Office of the
Inspector General

A PERFORMANCE AUDIT OF DHCF'S OVERSIGHT OF MEDICAID MANAGED CARE ENTITIES

Does DHCF Provide Adequate Oversight of Medicaid Managed Care Entities' Fraud and Abuse Programs?

August 2011

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OFFICE OF THE INSPECTOR GENERAL
KDHE DIVISION OF HEALTH CARE FINANCE

The Kansas Health Policy Authority Office of Inspector General (OIG) was created by the 2007 Kansas Legislature as part of a much larger health reform bill, commonly referred to as Senate Bill 11. This creation of an independent oversight body, with the responsibility to review and investigate Kansas Health Policy Authority's performance in delivering health services, was a significant step in reforming public health care in Kansas. On July 1, 2011, the Kansas Health Policy Authority merged with the Kansas Department of Health and Environment and became the Division of Health Care Finance (DHCF).

The DHCF OIG, whose enabling statute is K.S.A. 75-7427, is the first statutorily created Office of Inspector General in Kansas. Its mission is:

- To provide increased accountability and integrity in DHCF programs and operations;
- To help improve DHCF programs and operations; and
- To 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 DHCF OIG conducts:

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

The DHCF OIG conducts its audits in accordance with applicable government auditing standards set forth by the U.S. Government Accountability Office and its reviews and investigations in accordance with the Quality Standards for Investigations, Inspections, Evaluations, and Reviews of the Association of Inspectors General.

As required by K.S.A. 75-7427, the DHCF OIG will report findings of fraud, waste, abuse or illegal acts to DHCF and also refer those findings to the Attorney General.

At the time of this audit the Inspector General was Nicholas Kramer. Other members of the team were: Felany Opiso-Williams, Auditor; Stephen Mhere, Data Auditor and Kimberly Epps, Program Specialist.

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Table of Contents

Executive Summary i
Audit Scope and Methodology 1
Overview 3
I. Managed Care Program Oversight 7
II. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities in HealthWave? 10
III. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities at Cenpatico Behavioral Health? 20
IV. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities at Medical Transportation Management, Inc.? 23
Appendix A: DHCF Response 31
Appendix B: Acronyms 37

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Executive Summary

Medicaid is a health program designed to provide medical care primarily for low income individuals, people with disabilities and the elderly. The Division of Health Care Finance (DHCF) is responsible for administering the Kansas Medicaid program.

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 saving money but improving the quality of, and access to, care. Kansas Medicaid pays the managed care entities (MCEs) a fixed capitated rate for the care of patients. Payments are made to MCEs on a prospective, per-member per-month basis.

It is sometimes asserted in Medicaid managed care that the MCE assumes the risk of fraud, abuse and overpayment of claims. That is only partially correct. The State assumes a large risk because it bears the public responsibility for failings and shortcomings of the MCE's performance. Also, Federal regulations require that State Medicaid agencies ensure that MCEs have effective fraud and abuse controls. Furthermore, fraudulent or inappropriate claims will inevitably lead to higher capitation rates in future contract years as MCEs pass along these costs to the Medicaid program.

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 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?**

[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.

[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.

To answer this question, we interviewed senior managers and managed care program staff, identified and reviewed federal regulations relevant to fraud and abuse, and evaluated the managed care entities' contractual documents. We also surveyed the four MCEs' compliance officers and reviewed reports, including fraud and abuse reports from the MCEs, the latest external quality review report prepared by the Kansas Foundation for Medical Care, Inc. (KFMC),[3] and the *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* from the National Fraud and Abuse Initiative.

Because the encounter data has not been validated for a number of years, we did not analyze it for fraudulent payments or attempt to estimate the amount of fraud and abuse that might be going undetected. We evaluated DHCF's design and execution of controls to see if they comply with federal requirements and whether they are prudent in light of recognized risks.

The OIG found that the contracts and Requests for Proposal (RFPs) used to procure the contractual services were well-written and covered the required elements adequately. We concluded that, given the reduction in staffing levels in the managed care unit, DHCF is generally doing well in balancing its oversight activities with associated risks to the agency.

However, we found areas where DHCF's oversight of the managed care entities could be improved which led to the recommendations below.

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.*

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.*

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.*

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.*

[3] KFMC is DHCF's External Quality Review Organization.

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.*
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.*

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.*

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.*

We wish to thank Sharon Johnson, Tracy Conklin, Tammy Demmitt, Mary Stewart, Paul Endacott, Christiane Swartz and Barb Langner for their assistance during the course of this audit.

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Audit Scope and Methodology

Objectives

The primary objectives of this audit were to evaluate the Division of Health Care Finance's oversight and monitoring of managed care entities' activities to prevent and detect fraud and abuse in Medicaid programs. More specifically, auditors wanted to determine if management policies, processes, and procedures in place are sufficient to provide reasonable assurance that managed care entities are compliant and consistent with:

1. Relevant federal regulations set forth to help prevent and detect fraud and abuse.
2. Terms and provisions set forth in their contracts to help mitigate the effects of fraud and abuse.
3. Best practices and guidelines from the Centers for Medicare and Medicaid Services (CMS) on mitigating fraud and abuse.

Scope

Our audit scope included reviewing DHCF's oversight and monitoring activities over four managed care entities,[4] namely Children's Mercy Family Health Partners (CMFHP), UniCare Health Plan of Kansas, Inc., Cenpatico Behavioral Health, LLC, and Medical Transportation Management, Inc (MTM). We reviewed the fraud and abuse requirements in federal regulations and contracts, and examined the processes and procedures DHCF uses to track the managed care entities' (MCEs) compliance. We also reviewed the fraud and abuse guidelines provided by CMS and assessed whether DHCF was implementing them. Our scope also included an evaluation of CMS' Kansas Comprehensive Program Integrity Review report as well as DHCF's resultant Corrective Action Plan.

The audit analyses we undertook in this audit were not comprehensive. We did not evaluate mental health services provided through a Prepaid Ambulatory Health Plan (PAHP) operated by Kansas Health Solutions because the plan's oversight responsibilities are outside DHCF's purview.[5] We did not include an examination of encounter/claims data, tests of network providers to assess compliance with federal exclusion requirements, and tests of MCE compliance with federal requirements for disclosure of information on ownership and control. If we had performed additional analyses, we might have found other reportable matters needing remedial action. Such analyses would have required more time than was intended for this audit.

[4] UniCare and CMFHP provide HealthWave managed care services, Cenpatico provides managed care mental/behavioral health services, and MTM provides non-emergency medical transportation services, all on a capitated payment basis. The four organizations are collectively referred to as managed care entities in this report.
[5] Oversight of PAHP lies with Social and Rehabilitation Services (SRS).

Methodology

The audit methodology consisted of interviewing senior managers to get their overall strategy and policy perspectives on managed care programs and to give them an opportunity to share with us their successes, concerns and challenges in mitigating risks of fraud and abuse. In addition, we interviewed managed care program staff to understand the procedures and processes they utilize to monitor MCE compliance with regulatory and contractual requirements.

Our methodology included identifying and reviewing federal regulations relevant to fraud and abuse, as well as collecting and evaluating the managed care entities' contractual documents. We also surveyed the four MCEs' compliance officers to obtain information and clarifications about their organizations' fraud and abuse compliance activities.

In addition, we reviewed reports, including fraud and abuse reports from the MCEs, the latest external quality review report prepared by the Kansas Foundation for Medical Care, Inc. (KFMC),[6] and the *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* from the National Fraud and Abuse Initiative.

This audit's fieldwork was conducted between January 31, 2011 and June 6, 2011. We conducted this audit in accordance with generally accepted government auditing standards except for the limitation of scope as described in the scope statement above. Generally accepted government auditing standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The following members of the Office of Inspector General performed the audit work:

- Nicholas Kramer, MBA, CPA, CIA, CISA, CIG
- Kimberly Epps
- Felany Opiso-Williams, MPA, CIA
- Stephen Mhere, MBA, CISA

[6] KFMC is DHCF's External Quality Review Organization.

Overview

Medicaid is a health program designed to provide medical care primarily for low income individuals, people with disabilities and the elderly. The program is jointly funded by the state and federal governments and is managed by the states. The Kansas Legislature tasked the Division of Health Care Finance with administering the Medicaid program under K.S.A. 75-7405.

