Information Systems Can Help Prevent, but Not Eliminate, Health Care Fraud and Abuse

Program Review and Investigations Committee

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Research Report No. 333

Legislative Research Commission
Frankfort, Kentucky
lrc.ky.gov

Adopted June 8, 2006

Paid for with state funds. Available in alternative form by request.

Foreword

Program Review staff would like to thank the staff of the Finance and Administration Cabinet, the Cabinet for Health and Family Services, the Office of Attorney General, the Office of State Budget Director, and the Kentucky Board of Pharmacy for their assistance in providing information for this report. Program Review staff also would like to thank the staff of the Legislative Research Commission's Library, Budget Review Office, Health and Welfare Committee, and Office of Constituent Services for their assistance.

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Frankfort, Kentucky
June 8, 2006

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Summary

On November 9, 2004, the Program Review and Investigations Committee directed staff to review two computerized information systems used by the Commonwealth: 1) the Kentucky All Schedule Prescription Electronic Reporting system and 2) the Medicaid Management Information System. The committee also directed staff to review fraud and abuse in Kentucky's Medicaid program.

Kentucky All Schedule Prescription Electronic Reporting System

The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system began operating in 1999 as the state's first centralized system to monitor controlled substance prescriptions. Controlled substances are classified according to a schedule ranging from I to V, the lower the number the higher the potential for abuse. For example, Schedule II includes codeine and OxyContin; Schedule V includes cough syrups. A branch of the Cabinet for Health and Family Services' Office of Inspector General operates KASPER. In 2005, more than 185,000 requests were processed by the system, more than double the amount from 2001.

A major purpose of KASPER is as a resource to physicians and pharmacists so they can provide the most appropriate medical treatment to patients. Another purpose is to aid law enforcement's investigations of controlled substance problems by providing access to prescription information. Evidence shows that KASPER has been effective in assisting law enforcement investigations.

In 2004, the General Assembly enacted legislation based on the report of the Prescription Drug Abuse Task Force and appropriated $1.4 million to develop an enhanced KASPER system. Introduced in 2005, eKASPER provides Web-based, real-time access to data for requesters and automates the generation of most reports. The Cabinet for Health and Family Services has also utilized funding from federal grants to improve KASPER.

The eKASPER system is effective in preventing and detecting prescription drug abuse and diversion. It is the most comprehensive system of its kind in the United States. Information gathered from previous studies and relevant officials suggests several potential areas for improvement, many of which are already being addressed.

Medicaid program integrity could be enhanced considerably by developing a fully functional Medicaid-eKASPER interface to help detect controlled substance abusers who receive Medicaid benefits. Office of Inspector General officials are working with the new Medicaid Management Information System (MMIS) vendor, Electronic Data Systems, to build the interface as part of the new MMIS.

KASPER could be more useful if it collected data on the method used to pay for a prescription. For instance, this would help identify Medicaid recipients or cash transactions that are key for identifying abusers.

More timely data would benefit health care practitioners who use KASPER. Data in KASPER's database are generally about a month old. Implementation of plans under consideration by the Office of Inspector General would reduce this to approximately two weeks. A way to make information even more up to date is to obtain prescription transactions directly from the electronic pharmacy network companies that route electronic claims from pharmacies to payers. The Cabinet for Health and Family Services plans to issue a request for proposals for obtaining electronic prescription information, and collection of data should begin by the end of 2006.

Without a required unique identifier, the task of associating different prescription records in KASPER with an individual can be difficult and can result in some inaccuracy. A regulation change has been filed to require reporting of a Social Security number or a driver's license number (if either exists) for the person prescribed the controlled substance.

KASPER does not contain data on prescriptions filled outside Kentucky. This is a symptom of other states not having systems that can share data with Kentucky, rather than a shortcoming of KASPER. Until other states have the capacity to collect data similar to that in KASPER, little formal data sharing is possible.

The overall effectiveness of KASPER could be improved with increased use. KASPER has more than 1,700 medical users and 500 law enforcement users. Office of Inspector General officials estimate that about half the eligible health practitioners in the state use KASPER regularly. Primary goals include increasing the number of KASPER users, encouraging current users to use eKASPER, and providing users with more information on how to identify patients who may be at risk for abusing or diverting medications.

Some online pharmacies do not report controlled substance prescriptions to KASPER as required. Illegitimate Internet pharmacies and the diversion they facilitate are national problems that require a national course of action.

Medicaid Modernization and the Medicaid Management Information System

This report's assessment of the Medicaid Management Information System and its integration with Medicaid modernization is limited because many of Program Review staff's questions remained unanswered by the Department for Medicaid Services. Another study of the MMIS and related systems would need to be conducted to cover unresolved issues.

In order to improve recipient health care and manage costs more effectively, Kentucky Medicaid proposed an overhaul of the Medicaid program itself. The U.S. Centers for Medicare and Medicaid Services (CMS) gave preliminary approval to the proposal, called a 1115 waiver, in January 2006. The waiver plan, called KyHealth Choices, includes a number of distinct health plans tailored to the needs of recipients, increased recipient cost sharing, and individual health care accounts for some recipients.

In support of Medicaid modernization, Kentucky Medicaid has contracted with two specialized contractors to improve the quality of medical care and to control costs.

The contract for a pharmacy benefit administrator was awarded to First Health Services in 2004. In 2005, the contract for a Medicaid administrative agent to manage utilization of health care and to perform other services was also awarded to First Health Services. First Health has taken over some of the administrative functions of the Medicaid program, but its systems may not be implemented fully until later in 2006.

Another key element of modernization is the building of a replacement for the existing Medicaid Management Information System. An MMIS comprises one or more software packages and databases. The information stored in the system includes provider enrollment, recipient eligibility, benefit plan coverage rules, prior service authorizations, and service claims for health care. The software tools process and pay claims and allow Medicaid personnel to update information and manage Medicaid.

The MMIS contract was awarded to Electronic Data Systems (EDS). EDS took over operation of the existing MMIS in November 2005 and is scheduled to have a new MMIS in full operation by November 2006.

The *State Medicaid Manual* from CMS lists the functions, called subsystems, that the MMIS must perform:

- The Provider subsystem contains a database of Medicaid providers. Functions include enrolling, certifying, and updating provider information.
- The Recipient subsystem contains member eligibility data and third-party payer information.
- The Reference File subsystem contains a reference library of information and code sets needed to run the MMIS, including the billing, diagnosis, and formulary codes for health services. It maintains the file of reasonable and customary charges and all other reference information needed by other subsystems. It also provides access to claims history for detecting duplicate claims and access to listings of suspended claims.
- The Claims Processing subsystem receives claims for health care services and processes them; checks to see whether the service is covered for a member who was eligible at the time of service; determines whether other insurance should pay instead of Medicaid; checks that the provider was properly enrolled at the time of service; verifies that the claim meets program rules; and determines whether a claim should be paid, denied, or suspended for further review. The subsystem then pays the payable claims in a timely manner and issues remittance advice forms.
- The Surveillance and Utilization Review subsystem provides reporting, statistical analyses, and other tools to ensure quality of services and to detect improper payments. The subsystem supports efforts to identify and correct misutilization of services and to monitor the level of care and quality of services; provides access to reports and data for medical review and fraud control units; and keeps a history of adjudicated claims from which the reporting and analyses are done.

- The Management and Administrative Reporting subsystem supports overall Medicaid program administration, including production of federally required reports.

Traditionally, the MMIS was seen as a self-contained system with subsystems that performed all the required functions. CMS now recognizes that separate software systems can perform some of the MMIS functions. In practice, this means that the traditional MMIS functions in Kentucky are shared among the three Medicaid modernization contractors.

Several kinds of specialized software supplement the basic MMIS for surveillance and utilization review functions and detection of fraud and abuse. These include data warehouses, decision support systems, and fraud and abuse detection systems.

