TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Budget Review Subcommittee on Health and Family Services

February 26, 2025

Department for Medicaid Services
Lisa Lee, Commissioner
Jennifer Dudinskie, Director, Division of Program Integrity

Medicaid

- Largest program that provides medical and health-related services to low-income individuals
- Governed by Title XIX of the Social Security Act
- Partnership between federal government and states
- Federal government sets broad guidelines:
  - Populations, Mandatory and Optional
  - Benefits, Mandatory and Optional
  - Guaranteed minimum of 50% match for qualified services
- State responsible for administering program and has some flexibility regarding:
  - Enrollment Eligibility
  - Covered Services
  - Provider Payment Methodology and Rate
  - Care Delivery

Federal Medical Assistance Percentage (FMAP)

- Traditional Medicaid
  - Benefits: 71.48%
  - Administration – 50%
  - Personnel – 50%
  - Nurses – 75%
  - Information Technology
    - 90% for Design and development
    - 75% for Maintenance and Operations
- Expansion Population Benefits – 90%
- KCHIP Benefits and Administration – 80.04%

Kentucky Medicaid at a Glance

- Approximately 1.4 million members
- Over 600,000 children – more than half of the children in Kentucky (includes KCHIP)
- 485,000 expansion members
- Over 69,000 enrolled providers
- $18.5 billion in total SFY 2024 expenditures (Administrative and Benefits combined)

ORGANIZATIONAL STRUCTURE

OFFICE OF THE COMMISSIONER

Division of Quality & Population Health	Division of Program Integrity
Division of Long-Term Services & Supports	Division of Fiscal Management
Division of Health Care Policy	Division of Health Plan Oversight

Division of Information Systems

MEDICAID POPULATIONS

- **Aetna - plus SKY for foster population**
- **Humana**
- **Passport by Molina**
- **UnitedHealthcare**
- **WellCare**

Fee for Service (FFS)

- Long-term care
- Program of All-Inclusive Care for the Elderly (PACE)
- Home and Community Based (HCB) 1915(c) waivers
- Intellectual or developmental disabilities
- Receive supports to remain in their home or community
  - Personal care supports
  - Activities of daily living

Managed Care Organization (MCO)

- **Predominantly children and adults other than elderly or individuals with disabilities**
- **Must cover all services outlined in Medicaid regulations and state plan**
- **Can negotiate rates with providers**
- **Flexibilities to deliver value-added services**
- **Some provide transportation to job interviews, educational classes or other services not covered under Medicaid NEMT**

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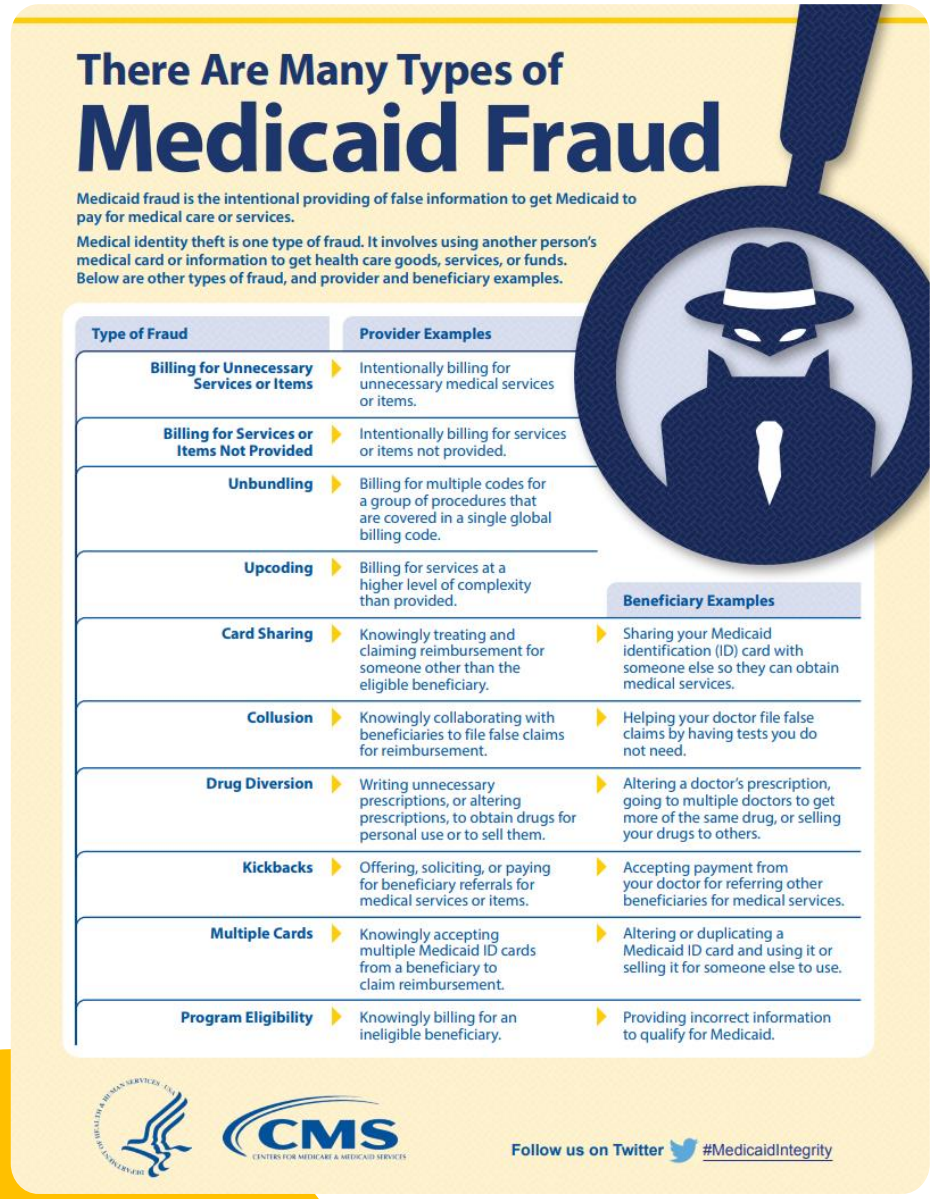
Medicaid Spend by Provider Type SFY2024 – Top 20

