



Issued 2012

**OFFICE OF THE INSPECTOR GENERAL
2011 ANNUAL REPORT**

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LETTER FROM THE OFFICE OF INSPECTOR GENERAL

March 2012

Dear Reader:

We are pleased to issue the annual report of the Kansas Department of Health and Environment (KDHE) Office of Inspector General (OIG) for Calendar Year 2011. This report is issued pursuant to the requirements of K.S.A. 75-7427 and is respectfully submitted to:

- The people of the State of Kansas
- The Governor of the State of Kansas, the Honorable Sam Brownback
- Honorable members of the Kansas Senate's Committee on Ways and Means
- Honorable members of the Kansas House of Representatives' Committee on Appropriations
- Honorable members of the Kansas Legislature's Joint Committee on Health Policy Oversight
- The Secretary of the Kansas Department of Health and Environment, Dr. Robert Moser, M.D.
- Director of the Division of Health Care Finance, Ms. Kari Bruffett
- The Legislative Post Auditor, Mr. Scott Frank
- The Audit Committee for the KDHE Division of Health Care Finance Office of Inspector General

This report provides an overview of the KDHE OIG and describes the OIG's accomplishments in calendar year 2011. It also provides general statistics on provider billing, payments and sanctions submitted to the OIG by the Kansas Department on Aging, Kansas Social and Rehabilitation Services, and the KDHE Division of Health Care Finance and has been reviewed by the OIG Audit Committee.

We hope this report provides you with valuable information and we welcome any questions or comments you may have regarding the report contents or our operations. Please feel free to contact us at OIG@kdheks.gov or (785) 296-1076.

Sincerely,

Stephen Mhere, MBA, CISA, CIA
Auditor, KDHE OIG

Kim Epps
Program Specialist, KDHE OIG

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INTRODUCTION TO THE OFFICE OF INSPECTOR GENERAL

During the 2007 Legislative Session, the Kansas Legislature created an Office of Inspector General (OIG) within the Kansas Health Policy Authority (KHPA) with the responsibility to audit programs under Medicaid, State Children's Health Insurance Plan, the State Employee Health Benefit Plan and the State Self-Insurance Workers Compensation. On February 4, 2011, Executive Reorganization Order 38 was issued to abolish KHPA and create the Division of Health Care Finance (DHCF) within the Kansas Department of Health and Environment (KDHE). All the statutory obligations of KHPA were transferred to DHCF in that reorganization.

The KDHE OIG's enabling statute is K.S.A. 75-7427. The OIG's mission is to:

- Provide increased accountability and integrity in DHCF programs and operations.
- Help improve DHCF programs and operations.
- Identify and deter fraud, waste, abuse and illegal acts in the State Medicaid Program, the MediKan Program and the State Children's Health Insurance Program.

To fulfill its mission, the KDHE OIG conducts:

- Audits of DHCF programs, contractors, vendors and health care providers.
- Investigations of fraud, waste, abuse, and illegal acts by DHCF or its agents, employees, vendors, contractors, consumers, clients, health care providers or other providers.
- Reviews, inspections, or evaluations.

Audits are formal evaluations of an organization, its systems, processes, projects or products. Performance audits examine the effectiveness or efficiency of a program or operation. The overarching goal of all OIG audits is to review the quality of DHCF programs and processes and recommend policies which enhance the prevention and detection of fraud, waste and abuse. The OIG conducts its audits in a manner consistent with generally accepted government auditing standards developed by the U.S. Government Accountability Office (GAO). OIG audit topics are identified through periodic risk assessments, suggestions by DHCF and KDHE management, suggestions from members of the Legislature, or from OIG audit staff.

Investigations attempt to determine the validity or extent of reported allegations/incidents, the amount of loss, and what weaknesses may have existed that led to the allegations/incidents. Investigative reports may make corrective action recommendations intended to avoid similar problems in the future. The OIG conducts investigations that are consistent with the principles and quality standards set out for investigations by the Association of Inspectors General. Topics for OIG investigations are identified by audit work performed by OIG staff as well as referrals from DHCF staff, legislators and the general public. The results of investigations are reported to

DHCF and KDHE management and are referred, if necessary, to the Medicaid Fraud Control Unit (MFCU), a division of the Kansas Attorney General's Office, for further investigation or prosecution.