Department for Medicaid Services officials—both in the wording of the requests for proposals and in interviews—indicated that the MMIS, administrative agent, and pharmacy benefit vendors would have to work out many of the details regarding the division of labor. The requests for proposals were intentionally ambiguous about several functions to allow the greatest flexibility on the part of the bidders. During the design, development, and implementation process, the three major vendors will negotiate the boundaries of their tasks.

For certain areas of functionality, however, Program Review staff raised some concerns that department officials did not adequately resolve. Many of the concerns involved apparent duplication of software or duplication of effort. Other concerns were not related to the tasks themselves, but rather to the proposed schedule and project management.

An improper payment can occur accidentally when a claim has the wrong procedure code or other information. It can occur when unnecessary medical care is provided or when a recipient is not eligible for the service. It also can occur when an unscrupulous provider intentionally bills for a procedure that was not performed. It is far more desirable to avoid paying an improper claim in the first place than to attempt to recover the funds later. Primarily, this is done by applying edits and audits to the claims to make sure the claims meet program rules and do not fit patterns known to indicate likely improper claims. Edits are rules that apply to a single claim, making sure the information on the claim is self-consistent. Audits are rules that compare the current claim against the history of claims and other information for that recipient or provider, making sure the claim is consistent with the medical history or provider practice. In Kentucky, the administrative agent, pharmacy benefit administrator, MMIS, other vendor staff, and the Office of Inspector General all work to improve the system of edits and audits.

CMS has broadened its definition of systems that qualify for enhanced federal financial participation. In its approval letter for the Kentucky pharmacy benefit administrator, CMS approved federal financial participation of 50 percent but noted that Kentucky could submit a "cost distribution plan" that described the functions of the pharmacy benefit administrator that are "qualifying [MMIS] functions" as defined in the *State Medicaid Manual*. If approved, such a plan would result in federal participation of

90 percent for the purchase and development of systems and 75 percent for operations, prorated to the specified functions.

Program Review staff's examination of the pharmacy benefit administrator procurement suggested that many of its functions do correspond to MMIS functions in the *State Medicaid Manual*. To qualify for the 90 percent federal participation, however, the state must obtain rights to the software, which the pharmacy contract does not appear to grant.

Enhanced funding for administrative agent systems is less clear but CMS might consider such funding. The contract did not grant software rights to Kentucky and did not include any startup costs. If startup costs could be identified, some enhanced funding might be available. A limited amount of enhanced funding for operations might be available.

Medicaid Fraud, Abuse, and Other Improper Payments

Kentucky's Medicaid Program is at high risk for making improper payments. Improper payments include inadvertent errors, such as duplicate payments and calculation errors; payments for unsupported or inadequately supported claims; payments for services not actually received by Medicaid recipients or rendered to ineligible recipients; and payments resulting from outright fraud and abuse.

Medicaid fraud controls in Kentucky are the joint responsibility of the Office of the Attorney General and the Department for Medicaid Services. Many of the department's responsibilities are delegated to its contractors, including the Cabinet for Health and Family Services' Office of Inspector General and the operator of its MMIS, Electronic Data Systems. In simplified terms, the contractors are charged with preventing and detecting fraud, abuse, and errors, whereas the Office of the Attorney General's Medicaid Fraud and Abuse Control Division is responsible for investigating and prosecuting fraud.

Some incidents of Medicaid fraud in Kentucky can be discovered by analyzing information from the MMIS. For example, if cases involve fee-for-service provider billings, the relevant information would be the claims submitted by the providers for payment. Information from the provider claims is stored in the MMIS. Trend reports often are used to identify providers whose levels of service differ significantly from those of their peers.

In other cases, the MMIS cannot document fraud, but information from the MMIS may be useful. This report cites instances in which Medicaid fraud due to patient neglect was initially reported by other sources. However, analysis of claims information from the MMIS was later used to determine liability to the Medicaid program because the provider billed for health care services not provided.

Some fraudulent acts cannot be discovered by analyzing information from the MMIS. These cases involve entities that report inaccurate information to the Medicaid program to increase their profits. Such cases normally come to light from whistle-blower lawsuits filed under the federal False Claims Act and involve multiple Medicaid programs in

many states. These cases illustrate that computerized systems are one tool but are not a panacea in preventing and detecting Medicaid fraud and abuse.

Given the importance of the efforts of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division, adequate funding is essential. The state Medicaid Fraud Control Units are reimbursed by the federal government for 75 percent of their costs. No state accesses all the federal funds available. In Kentucky, nearly 90 percent (more than $9 million) of available federal funding was not drawn down in 2004. Approximately $3 million in state funds would have been required to increase federal funding by this amount.

The extent of Medicaid's improper payments has not been measured at the state or national level. The purpose of the federally funded Payment Accuracy Measurement project was to determine the accuracy of payments made by Medicaid and the Children's Health Insurance Program. Kentucky's Medicaid program participated in the project and issued a report in January 2005. The project measured an overall payment accuracy rate of 94 percent with a total dollar error of $48 million for underpayments and overpayments. The estimated error amount does not imply that the Medicaid program could immediately collect overpayments of $48 million from providers.

The research methods of the federal projects were not designed to detect false claims. A false claim can be defined as a claim that contains a material falsehood but is billed correctly, processed correctly, and paid by Medicaid. The falsehood may be accidental or deliberate. Investigations of false claims would involve, at the least, contacting patients or others who would be knowledgeable as to whether services were provided as billed.

The Cabinet for Health and Family Services' Office of Inspector General helps prevent and detect errors, fraud, and abuse against the Medicaid program. The office's Division of Fraud, Waste and Abuse/Identification and Prevention collects and analyzes information to prevent improper payments and to detect and recover improper payments already made. The division administers the contract for identifying third-party liability for claims presented to Medicaid for payment. KRS 205.623 requires insurance companies to provide coverage information and data on claims paid on behalf of Medicaid-eligible policyholders and dependents but does not include a penalty for noncompliance. Collections and avoided costs due to third-party liability are increasing. In fiscal year 2005, more than $755 million in cost was avoided, and more than $42 million was collected.

The Division of Special Investigations operates the Office of Inspector General's hotline; conducts preliminary investigations of allegations against providers and recipients; and serves as the direct contact to law enforcement, prosecutors, and judges. In addition, the division has recently created an administrative civil enforcement team to pursue cases administratively and to recover overpayments through civil settlements.

The Office of the Attorney General's Medicaid Fraud and Abuse Control Division investigates allegations of provider fraud only. If the division declines to pursue a case

against a provider, the case is returned to the Office of Inspector General. However, the Office of Inspector General is limited in its ability to independently pursue the case. The office must enlist the aid of a U.S. attorney for criminal prosecution, or it can attempt to apply an administrative action, such as disenrolling the provider. The office's options are limited because it does not have administrative subpoena power and is limited in its ability to impose civil penalties.

The goal of the Division of Audits and Detection in the Office of Inspector General is to perform internal audits of the programs in the Cabinet for Health and Family Services.

Under the federal False Claims Act, a prosecutor does not have to prove criminal intent on the part of a provider that submits false claims. A prosecutor only has to prove that an entity knowingly made a false claim or presented false information to a federal agency to obtain payment. These cases often come to light through the efforts of whistle-blowers, typically persons who work for or have previously worked for the corporations charged under the Act. Sixteen states also have false claims statutes, but Kentucky is not one of them. The federal Deficit Reduction Act of 2005 will provide additional resources to states that have a false claims statute that satisfies federal requirements. When the state brings an action under its statute and recovers Medicaid funds related to false or fraudulent claims, the federal government will decrease by 10 percent the amount that must be returned to the federal government.

Recommendations

The report has 20 recommendations.

2.1 The Cabinet for Health and Family Services' Office of Inspector General should develop an estimate of the cost and effort involved in adding the method of payment field to KASPER, as recommended by the House Bill 303 Prescription Drug Abuse Task Force. This estimate should include the changes needed by pharmacies that report information to KASPER and should consider any options that might minimize such changes. The cabinet should report its findings to the Program Review and Investigations Committee and the Health and Welfare Committee.

