TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

House Standing Committee on Appropriations and Revenue

February 10, 2026

Department for Medicaid Services
Lisa Lee, Commissioner
Veronica Judy-Cecil, Senior Deputy Commissioner

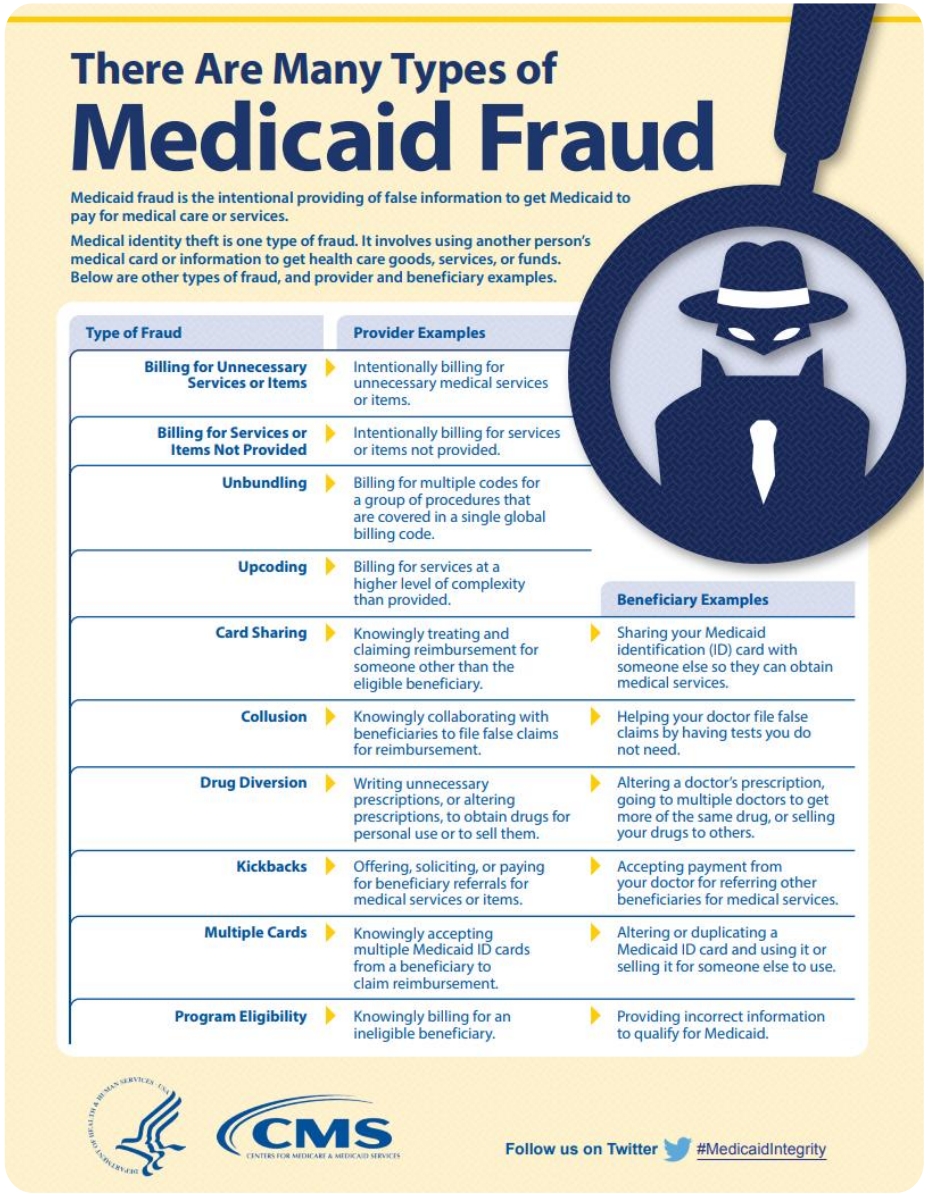
Kentucky Medicaid at a Glance

- Approximately 1.4 million members
- Over 600,000 children – more than half of the children in Kentucky (includes KCHIP)
- About 450,000 expansion members
- Approximately 75,000 providers (CY 2025)
- $20.6 billion in total SFY 2025 expenditures (Administrative and Benefits combined)

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]



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What is Medicaid 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.

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 Branch

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 Program Integrity Checks Performed on Providers

- Death Master File
- 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

Provider Termination

❖ **Reasons for Termination:**

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

- 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 may be immediately terminated to protect the health, safety, or well-being of Medicaid recipients.**

❖ Terminations occur prior to a hearing, except for nursing facilities or intermediate care facilities.

❖ Member access to care may be considered prior to a termination, allowing 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, the Department for Medicaid Services (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 cannot take action against the provider until the law enforcement exception is lifted.
- DMS meets with OMFA at least monthly to review new or pending cases.

Fraud Investigations

- Not all Medicaid fraud cases originate from a credible allegation of fraud referral from DMS
- OMFA or other law enforcement agencies 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

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

A pre-payment review means a specific review of claims or services prior to payment.

An MCO generally implements a pre-payment review when there is a sustained or high level of payment error, or data analysis identifies a problem.

MCOs must submit pre-payment policies and procedures to DMS for review and approval before implementation.

An MCO must provide written notice to a provider being placed on pre-payment review that contains the reason for the review and how to remove it.

Pre-payment review is a tool used to prevent or reduce fraud, waste and abuse.

Post-payment Audits

Utilized for both managed care and fee for service claims.

Identify fraud, waste, and abuse primarily 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.

Post-payment audit is a tool used to prevent or reduce fraud, waste and abuse.

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

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

Payment Suspension

Providers receive a notice containing 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, although the notice shall not disclose specific information concerning the ongoing investigation.

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)

QUESTIONS?