Provider Type Description	Claim Count	Members Served	FFS Paid Amount	MCO Paid Amount	Total Paid Amount	% Paid out of Total
Hospital	3,906,400	987,335	$274,275,628.14	$3,539,748,410.44	$3,814,024,038.58	26.47%
Pharmacy	26,018,007	1,196,417	$127,032,826.76	$2,919,016,302.28	$3,046,049,129.04	21.14%
Nursing Facility	400,467	24,797	$1,398,629,121.92	$477,268.30	$1,399,106,390.22	9.71%
Support for Community Living (SCL)	2,242,773	16,233	$915,135,186.74	$2,264,820.25	$917,400,006.99	6.37%
Physician - Group	8,769,212	1,133,162	$33,020,490.26	$633,953,602.65	$666,974,092.91	4.63%
Adult Day Care	1,907,837	16,661	$582,529,984.27	$0.00	$582,529,984.27	4.04%
Primary Care Center/Federally Qualified Health Ctr	4,967,148	469,949	$351,854,628.03	$106,573,844.16	$458,428,472.19	3.18%
Behavioral Health Service Organization (BHSO)	2,623,595	69,869	$3,673,414.07	$426,396,418.06	$430,069,832.13	2.98%
Rural Health Clinic	5,317,533	467,868	$289,800,402.19	$124,545,015.42	$414,345,417.61	2.88%
Behavioral Health Multi-Specialty Group	2,491,282	139,925	$11,899,238.98	$309,510,376.27	$321,409,615.25	2.23%
MSEA Supplier	1,023,873	198,411	$36,193,134.96	$149,135,095.29	$185,328,230.25	1.29%
ICF/IID	6,359	440	$169,823,539.91	$0.00	$169,823,539.91	1.18%
Net (Capitation)	3,562,782	57,355	$0.00	$164,672,446.42	$164,672,446.42	1.14%
Psychiatric Hospital	21,976	13,321	$4,235,641.44	$143,185,395.34	$147,421,036.78	1.02%
Certified Nurse practitioner	2,474,910	683,710	$7,032,890.67	$132,494,973.40	$139,527,864.07	0.97%
Community Mental Health Center	1,069,782	71,990	$5,164,716.32	$126,717,047.94	$131,881,764.26	0.92%
Independent Laboratory	1,663,247	465,613	$3,146,289.64	$125,657,831.57	$128,804,121.21	0.89%
Certified Community Behavioral Health Clinic	919,613	49,997	$65,678,700.39	$51,607,673.28	$117,286,373.67	0.81%
Dental - Group	447,749	234,973	$2,885,582.99	$103,192,145.69	$106,077,728.68	0.74%
Dentist - Individual	456,727	238,264	$1,098,050.44	$103,821,736.74	$104,919,787.18	0.73%



Most common types of Medicaid fraud:

- Billing for services not performed
- Double billing
- Substitution of generic drugs
- Unnecessary services
- Kickbacks
- Cost report inflated expenses
- Upcoding
- Unbundling
- Identity theft/use of provider numbers

[Common Types Medicaid Fraud | Washington State]

Division of Program Integrity

What is the function of Program Integrity?

1

Guarding against fraud, waste, and abuse of Medicaid benefits by providers and members.

2

Assuring state agency, provider and member compliance with federal and state Medicaid rules and regulations.