As Medicaid costs increase, States are looking to managed care entities to provide cost-effective medical care while preventing unnecessary treatment. The goal is not only saving money but improving the quality of, and access to, care.[7]

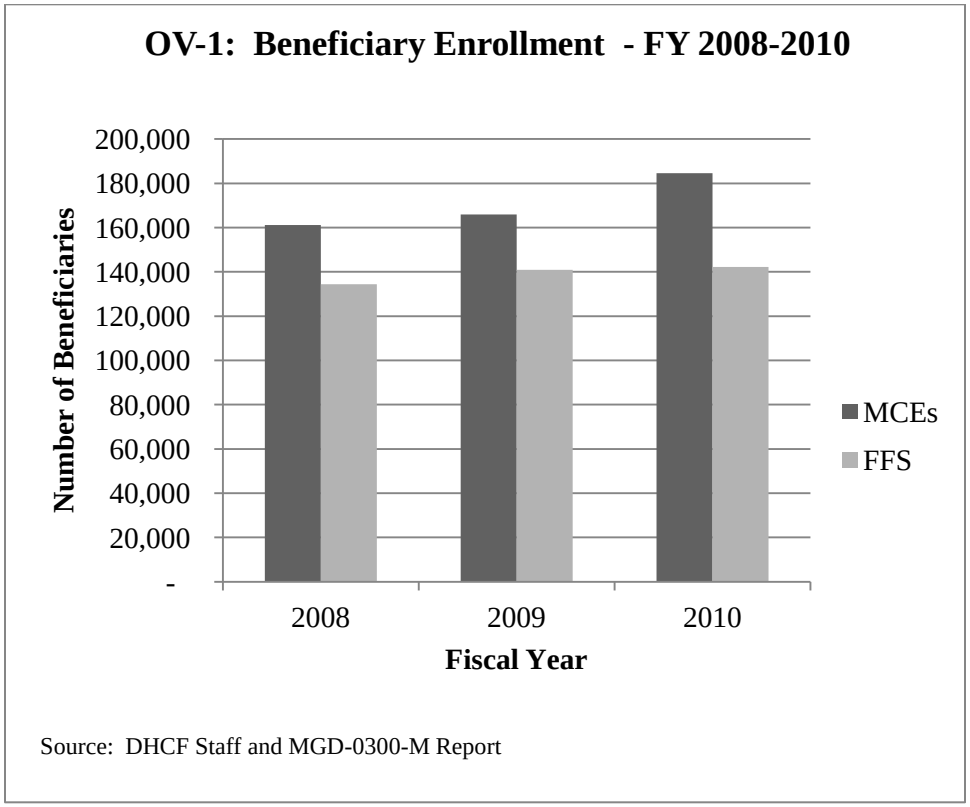
Managed care for the Kansas Medical Assistance Program is defined in DHCF's *Managed Care Business Practice Manual* as "any form of health plan which provides healthcare services to beneficiaries by using a single doctor, case manager, or entity to emphasize preventive healthcare and reduce utilization of unnecessary and high cost care." Beneficiaries see one provider for most of their healthcare needs and receive referrals when needed for specialty care.

One main purpose of managed care is to provide an alternative delivery system to fee-for-service (FFS) that actively seeks potential cost savings and utilization control of medical services. Another goal of managed care is to promote a holistic approach to healthcare resulting in positive outcomes. This is accomplished through contracting, administrative oversight, case management, disease management and healthy behavior incentive programs. For managed care to work there must be strong oversight and proper incentives for the health plans.[8]

Kansas Medicaid pays Children's Mercy Family Health Partners (CMFHP), UniCare, Cenpatico and Medical Transportation Management, Inc. (MTM) a fixed capitated rate for the care of patients. Payments are made to MCEs on a prospective, per-member per-month basis and do not depend on members receiving services. However, contracts are risk-based from the MCEs' perspective – the capitation rates will only be adequate if the volume and intensity of services provided to beneficiaries in the programs result in total costs to the MCEs that are equal to or less than the projected costs. The MCEs compensate their medical providers for services delivered to Medicaid and SCHIP members.

Generally, fee-for-service recipients are older, disabled or receive long-term care services. A comparison of the number of beneficiaries enrolled with the MCEs and those enrolled in the FFS program is shown in Chart OV-1.

[7] Interim Report: Fraud and Error in Virginia's Medicaid Program, Joint Legislative Audit and review Commission, Dec. 2010, p.4
[8] A Performance Audit of Utah Managed Care, January 2010, Office of the Legislative Auditor General, p. 4

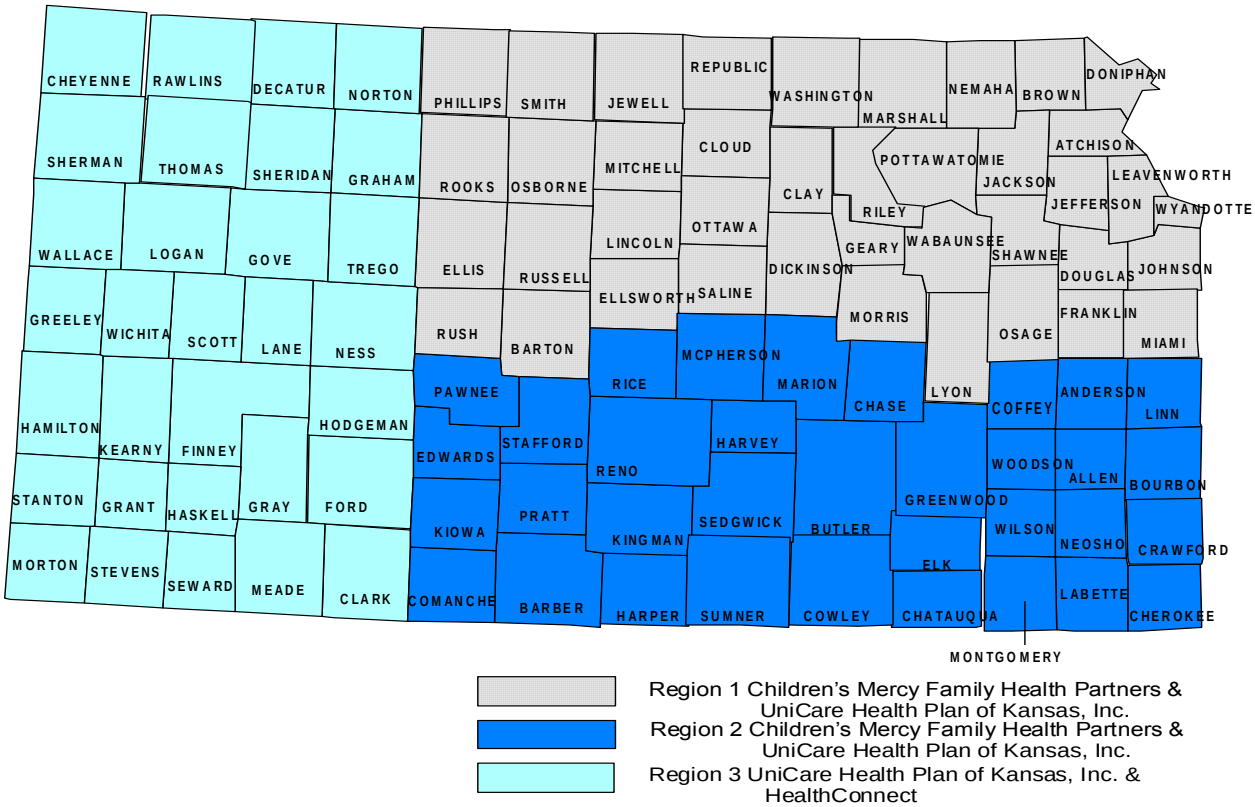


DHCF has oversight of two MCEs and two other entities receiving capitated payments.

Physical health managed care services are provided by two MCEs, namely CMFHP and UniCare. In addition to the physical health managed care organizations, two other providers receive capitated payments for services to Medicaid recipients. Cenpatico provides mental/behavioral health services for the State Children's Health Insurance Program (SCHIP). MTM provides non-emergency medical transportation services. These four organizations are all paid a monthly capitated fee, i.e., they are paid a fixed amount per member per month.

The state is divided into three distinct service regions which serve HealthWave beneficiaries requiring physical health services. Approximately 95% of all HealthWave beneficiaries reside in Regions 1 and 2. The service regions, as well as the managed care plans active in each region, are identified in Chart OV-2.