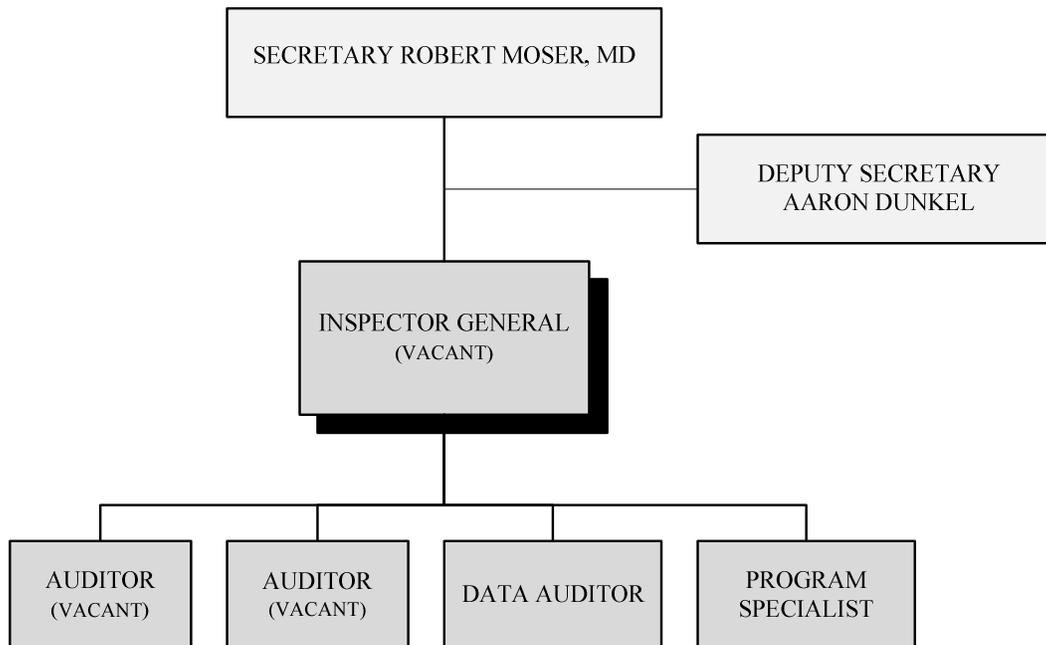
Reviews are inquiries into a specific programmatic aspect of DHCF's operations. Reviews may attempt to determine many issues, such as whether a component of the program is effective and efficient or whether the program component has good strategies to safeguard the appropriate use of state funds. Like investigations, the OIG will conduct reviews which are consistent with the principles and quality standards set out for inspections, evaluations and reviews by the Association of Inspectors General.

The results of all audits are presented in formal, written audit reports. Members of the Kansas Legislature, the public and other interested parties may access audit reports, annual reports and other information on our website at <http://www.kdheks.gov/hcf/oig/>.

Members of the public who suspect fraud, waste or abuse in the State Medicaid Program, MediKan or the State Children's Health Insurance Program are encouraged to email their concerns to the OIG at OIG@kdheks.gov or call 785-296-1076.

As required by K.S.A. 75-7427, the KDHE OIG will report findings of fraud, waste, abuse or illegal acts to KDHE and also refer those findings to the Attorney General via the Medicaid Fraud Control Unit (MFCU).

ORGANIZATIONAL STRUCTURE



OFFICE OF INSPECTOR GENERAL STAFF

A fully staffed Office of Inspector General would have five full-time equivalent positions: One inspector general, one program specialist and three auditors, one of whom is a data auditor. However, the position of Inspector General is currently vacant. The former incumbent, Nick Kramer, resigned effective June 10, 2011. Two auditor positions are currently vacant as well. The office is therefore currently operating with one auditor and one program specialist.

The OIG's current auditor, Stephen Mhere, joined the OIG as a Data Auditor in 2008 after serving as a Management Systems Analyst for the Kansas Department of Revenue. He received a Master of Business Administration from Baker College in Michigan. He holds the Certified Internal Auditor (CIA) credential from the Institute of Internal Auditors (IIA) as well as the Certified Information Systems Auditor (CISA) certification from the Information Systems Audit and Control Association (ISACA).

Kimberly Epps is the Program Specialist. She served at the Kansas Division of Emergency Management before joining the OIG in 2008. She attended William Jewell College in Liberty, Missouri.