3.1 The Department for Medicaid Services should evaluate whether it would be feasible and desirable to maintain in Kentucky a duplicate copy of Medicaid data stored by vendors outside Kentucky. The department should ensure that adequate contractual obligations are in place for vendors to transfer all Medicaid-related data to the Commonwealth upon termination of the contracts.

3.2 The Department for Medicaid Services should ensure that the MMIS and enterprise data warehouse contain full information about pharmacy and managed care claims, including all claims data fields, attempted claims that were denied, resubmissions, prior authorizations, adjustments, and corrections.

3.3 The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's pharmacy benefit software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the pharmacy benefit administrator should use EDS software to perform their tasks.

3.4 The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's administrative agent software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the Kentucky Medicaid administrative agent should use EDS software to perform their tasks.

3.5 The Department for Medicaid Services, the Office of Inspector General, and Medicaid vendors should review the need for multiple data warehouses and decision support systems. When feasible and cost effective, the enterprise data warehouse and decision support system should be used rather than having additional copies of the Medicaid data and additional decision support software.

3.6 The Department for Medicaid Services and the Office of Inspector General should take as aggressive a stance as possible to implement effective edits and audits and prevent improper payments. Both organizations should evaluate the benefits and disadvantages of point-of-service claims processing versus traditional batch processing, including manual review of suspended claims.

3.7 The Department for Medicaid Services should document and follow edit/audit management procedures that require high-level management control over any request to change or disable an edit/audit, that require immediate corrective action to reactivate the edit/audit, and that require prompt review of all affected payments and prompt recovery of all resulting improper payments.

3.8 For surveillance and utilization review, the Kentucky Medicaid administrative agent, pharmacy benefit administrator, related vendors, and the Office of Inspector General should include and analyze all available data from the MMIS and pharmacy benefit and managed care systems.

3.9 The Department for Medicaid Services should report the following information to the Program Review and Investigations Committee by December 2006:

- What measurements will be used to determine the health improvements and cost effectiveness of the pharmacy benefit administrator? Who will conduct the assessment and when will it be done?
- What measurements will be used to determine the health improvements and cost effectiveness of the Kentucky Medicaid administrative agent? Who will conduct the assessment and when will it be done?
- What measurements will be used to determine the health improvements and cost-effectiveness of the KyHealth Choices program? Who will conduct the assessment and when will the assessment be done?

3.10 The Department for Medicaid Services should consult with the Centers for Medicare and Medicaid Services about potential enhanced federal financial participation for the development and operational phases of the pharmacy benefit administrator and Kentucky Medicaid administrative agent contracts. If CMS so advises, the department should submit to CMS cost distribution plans for the systems in an effort to obtain enhanced federal financial participation. The department should report the CMS response to the Program Review and Investigations Committee by December 2006.

3.11 The Department for Medicaid Services should obtain a legal opinion on the rights of the Commonwealth to MMIS software developed under the MMIS contract, particularly pages 6-7 of the Master Agreement. If necessary, the contract language should be modified to ensure compliance with requirements of the Centers for Medicare and Medicaid Services.. The department should report the opinion and any action taken to the Program Review and Investigations Committee by December 2006.

4.1 The Office of the Attorney General should consider requesting additional state funding from the General Assembly to more fully access the federal funds to operate its Medicaid Fraud and Abuse Control Division. The office should allocate state appropriations to the division in amounts necessary to maximize access to the federal funds. If at any time the office believes additional state funds are necessary to access federal matching funds for operation of the Medicaid Fraud and Abuse Control Division, an emergency appropriation increase should be requested for the division utilizing unused or discretionary funds from other budget units within the Office of the Attorney General. This action by the office should be utilized to the greatest extent possible without significantly impairing other legal, investigative, and administrative functions. When requesting additional funds from the General Assembly during the budget process, the Office of the Attorney General should present a comprehensive plan with the request outlining how the new funds will be used and the expected results from the increased expenditures.

4.2 The General Assembly should consider appropriating additional state funds to the Office of the Attorney General for the specific purpose of accessing a larger amount of federal funds to operate its Medicaid Fraud and Abuse Control Division only after the office has shown that appropriation increases provided through fund transfers from other budget units within the office are insufficient to obtain the specified goals of the Medicaid Fraud and Abuse Control Division. Additional funding by the General Assembly should be made as a specific line-item appropriation for the purpose of accessing larger amounts of federal funds to operate the Medicaid Fraud and Abuse Control Division. Specified appropriations by the General Assembly should be contingent upon demonstrating, to an appropriate legislative committee, by the Office of the Attorney General actual results produced by the Medicaid Fraud and Abuse

Control Division and obtaining a determination by the General Assembly that the results warrant the additional funding requested.

4.3 To maximize Medicaid's ability to avoid paying claims that are the responsibility of a liable third party, the General Assembly may wish to consider amending KRS 205.623 to include a penalty for noncompliance.

4.4 The General Assembly may wish to consider amending KRS 194A.020(5) to enhance the ability of the Office of Inspector General to pursue administrative actions in allegations of fraud and abuse against the Medicaid program, including the ability to issue administrative subpoenas and impose civil penalties.

4.5 The Office of Inspector General should conduct a cost-benefit analysis of the initiatives of its Division of Special Investigations and its Division of Audits and Detection and report the results to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

4.6 The Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General should work with Medicaid contractors to develop a plan for controlling fraud against Kentucky's Medicaid program. The plan should consider the roles of the Department for Medicaid Services, the Office of Inspector General, the Office of the Attorney General, and each relevant contractor, and should provide a timeline for implementing a cohesive fraud control strategy. The Department for Medicaid Services should report the plan to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

4.7 The Office of the Attorney General's Medicaid Fraud and Abuse Control Division and the Cabinet for Health and Family Services' Office of Inspector General should work together to explore the feasibility of implementing a false claims statute in Kentucky. Issues to be considered include required staffing of all agencies, required monetary resources, and a cost-benefit analysis of implementing such a statute. The two agencies should present a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, the Health and Welfare Committee, and the Judiciary Committee.

4.8 The Cabinet for Health and Family Services should a) reexamine the costs and benefits of providing greater financial incentives to county child support offices for improving enforcement of medical support orders and b) determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care through the Medicaid program and the Kentucky Children's Health Insurance Program. The cabinet's Department for Medicaid Services and Department for Community Based Services should provide a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

Glossary

Capitation is a method of payment for medical services. A periodic predetermined payment is made for a group of members as a whole, rather than for individual services. The capitation rate is the same, regardless of the number of services provided to a member.

DDI is the design, development, and implementation phase of building an MMIS.

A **decision support system (DSS)** is a software system that manipulates information to answer questions about the enterprise.

The system of Web-based access to KASPER is **eKASPER**.

An **encounter** is an individual service performed by a capitated managed care organization (MCO). MCOs are paid on a capitated basis and submit data about encounters instead of submitting claims for payment.

The **False Claims Act (31 USC §§ 3729-3733)** is used by federal prosecutors to pursue civil actions involving false claims against the federal government, including its Medicaid and Medicare programs. Under the Act, a prosecutor has only to prove that an entity knowingly made a false claim or presented false information to a federal agency to obtain payment. In other words, the entity knew or should have known that the claim or information leading to a payment from the federal government was false. The prosecutor does not have to prove criminal intent to defraud the government to obtain a False Claims Act judgment.

Federal financial participation (FFP) is the federal government's financial match to the state's spending on the Medicaid program.

Fee-for-service (FFS) is a method of payment for medical services. A medical provider will submit a claim for each service rendered and will be paid based on those claims.

A **formulary** is a list of medications approved for use and/or covered by the plan.

Fraud is an intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law.

Improper payments are overpayments, including amounts that should not have been paid or were paid for the wrong amount.

The **Kentucky All Schedule Prescription Electronic Reporting (KASPER) system** is a centralized system that monitors controlled substance prescriptions in Kentucky.