OV-2: HealthWave Service Regions



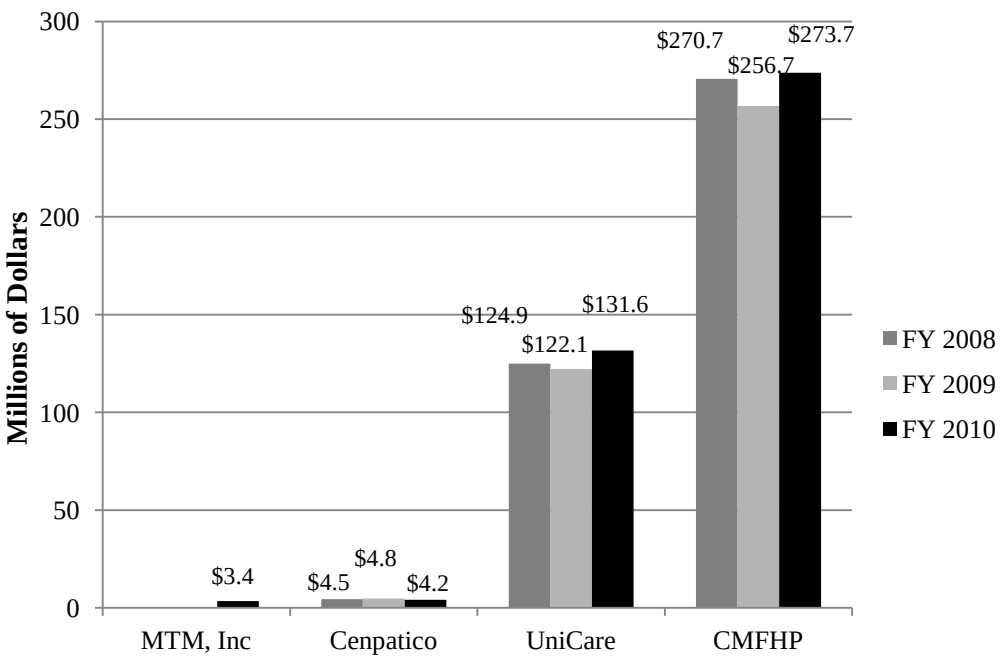
Source: KHPA 2009 Medicaid Transformation Program Review HealthWave Program

In January 2007, HealthWave moved from a one-MCE program to a competitive two-MCE program for physical health. Contracting with CMFHP and UniCare allowed HealthWave to expand managed care enrollment in Regions 1 and 2 to approximately 50,000 Medicaid members who were previously covered by the fee-for-service program through HealthConnect Kansas' network of primary care case managers. UniCare's contract with the state covers all three regions while CMFHP's contract covers Regions 1 and 2. Therefore, Medicaid and SCHIP members in Regions 1 and 2 choose between CMFHP and UniCare. Federal regulations prohibit HealthWave from requiring Medicaid members to participate in managed care if they do not have a choice of health plans. Therefore, Medicaid members in Region 3 choose between UniCare and HealthConnect Kansas which serves members through the fee-for-service Medicaid program. SCHIP members in Region 3 are all assigned to UniCare, as allowed by federal guidelines.

Capitated Payments

Capitation for providing physical health, behavioral/mental health or transportation services is a reimbursement fee paid monthly for each beneficiary assigned through the managed care program. Capitation rates for physical health MCEs are determined by region and population code and vary based on the beneficiary's gender and age.

Chart OV-3 shows a comparison of the capitated amounts paid to each managed care entity.



(a) MTM contracted to begin providing NEMT services 11/1/09. Therefore, there are no amounts for FY 2008-2009.
Source: DHCF staff and MAR report

I. Managed Care Program Oversight

Managed care entities face the risk that the capitated rates they are paid for their services will not cover all the costs of treating beneficiaries. Consequently, state agencies must recognize the risk that as a way to keep operational costs down and increase profits, MCEs may provide less care to Medicaid beneficiary members. Capitated managed care has opened the door for less obvious forms of fraud and abuse including:

- Underutilization and denial of necessary covered medical care.
- Exclusion of certain groups from services.
- Unreasonable times and distances for appointments to prevent beneficiaries from obtaining services.
- Submission of falsely elevated cost data to justify higher capitation payments.

Medicaid managed care entities face the same kind of fraud threats as traditional fee-for-service programs. Though the MCE is paid a capitated rate, they reimburse their providers on a fee-for-service basis and therefore must have effective controls to thwart fraud and abuse, just like DHCF has for its FFS program. It is likely that traditional forms of fee-for-service fraud also impact managed care operations.

It is sometimes asserted in Medicaid managed care that the MCE assumes the risk of fraud, abuse and overpayment of claims. That is only partially correct. The State assumes a large risk because it bears the public responsibility for failings and shortcomings of the MCE's performance. In addition, Federal regulations require that State Medicaid agencies ensure that MCEs have effective fraud and abuse controls. Fraudulent or inappropriate claims will inevitably lead to higher capitation rates in future contract years as MCEs pass along these costs to the Medicaid program.

Managed care plans can also engage in fraud activity. According to the HHS OIG,[9] 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 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

[9] 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.

natural reluctance with the MCO to make the effort to police itself and its providers."[10] These observations underline the need for effective oversight from State Medicaid agencies.

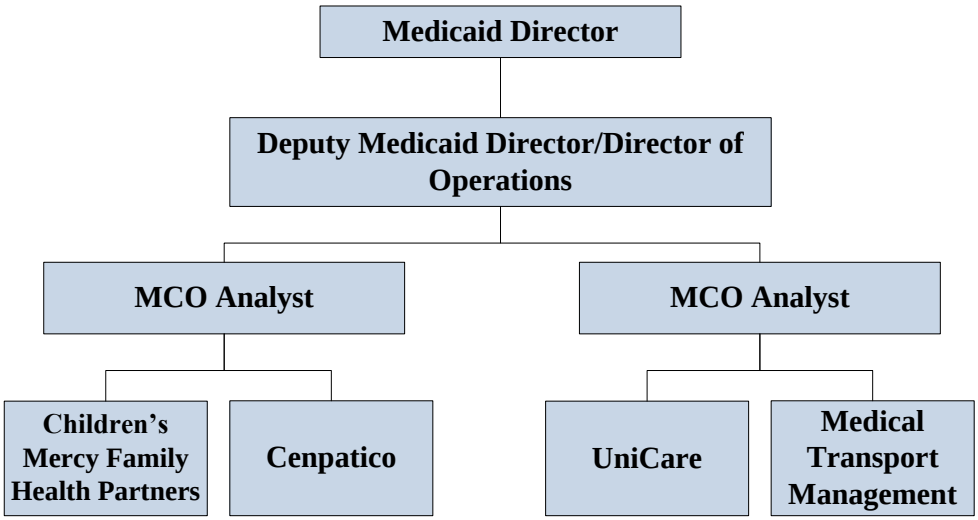
The Kansas Medicaid agency is required and expected by Kansas law, federal regulations, and best practice standards to implement internal controls as well as oversight activities to provide reasonable assurance against fraud and abuse in managed care programs. DHCF is tasked under K.S.A. 75-7405 and K.S.A. 38-2001 to oversee managed care entities under its supervision. This would include the oversight of the MCEs' fraud and abuse efforts. According to the *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* from the National Medicaid Fraud and Abuse Initiative, the state Medicaid agency:

- Designs and implements cost effective programs to combat fraud and abuse.
- Develops contract provisions relating to program integrity, and requires MCEs to implement program integrity programs.
- Provides technical assistance to MCEs to identify fraud and abuse, promote best practices in program integrity, and improve program outcomes.
- Provides periodic training to MCEs.
- Disseminates information and coordinate efforts to comply with reporting requirements.
- Develops procedures to report suspected fraud and abuse to MFCUs and CMS.
- Audits and contracts reviews to assess compliance.
- Analyzes EQRO data to identify potential fraud and abuse issues and inform the MCE and MFCU as appropriate.

DHCF established a unit within its operations tasked with providing oversight of the four managed care entities included in this audit, as shown in the organizational chart I-1 on the next page.

[10] 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.

I-1: MEDICAID MCO OVERSIGHT STRUCTURE



Source: DHCF Organizational Chart & Staff.