CALENDAR YEAR 2011 ACTIVITIES AND ACCOMPLISHMENTS

Notwithstanding the staffing shortages being experienced at the moment, the OIG looks forward to continuing its service to the citizens of the State of Kansas and fulfilling the mission of providing increased accountability and integrity in DHCF programs and operations. The goal continues to be helping to improve DHCF programs and operations, and identifying and deterring fraud, waste and abuse in the state Medicaid program, MediKan and the State Children's Health Insurance Program.

The KDHE OIG conducts audits listed on its annual audit plan. The audit plan is established by the OIG and reviewed by the Audit Committee. The audits performed in 2011 were in the audit plan reviewed by the Finance and Audit committee of the now-defunct Kansas Health Policy Authority. The OIG conducts investigations and limited scope reviews based on complaints received from the public, referrals from legislators, and issues identified by DHCF management and OIG staff. During 2011, the OIG completed the audits described below.

AUDITS

I. Performance Audit of KHPA's Medicaid Provider Enrollment and Terminations

The Federal government has instituted a system of procedural requirements designed to protect the integrity of the Medicaid program by implementing federal exclusion databases, namely the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). The U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) maintains the LEIE. The General Services Administration (GSA) maintains the EPLS. These databases contain information about individuals and entities that are prohibited from participating in federally-funded health care programs for reasons such as failure to comply with health care program requirements or convictions for committing healthcare-related fraud. State health care agencies are required to terminate any excluded individual or entity that may already be enrolled in Medicaid and to deny those attempting to enroll.

The audit sought to answer the following questions with regard to KHPA's administration of these requirements:

- Does KHPA, upon receiving official notification of a provider's exclusion, terminate the excluded provider from participation in Kansas Medicaid?
- Do KHPA's existing controls prevent excluded providers from enrolling in Kansas Medicaid?
- Do KHPA's existing controls prevent payment to excluded providers for any services

they rendered after the termination date?

- Do KHPA's existing controls prevent payment for services rendered by excluded individuals?

The audit findings and observations were as follows:

- KHPA terminates all KMAP-enrolled excluded providers upon notification of exclusion from Centers for Medicare and Medicaid Services (CMS), as required by law.
- KHPA has been effective in preventing excluded providers from enrolling in KMAP. However, enrollment documentation shows that despite not supplying their social security numbers (SSNs) on the application forms, some applicants were still approved as providers. Providers' exclusion status can be verified on either the LEIE or EPLS databases by using both name and SSN, and KHPA could strengthen this control by requiring the SSN as a prerequisite for any provider application to be processed.
- KHPA's system of controls appears to be effective against excluded billing providers. The OIG did not find any payments KHPA made to excluded Medicaid *billing* providers for the period beginning July 1, 1999 through June 30, 2010.
- KHPA's system of controls has not been as effective against non-billing excluded providers. Payments were made to several billing entities which, although they themselves were not on any of the exclusion lists, they utilized excluded providers to furnish services for which they billed. These inappropriate payments, totaling more than \$4 million, were made between 2001 and 2009. Details of these payments were passed on to KHPA management for possible recoupment action.

Federal law stipulates the following:

- No payment shall be made for services furnished, ordered, or prescribed by an excluded individual or business entity, and
- No payment shall be made to an entity that employs an excluded individual, even if the individual only provides administrative or management services.

KHPA should emphasize to provider organizations the risk of employing or utilizing the services of excluded individuals.

The Provider Enrollment and Terminations audit was issued with the following four recommendations and responses (italicized) from management:

1. KHPA program officials should ensure the KMAP enrollment applications include all federally-required information and should reject incomplete applications, such as those that do not provide the social security number of applicants, e.g. each individual in a group practice, and the taxpayer identification number of the provider organization.

KHPA agrees with the recommendation and has begun the process of requiring this information. This was previously identified in the June, 2010, draft of the U.S. Department of Health and Human Services Medicaid Integrity Group Program Integrity review (MIG PI). The MIG PI review recommended collection of the social security numbers and dates of birth for all persons with a controlling interest in the provider and for all managing employees. Additionally, the Affordable Care Act (ACA) requires collection of social security numbers and dates of birth. KHPA has updated the Disclosure of Ownership and Control Interest Statement and provider agreement to meet all the recommendations and requirements identified in the MIG PI review, items identified in a Best Practices In Provider Disclosures document released by CMS in August, 2010, as well as the new requirements established by the ACA. These will be implemented beginning in March, 2011.

Although this information was not a conditional requirement for enrollment for the time period of the review, the application asked for the information. Many applicants provided the information which was captured and stored with the provider's records.

