for allowable cost in regards to uncashed checks. CHFS did not refund the federal government at the time the checks were escheated creating a risk for overstating FFP. In addition, the CMS-64 report was not updated to properly report refunds to the federal government, resulting in an overstatement on the CMS-64 for the quarters in which escheated checks were issued. Furthermore, when escheated checks are not handled in a timely manner a risk of improper refunds is created. An incorrect FMAP used in determining the amount to be refunded to Federal government caused an incorrect amount of FFP to be refunded to the Federal government.

42 CFR §433.40 (c)(1) states "If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received."

42 CFR §433.40 (c) (2) states "The State agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter."

Recommendations

We recommend that CHFS:

- Strengthen policies and procedures to ensure the timely refunding of all FFP received for escheated checks to the Federal government.
- Comply with reporting requirement on the CMS-64 to ensure refunds are properly reported.
- Ensure that the proper FMAP is being used when calculating the amount of FFP to refund to the Federal government.

Management's Response and Corrective Action Plan

The Division of General Accounting (DGA) has developed procedures for the Escheated Check process. The procedures were developed after the completion of this audit. However, during the process of developing these procedures, DGA determined that no refund is due the federal government with regard to escheated checks. These checks were never included in the Medicaid daily draw. DGA receives a daily report from Chase bank which indicates all checks that cleared the bank the previous day. The cash draw is based on this report. Since these checks never cleared the bank and were not included in the daily draw, no refund is necessary.

DGA does agree the amount of Escheated Checks based on a 180 day turnaround has to be reported on the CMS 64 Report. DGA met with the Medicaid Federal Liaison and discussed how to report this information accurately. In addition, DGA is working with the Office of the Controller to obtain a report that lists the Medicaid escheated checks for each quarterly report based on the 180 day turnaround. DGA will be performing prior period adjustments on future CMS 64 reports to reflect escheated checks for prior years and the current year.

Finding 11: The Cabinet For Health And Family Services Did Not Maintain Third Party Liability Information In The Medicaid Management Information System

During the FY12 audit of the Cabinet for Health and Family Services (CHFS), the third party liability (TPL) system was tested to ensure effective identification techniques for third parties which have the legal obligation of payment for medical services provided to Medicaid members were being utilized.

Effective identification of third parties includes the collection and storage of TPL information in the Medicaid Management Information System (MMIS). An information collection function performed through utilization of the MMIS is the generation of questionnaires which are mailed to Medicaid members requesting TPL information be provided

During testing of member questionnaires, an exception was noted in which one questionnaire was not available for review in the MMIS OnBase imaging application. Upon further investigation, it was discovered by the Medicaid fiscal agent HP Enterprise Services (HP) that the MMIS was not storing a copy of all mailed questionnaires. It was also discovered that the MMIS was not updating the member letter history panel within the MMIS with information related to questionnaires mailed to members. CHFS was unable to provide any documentation for this questionnaire because paper copies of the questionnaires are not maintained.

It is noted that upon discovery of these technical issues within the MMIS, HP has initiated procedures to implement corrective actions to address these technical issues.

Defects in the MMIS interrupted the transfer of TPL member questionnaires to the OnBase imaging application and the updating of the member letter history panel to accurately reflect all questionnaires mailed to the member.

Reasonable assurance cannot be attained by auditors that questionnaires are being generated and sent to members to obtain TPL information. Images and records of the questionnaires mailed to members are not being maintained within the MMIS.

Without proper reliance on the MMIS that questionnaires are generated and mailed to members, the risk that claims could be paid by Medicaid instead of a responsible third party, such as private health or accident insurers, is present. Moreover, due to its crucial nature in regards to program functionality, undetected technical issues within the MMIS could threaten program integrity and operations

42 CFR §433.138 (a) states "The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan."

Recommendations

We recommend that CHFS:

- Test all MMIS applications, specifically TPL operations, for proper functionality.
- Perform periodic checks in the MMIS OnBase system to ensure questionnaires for TPL information are maintained.
- Ensure that all TPL information is accurately reflected in the MMIS to prevent payment of claims which are the responsibility of liable third parties.