Below is a summary of the oversight responsibilities of the managed care analysts:

- Coordinating program integrity activities with DHCF's program integrity manager.
- Helping improve managed care program integrity by sharing with MCEs best practices and national benchmarks identified by the Medicaid Integrity Group and the Medicaid Integrity Contractors."
- Helping the MCEs by sharing with them information about the implementation of new federal regulations, such as new provider enrollment mandates and new MCE drug rebate processes.
- Working with State and federal auditors and complying with recommendations they may make regarding the Kansas managed care program.

DHCF's oversight functions also include coordinating with the agency's program informatics director with the goal of monitoring the managed care plans' mandated quality initiatives. This is accomplished in part by working in conjunction with the external quality review organization. Mandated quality initiatives include federally required performance improvement projects utilizing HEDIS[11] measurements and CAHPS[12] survey requirements.

[11] HEDIS (Healthcare Effectiveness Data and Information Set) is a widely used performance measure in the managed care industry designed to compare health plan performance to other plans and to national benchmarks.
[12] The CAHPS (Consumer Assessment of Healthcare Providers and Systems) program is an initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

II. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities in HealthWave?

Children's Mercy Family Health Partners is an organization headquartered in Kansas City, Missouri. It contracted with the State of Kansas as a managed care entity for purposes of providing physical healthcare services to Medicaid and SCHIP enrollees. CMFHP provides these services on a capitation basis. The contract between the State of Kansas and CMFHP first came into effect on August 23, 2006 and has been amended since. The last signed amendment was signed by the agency on July 14, 2010.

UniCare Life & Health Insurance Company is headquartered in San Diego, California and has subsidiaries in several states including Kansas. Among other things, it provides managed care health plans and specialty health care services. KHPA (now DHCF) contracted with this MCE's Kansas subsidiary, UniCare Health Plan of Kansas, Inc. for the provision of Medicaid and SCHIP managed care services in the State of Kansas. The original effective contract period is July 1, 2007 through June 30, 2011, with two additional optional one year renewal periods.

In 2008, Children's Mercy Family Health Partners had 85,648 beneficiaries enrolled in its programs. It had 88,150 in 2009 and 99,399 in 2010. UniCare had 37,448 enrollees in 2008, 39,126 in 2009, and 45,053 in 2010.

Capitation rates that DHCF pays CMFHP and UniCare on behalf of HealthWave enrollees are different between the contractors. They depend on several factors, including geographic location of the beneficiary's residence, the program type under which services are rendered, as well as the age and gender of the beneficiary. DHCF negotiates and agrees to a 'per member per month' fee with each of the contractors for each of the subgroups. However, before the capitation rates become effective, the agency submits them to CMS for approval.

Test for Compliance with Medicaid Federal Requirements for MCEs

Medicaid services provided through managed care contracts must comply with federal requirements, specified in Title 42, Part 438 of the Code of Federal Regulations (42 CFR 438). These regulations consist of nine sections providing guidelines on the following:

1. General Provisions
2. State Responsibilities
3. Enrollee Rights and Protections
4. Quality Assessment and Performance Improvement
5. External Quality Review
6. Grievance System
7. Certifications and Program Integrity

8. Sanctions
9. Conditions for Federal Financial Participation

The section on program integrity (42 CFR 438.608(a) and (b)) provides a description of the minimum elements that MCEs must have in order to mitigate the impact of fraud and abuse in managed care programs. Leading among these is the need for an MCE to have a documented fraud and abuse compliance plan. To that end, as part of internal controls to counter fraud, every MCE's operations should include the requirements listed below.

II-1: Program Integrity Compliance Checklist for CMFHP & UniCare				
Regulatory Requirement and Basis	**CMFHP**		**UniCare**	
	Inclusion in Contract	**Inclusion in Plan**	**Inclusion in Contract**	**Inclusion in Plan**
The MCE must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. ***42 CFR 438.608(a)***	✓	✓	✓	✓
The MCE must have written policies, procedures, and standards of conduct that articulate its commitment to comply with all applicable Federal and State standards. ***42 CFR 438.608(b)(1)***	✓	✓	✓	✓
The MCE must designate a compliance officer and a compliance committee accountable to senior management. ***42 CFR 438.608(b)(2)***	✓	✓	✓	✓
The MCE must provide effective training and education for the compliance officer and its employees. ***42 CFR 438.608(b)(3)***	✓	✓	✓	✓
There must be effective lines of communication between the compliance officer and the organization's employees. ***42 CFR 438.608(b)(4)***	✓	✓	✓	✗
The MCE must enforce standards through well-publicized disciplinary guidelines. ***42 CFR 438.608(b)(5)***	✓	✓	✓	✗
The MCE must have provision for internal monitoring and auditing. ***42 CFR 438.608(b)(6)***	✓	✓	✓	✓
The MCE must have provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCE's or PIHP's contract. ***42 CFR 438.608(b)(7)***	✓	✓	✓	✓
Source: OIG review of Federal regulations and evaluation of CMFHP and UniCare's Compliance Plans				

Both CMFHP and UniCare have documented fraud and abuse compliance plans. CMFHP's plan came into effect on January 1, 2007. It was revised on April 14, 2009 and approved by the State

on May 5, 2009. UniCare's plan was originated on October 23, 2006. It was last reviewed on August 10, 2010 and approved on the same date. Top members of both organizations' management are involved in program integrity activities and are members of the compliance committees of their respective organizations.

Conclusion:
In terms of documenting its fraud and abuse compliance plan, CMFHP is compliant with all the requirements of 42 CFR 438.608. UniCare is compliant with all but two requirements (42 CFR 438.608(b)(4) and 42 CFR 438.608(b)(5)). UniCare's fraud and abuse compliance plan does not show evidence of the existence of effective lines of communication between the compliance officer and the organization's employees and of the enforcement of standards through well-publicized disciplinary guidelines.

Recommendation:
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.

Test for DHCF's Monitoring of the Implementation of MCEs' Fraud and Abuse Compliance Plans

Auditors evaluated DHCF's oversight activities of the MCEs' practical implementation of the fraud and abuse compliance requirements in their plans. We found DHCF's oversight activities to be generally satisfactory in five of the seven requirements. We describe below our review of the two (effective training and education for the compliance officer and employees as well as internal monitoring and auditing) in which we think more could be done to bridge the gap between risk and control.

Effective Education and Training of Employees

Regulation 42 CFR 438.608(b)(3) requires that MCE employees be provided with effective training and education on issues relating to fraud and abuse compliance. CMFHP appears to provide education and training for its employees. All new employees undergo training as part of their job orientation. In addition to that, all employees are required to undergo continual mandatory training for the duration of their employment. Every year, CMFHP employees attend four sessions of training in four weeks. The organization keeps records of employee attendance at these instructor-led training sessions to verify that everyone takes part.

UniCare trains all its associates on an annual basis on fraud and abuse. The organization has a policy to train all new employees within 90 days of employment. An online training program educates claims processors, customer service representatives, medical review personnel and other associates to identify patterns and trends indicating potential fraud and abuse. Education on how to report fraud and abuse as well as the False Claims Act is also provided online. UniCare's Program Integrity Unit staff undergoes additional formal training provided by professional organizations such as the National Health Care Anti-Fraud Association and the Association of Certified Fraud Examiners.

Auditors did not request education and training materials from the MCEs to evaluate their appropriateness to fraud and abuse in Medicaid. According to agency managers, DHCF does not participate in the formulation of the training curricula and does not review the training materials. As such, the agency cannot be certain that the training provided to the employees covers the essential elements of an effective Medicaid fraud and abuse training program.

Conclusion:
DHCF does not have control of, or influence over the subject matter or material that managed care entities use to train their employees to meet the fraud and abuse education requirement. The risk in this practice is that MCEs may be providing training whose scope and detail are inadequate to equip employees with the knowledge they need to detect Medicaid fraud and abuse.

Recommendation:
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.

Effective Education and Training of Compliance Officers on Referrals

Regulations also require the State Medicaid agency to provide effective training and education for MCE compliance officers. However, after reviewing the education and training protocol for compliance officers, we are not convinced that the training is as effective as it should be. According to DHCF's managed care program analysts, DHCF provides awareness training to MCEs by making sure they know the relevant policies in place at any given time. DHCF makes sure its program analysts are available to disseminate and explain policies to MCEs, especially those related to the Health Insurance Portability and Accountability Act (HIPAA). The training mode is a sharing of information between DHCF, the EQRO, and MCEs.