The primary objectives of the **Kentucky Medicaid administrative agent (KMAA)** are improving patient care and optimizing costs. The KMAA will administer provider enrollment, provider and member management, case and disease management, quality management, and several other functions.

A **managed care organization (MCO)** provides medical care to a group of members and receives a predetermined payment for the group as a whole, rather than submitting claims for services rendered.

The **Medicaid Information Technology Architecture (MITA)** model describes how future information systems should be built and certified. MITA is in the conceptual stage. CMS, the states, and vendors are working to flesh out the standard and show how it can be used.

A **Medicaid Management Information System (MMIS)** provides computer support for the state Medicaid agency. Medicaid staff members—state employees and contractors—use the system to manage the Medicaid program and to carry out other duties.

The purpose of the **Payment Accuracy Measurement (PAM)** federal demonstration project was to determine the accuracy of payments made by Medicaid and the Children's Health Insurance Program. State participation in the project was voluntary and 100 percent federally funded.

The purpose of the **Payment Error Rate Measurement (PERM)** pilot was to determine an error rate for payments made by Medicaid and the Children's Health Insurance Program.

A **pharmacy benefit administrator (PBA)** is responsible for handling and paying pharmacy claims, managing pharmacy usage, negotiating drug rebates, and handling pharmacy provider relations.

Program integrity consists of audit, evaluation, and investigation activities designed to improve the Medicaid program and protect it against fraud, waste, and abuse.

A **provider** is an individual, company, corporation, association, facility, or institution that is providing or has been approved to provide medical services, goods, or assistance to recipients under the Medicaid program.

Provider abuse consists of provider practices that are inconsistent with sound fiscal, business, or medical practices that result in unnecessary cost to the Medicaid program; that result in reimbursement for services that are not medically necessary or are excessive; or that fail to meet professionally recognized standards for health care.

A **recipient** is any person receiving or who has received Medicaid benefits.

Recipient abuse consists of recipient practices that result in unnecessary cost to the Medicaid program or the obtaining of goods, equipment, medicines, or services that are not medically necessary, are excessive, or constitute flagrant overuse or misuse of Medicaid benefits for which the recipient is covered.

The **Surveillance and Utilization Review Subsystem (SURS)** provides reporting, statistical analyses, and other tools to ensure quality of services and detect improper payments. It supports efforts to identify and correct misutilization of services and to monitor the level of care and quality of services. It also provides access to reports and data for medical review and fraud control units and keeps a history of adjudicated claims from which the reporting and analyses are done.

Third-party liability (TPL) is the legal obligation of health care sources to pay the medical claims of Medicaid beneficiaries before Medicaid pays these claims. Medicaid is the payer of last resort and only pays after TPL sources have met their legal obligation to pay. Third parties include private health insurance, Medicare, medical support from noncustodial parents, and estate recoveries.

Upcoding is billing for a higher level of service than the service actually performed by using an inappropriate billing code on the claim. Higher-level codes generate higher-level payments to providers.

Source: Compiled by Program Review staff.

Chapter 1

Overview and Major Conclusions

On November 9, 2004, the Program Review and Investigations Committee directed staff to review two computerized information systems used by the Commonwealth: 1) the Kentucky All Schedule Prescription Electronic Reporting system and 2) the Medicaid Management Information System. The committee also directed staff to review fraud and abuse in Kentucky's Medicaid program.

Objectives and Overview of the Report

Specific objectives of the study were as follows:

1. Review the new and proposed contracts for MMIS services and assess their features for identifying and controlling Medicaid fraud and abuse and misuse of prescription drugs.
2. Determine how the Cabinet for Health and Family Services and law enforcement agencies can coordinate efforts in identifying and controlling Medicaid fraud and abuse and misuse of prescription drugs.

This report consists of four chapters. Chapter 1 provides an overview of the report and describes the study's research methods and major conclusions.

Chapter 2 discusses the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system for collecting information on controlled substances dispensed in Kentucky.

Administered by the Cabinet for Health and Family Services, the Kentucky All Schedule Prescription Electronic Reporting system is a Web-based system used to collect information on drugs dispensed in Kentucky. Cabinet, law enforcement, and other authorized officials use KASPER to monitor patterns in prescribing, dispensing, and use of controlled substances. KASPER is helpful in identifying potential abuse and diversion of prescription drugs. Because of recent enhancements to the system, it is also known as enhanced KASPER (eKASPER). Chapter 2 describes the KASPER system and includes one recommendation on how it could be improved.

Chapter 3 describes the Medicaid Management Information System (MMIS) and its relationship to Kentucky's Medicaid modernization initiative. The MMIS is a computerized information system for Medicaid claims processing and information retrieval.

Chapter 3 describes the Medicaid Management Information System (MMIS) and its relationship to Kentucky's Medicaid modernization initiative. The MMIS is a federally required computerized information system for Medicaid claims processing and information retrieval. Required subsystems of the MMIS include the Surveillance and Utilization Review subsystem and the Management and Administrative Review subsystem. The information in these two subsystems can be used to identify potentially fraudulent, abusive, and other improper payments made by the Medicaid program. In this report, the term "improper payments" means overpayments and includes amounts that should not have been paid or were paid for the wrong amount. Kentucky recently contracted for a new MMIS that is designed to be superior to the existing system and will help the Medicaid program better manage the care provided to recipients under Kentucky's Medicaid modernization initiative. Different contractors are carrying out the various functions of a traditional MMIS. Chapter 3 includes 11 recommendations.

Chapter 4 discusses improper payments made by the Medicaid program due to fraud, abuse, and error. It also discusses unnecessary Medicaid payments caused by unenforced medical support orders.

Fraud and abuse are believed to be widespread throughout the nation's health care industry, including the Medicaid program. The U.S. Government Accountability Office has estimated that fraud and abuse represent as much as 10 percent of Medicaid expenditures in the United States each year. The Medicaid program can make improper payments for many reasons, including fraud, abuse, and error. Improper payments made by the Medicaid program are discussed in Chapter 4 of this report. Where possible, the report notes when information from computerized systems could be used to help identify improper payments. The chapter includes eight recommendations.

Appendix F contains the Office of the Attorney General's response to this report.

How This Study Was Conducted

For this study, Program Review staff interviewed officials in the Commonwealth, other states, and the federal government. Staff reviewed audit and research reports from Kentucky's Auditor of Public Accounts, 11 other state governments, the federal government, and nongovernmental sources relating to prescription drug abuse and diversion, health care information systems, and health care fraud and abuse. Staff attended two national conferences, one on the Medicaid Management Information System and the other on Health Care Fraud. In addition, staff reviewed contracts, requests for proposal, vendor proposals,

information system documentation, the *State Medicaid Manual*, and other policy and procedure manuals.

Major Conclusions

The subjects addressed in Chapters 2, 3, and 4 are important enough that any one could have merited its own report.

The KASPER system is effective in preventing and detecting prescription drug abuse and diversion. However, its usefulness could be improved.

The Web-based eKASPER system is effective in preventing and detecting prescription drug abuse and diversion. It is the most comprehensive system of its kind in the United States. With all its strengths, it could be made even more effective by adding information on the method of payment for prescriptions and by more quickly obtaining prescription information. In addition, having an interface to the Medicaid Management Information System would strengthen the Medicaid program integrity function.

Several vendors have contracts for MMIS functions that are tied to Medicaid modernization initiatives. Other contractors and the Office of Inspector General assess improper payments made by the Medicaid program. All systems and initiatives are not yet in place and so cannot be assessed. The committee may want to consider a future study to review the effectiveness of the new systems.

The new Medicaid Management Information System and Kentucky's Medicaid modernization plan must be considered together to understand either one. Several vendors have contracts for MMIS functions that are tied to modernization initiatives, and other contractors and the Office of Inspector General are involved in assessing improper payments made by the Medicaid program. However, numerous operational issues remain to be resolved among the contractors, the Department for Medicaid Services, and the Office of Inspector General. Medicaid modernization's goals of improved health care and optimized costs depend on the effectiveness of the information systems and the proposed Medicaid program initiatives. All the systems and initiatives are not yet in place and so cannot be assessed. The committee may want to consider authorizing another study, commencing as early as 2007, to review the effectiveness of the new Medicaid information systems.