The Division of Program Integrity

Provider Licensing and Certification Branch

- Application Review Section
- Maintenance Section

Audits and Compliance Branch

Recovery Branch

Third-Party Liability and Estate Recovery Branch

Provider Licensing & Certification

Responsible for the timely and accurate assessment of eligibility of in-state and out-of-state Medicaid providers at time of application, revalidation, reinstatement, reapplication and when there is a reported change.

The branch has two sections:

1. Application Review is responsible for processing and screening new providers
2. Maintenance Review is responsible for reviewing and approving requests from the provider to update the provider file, such as changes in ownership, renewing a license or certification, updating addresses, and revalidation of providers.

Provider credentialing and enrollment are tools used to prevent or reduce fraud, waste and abuse.

Types of Checks Performed on Providers

- Death Master
- OIG Exclusions – SAM/EPLS (Excluded Parties List System)
- Medicare Revocations
- All State Terminations
- KY Termination
- Payment Suspension
- Accounts Receivable Review
- Site Review
- Fingerprint Background Check (FCBC) Review
- Risk Review

Terminations

Provider termination is a tool used to prevent or reduce fraud, waste and abuse.

Reasons for Termination:

- Incorrect information provided at the time of application or reinstatement.
- Failure or refusal to pay an imposed penalty.
- Conviction through the judicial process pursuant to 42 U.S.C. 1320a-7.
- Termination or suspension from Medicare.
- Termination, revocation, or suspension of a registration, certification or license to practice a medical profession.
- Ownership or controlling interest of the provider has substantially changed since the acceptance of the current enrollment application.
- A provider shall be determined to have abandoned his provider number if twenty-four (24) consecutive months shall have expired without a claim being submitted upon that provider number to the department, or its fiscal agent for payment.

- ***The department may terminate a provider immediately to protect the health, safety, or well-being of Medicaid recipients.***
- *Except for nursing facilities or immediate care facilities, terminations occur prior to a hearing.*
- *The Department may take into consideration member access to care prior to a termination and allow additional days for member transition.*

Audits & Compliance Branch

- Partner with federal and state law enforcement agencies to identify fraud, waste and/or abuse of the Medicaid program
- Partner with Managed Care Organizations (MCOs) and their special investigative or program integrity units
- Conduct reviews and pre- and post-payment audits identified through:
  - In-house data mining and algorithms
  - High utilizers of services and/or providers
  - Waiver service providers
  - Required Federal audits
  - Special requests
  - Unified Program Integrity Contractor (UPIC)
  - Healthcare Fraud Prevention Partnership (HFPP) tips
  - Office of Inspector General hotline
  - Member or provider complaints

Reviews and audits are tools used to prevent or reduce fraud, waste and abuse.

Credible Allegations of Fraud

- Per 42 CFR 455.23, DMS is required to refer all cases where there is a credible allegation of fraud to the Kentucky Attorney General's Office of Medicaid Fraud and Abuse Control (OMFA), the federally designated entity to investigate and prosecute Medicaid fraud.
- When a case is referred to OMFA, they may request a law enforcement exception that puts the provider on a stand down list while the case is pending. DMS does not take action on the provider until the law enforcement exception is lifted.
- DMS meets with OMFA monthly to review new or pending cases.

Fraud Investigations

- There are also Medicaid fraud cases that may not originate from a credible allegation of fraud referral from DMS.
- The Office of Medicaid Fraud and Abuse Control or other law enforcement agency such as the United States Attorney may originate an investigation
- DMS assists law enforcement agencies in the investigation and prosecution of fraud cases by providing information, data analysis and testimony as requested
- DMS has no control over how long a case may take and whether a case is prosecuted or closed

Medicaid Program Integrity Audits

- Social Security Act, Section 1936
- Requires the program to review the actions of individuals or entities furnishing items or services for which payment is made under a State plan (or any waiver plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds which is not intended under the provisions of the program.
- Identification of overpayments to individuals or entities.

Pre-payment Reviews

Currently only utilized by the Managed Care Organizations (MCOs).

Effective January 1, 2024, MCOs must submit pre-payment policies and procedures to DMS for review and approval before implementation.

When there is a sustained or high level of payment error, or data analysis identifies a problem, an MCO may request approval from DMS to implement a pre-payment review.

Pre-payment review requests must meet certain criteria and DMS may approve/deny the request, or ask the MCO for additional information or modification.

Post-payment Audits

Utilized by the Managed Care Organizations (MCOs) and the Department for Medicaid Services for both managed care and fee for service claims.

Identify fraud, waste and abuse generally through review of records.

Findings may include inadequate documentation or improper billing.

May result in fraud referral or administrative recoupment of claims paid. DMS must return the federal share to the federal government.