Auditors also evaluated the effectiveness of the fraud referral system, whereby MCE compliance officers report to the Medicaid Fraud Control Unit (MFCU) any cases involving suspected provider fraud and abuse. This is a requirement of 42 CFR 455.21 placed upon all State

Medicaid agencies. Our review showed there were both a discrepancy in the number of cases referred and the cases referred seemed too few.

CMFHP and UniCare say they referred a total of five cases in 2008, 2009, and 2010 combined, with three coming from CMFHP. However, MFCU indicates that only four cases were referred in those three years. According to a report by the Department of Health and Human Services Office of Inspector General published in 1999, Arizona and Tennessee made 490 managed care referrals in a 12-month period. This led auditors to doubt that the four or five referrals made in Kansas truly reflect the amount of fraud and abuse taking place in managed care programs.[13] Possibly such a low referral number may be a result of MCEs underreporting cases of suspected fraud to DHCF or MFCU. Underreporting could be a result of MCEs' inability to detect fraud and abuse, or it could be because they are resolving the cases internally. Failure to detect would represent a shortcoming in the internal controls. Internal resolution of detected cases without notifying DHCF would be a violation of contractual requirements, which compromises the integrity of the whole Medicaid program because perpetrators that go unreported could participate in fee-for-service programs as well.

Conclusion:
The number of fraud and abuse cases reported to MFCU and DHCF appears too low relative to the standards set by Arizona and Tennessee, which the federal Health and Human Services Office of Inspector General (HHS-OIG) has used as a benchmark. Kansas' referral system involving managed care entities could be improved.

Recommendation:
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.

Internal Monitoring and Auditing

The intent of the regulations in 42 CFR 438 is to deter and detect fraud and abuse in managed care programs. The existence of a documented fraud and abuse compliance plan must be complemented by sound and effective implementation efforts. While CMFHP and UniCare have compliance plans that lay down procedures to report fraud and abuse, they do not have field auditors or investigators. In addition, the organizations do not make any unannounced visits to the facilities of their network providers. According to CMFHP's Compliance Officer, the organization has representatives in the field who visit all contracted practitioners' facilities. At a minimum, primary care physicians are visited once every quarter and all other provider types twice a year. Many of the visits are unscheduled, but are not focused on fraud and abuse.

[13] Due to encounter data not being validated in the last three years, auditors did not assess whether Kansas' four or five referrals in three years can be accepted as a reliable representation of fraud and abuse in managed care programs.

According to a UniCare manager, the organization does not have field investigators physically present in the State of Kansas but in other places such as California. Those investigators can be deployed to Kansas to carry out investigations if and when the need arises. UniCare believes that it operates more effectively and efficiently by reviewing medical claims data and medical records that are available on its data systems and applying issue based investigations against that data.

Both these organizations carry out fraud related program reviews and produce reports submitted to DHCF documenting their efforts to combat fraud. For CMFHP one of the reports is the Fraud and Abuse Lock-in report which is compiled every quarter as well as annually. The Fraud and Abuse Lock-in report provides information on member fraud and abuse, provider fraud and abuse, and member lock-in. As an example, in calendar year 2010, CMFHP reviewed 38 cases related to beneficiary fraud and abuse as well as two related to provider fraud and abuse. Some of the beneficiary cases resulted in lock-ins and some in no action taken because fraud could not be substantiated. Provider member reviews resulted in both providers being terminated from CMFHP's network. UniCare produces the Program Integrity Quarterly Fraud Report. UniCare's 2010 fourth quarter report shows there were four active provider member investigations, two beneficiary member investigations, no referrals to DHCF or MFCU, and one beneficiary member placed in lock-in.

Conclusion:
The lack of field investigators or field auditors, and of unannounced provider site visits, deprive the managed care entities the opportunity for deterrence or early detection of potential fraud and abuse activities.

Recommendation:
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.

Encounter Data Validation

A service provided by an MCE to a Medicaid enrollee in one setting or timeframe is referred to as an encounter. Medicaid agencies such as DHCF pay the MCE a capitated payment for these services. Capitation payments are based on fees calculated by actuaries using a variety of methods including demographic scales and risk-adjusted tables in what are called capitated payment arrangements.

Regulation 42 CFR 438.358 (c)(1) provides that the State or an EQRO contracted by the State may, as an optional activity, validate encounter data reported by an MCE. Encounter data[14] can be a useful source of information for States and MCEs for the following reasons:

1. Encounter data can be used to produce reports, allowing the assessment of managed care program effectiveness and enabling improvement of program quality.
2. Encounter data can be used to monitor program integrity by running algorithms through it focused on fraud and abuse.
3. The usage or utilization rates in managed care programs in one year can be used to project usage rates in subsequent years. Encounter data is an important resource to actuaries in their capitation rate setting activities.

Therefore, in order to effectively serve these purposes, encounter data must be complete and accurate. KFMC last validated encounter data in September 2008. Therefore, all capitation rate settings that were performed since 2008 did not benefit from the use of validated data. However, managers said the encounter data has now been cleaned up and they plan to reconsider its validation by the EQRO. This activity is slated for consideration once DHCF's organizational restructuring takes place July 1, 2011. Auditors strongly believe the validation of encounter data is essential in managed care programs.

Conclusion:
Encounter data that MCEs submitted to DHCF have not been validated since September 2008. As such, if DHCF's capitation rate setting process utilized historical encounter data, it possibly yielded erroneous results as it would have been based upon data that has not been validated.

Recommendation:
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.

Contractual Fraud and Abuse Requirements for MCEs

The Kansas Health Policy Authority (now DHCF) incorporated fraud and abuse provisions in its contracts with both CMFHP and UniCare. In turn, these managed care entities entered into their own arrangements with subcontractors for delivery of services to Medicaid consumers. Under these circumstances, the MCEs assume responsibility over their subcontractors' compliance with

[14] Encounter data is data pertaining to the distinct health care services provided to each Medicaid managed care enrollee.

all pertinent regulations, including fraud and abuse requirements. Some of the MCEs' responsibilities include the following:

- Verifying the qualifications of subcontractors in accordance with all state licensing and applicable accrediting standards.
- Reporting to the State and MFCU any suspected fraud or abuse by providers within 24 hours after the MCE or its subcontractors suspects or has reason to suspect fraud or abuse.
- Obtaining State approval of any Physician Incentive Plan (PIP) before it is implemented.
- Avoiding the use of ineligible physicians, ineligible groups, or entities associated with individuals that are excluded from participation in federally-funded healthcare programs.
- Promptly terminating contracts with any provider who has been terminated by the state.

Test for DHCF's Monitoring of MCE Compliance with Contractual Obligations

After reviewing DHCF's contracts with managed care entities, auditors concluded that sufficient terms and provisions were included to address issues of fraud and abuse. We conducted further evaluations to determine the effectiveness of DHCF's activities to monitor the organizations for compliance with their contractual obligations. The following are our observations and findings.

Verification of qualifications of subcontractors or network providers

KFMC verified in a report issued in February 2011 that both CMFHP and UniCare are compliant with the requirement to verify subcontractor qualifications and exclusion status. The MCEs verify provider information by researching in various registries such as the Kansas Board of Healing Arts, National Practitioner Data Bank and other board certification sites. They verify every provider's National Provider Identification Number (NPI) by double-checking it with the provider master file provided by the state. The state also provides the MCEs with the Medicaid ID number of any prospective subcontract provider. MCEs carry out additional research by using an online system of registered practitioners maintained by the Council for Affordable Quality Healthcare (CAQH). CAQH is a non-profit alliance of health plans and trade associations of practitioners that keeps an online database that MCEs can access for credentialing purposes. MCEs perform re-credentialing for providers already in its system once every three years. We are satisfied that the credentialing process is sufficient to prevent unqualified individuals from enrolling as providers in MCE networks.

Obtaining State approval of any Physician Incentive Plan

The contractor must obtain the approval of the State before implementing any physician incentive plan or any other plan that offers incentives to subcontractors. None of the four managed care entities in this audit have asked to implement a physician incentive plan. UniCare has asked to pay their physicians a stipend to encourage them to fill out and return a form used to

identify members meeting the criteria for an injection that helps expectant mothers carry their babies longer and prevent early births. This request was evaluated by DHCF's contracts division and deemed not to constitute a Physician Incentive Payment as defined by the federal statutes.