Management's Response and Corrective Action Plan

The Department for Medicaid Services agrees with the finding that the questionnaire was not posted correctly in On Base. Upon analysis, a defect was discovered that when the HP third party liability worker input the request for a manual questionnaire, the request did not post to On Base or to the Questionnaire History Panel.

The defect is being worked by the MMIS vendor and will be scheduled for implementation as soon as possible.

Finding 12: The Cabinet For Health And Family Services Did Not Properly Follow Up On All Preliminary Investigations To Ensure That Appropriate And Recommended Administrative Action Occurred

The Kentucky Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) are in agreement with the CHFS Office of the Inspector General (OIG) to conduct the preliminary investigations of fraud and abuse in relation to Medicaid. During the FY 2012 audit of CHFS the procedures for OIG and DMS investigations were reviewed for internal controls and for compliance with federal requirements. CHFS DMS Division of Program Integrity (Program Integrity) is not properly following up on referrals from OIG, and OIG is referring cases without performing any follow-up procedures.

Thirty complaint cases investigated by the CHFS OIG Preliminary Investigations Branch for FY 2012 were reviewed. Each case was evaluated to determine if CHFS OIG had established and implemented procedures to identify and investigate fraud cases. If a case is not fraudulent, but an administrative action such as a collection of monies or policy recommendation for provider education was necessary the case was referred by OIG to Program Integrity. Two cases reviewed had been referred by OIG to Program Integrity for administrative action; however, Program Integrity did not properly follow up on these cases and no administrative action was taken.

CHFS does not have a written procedure for the referral of complaint cases between OIG and Program Integrity. A lack of written policies creates a risk of improper referrals to Program Integrity which can result in cases not being investigated.

42 CFR 455.14 states, "If the agency receives a compliant of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation."

Per the agreement between DMS and OIG, "WHEREAS the Department has delegated to the OIG the exclusive authority to conduct its preliminary investigations in accordance with 42 CFR 455.14, and the authority to conduct investigations of the Medicaid program for the purpose of detecting, preventing, and substantiating fraud and abuse in accordance with the authority contained in KRS 194A.030(5) and KRS 205."

Good internal controls dictate that all cases investigated by OIG and then referred to DMS should be followed up on accordingly.

Recommendations

We recommend:

- Program Integrity and OIG develop a written policy for referring cases to identify responsibilities between the two divisions.
- Program Integrity ensure all administrative actions requested from OIG are investigated.
- OIG implement procedures to track all referrals to Program Integrity ensure proper action is performed.
- OIG apply follow up procedures to ensure all referrals within CHFS are properly investigated

Management's Response and Correction Action Plan

The Department for Medicaid Services (DMS) and the Office of Inspector General (OIG) are committed to addressing these discrepancies and have scheduled meetings for both agencies to refine and improve the referral process to address all issues.

Program Integrity and OIG will meet to refine the process for referring cases between the two divisions. Program Integrity will review the procedures contained within the program integrity manual and determine if updates are required. The target date for DMS completion of the review of the program integrity manual is April 30, 2013. These procedures will be reviewed with the OIG.

Additionally, Program Integrity will update its process for ensuring that cases from OIG are reviewed for accuracy and appropriate administrative action. The target date for DMS completing the process update is May 30, 2013.

OIG and DMS will work together to improve the process to track all referrals to Program Integrity using OIG tracking database to ensure that all cases are tracked from inception to completion. Program Integrity will work with the OIG to refine procedures to ensure all referrals within Medicaid are properly investigated. Target date for completion of the review and any process changes is May 30, 2013.