Some improper payments made by the Medicaid program can be detected through the use of information in computerized systems. Other improper payments are not apparent from a review of such information. The Medicaid program also makes unnecessary payments because of unenforced dependent medical support orders.

The Medicaid program can make improper payments because of fraud, abuse, or error. Some improper payments can be detected through the use of information in computerized systems, while other improper payments are not apparent from a review of such information. In addition to improper payments, the Medicaid program makes unnecessary payments because of unenforced medical support orders for dependent children. Many issues surrounding improper payments could be addressed in part in the potential new study of Medicaid information systems. Other issues—such as medical support orders, funding, and possible statute revisions—are not related to computerized systems.

Chapter 2

Kentucky All Schedule Prescription Electronic Reporting System

KRS 218A.202 requires the Cabinet for Health and Family Services to establish a system to monitor the dispensing of controlled substances for Schedules II through V. That system is the Kentucky All Schedule Prescription Electronic Reporting system.

KRS 218A.202 requires the Cabinet for Health and Family Services to establish a system to monitor the dispensing of controlled substances for Schedules II through V. The Kentucky All Schedule Prescription Electronic Reporting system originated from the 1997 Prescription Drug Abuse Task Force and House Bill 115 from the 1998 Regular Session of the General Assembly. Before KASPER began operating in 1999, Kentucky had no centralized system that monitored controlled substance prescriptions. Descriptions and examples of the schedules of drugs are depicted in Table 2.1.

Table 2.1
Controlled Substance Schedules, Characteristics, and Examples

Schedule	Characteristics	Examples
I	High potential for abuse, has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision	Heroin Marijuana LSD
II	High potential for abuse, has currently accepted medical use in treatment in the United States or currently accepted medical use with severe restrictions, abuse of the substance may lead to severe psychic or physical dependence	Morphine Codeine Demerol OxyContin
III	Less potential for abuse compared to Schedules I and II substances, has currently accepted medical use in treatment in the United States, abuse of the substance may lead to moderate or low physical dependence or high psychological dependence	Tylenol with codeine Anabolic steroids
IV	Less potential for abuse compared to Schedule III substances, has currently accepted medical use in treatment in the United States, abuse of the substance may lead to limited physical dependence or psychological dependence compared to Schedule III substances	Valium Weight loss drugs
V	Less potential for abuse compared to Schedule IV substances, has currently accepted medical use in treatment in the United States, has limited physical dependence or psychological dependence liability compared to Schedule IV substances	Cough syrups

Sources: KRS Chapter 218A; Commonwealth of Kentucky. Legislative. *A Study* 3.

KASPER is operated by the cabinet's Office of Inspector General.

KASPER is operated by the Drug Enforcement and Professional Practices Branch in the Division of Fraud, Waste and Abuse/Identification and Prevention within the Cabinet for Health and Family Services' Office of Inspector General.

Purposes of the KASPER system include a) helping physicians and pharmacists provide the most appropriate medical treatment to patients and b) enhancing law enforcement's capabilities to investigate controlled substance problems.

The KASPER system was designed with many purposes. Prominent among them was to be a resource to physicians and pharmacists so they could provide the most appropriate medical treatment to patients. Physicians and pharmacists can obtain a history of the controlled substances prescribed for a patient to identify potential adverse drug interactions or drug abuse. KASPER also was intended to enhance law enforcement's capabilities to investigate controlled substance problems by providing access to prescription information (Commonwealth of Kentucky. Legislative. *A Study* 6). An example of such a problem is "doctor shopping," in which a patient may visit several doctors to obtain multiple controlled substance prescriptions by deception.

The use of KASPER has increased significantly.

The use of KASPER has increased significantly. Table 2.2 displays the annual growth in number of requests processed. During the first six months of operation in 1999, KASPER processed 3,105 requests. In 2005, the system processed more than 186,000 requests.

Table 2.2
Requests Processed by KASPER by Calendar Year

	2000	2001	2002	2003	2004	2005
Number of Requests Processed	36,172	71,381	95,032	109,442	122,469	186,279
Percent Growth From Prior Year		97.3%	33.1%	15.2%	11.9%	52.1%

Source: Information provided by Cabinet for Health and Family Services' Office of Inspector General.

Effect of Prescription Monitoring Programs

A growing body of academic research literature examines the impact of prescription monitoring programs in achieving better health care treatment and reductions in diversion of controlled substances. The literature generally indicates that prescription monitoring programs help reduce diversion and abuse (Simoni-Wastila and Thompkins). However, this literature has not examined the more recent prescription monitoring programs such as the enhanced KASPER system. In addition, the literature shows some evidence that prescription monitoring programs can lead to a chilling effect on appropriate medications being prescribed by physicians (Brushwood; Wagner et al.; Ross-Degnan et al.). Brushwood reported that the publicized disciplinary actions and the related risks associated with controlled substances resulting from prescription monitoring programs could lead providers to

focus more on the negatives of controlled substances and be fearful of an investigation (51). This situation leads physicians to be less likely to prescribe controlled substances, all other influences remaining the same. So far the chilling effect mentioned in the study has not been observed in Kentucky. Most feedback from prescribers indicates that they are more comfortable prescribing controlled substances based upon their use of KASPER.

Since KASPER's introduction, the average time to complete an investigation into doctor shopping has decreased from 156 days to 16 days.

Evidence shows that KASPER has been effective in assisting law enforcement investigations. In its 2002 report *Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion*, the U.S. Government Accountability Office stated that the average time for state drug control investigators to complete an investigation into doctor shopping in Kentucky was reported as about 156 days. After KASPER's introduction, the report stated, the average time for an investigation fell to about 16 days (3).

The introduction of the new Web-based eKASPER system has improved effectiveness because of the convenience and quick turnaround for most reports.

Officials with the Kentucky Bureau of Investigation of the Office of the Attorney General and the Office of Inspector General of the Cabinet for Health and Family Services expressed similar views that KASPER has aided law enforcement efforts immeasurably. Both staffs noted that they could not provide exact figures on KASPER's impact on controlled substance diversion. However, the collective professional feeling and sum of anecdotal evidence implies that KASPER has been effective in assisting law enforcement. Both staffs also commented that the introduction of the Web-based enhanced KASPER (eKASPER) has made the system more effective because of the convenience and quick turnaround for most reports.

Recent Changes in the KASPER System

Many recommendations of the 2003 Prescription Drug Abuse Task Force have been or are being implemented through legislative, regulatory, and policy change.

KASPER has undergone significant change from its original form in 1999 (Manchikanti et al. 309). In 2003, the Kentucky General Assembly established in House Bill 303 the Prescription Drug Abuse Task Force to propose recommendations and legislation that would improve the effectiveness of KASPER. The work of the task force led to a report detailing its recommendations and to the introduction of Senate Bill 14, which was enacted during the 2004 Regular Session of the General Assembly. The task force also made recommendations to improve KASPER that did not require legislative action but could be accomplished through regulatory changes. The Office of Inspector General provided the status of the recommendations of the task force and of directives enacted by

Senate Bill 14. Table 2.3 summarizes the office's response by task force recommendation.