Termination of provider contracts

MCEs are contractually required to promptly terminate contracts with any provider who would have been terminated by the state. To that effect, upon terminating a provider, DHCF's provider enrollment manager informs the MCEs, the agency's managed care analysts and its utilization review manager, as well as the fiscal agent's SURS and provider enrollment supervisors. Thus any terminated provider still actively providing services can be identified.

Staffing Levels in DHCF's Managed Care Program Unit

Currently, DHCF has two managed care program analysts. They are the interface between DHCF, the MCEs, and other state agencies on matters of Medicaid managed care. In addition to their oversight responsibilities described in the section of this report entitled "Managed Care Program Oversight," below are some of their other functions:

- Serve as liaisons to MCEs for questions regarding coverage, contract requirements, etc.
- Perform the day to day managed care operations, such as responding to requests for clarifications regarding new CMS directives.
- Receive the contractually required reports from the MCEs and decide whether to take action or follow up on issues of concern.
- Perform desk audits for contract compliance, i.e., look at performance measures and identify areas with deficiencies.
- Perform a comprehensive compliance contract review every three years.
- Participate in CMS or HHS audits, i.e., accompany CMS staff during onsite visits at MCEs.
- Participate in monthly CMS managed care regional phone calls regarding managed care issues as well as regional CMS TAG calls and, depending on whether there are new guidelines coming up; also participate in CMS Affordable Care Act national calls.
- Participate in monthly face-to-face joint Performance Improvement Plan meetings facilitated by KFMC and attended by CMFHP and UniCare representatives. These meetings are focused on program quality improvement, as Performance Improvement Projects are mandated activities for Medicaid participating MCEs. MCEs may request individual meetings with DHCF and/or KFMC to address program quality issues outside of joint meetings.
- DHCF also hosts monthly phone conferences with MCEs, the NEMT program and Cenpatico Behavioral Health.

- Work with DHCF's program informatics unit with the goal of utilizing the Data Analytic Interchange data to review and match encounter data to EQRO quality reports and corrective action plans.

DHCF's organizational chart for FY 2009 shows that the managed care program unit was staffed with seven people, namely a senior manager, five program managers, and one support staff. Their functions included oversight, administrative and other responsibilities related to CMFHP, UniCare, and Cenpatico. In November 2009, MTM, Inc., a non-emergency medical transportation broker was added to DHCF's list of managed care contracts, thereby increasing the workload of managed care staff. Subsequent to the MTM contract, DHCF experienced staff turnover that left only two analysts in the managed care program unit.

The current MCE team carries out its responsibilities with professionalism and diligence, but we believe that effectiveness is likely to suffer when two full time equivalent positions (FTEs) are expected to perform more tasks than were performed by seven FTEs. Indeed, program managers have said that due to the amount of work that must be accomplished in this unit, routine monitoring and oversight activities are now mostly done by exception management.

Conclusion:
The managed care program unit's 70% staff reduction at a time when the organization took on an additional contractor is likely to have impacted the unit's ability to effectively monitor and provide oversight of the four MCEs.

Recommendation:
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.

III. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities at Cenpatico Behavioral Health?

Cenpatico Behavioral Health, LLC is a provider of behavioral or mental health services. It is headquartered in Austin, Texas. It provides services to the State Children's Health Insurance Program beneficiaries on a managed care basis. Cenpatico entered into a contractual agreement with KHPA (now DHCF) to furnish capitated managed care mental/behavioral health services to these beneficiaries from May 1, 2006 to June 30, 2008. The contract stipulated four additional optional one year renewal periods. The latest amendment to this contract was signed February 23, 2011. Table III-1 shows the capitation payment rates in the initial contract.

III-1: Capitation Rates for Mental/Behavioral Health Services

YEAR	PERIOD	RATE
Contract Year 1	July 1, 2006 through June 30, 2007	$9.61
Contract Year 2	July 1, 2007 through June 30, 2008	$9.89
Contract Option Year 3	July 1, 2008 through June 30, 2009	$10.11
Contract Option Year 4	July 1, 2009 through June 30, 2010	$10.34*
Contract Option Year 5	July 1, 2010 through June 30, 2011	$10.58
Contract Option Year 6	July 1, 2011 through June 30, 2012	$10.82

Source: KHPA/Cenpatico contract (Contract # 09072) signed March 17, 2006.

* Effective August 1, 2010, this rate was amended to $13.00 per member per month (PMPM) subject to conditional adjustments dependent on Cenpatico's profit or loss ratio for August 1, 2010 through June 30, 2011. If Cenpatico made a profit in excess of 10%, it would reimburse DHCF an amount equivalent to the excess. On the other hand, if Cenpatico made a loss in excess of 10%, DHCF would pay the contractor an amount equivalent to the excess loss. This arrangement was necessitated by the uncertainty brought about by changes in federal law requiring parity between the services provided to Medicaid and SCHIP beneficiaries. The State determined it was in its best interest to limit Cenpatico's potential losses or gains to 10% during the contract year. In order to make this determination, this amendment requires Cenpatico to submit to DHCF, on or before July 31, 2011, a summary of the organization's claims experience and other financial information related to this contract for the preceding 11 months. DHCF would use this information to determine the contractor's profit or loss ratio for the period.

Cenpatico had 38,047 enrollees in 2008, 38,731 in 2009, and 40,160 in 2010. Cenpatico is regulated by its contract with DHCF and by the Code of Federal Regulations.

Federal Requirements for Program Integrity in SCHIP Programs

Healthcare services provided under SCHIP are required to comply with specific federal regulations. These are provided in Title 42, Part 457 of the Code of Federal Regulations (42 CFR 457). Important among these are the regulations relating to program integrity, particularly the ones providing guidance on fraud detection, investigation, resolution, reporting requirements, and sanctions. Among other things, the state is required to do the following:

1. Establish procedures for ensuring program integrity.
2. Conduct a preliminary investigation of fraud or abuse.
3. Implement effective procedures for investigating suspected instances of fraud and abuse.
4. Not make payments for services provided by excluded providers.

Table III-2 shows the compliance level of the contractors with requirements in 42 CFR 457.

III-2: Program Integrity Compliance Checklist for Cenpatico

Regulatory Requirement and Basis	Inclusion in Contract	Inclusion in Plan
Fraud detection and investigation: Establishment of procedures for ensuring program integrity and detection of fraudulent or abusive activity. ***42 CFR 457.915 (a)***	✓	✓
Fraud detection and investigation: Development and implementation of procedures for referring suspected fraud and abuse cases to the State program integrity unit and to appropriate law enforcement officials, (HHS-OIG, State Attorney General's Office, U.S. Attorney's Office, Department of Justice, or FBI). ***42 CFR 457.915 (c)***	✓	✓
Preliminary Investigations: Conducting preliminary investigations within a reasonable time to determine whether there is sufficient basis to warrant a full investigation whenever a complaint of fraud or abuse is received. ***42 CFR 457.925***	✓	✓
Full investigation, resolution, and reporting requirements: Implementation of effective procedures for investigating and resolving suspected instances of fraud and abuse, including referring potential fraud and abuse cases to the State program integrity unit, conducting a full investigation, and referring the fraud and abuse cases to appropriate law enforcement officials (e.g., MFCU). ***42 CFR 457.930***	✓	✓
Sanctions and related penalties: Not making payments for any item or service furnished, ordered, or prescribed by any provider who has been excluded from participating in the Medicare and Medicaid programs. **42 *CFR 457.935***	✓	✓

Source: OIG review of Federal regulations and evaluation of Cenpatico's Compliance Plans.

Cenpatico's fraud and abuse compliance plan became effective in October 2006. It has been reviewed annually since then with the last internal review completed on May 19, 2010. Cenpatico is contractually required to submit its fraud and abuse plan to DHCF for review and approval upon the inception of the contract and each time the plan is revised. DHCF has received copies of Cenpatico's revised fraud and abuse plans since 2006, but managers did not formally document their review and approval of those plans.

Conclusion:

DHCF's managed care program managers do not formally document the process by which they review and approve MCEs' fraud and abuse compliance plans. They do not keep records showing the name and/or signature of the reviewing individual or the approval date.