2. KHPA program officials should review, modify and apply edits and other program controls to deny or suspend claims for services provided by non-billing excluded providers.

KHPA agrees with this recommendation. The system edit was not working as expected when the claims for provider "A" were submitted and claims were paid in error. The edit was corrected on 12/1/2005 and is posting as expected.

Provider "B" was inactivated due to no claim activity prior to being excluded; therefore, the editing for federal program exclusion would not have been applicable. At the time the claims were processed, prescribing providers were not required to be enrolled as Medicaid providers. While this will change with the implementation of the ACA, this requirement was not in place at the time the claims were processed.

The ACA requires "rendering, ordering and referring physicians and other professionals" to be enrolled with Medicaid. This recommendation will be resolved with the implementation of the ACA regulations.

3. KHPA management should review all payments to businesses that may have utilized the services of excluded individuals and should seek recoupment if warranted.

KHPA agrees with the recommendation. This activity will take place as part of the implementation on the Recovery Audit Contractor initiative.

4. KHPA program officials should improve applicable provider manuals by including specific instructions to providers to check the exclusion lists before utilizing the services of any individual or entity, and by clearly stating that reimbursement cannot be claimed for services provided by excluded individuals.

KHPA agrees with this recommendation and has begun taking steps to determine the most appropriate way to ensure providers are aware of their program integrity obligations and the potential consequences for being non-compliant with federal and state program integrity regulations.

The Office of Inspector General released this audit report in April 2011. The complete audit report, including management's response, can be accessed on the KDHE OIG's website at <http://www.kdheks.gov/hcf/oig/default.htm>.

II. Performance Audit of DHCF's Oversight of Medicaid Managed Care Entities

As Medicaid costs increase, States, including Kansas, are looking to managed care entities to provide cost-effective medical care while preventing unnecessary treatment. The goal is not only to save money but also to improve the quality of, and access to, care. Kansas Medicaid pays each of the managed care entities (MCEs) fixed capitated rates for the care of patients. Payments are made to MCEs on a prospective, per-member per-month basis.

In managed care settings, MCEs assume some of the risk of fraud and abuse. However, states assume high risks as well because public responsibility for failure of managed care programs falls on them. Thus Federal regulations require State Medicaid agencies to ensure that their managed care plans have effective internal controls. Failure to do so ultimately leads to higher capitation rates in future contract years as MCEs pass the cost of fraud and abuse to the States.

Managed care plans can also engage in fraud activity. According to the HHS OIG,¹ the National Association of Attorneys General (NAAG), highlighted this in a report entitled *Health Care Fraud in a Managed Care Environment*, expressing the inherent problems in managed health

¹ Brown, J. G. (1999, June). Medicaid Managed Care Fraud and Abuse. *HHS OIG Audit Report OEI-07-96-00250*, p. 4. Retrieved from the World Wide Web at: <http://oig.hhs.gov/oei/reports/oei-07-96-00250.pdf>.

care settings as follows: “The managed care organizations (MCOs), being the entity closest to the provider, would be in the best position to monitor the activities of the providers and to match services to costs through a reporting process. But this has not always been the case....In some instances it is the MCO itself that is attempting to cap services to save money. There would be a natural reluctance with the MCO to make the effort to police itself and its providers.²” These observations underline the need for effective oversight from State Medicaid agencies.

In this audit the DHCF Office of Inspector General addresses the following question:

- **Does DHCF provide adequate oversight of the managed care entities’ fraud and abuse programs?**

This audit report was issued with recommendations highlighting several areas where DHCF’s oversight of managed care plans could be improved. The following are the recommendations and the respective management response:

1. DHCF should review UniCare Health Plan of Kansas’ Fraud and Abuse Compliance Plan and make a determination of whether the document is compliant with the requirements of 42 CFR 438.608(b)(4) and 42 CFR 438.608(b)(5). If not, DHCF should request UniCare revise its fraud and abuse compliance plan and include the missing sections.

DHCF agrees with this recommendation and will determine if UniCare Health Plan of Kansas’ Fraud and Abuse Compliance Plan is compliant with requirements of 42 CFR 438.608(b)(4) and 42 CFR 438.608(b)(5). If the Plan is not compliant, DHCF will require UniCare to revise its fraud and abuse compliance plan to include the missing sections.

2. DHCF should take part in the formulation and/or review of the content of the training curricula the MCEs use with the view to ascertain that all the key elements of Medicaid fraud and abuse are covered.