Table 2.3
Summary of the Office of Inspector General's
Responses to the Recommendations in the House Bill 303
Prescription Drug Abuse Task Force Final Report

Task Force Recommendation	Summary of Office of Inspector General's Response
1. Submission of data by dispensers: Data should be submitted at least weekly, and the Cabinet for Health Services (CHS) should develop more efficient and effective methods for the transmission of point-of-sale data.*	Regulation changes have been filed to 902 KAR 55:110 requiring data submission every 8 days (currently 16 days). Based upon discussions with a large retail chain pharmacy, a request for proposals to contract for "near real time" data collection will be issued.
2. Dispensers should be required to submit data accurately.	KRS 218A.202(5) was modified to read: "The cabinet shall establish acceptable error tolerance rates for data. Dispensers shall ensure that reports fall within these tolerances. Incomplete or inaccurate data shall be corrected upon notification by the cabinet if the dispenser exceeds these error tolerance rates." The modifications to 902 KAR 55:110 will significantly curtail the ability of dispensers to report "dummy" numbers (000000) or (99999) to the system, which should improve the current auto-match process in the Web-based system.
3. Unique patient identifier requirement should be strengthened.	In the regulation changes filed for 902 KAR 55:110, the Office of Inspector General (OIG) hopes to limit the use of "dummy" identification numbers and require the reporting of Social Security or drivers license numbers, if they exist, for each person receiving a prescription for a controlled substance.
4. CHS should work with dispensing community to explore the possibility of adding data fields, particularly method of payment.	Discussions have been held, through the focus groups established as part of the Hal Rogers Grant program, regarding adding payer information to the database. However, a statute and regulation change would be required to specify a different data set, and each dispenser in the state would need modified dispensing software.
5. CHS should be given the authority to limit the length of time patient information remains active in the KASPER database.	KRS 218A.202(15) was added: "The Cabinet for Health and Family Services may limit the length of time that data remain in the electronic system. Any data removed from the system shall be archived and subject to retrieval within a reasonable time after a request from a person authorized to review data under this section." KASPER data for the prior three full years and the current year is maintained online.
6. The lag time between the request and the receipt of a KASPER report should be reduced.	In March 2005, the eKASPER system was introduced allowing "real time" access to data. Ninety percent of the Web requests for KASPER reports are ready to be printed by the requestor in less than 15 minutes.
7. CHS should enter into agreements with other states to share information.	Informal contacts have been made, but neighboring states either do not have active programs or their programs are so new they are not prepared to work on information sharing. OIG has hosted groups from Tennessee and Virginia and has ongoing discussions with Indiana and Ohio. Opportunities in this area will be furthered through the National Alliance for Model State Drug Laws and the National Association of State Controlled Substance Authorities. OIG will be represented at both meetings. New federal legislation may offer grant opportunities to neighboring states to build equivalent systems such that data can be shared.

8. Law enforcement agencies and officers should be allowed to share KASPER reports and information when working on joint or related investigations.	KRS 218A.202(8)(a) was added: "A peace officer specified in subsection (6)(b) of this section who is authorized to receive data or a report may share that information with other peace officers specified in subsection (6)(b) of this section authorized to receive data or a report if the peace officers specified in subsection (6)(b) of this section are working on a bona fide specific investigation involving a designated person. Both the person providing and the person receiving the data or report under this paragraph shall document in writing each person to whom the data or report has been given or received and the day, month, and year that the data or report has been given or received. This document shall be maintained in a file by each law enforcement agency engaged in the investigation."
9. The Board of Medical Licensure should be authorized to receive KASPER reports in certain instances.	KRS 218A.202(6)(f) was added. In addition to the purposes authorized under paragraph (a), the Cabinet for Health and Family Services is authorized to provide data to "the Kentucky Board of Medical Licensure, for any physician who is: 1. Associated in a partnership or other business entity with a physician who is already under investigation by the Board of Medical Licensure for improper prescribing practices; 2. In a designated geographic area for which a trend report indicates a substantial likelihood that inappropriate prescribing may be occurring; or 3. In a designated geographic area for which a report on another physician in that area indicates a substantial likelihood that inappropriate prescribing may be occurring in that area." In addition, the board has always had the ability under KRS 218A.202 to receive KASPER reports for active specific investigations on physicians. With the above changes from the 2004 Session, the board can now receive trend reports, which OIG is presently developing.
10. The Medicaid program should be given the authority to share KASPER reports and other information regarding overutilization of scheduled drugs with regulatory boards and law enforcement officials.	There were additions to KRS 218A.202: "A representative of the Department for Medicaid Services may share data or reports regarding overutilization by Medicaid recipients with a board designated in paragraph (a) of subsection (6) of this section" (8)(b), and "The Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B" (8)(c).
11. Judges, probation officers, and parole officers of drug courts should be allowed to request KASPER reports.	KRS 218A.202(6)(g) was added, which authorizes the Cabinet for Health and Family Services to provide data to "[a] judge or a probation or parole officer administering a diversion or probation program of a criminal defendant arising out of a violation of this chapter or of a criminal defendant who is documented by the court as a substance abuser who is eligible to participate in a court-ordered drug diversion or probation program...." Work is in progress to modify eKASPER to provide Web-based access to the appropriate judges. The system modifications are expected to be completed by the end of July 2006.

12. CHS should be required to use KASPER data for educational, research, and statistical purposes to proactively identify trends and potential problem areas.	KRS 218A.240(7) defines the requirement for the Cabinet for Health and Family Services to use the data for research, statistical analysis, and educational purposes. The cabinet utilized the Kentucky Injury Prevention and Research Center to analyze KASPER data from 2000-2002 and establish a data baseline for further analysis. The cabinet is currently working with the Board of Medical Licensure, the Board of Pharmacy, and the Board of Dentistry to identify KASPER data trend reporting requirements and a quarterly reporting process that will allow the boards to identify trends and potential problem areas that they may need to address. Trend reports based upon KASPER data will be posted in geographic information system map format on the KASPER Web site on a quarterly basis. The first set of reports will be posted on the Web site by the end of May 2006.
13. The Board of Pharmacy, Board of Medical Licensure, Kentucky Bar Association, and Justice Cabinet should work with CHS to develop continuing education programs regarding the purposes and appropriate use of the KASPER system.*	The Hal Rogers Grant working groups included members from the professional licensure boards and Office of Drug Control Policy in the Justice and Public Safety Cabinet. Activities to address the requirement for continuing education include 1. brochures explaining KASPER and its role in fighting prescription drug abuse (four versions address practitioners, law enforcement, attorneys, and the general public); 2. a KASPER exhibit for use at trade shows and meetings; 3. KASPER training presentations for physicians, pharmacists, and law enforcement on use of the system; 4. a training presentation designed for practitioners that covers professional intervention and use of KASPER (OIG is pursuing making this training available on the Web and providing continuing education credit for successful completion); and 5. publication of articles about KASPER in professional publications and trade journals and presentations on KASPER to practitioners, law enforcement, the legal community, and the general public.
14. CHS should convene a multidisciplinary group to assess the effectiveness of the KASPER system.	Under the 2004 Hal Rogers Grant, two interdisciplinary focus groups composed of law enforcement and health care professionals were assembled. The focus groups were further broken down into working groups that met to review KASPER and issues related to pharmaceutical drug abuse and diversion. In 2005, the working groups made recommendations, which are being implemented as are feasible. A survey of KASPER system users was completed in 2005. The survey results were generally positive and will provide a baseline to track satisfaction with the system as eKASPER training is implemented and use of the system increases.

*The former Cabinet for Health Services is now part of the Cabinet for Health and Family Services. The former Justice Cabinet is now part of the Justice and Public Safety Cabinet.
Sources: Commonwealth of Kentucky. Legislative. Prescription. v-vii; Program Review staff's compilation of responses provided by the Cabinet for Health and Family Services' Office of Inspector General.

State Appropriations

The eKASPER system became operational in early 2005. Initial results showed that 90 percent of reports requested were ready within 15 minutes.

With the passage of Senate Bill 14, the 2004 General Assembly appropriated $1.4 million to develop an enhanced KASPER system that would result in Web-based, real-time access to data for requesters. In March 2005, the Cabinet for Health and Family Services introduced the eKASPER system to allow users to access KASPER data in a real-time fashion and to automate the

generation of most reports. The cabinet reported that, in initial results, 90 percent of reports requested in the system were ready within 15 minutes (Commonwealth of Kentucky. Cabinet. Office). About 900 KASPER reports are generated by the electronic system each day, with approximately 100 being generated outside normal business hours.