Recommendation:

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.

IV. Does DHCF's System of Controls Effectively Deter and Detect Fraudulent Activities at Medical Transportation Management, Inc.?

Medical Transportation Management, Inc. (MTM), based in Lake St. Louis, MO., started managing and coordinating all fee-for-service non-emergency medical transportation (NEMT) for the Kansas Medicaid program on November 1, 2009. Founded in 1995, MTM provides transportation for the disabled, underserved, and elderly populations.

Prior to November 1, 2009, Kansas Medicaid reimbursed transportation on a fee-for-service basis. That meant beneficiaries themselves arranged for a taxi, medical van or other professional service to pick them up, take them to their appointment and bring them home. The Deficit Reduction Act of 2005 (DRA) Section 6803 1902(a)(70) gives the State the right to establish a transportation brokerage. Therefore, DHCF contracted with MTM effective November 1, 2009 and pays MTM a set monthly fee for each beneficiary. MTM pays claims submitted by the provider and ensures that the providers are using safe, dependable vehicles that meet quality standards. This program provides transportation for the fee-for-service population only.

DHCF has contracted with MTM to provide services through June 30, 2012 with an option to extend the contract for two additional one-year renewals. While payments are made to MTM on a prospective, per member per month basis, MTM reimburses its providers on a fee-for-service basis. In the time period from November 1, 2009 through June 30, 2010 MTM had 97,616 beneficiaries and was paid approximately $3.4 million.

The capitation rate when the contract began was $3.87 PMPM. That rate was adjusted to achieve a 10% reduction in provider payments as ordered by the Governor of Kansas, effective January 1, 2010. This lowered the rate to $3.56 PMPM. For FY 2011, the capitation rate is $4.03 PMPM. On July 1, 2011, the rate increased to $4.13 PMPM, and will be effective for the rest of FY 2012.

MTM is regulated by its contract with DHCF, 42 CFR 440.170,[15] and by Federal Register SSA Section 1902(a)(70).

MTM's Fraud and Abuse Controls

In guarding against fraud and abuse both the State Medicaid agency and the NEMT broker have responsibilities to fulfill. These responsibilities can be found in a variety of laws and regulations as well as best practices which provide direction in fighting fraud and abuse in managed care.

Medicaid laws and regulations, as well as CMS guidance, have always required that there be documentation of medical services that are provided to beneficiaries and that they be made

[15] This regulation allows for the use of a transportation brokerage program.

available to CMS upon request. In general, documentation should include verification of eligibility, verification that the service was provided on the date claimed and information about the cost of services. When NEMT is provided as a medical service there should be documentation, not only that the specific ride was provided, but that a Medicaid reimbursable service other than the transportation itself was actually provided on the dates when transportation was claimed. MTM verifies this condition by faxing the doctor's office requesting confirmation that the beneficiary showed up for their appointment on the date transportation service was provided.

A best practice for the transportation broker is to have a well-written fraud and abuse plan. MTM's "plan" comprises sections included in the following documents: MTM's Quality Management Program, its Fraud Alert Investigation Policy & Procedure document, and its Fraud & Abuse Policy & Procedure document. Activities included in MTM's fraud and abuse plan include:

1. Investigating issues on the fraud alert report. OIG staff confirmed that an MTM auditor reviews this report and each fraud alert issue and then initials the appropriate lines of the report.

2. Monitoring weekly utilization report to detect beneficiary fraud. MTM's Quality Management staff monitors weekly utilization reports to detect issues of beneficiary fraud and excessive use of the service that is devoid of medical necessity. OIG staff confirmed that there are regular utilization reports and they are submitted to DHCF monthly.

3. Confirming a sample of beneficiaries who received services when transported. DHCF managed care staff confirmed that MTM faxes providers and requests verification that beneficiaries received their services. On average about two-thirds of these faxes are completed and returned to MTM, Inc.[16]

4. Verifying annually that transportation providers are not on federal exclusion lists as directed by 42 CFR 1001.1901. The federal exclusion lists identify individuals and entities that are not allowed to participate in healthcare programs funded by the federal government.

   The result of MTM's search of the exclusion lists is recorded with other information such as driver's license number, results of criminal background check and notes on their driving history on a credentialing checklist. The name of the MTM employee checking the exclusion lists is recorded along with the date the list was checked.

[16] KSM Verification Report and DHCF staff

5. Conducting audits of transportation providers for a number of reasons including:

    - The receipt of a fraud alert on that provider. Upon receipt of a fraud alert, investigation begins by acquiring all pertinent documentation. If it appears to be a legitimate fraud alert, notification is sent to the Program/Account Manager for further action.

    - A provider's departure from the MTM Transportation Provider network. The transportation provider's trip records are reviewed for the last three months of service.

    - As a follow up on a provider who was placed on a corrective action plan (CAP). This audit reviews the provider's trip records for the two week period following the end of the 30 day corrective action plan.

According to DHCF program staff, the MTM fraud and abuse plan was approved 10/16/09. We requested managed care program managers provide us with documentation showing their review and approval of the MTM plan. That documentation was not available.

MTM Controls against Provider Fraud

Auditors evaluated internal controls that MTM has implemented to mitigate potential fraud and abuse perpetrated by its transportation providers. These controls are placed at various stages of the service delivery process, from the beneficiary's request of medical transportation to their completion of the medical appointment:

- Controls for services not rendered
  Every trip is arranged and approved by MTM, therefore the transportation provider cannot submit a claim that MTM does not know about. When submitting claims, the provider must also submit documents signed by the beneficiary to show that they were transported to and from the appointment. This prevents the providers from billing for "phantom trips."

- Controls for falsification of records
  Since MTM gathers the necessary information from the beneficiary and gives it to the provider, MTM already knows the identity, total distance traveled, the level of service provided (whether special van, etc), the reimbursement rate, the date of service and other relevant data elements pertaining to the service or claim.

- Controls for collusion between provider and beneficiary to defraud
  There is a risk that a beneficiary and a provider may collude to enable the provider to submit a claim for a trip that did not occur. MTM guards against this by verifying by fax with the appointment office (doctor's office, clinic, etc) that the beneficiary did indeed receive services on a particular date. If that appointment did not happen, the claim is denied. Doctors return these faxes approximately 60% of the time. When doctors do not return the verifications MTM pays the claims. The contractor does keep a list of the entities that have the highest rate of not replying. The problem of unreturned verifications does not mean there is any fraud involved, just that the verification request was not returned.

- Controls for beneficiaries getting transportation unrelated to medical needs
  A beneficiary may make arrangements with MTM for transportation to go to a doctor's appointment when they really want free transportation to go elsewhere (e.g. going shopping). MTM can detect this behavior by verifying with the doctor's office that the beneficiary showed up for their appointment.

- Controls for masquerading or theft of beneficiary's identity
  The best way to prevent this from happening would be for drivers to check picture IDs of their passengers and match them with beneficiary names. According to the MTM Compliance Officer, drivers do not check beneficiary picture IDs.

DHCF Oversight

We have shown previously the system of controls used by MTM to prevent transportation providers from committing fraud. Now we will look at DHCF's oversight of MTM, our current transportation broker.

Best Practices

The OIG has identified some best practices and included them in Table IV-1. We analyzed the contract to see if these were included and whether MTM was compliant in following these practices. Finally, we looked to see that DHCF staff verified that MTM was in compliance. Though the elements of 42 CFR 438 do not specifically apply to transportation brokers, they represent "best practices" as they were designed by the federal government to help guard against fraud and abuse in a capitated rate environment.