DHCF agrees with this recommendation and will review content of MCE training curricula to ascertain that all key elements of Medicaid fraud and abuse are covered; incorporating HHS/CMS best practice guidelines.

3. DHCF should work with MFCU and take steps to improve MCEs’ fraud and abuse reporting, including training of compliance officers on the deployment of more extensive and effective fraud detection and investigation methods.

² Judd, T. R. & Jones, S. E. (1996, April). Health Care Fraud in a Managed Care Environment. *Publication of the National Association of Attorneys General*, p. 23-24.

DHCF and the Health Plans meet with the MFCU monthly. DHCF agrees that the referral system involving managed care entities could be improved. DHCF has requested additional meetings with the MFCU to improve the process for documentation of referrals made to MFCU and resolution of those referrals. MFCU is receptive to discussing methods to improve these processes. DHCF program integrity staff will be part of this team.

4. DHCF should work with MCEs to have field investigators or auditors whose scope of work includes visiting network provider facilities with a focus to deter, detect, and investigate fraud and abuse. We also recommend DHCF work with the MCEs to encourage them to carry out unannounced provider site visits as an added activity to deter potential fraud and abuse.

While DHCF supports deterrence or early detection of potential fraud and abuse we believe the practices in place make the most effective use of resources available for this purpose. We employ a variety of activities to detect and deter provider fraud. Each of the Plans utilizes Provider representatives who call on and work to educate providers who participate in managed care. Plans also implement policies to monitor and prevent provider fraud and abuse, including provider profiling. CMFHP recently implemented an Explanation of Benefits process, and sends EOB's to 100 random members per month to verify that services billed were received by the member. CMFHP also contracts with a vendor to conduct medical bill audits. Both plans collect HEDIS and CAHPS data, both of which require in depth review of access to service, quality and utilization. Each plan is also required to staff Fraud and Abuse committees. All employees must be trained to identify potential fraud and abuse and internal processes to report potential fraud. Periodic desk audit reviews of claims could be implemented to monitor providers. On site medical records reviews are currently conducted every 3 years as per Federal regulation. The current budget environment precludes adding the additional staff needed to coordinate unannounced field visits; however, we are reviewing a collaborative fraud investigation approach which could be included in future MCE contracts.

5. DHCF should have encounter data from all managed care programs validated annually by an external quality review organization. This will not only improve the assessment of service quality and enhance program integrity but also render the actuaries' capitation rate setting process more reliable.

Encounter data has been reviewed and validated by the Agency's Actuary to establish MCE reimbursement rates for 2011. DHCF has negotiated with the External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC) to assess and validate encounter data as an ad hoc report upon Agency request.

6. DHCF should evaluate human resources in the managed care program unit with the view to bringing staffing to such a level that monitoring and oversight functions can be performed more efficiently and effectively.

DHCF acknowledges the OIG's recommendation. The Division's staffing capacity has been reduced as a result of administrative budget reductions in FY 2009, FY 2010, FY 2011 and FY 2012. Nevertheless, the Kansas Department of Health and Environment/DHCF is committed to efficient use of limited resources and has redirected staff from the fee-for-service program into a new health purchasing group. This group is intended to support the Administration's effort to reduce cost and increase the quality of services across populations, and is organized according to the major population groups covered by the Medicaid program. Further realignment and reassignment of existing staff is expected as Medicaid reforms are identified and initiated in the coming months. DHCF recognizes the need for dedicated and talented staff to oversee its managed care operation, and will continue to reevaluate allocation of staff and other resources to ensure appropriate coverage.

7. DHCF should improve documentation of its oversight activities. It should keep a checklist of items reviewed, the name and signature of the reviewer, as well as the date of review and approval.

DHCF managed care staff do not formally sign fraud and abuse compliance plans. Prior to contract signature, MCE's are required to submit fraud and abuse compliance plans, and other policies and procedures for approval. Managed care staff review the submitted policies and procedural plans to ensure contract and regulatory compliance mandates are met. Approval is sent electronically and policies are placed in an electronic file. Any updates or revisions to approved policies must be approved by DHCF managed care staff prior to implementation.

8. DHCF or fiscal agent staff should validate MTM's electronic claims data by selecting a sample of claims from the electronic claims data and comparing them to the paper claims as well as supporting documentation.