Other Sources of Funding

Enhancement of the KASPER system has been funded by state appropriations and federal grants, including a Hal Rogers Prescription Monitoring Program Grant.

The cabinet also obtained a 2004 Harold Rogers Prescription Monitoring Program Grant, managed by the U.S. Bureau of Justice in coordination with the U.S. Drug Enforcement Agency, to improve KASPER. This $350,000 grant project, according to cabinet officials, had five primary goals:

- charter focus groups,
- generate a KASPER satisfaction survey,
- gather baseline data sets,
- create educational intervention, and
- identify stratified sample populations for research.

In July 2005, the cabinet submitted the Phase I Findings and Recommendations report to the U.S. Department of Justice listing the goals and the status of the grant.

One goal of the grant was to charter focus groups to recommend improvements to KASPER.

Two focus groups provided recommendations impacting five communities: professional licensure boards, health care providers, law enforcement, Cabinet for Health and Family Services, and the general public (Commonwealth of Kentucky. Cabinet. *Hal Rogers...Phase I* 5). Table 2.4 shows some of the focus groups' recommendations being addressed under the grant that were not addressed by Senate Bill 14.

Table 2.4
Selected Findings and Recommendations of the Hal Rogers Prescription Drug Monitoring Program Grant Working Groups

Recommendations	Status
Licensure boards should • study how KASPER reports are used in the field.	• This is being planned.
Health care providers should • disseminate descriptions to health care providers of the typical behaviors associated with improper shopping among providers of controlled pharmaceuticals and • develop training for health care providers on how to conduct interventions briefly.	• Information has been incorporated into current KASPER literature, newsletters, and journal articles. • Training is being developed.
Law enforcement should • streamline the investigative process by using summary statistics and • provide investigators lists of the typical behaviors associated with pharmaceutical diversion.	• This is being investigated. • A brochure has been developed and training is being planned.
The Cabinet for Health and Family Services should • develop a phased approach to reaching real-time data collection.	• A new regulation is being written to require reporting every 7 days and for a contractor to process the data in another 7 days.
The General Public should be • educated about controlled pharmaceutical addiction and KASPER's uses.	• A brochure has been developed and distribution is being planned.

Source: Program Review staff compilation of recommendations (Commonwealth of Kentucky. Cabinet. *Hal Rogers...Working Group).*

Another goal of the grant was to generate a KASPER satisfaction survey.

The cabinet designed and administered a KASPER satisfaction survey. The survey concluded in June 2005 with a total of 434 responses (Commonwealth of Kentucky. Cabinet. *Hal Rogers...Phase I* 17). Although this information was collected prior to the eKASPER system, it provides a snapshot of the opinions of law enforcement officials and medical professionals on the older version of KASPER.

Approximately 81 percent of surveyed users reported being either somewhat satisfied or very satisfied with KASPER.

Generally, surveyed users responded positively. Almost 81 percent of responders reported being either somewhat satisfied or very satisfied with the KASPER reporting system. About 86 percent of those surveyed reported that KASPER is an excellent tool for helping to identify doctor shoppers (18).

Although KASPER generally is viewed as effective, some users are concerned that the information in the database is not timely enough.

According to the grant's Phase I Findings and Recommendations Report, the satisfaction survey demonstrated that the medical community has generally accepted KASPER. The report also noted that, while there are many providers that do not use KASPER, they are very likely to begin using it when they become aware of the usefulness of the system. While the survey indicated that KASPER is viewed as generally effective, it also highlighted the concern of

some users that the data in the KASPER database are not timely enough (19).

Another goal of the Hal Rogers Grant was to develop a prototype Medicaid-eKASPER interface to assist in Medicaid's program integrity function.

The 2004 Hal Rogers Grant also had a focus on developing a prototype Medicaid-eKASPER interface. This interface was envisioned to allow improved access to KASPER data for Medicaid program integrity specialists in the Office of Inspector General's Division of Fraud, Waste and Abuse/Identification and Prevention.

The cabinet has been awarded a 2005 Harold Rogers Prescription Monitoring Program Grant in the amount of $350,000. According to the cabinet, the 2005 grant objectives are to highlight trends of suspect behavior, to improve KASPER business processes, to improve system performance, to improve monitoring of system access, and to design a way to monitor KASPER efficiency.

National Activity on Prescription Monitoring Programs

Kentucky has not been alone among states in developing a prescription monitoring system. As of August 2005, 22 states had an active prescription monitoring system and 4 more had enacted legislation to create one. Twenty-one additional states were considering a prescription monitoring program (U.S. Department of Justice).

The Hal Rogers Grants are a source of funds for such prescription monitoring programs. Another source is the Ed Whitfield Grants, which have similar objectives.

Potential Improvements to KASPER

Officials with Kentucky's Office of the Attorney General and Office of Inspector General suggested potential improvements to KASPER and noted issues that cannot be resolved by system changes.

Understanding the history and changes to KASPER provides context. However, as directed by the Program Review and Investigations Committee, identifying improvements that can be made to KASPER to increase the system's effectiveness is the next step. In addition to reviewing previous studies, staff contacted officials with the Office of the Attorney General and the Cabinet for Health and Family Services' Office of Inspector General for their perspectives on how KASPER could be improved. Suggested improvements include a Medicaid-eKASPER interface, tracking the method of payment, access to more timely data, unique person identifiers, interstate data sharing, and increased use of the system. Other issues include electronic prescribing and controlling Internet pharmacies.

Medicaid-eKASPER Interface

A Medicaid-eKASPER interface could improve the detection of controlled substance abusers who receive Medicaid benefits.

Medicaid program integrity could be improved considerably by developing a fully functional Medicaid-eKASPER interface. As noted in the Hal Rogers Grant Phase I Findings and Recommendations Report, such an interface could improve the detection of controlled substance abusers who receive Medicaid benefits (Commonwealth of Kentucky. Cabinet. *Hal Rogers...Phase I* 24).

Cabinet officials are working with the MMIS vendor to build the Medicaid-eKASPER interface. Federal funds cover 90 percent of the development costs and will pay 75 percent of operations.

A Medicaid-eKASPER interface prototype has been developed. Office of Inspector General staff indicated that, although the prototype demonstrated that the concept would work, the prototype had limited functionality and was not usable on the necessary scale. In order to build a full-scale system with expanded capability, Office of Inspector General officials are now working with the new Medicaid Management Information System vendor, Electronic Data Systems, to build the interface as part of the new MMIS. As part of the MMIS, federal funds cover 90 percent of its development costs and 75 percent of its operations.

Tracking Method of Payment

KASPER would be more useful if the method of payment was recorded in the system.

KASPER does not collect information on method of payment, although the 2003 Prescription Drug Abuse Task Force recommended this. KASPER would be more useful if it collected data on the method used to pay for a prescription, whether it is cash, private insurance, Medicaid, or Medicare. For instance, it would help Medicaid identify its own recipients, and cash transactions are key for identifying abusers (Commonwealth of Kentucky. Legislative. Prescription 15).

Office of Inspector General officials said they believe the statute would need to be changed because the original KASPER legislation did not include method of payment in the database. However, KRS 218A.202(4) says that the "data for each controlled substance that is dispensed shall include but *not be limited to* [emphasis added] the following: patient identifier, drug dispensed, date of dispensing, quantity dispensed, prescriber, and dispenser." Thus, there is no statutory restriction to including method of payment in the database.

Office of Inspector General officials noted that adding a field could be complicated and involve not only changes to KASPER's programming but also to the software used by reporting pharmacies. It is not clear how extensive the changes would be.

Office of Inspector General officials reported that the absence of method of payment has not been an issue generally among users of KASPER.

Recommendation 2.1

The Cabinet for Health and Family Services' Office of Inspector General should develop an estimate of the cost and effort involved in adding the method of payment field to KASPER, as recommended by the House Bill 303 Prescription Drug Abuse Task Force. This estimate should include the changes needed by pharmacies that report information to KASPER and should consider any options that might minimize such changes. The Office of Inspector General should report its findings to the Program Review and Investigations Committee and the Health and Welfare Committee.