IV-1: Best Practice Guidance Relating to MTM			
Best Practice	**Contract Inclusion**	**KHPA Verification**	**MTM Compliance**
Have a mandatory compliance plan to guard against fraud and abuse.	✓	✓	Ideally this would be a "stand alone" document and KHPA would have a set list of criteria to use in its evaluation. It's approval should be signed and dated by appropriate staff.
Commit to prevent, detect, investigate and report potential fraud and abuse occurrences.	✓	✓	✓
Designate a compliance officer.		✓	Not required in the contract but MTM does have a compliance officer.
Conduct regular reviews/audits of operations to guard against fraud and abuse.	✓	✓	✓
Assess/strengthen internal controls to ensure claims are submitted and payments made properly.	✓	✓	✓
Educate employees, network providers and beneficiaries about what fraud and abuse is and how to report.			According to the MTM website and Compliance Officer, MTM conducts fraud, waste and abuse training for all employees on an annual basis. In addition, the same training is shared with transportation providers to use with their employees. Employees and providers are given a number to call to report fraud, waste or abuse.
Organize resources to respond to complaints.	✓	✓	✓
Establish procedures to process complaints.	✓	✓	✓
Establish procedures for reporting information to the State Medicaid agency.	✓	✓	✓
Develop procedures to monitor service patterns of providers, subcontractors and beneficiaries.	✓	✓	✓
Provisions for prompt response to detected offenses and for development of corrective action initiatives.	✓	✓	✓
Source: *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care,* and *The Code of Federal Regulations*			

Electronic Data Validation

When MTM subcontractors submit claims to the broker, they submit paper claims accompanied by proper supporting documentation. MTM then enters those claims into its system and submits them to DHCF in electronic form without the supporting documents. In the absence of supporting documentation, DHCF does not have a way to verify the authenticity of the services that MTM claims were provided.

The risk in this practice is that, hypothetically, a transportation broker could upcode[17] claims submitted to Kansas Medicaid. Potentially this could cause capitation rates in subsequent years to be calculated higher based on false estimates of costs.

However, we noted that the transportation broker is contractually required to keep all claims-related documentation and be able to furnish it upon request. While this is a good control, its

[17] Upcoding – A form of improper procedure coding that puts a service into a higher payment category.

effectiveness cannot be ascertained unless DHCF periodically requests the documentation in order to examine the validity of claims submitted.

Conclusion:
MTM has implemented internal controls to mitigate risks of fraud and abuse in the operation of non-emergency medical transportation services. However, DHCF could improve oversight by validating MTM's electronically submitted data.

Recommendation:

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.

Training
The Deficit Reduction Act of 2005 requires training for both employees and providers. MTM conducts fraud and abuse training for all employees on an annual basis. This training is also available to transportation providers for their own employees. The training includes dissemination of contact information for use when reporting fraud or abuse. It also includes training on how to use the organization's NET Management System to enter fraud alerts and notify Quality Management Compliance Staff of suspected fraud and abuse, irregularities, and highly erroneous activities.[18]

DHCF staff does not conduct any formal training for MTM or review and approve the content of MTM's training materials. Instead they share information they have available regarding fraud prevention.

Reporting Suspected Fraud to the State and MFCU
MTM's contract requires the contractor "report to the State and MFCU any suspected fraud and abuse by Title XIX providers within 24 hours after the vendor suspects or has reason to suspect fraud or abuse."

According to an attestation letter from MTM's Quality Management Supervisor there have been no confirmed fraud issues reported to Medical Transportation Management for Kansas Medicaid since the onset of the contract November 1, 2009. The letter was dated March 1, 2011.

Deficit Reduction Act of 2005
According to the Deficit Reduction Act of 2005 (DRA), Section 6803 1902(a)(70), among other things, the state is tasked with providing oversight by verifying that the transportation broker:

[18] MTM, Inc. Policy and Procedure Fraud Alert Investigation, revised 7/7/09

- Have oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous.

- Is subject to regular auditing and oversight by the state in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services.

- Complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

DHCF receives many monthly reports which cover issues such as beneficiary access, complaints and grievances, utilization, the quality of the transportation services provided and reports on fraud and abuse. In addition, transportation personnel's credentials are checked annually. DHCF undertakes annual desk audits of MTM. The most recent audit was initiated 1/26/11 and completed 4/8/11 by DHCF managed care staff.

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Appendix A: DHCF Response

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August 18, 2011

Office of Inspector General
Kansas Department of Health and Environment
Division of Health Care Finance
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The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE/DHCF) has received the Office of Inspector General's (OIG) report regarding its audit of DHCF's "Oversight Practices – Managed Care Entities". We are pleased that the overall findings revealed no systemic problems warranting significant or immediate action.

Appendix A: DHFC Response

KDHE/DHCF Comments on OIG Conclusions and Recommendations

1. **Test for compliance with Medicaid Federal Requirements for MCE's:**

   Conclusion:
   In terms of documenting its fraud and abuse compliance plan, CMFHP is compliant with all the requirements of 42 CFR 438.608. UniCare is compliant with all but two requirements (42 CFR 438.608(b)(4) and 42 CFR 438.608(b)(5)). UniCare's fraud and abuse compliance plan does not show evidence of the existence of effective lines of communication between the compliance officer and the organization's employees and of the enforcement of standards through well-publicized disciplinary guidelines.

   Recommendation:
   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 Response:
   DHFC 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. **Test for DHCF's Monitoring of the Implementation of MCE's Fraud and Abuse Compliance Plans:**

   Conclusion
   DHCF does not have control of, or influence over the subject matter or material that managed care entities use to train their employees to meet the fraud and abuse education requirement. The risk in this practice is that MCEs may be providing training whose scope and detail are inadequate to equip employees with the knowledge they need to detect Medicaid fraud and abuse.

Recommendation:
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 Response:
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. Effective Education and Training of Compliance Officers on Referrals

Conclusion:
The number of fraud and abuse cases reported to MFCU and DHCF appears too low relative to the standards set by Arizona and Tennessee, which the federal Health and Human Services Office of Inspector General (HHS-OIG) has used as a benchmark. Kansas' referral system involving managed care entities could be improved.

Recommendation:
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.

DHCF Response:
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. Internal Monitoring and Auditing

Conclusion:
The lack of field investigators or field auditors, and of unannounced provider site visits, deprive the managed care entities the opportunity for deterrence or early detection of potential fraud and abuse activities.

Recommendation:
DHCF should work with MCE's 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.

DHFC Response:
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 of 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. CMHFP 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. CMHFP 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. **Encounter Data Validation:**

Conclusion:
Encounter data that MCE's submitted to DHCF have not been validated since September 2008. As such, if DHCF's capitation rate setting process utilized historical encounter data, it possibly yielded erroneous results as it would have been based upon data that has not been validated.

Recommendation:
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.

DHCF Response:
Encounter data has been reviewed and validated by the Agency's Actuary to recalculate the MCE reimbursement rates for SFY 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. **Test of DHCF's Monitoring of MCE Compliance with Contractual Obligations; Staffing Levels in DHCF's Managed Care Program Unit:**

Conclusion:
The managed care program unit's 70% staff reduction at a time when the organization took on an additional contractor is likely to have impacted the unit's ability to effectively monitor and provide oversight of the four MCEs.

Recommendation:
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 Response:
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. **Federal Requirements for Program Integrity in SCHIP Programs:**

Conclusion:
DHCF's managed care program managers do not formally document the process by which they review and approve MCEs' fraud and abuse compliance plans. They do not keep records showing the name and/or signature of the reviewing individual or the approval date.

Recommendation:

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 Response:

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. Electronic Data Validation:

Conclusion:
MTM has implemented internal controls to mitigate risks of fraud and abuse in the operation of non-emergency medical transportation services. However, DHCF could improve oversight by validating MTM's electronically submitted data.

Recommendation:
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 Response:
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.

We appreciate the efforts of the OIG's staff in conducting the audit and discussing early drafts with our staff. Thank you for the opportunity to respond to the draft audit report.

Sincerely,

Dr. Andrew Allison
Director
Division of Health Care Finance

Appendix B: Acronyms

CAHPS	Consumer Assessment of Healthcare Providers & Systems
CAQH	Council for Affordable Quality Healthcare
CFR	Code of Federal Regulations
CMFHP	Children's Mercy Family Health Partners
CMS	Centers for Medicare and Medicaid Services
DHCF	Division of Health Care Finance
DRA	Deficit Reduction Act of 2005
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FTE	Full Time Equivalent
FY	State Fiscal Year
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
KFMC	Kansas Foundation for Medical Care, Inc.
KHPA	Kansas Health Policy Authority
KMAP	Kansas Medical Assistance Program
K.S.A.	Kansas Statute Annotated
MCE	Managed Care Entity
MFCU	Medicaid Fraud Control Unit
MTM	Medical Transportation Management, Inc.
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
OIG	Office of Inspector General
PAHP	Prepaid Ambulatory Health Plan
PIP	Physician Incentive Plan
PMPM	Per member per month
SCHIP	State Children's Health Insurance Program
SSA	Social Security Administration
TAG	Technical Advisory Group