DHCF concurs and will revise its auditing process in this regard. DHCF agrees to incorporate a random sample review process which compares electronic claims data against paper claims and other supporting documentation provided to MTM by their network of providers.

The Office of Inspector General released this audit report in August 2011. The complete audit report, including management's response, can be accessed on the KDHE OIG's website at <http://www.kdheks.gov/hcf/oig/default.htm>.

III. A Follow-Up Audit of Kansas' Medicaid Claims Processing

In January 2010, the DHCF Office of Inspector General (OIG) released an audit report entitled “*A Performance Audit of Kansas' Medicaid Claims Processing: Does KHPA Have Effective Oversight of its Fiscal Agent's Medicaid Claims Processing to Ensure Timeliness and Accuracy of Payments?*” The audit found a number of deficiencies in the processing of claims or management oversight of the fiscal agent, resulting in the issuance of a total of eight recommendations.

The Medicaid agency agreed with six of the eight recommendations and responded that they would be implementing corrective action to mitigate identified risks. Management agreed in principle with one recommendation but responded that the action already being taken was adequate to address the perceived risk. They did not agree with the auditors on one recommendation.

In September 2011, the OIG completed the fieldwork and draft report for an audit project entitled “*A Follow-Up Audit of Kansas' Medicaid Claims Processing.*” The objective was to determine whether DHCF (formerly KHPA) had implemented corrective action on the six recommendations it agreed to in the Medicaid Claims Management Audit Report (09PA02) and whether actions taken were adequate to address the findings cited in the original report. The draft report for this follow-up audit was submitted to DHCF management in mid-September 2011. The final report was scheduled for official completion and release on October 14, 2011. However, official completion and report release were both put on hold upon the request of DHCF management for the establishment of new protocols to guide the audit process in the post-KHPA era. This report awaits publication pending the establishment of new audit protocols and completion of related issues.

2011 ACCOMPLISHMENTS

In addition to completing the performance audits summarized in this report, the OIG accomplished the following in CY 2011.

- Stephen Mhere earned his Certified Internal Auditor designation from the Institute of Internal Auditors.
- The OIG received 19 complaints or concerns from the public. Complaints related to issues of possible eligibility fraud, beneficiary fraud, Workers Compensation concerns and provider fraud. Each complaint received was researched and an assessment made for possible referral.
- The OIG referred two potential cases of fraud to the Medicaid Fraud Control Unit.
- Audit staff completed Continuing Professional Education (CPE) credits as required by government auditing standards.
- OIG staff participated in the following three Medicaid Integrity Institute trainings offered by the Department of Justice:
 - The Reid Technique of Interviewing and Interrogation Program
 - Program Integrity Fundamentals Program
 - Data Expert Symposium
- OIG staff participated in nine program integrity related meetings.

2012 GOALS

- Conduct audits to help improve the Division of Health Care Finance programs and operations and to fulfill the OIG's mission.
- Develop an FY 2012-2013 audit plan that will allow the OIG to conduct audits of DHCF programs and operations, while preserving time for the OIG to be responsive to complaints from the public.
- Attend MFCU and other Program Integrity meetings and conference calls.
- Meet monthly with the DHCF Surveillance Utilization Review manager to discuss common issues.

FISCAL YEAR 2011 STATISTICS

K.S.A. 75-7427 requires this report to include information from other entities that administer or manage programs under Medicaid. The sources of the information below include the Kansas Department on Aging, Kansas Department of Social and Rehabilitation Services, KDHE Division of Health Care Finance and its fiscal agent, HP Enterprise Services. The Office of Inspector General reproduces the reports without editing them or auditing or evaluating the information for accuracy.

Aggregate Information on Health Care Provider Sanctions

Three broad types of health care providers who provide services to the Medicaid program and the State Children's Health Insurance Plan (SCHIP) may be sanctioned for improper behavior: (1) nursing facilities and long-term care units; (2) providers contracting with managed care organizations (MCOs); and (3) fee-for-service providers, including those who provide services for Medicaid waiver participants. The reported statistics for each type of provider are found below.