- *Eight out of the nine expenditures related to non-emergency medical transportation was not procured using the proper Cited Authority.*

Response: CHFS discovered an incorrect cited authority was used in FY 2012 and corrected the cited authority for all FY 2013 payments. In addition, in October 2012 the Division of General Accounting moved these payments from the Grants Branch to the Payables Branch to ensure proper cited authority is always selected. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

- *Five requests for wire transfers related to the Medicaid managed care organization payments were missing authorization signatures.*

Response: The lack of authorized signatures on the SAS 62 form was an oversight and will be reviewed closely in the future. It is noted that these wire transfers were approved electronically in eMARS by CHFS. As indicated above, in October 2012, responsibility for these payments was moved from the Grants Branch to the Payables Branch to ensure a more detailed document review. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

- *One request for a wire transfer related to Medicaid pharmacy benefits was missing an authorization signature.*

Response: The lack of authorized signatures on the SAS 62 form was an oversight and will be reviewed closely in the future. It is noted that this wire transfer was approved electronically in eMARS by CHFS. In October 2012, responsibility for these payments was moved from the Grants Branch to the Payables Branch to ensure a more detailed document review. The standard procedures utilized within this organizational unit are designed to ensure the requested controls are exercised on all payment transactions.

Management's Response and Corrective Action Plan (Department for Public Health):

The Department for Public Health agrees with the finding. The 2012 invoice form has been updated to ensure all supporting documentation is attached to the invoice. The Point of Entry contractors are now required to submit the documentation of expenditures with the billing each month. Additionally each Point of Entry has a formal, independent financial audit done annually that we can review.

Finding 13: The Cabinet For Health And Family Services Did Not Recertify Long Term Care Facilities Within The Regulatory Limit

The Cabinet for Health and Family Services (CHFS) performs a vital regulatory function in overseeing the activities of the facilities that serve our most vulnerable citizens. During the audit of CHFS the auditor noted two Long Term Care (LTC) facilities had not been recertified by CHFS within the allowable time frame. Although evidence of recertification and follow up on prior site visit findings was provided to the auditor upon request, the recertification occurred beyond the regulatory limit of 15 months from the previous site visit.

An oversight on the part of CHFS led to these facilities not having site visits within the allowable time frame. If CHFS does not certify that facilities serving Medicaid members meet nationally accepted provider health and safety standards a risk of litigation and, most importantly, poor member quality of life exists.

KRS 216.530 Section (1) states: "… Except for complaint investigations, inspections shall be performed no later than seven (7) to fifteen (15) months after the previous inspection."

Recommendations

We recommend CHFS improve their internal procedures to better track and monitor the expired time between site visits to ensure that all LTC facilities are inspected within the allowable time frame.

Management's Response and Corrective Action Plan

The OIG concurs with the finding by the APA that 2 long-term care facilities were not recertified by the Cabinet for Health and Family Services (CHFS) within the allowable time frame, beyond the regulatory limit of 15 months from the previous inspection.

The two long-term care facilities that were not surveyed within the regulatory limits were both located in the Western Enforcement Branch

Action Plan:

- *November 1, 2012, the Western Enforcement Branch hired new leadership, known as the Regional Program Manager (RPM).*
- *February 19, 2013, KRS 216.530 Section (1) was reviewed with the Office of Inspector General's (OIG) four RPMs during a meeting. Emphasis was placed on the significance of ensuring long-term care facilities are inspected timely.*
- *February 19, 2013 was the first of weekly meetings/calls to review data/reports to ensure compliance with KRS 216.530 Section (1). The Director of the Division of Health Care, the Division's Assistant Directors, and a Resource Management Analyst will be attending these meetings.*
- *A tracking system has been developed to monitor and ensure compliance with KRS 216.530 Section (1).*
- *February 19, 2013, training held with all appropriate staff on the new tracking system with accountability measures outlined.*
- *March 1, 2013 is the date in which the tracking system will be deployed to the regions for use.*
- *Once in place, the tracking system will be monitored by the RPMs weekly to ensure timely scheduling of surveys.*
- *The Division of Health Care's Assistant Directors will monitor the tracking system monthly for adherence to KRS 216.530 Section(1). Any concerns noted will be reported to the Division Director.*
- *The Inspector General and the Director of the Division of Health Care shall be responsible for ensuring appropriate corrective actions are followed and adherence to KRS 216.530 Section (1) is met.*