Recovery Branch

Processing and Collecting Monies from:

- Provider and Member Fraud
- Post Payment Review Recovery
- Denial of New Admissions
- Accounts Receivable
- Bankruptcy
- Payment for Services After Date of Death
- Bad Bills and Explanation of Benefits
- Reconciliation of settlements
- Payment Suspension and Escrow
- Open Records and Data Collection

Payment Suspension

Payment suspension is a tool used to prevent or reduce fraud, waste and abuse.

42 CFR 455.23 requires the Department to suspend payments to a provider when there is a credible allegation of fraud against the provider, unless a "good cause" exists not to suspend payment or a law enforcement exception is requested.

Good Cause Exception: A temporary good cause exception may be issued by the Department if it is determined that a health, safety, or welfare concern exists for the Medicaid member if the payment suspension is applied. If a good cause exception or a welfare exception is requested, the suspension is placed on hold.

Payment suspensions based on credible allegations of fraud can swiftly stop the flow of Medicaid dollars to providers defrauding Medicaid.

A payment suspension can remain in place throughout a law enforcement investigation and potential prosecution of a health care fraud case.

Payment Suspension Notification

- The payment suspension notice to the provider shall establish the general allegations of the nature of the withholding action, including the types of payments and payment code sections to which fraud or willful misrepresentation is alleged to have occurred.
- The notice shall not disclose specific information concerning its ongoing investigation.
- The notice includes appeal rights.

Payment Suspension Escrow Release

If there is a determination that there is insufficient evidence of fraud, or legal proceedings are completed, the payment suspension is lifted.

Once a payment suspension has been lifted, the recovery team initiates the escrow release process, if applicable.

Process involves MCOs and DMS release of funds being withheld.

Timely process and dependent on circumstances of the release (i.e. settlement agreement processing).

Utilization Management

Other tools to prevent or reduce fraud, waste and abuse:

- Prior authorizations
- Diagnostic criteria
- Caps on type or frequency of services

Monitoring Trends

- Quarterly meetings with representatives from the U.S. Attorney's office, Kentucky Attorney General's Medicaid Fraud Control Unit, Office of Inspector General, Department for Medicaid Services and each Managed Care Organization
- MCO Special Investigative Unit collaboration and oversight
- MedImpact (Pharmacy Benefit Manager for MCOs and FFS) collaboration and oversight
- Health Fraud Prevention Partnership (HFPP)
- Unified Program Integrity Contractor (UPIC)

<u>Recent Priorities</u>
Behavioral Health Services
Targeted Case Management
Telehealth
School-Based Services

Third-Party Liability & Estate Recovery Branch

- Identify any responsible party that should pay primary to Medicaid; ensure Medicaid is the payer of last resort through:
  - Annuity, Casualty, Estate and Trust recovery cases;
  - Collecting liable party information and recover monies from liable third parties;
  - Collecting from deceased Medicaid members annuity, estate and trust;
  - Collecting from Medicaid members on accident settlements;
  - Reimbursing the employee portion of employer sponsored health insurance, if qualifications are met
- Use data matches with various entities, such as insurance carriers and claims to identify and collect
- Only collect up to the amount Medicaid paid
- For estate recovery, the deceased must be 55 or older at the time of death and in a long-term care facility and/or receiving home and community-based waiver services.

Kentucky Integrated Health Insurance Premium Program (KI-HIPP)

- Medicaid member is already enrolled or can be enrolled on employer, retirement or private insurance plan policy
- Specific information is collected and entered into the Integrated Enrollment and Eligibility System(IEES) system to perform a cost-effective analysis
- If determined cost-effective for Medicaid, the employee's portion of the employer sponsored health insurance premium will be covered even if multiple family members are on the plan

SFY2025 YTD Savings

Branches	YTD Savings
TPL Cost Avoidance Total	$ 243,191,585.06
TPL Non-Commercial Recoveries Total	$ 3,678,733.47
TPL Commercial Recoveries Total	$ 1,306,682.47
Recovery Provider/Member Total	$ 3,065,367.47
A & C Amount Recovered Total	$ 5,991.29
**** A & C Outstanding (pending recoupment) ****	*$ 8,290.97*
Overall YTD Division Savings:	**$251,256,650.73**

Regulations

- Department for Medicaid Services Regulations
  - 907 KAR 1:671 Provider Participation
    - Conditions of Medicaid provider participation; withholding payments, administrative appeals process, and sanctions
    - Recoupments/Overpayments
    - Preliminary Investigations
    - Terminations/Reinstatements
  - 907 KAR 1:672 Provider Enrollment
    - Provider enrollment, disclosure, and documentation for Medicaid participation
  - 907 KAR 1:675 Program Integrity
    - Medicaid Intentional Program Violations (members)

Questions?

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Division of Program Integrity

Department for Medicaid Services

Cabinet for Health and Family Services

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