- Federal certification enforcement actions of Medicaid-only certified nursing homes are handled by the Kansas Department on Aging (KDOA). Staff at KDOA report that in FY 2011, there were a total of 63 Medicaid-only nursing facilities of which 43 were long term care units (LTCUs.) In FY 2011 there were no terminations and six Medicaid only nursing facilities had a Civil Monetary Penalty imposed; five were LTCU's one was a nursing facility. CMPs were generally imposed due to immediate jeopardy (IJ) existing for one or more residents. All IJ's in FY 2011 were abated at the time of survey.
- There were 26 surveys on Medicaid-only facilities where the nursing facility did not meet compliance standards at the time of the survey. There were a total of eight Denial of Payment on New Admissions (DOPNA) imposed on Medicaid-only nursing facilities and LTCUs during the same period. It took facilities that were found out of compliance and remained non-compliant at the time of the revisit survey an average of 29 days to be found back in compliance. DOPNAs are imposed for a wide range of issues, which include: Resident Rights; Admissions: Transfer and Discharge Rights; Resident Behavior and Facility Practices; Quality of Life; Resident Assessment; Quality of Care; Nursing services; Dietary services; Physician services; Specialized Rehabilitation services; Dental services; Pharmacy services; Infection Control; Physical Environment; or Administration.
- Sanctions of *providers credentialed by MCOs* are imposed by the MCOs with whom providers have a direct relationship. DHCF contracts with four MCOs to provide services for the Medicaid program and SCHIP. DHCF staff report the following:

- 53 providers were placed on corrective action plans.
- 18 providers were terminated.
- No cases were forwarded to the Attorney General’s Medicaid Fraud Control Unit.

Two other MCOs overseen by SRS provide care to Medicaid and SCHIP consumers. Sanctions of providers in these MCOs included the following:

- Seven providers were placed on corrective action plans.
- Twenty-two providers were terminated or disenrolled.
- No cases were forwarded to the Attorney General’s Medicaid Fraud Control Unit.

- Sanctions of *providers in the fee-for-service and waiver programs* are handled by DHCF staff, who report the following statistics for FY 2011:

- No providers were on “pre-pay review” status, which means before receiving payment; these providers are required to submit treatment records supporting the services provided. DHCF utilizes pre-payment review in cases where questionable billing practices or poor documentation have been identified.
- Three providers were terminated for cause by DHCF. A provider may be terminated for the reasons specified in KAR 30-5-60.
- Two providers were placed on corrective action plans.
- 495 beneficiaries that were eligible for Medicaid were placed on “lock-in” status. 265 beneficiaries lost eligibility but continue to be monitored for regaining eligibility. Beneficiaries determined to be inappropriately using their medical card are restricted to assigned lock-in medical providers. Standard assignments for lock-in beneficiaries are a physician and a pharmacy. If emergency room or outpatient services have been used inappropriately, lock-in assignment includes a hospital.
- 25 provider cases of suspected fraud were referred to the Kansas Attorney General’s Medicaid Fraud and Abuse Unit for further investigation by DHCF and HP Enterprise Services.

Aggregate Information on Provider Billing and Payments

DHCF's fiscal agent, HP Enterprise Services, which processes claims for DHCF, reported processing approximately 19.5 million claims in FY 2011, which resulted in payments of almost \$2.6 billion. These numbers include payments to fee-for-service and waiver providers. In addition, approximately \$466.4 million was paid in capitation payments to the four MCOs overseen by DHCF, who reported processing more than 2.0 million provider claims in FY 2011. The MCOs who contract with SRS report capitation payments of approximately \$222.2 million.

APPENDIX A

ACA	Affordable Care Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CFR	Code of Federal Regulations
CMFHP	Children’s Mercy Family Health Partners
CMP	Civil Monetary Penalty
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DHCF	Division of Health Care Finance
DOPNA	Denial of Payment on New Admissions
EPLS	Excluded Parties List System
EOB	Explanation of Benefits
EQRO	External Quality Review Organization
FY	State Fiscal Year
GAO	US Government Accountability Office
GSA	General Services Administration
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
IJ	Immediate Jeopardy
K.A.R.	Kansas Administrative Regulation
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging
KFMC	Kansas Foundation for Medical Care, Inc.
KHPA	Kansas Health Policy Authority
KMAP	Kansas Medical Assistance Program
K.S.A.	Kansas Statute Annotated
LEIE	List of Excluded Individuals/Entities
LTCU	Long Term Care Unit
MCE	Managed Care Entity
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MIG	Medicaid Integrity Group
MMIS	Medicaid Management Information System
MTM	Medical Transportation Management, Inc.
NAAG	National Association of Attorneys General
OIG	Office of Inspector General
SCHIP	State Children’s Health Insurance Program
SRS	Social and Rehabilitation Services
SSN	Social Security Number