Access to More Timely Data

Information in the KASPER database is about a month old. The age of the KASPER data is not an issue for law enforcement, but most health care practitioners report that the age of the KASPER data is a problem.

Another suggestion from some users of KASPER is that the database should contain more timely data. Officials in the Office of Inspector General stated that the data in KASPER's database is generally about a month old. Pharmacies are required to report the activity every 16 days to Atlantic Associates, the vendor that collects and prepares the prescription data. Atlantic Associates then has approximately two weeks to prepare the data and turn it over to KASPER.

Some users of KASPER indicated that the age of data is not a significant issue. Generally, for law enforcement activities, having data that are current to the day is not essential, according to officials of both the Office of the Attorney General and the Office of Inspector General. Diversion activities, such as doctor shopping, happen over time and can be detected and documented with the current KASPER time constraints.

The KASPER users most concerned with having more timely data are health care practitioners, according to Office of Inspector General officials. In the 2004 KASPER satisfaction survey, about 82 percent of respondents reported that the current time lag for data to enter KASPER's database is problematic. The cabinet is amending regulations to require data to be submitted within eight days. The officials also noted that they are considering a requirement for Atlantic Associates to implement a seven-day turnaround of data once they receive it. Both of these actions, if successfully implemented, will likely result in more timely data,

but the database will still continue to be roughly two weeks old at any given time.

More up-to-date information could be obtained directly from the electronic pharmacy network claims switching companies that route electronic claims to the appropriate payer.

One way to obtain up-to-date information is to obtain prescription transactions directly from the electronic pharmacy network claims switching companies. A pharmacy sends electronic claims to the claims switching service, and the service routes them to the correct payer. These claims switching companies currently handle the majority of prescription claims, regardless of method of payment, and the transactions occur as the prescriptions are being filled. However, the claims switches do not receive transactions on veterinary medicines or drugs dispensed directly by physicians.

Cabinet officials plan to issue a request for proposals and start receiving pharmacy transactions electronically by the end of 2006.

Office of Inspector General officials stated that obtaining electronic prescription information is one of their top priorities. The officials also stated their belief that the cost per transaction would be minimal. The cabinet plans to issue a request for proposals by the end of July 2006 to implement this data collection process. Collection of data should begin by the end of 2006.

Cabinet officials are examining the contract with Atlantic Associates to determine the changes that would be needed if a switching company were used to obtain most of the prescription data.

Unique Person Identifiers

A commonly cited shortcoming of KASPER is the lack of a unique person identifier in the database.

One of the most commonly cited shortcomings of prescription monitoring programs is the lack of unique person identifiers in their databases. This issue was raised in the House Bill 303 Prescription Drug Abuse Task Force Final Report in 2003 and the 2004 Hal Rogers Grant Phase I Findings and Recommendations Report. An entry into the KASPER database corresponds to one filled controlled substance prescription. Therefore, there is a new entry into the KASPER database with every controlled substance prescription filled in Kentucky, no matter who the patient is. Patient Joseph W. Doe who fills 12 prescriptions in a year will generate 12 records in KASPER. When pulling a report on an individual, the entire KASPER database is searched. For KASPER to be even more effective in producing prescription results for individuals, each record must be correctly linked to a unique individual. For example, if Joseph W. Doe has one prescription under the name Joe Doe, one under the name Joe W. Doe, and 10 under the name Joseph W. Doe, a search on the name Joseph W. Doe might identify only 10 records rather than 12.

Without a unique person identifier, the task of associating prescription records with an individual can be difficult and result in some inaccuracy.

In practice, without a required unique identifier, the task of associating different prescription records with an individual can be difficult and result in some inaccuracy. Without a single identifier, different identifiers that are not unique (such as birth date, gender, and last name) must be combined to link prescriptions with an individual.

The cabinet has developed an automated matching system that is as accurate as or more accurate than the previous manual system.

Before eKASPER, identifying individuals for KASPER reports was done exclusively by staff searching the KASPER database. For eKASPER, this approach was not feasible, and the cabinet developed an auto-matching system that uses a number of algorithms to isolate individuals so a KASPER report can be generated without human involvement. Office of Inspector General officials commented that, in their tests, the auto-matching system was generally at least as accurate as, and often more accurate than, staff matching. While the auto-matching system's goal is to identify and group prescriptions by an individual, it is not foolproof. If the matching system cannot complete a request, the request is manually investigated by staff.

Officials plan to amend a regulation to require reporting of a Social Security number or a driver's license number for the person prescribed the controlled substance.

The Prescription Drug Abuse Task Force Final Report specifically recommended that the patient identifier requirement be strengthened through regulatory change. Office of Inspector General officials have filed a regulation change to require reporting the Social Security number or driver's license number (if either exists) for the person prescribed the controlled substance. Office of Inspector General officials commented that a prescription cannot be denied to a patient for lack of identification. In addition, any requirement for providing a unique identifier could raise a number of issues, such as when medications are picked up by another person, when medications are for minors, or when the patient does not have a Social Security card or driver's license.

Interstate Data Sharing

Another shortcoming in the KASPER database is the absence of information on prescriptions filled outside Kentucky. Many other states do not have systems that can share data with KASPER.

Another pertinent issue for KASPER is that it does not have data on prescriptions filled outside Kentucky. For example, if a Kentucky physician writes a controlled substance prescription in Kentucky, but the patient fills the prescription at a pharmacy in Indiana, KASPER would have no record. This problem is a symptom of other states not having systems that can share data with Kentucky and KASPER, rather than a shortcoming of KASPER. Office of Inspector General officials report increased interest by other states in developing a monitoring system, but much work is needed before any significant data sharing can take

place. Until other states have the capacity to collect data similar to that in KASPER, little formal data sharing is possible.

Interstate data sharing is a top priority for KASPER.

Office of Inspector General officials stated that interstate data sharing is another top KASPER priority. Kentucky is working with Indiana to develop a data-sharing protocol between KASPER and the existing Indiana registry. Ohio has a vendor in the process of implementing a prescription monitoring program and has talked with Kentucky officials about sharing data with KASPER.

Federal grants encourage states to implement monitoring systems similar to KASPER and to share information among states.

The Whitfield Grants give states a greater incentive to develop and implement monitoring systems similar to KASPER. Similar systems can lead to significant data sharing among states. Office of Inspector General officials said that Kentucky's statute already allows such state-to-state sharing. The grants also direct minimum standards and requirements on how and what data should be collected or created that will promote baseline standards to facilitate data sharing between state monitoring programs.

Even though KASPER cannot share electronic data with other states' prescription monitoring programs, qualified individuals in other states use KASPER reports. Some of these individuals have been granted access to eKASPER. Thus, Kentucky assists other states in combating diversion.

Increased Use of KASPER

The overall effectiveness of KASPER could be improved with increased use. Cabinet officials estimated that only half the eligible health care practitioners in Kentucky use KASPER regularly.

The overall effectiveness of KASPER could be improved with increased use. Office of Inspector General officials reported that KASPER has more than 1,700 medical users and 500 law enforcement users. The officials estimated that about half the eligible health practitioners in the state use KASPER regularly. Primary goals include increasing the number of KASPER users, encouraging current users to use eKASPER, and providing users with more information on how to identify patients that may be at risk for abusing or diverting medications. Officials indicated that considerable efforts are being made to educate and encourage current and potential KASPER users.

Electronic Prescribing

An initiative in achieving electronic health information technology systems is electronic prescribing, e-Rx. One advantage of e-Rx is preventing forged or altered prescriptions.

Among the many initiatives toward electronic health information technology systems is the electronic prescribing initiative, e-Rx, which begins with the physician or other prescriber. The prescriber uses a handheld computer or other device to enter prescriptions. An e-Rx system then transmits the information to a data repository that is available to the pharmacy. Advantages of e-Rx include prevention of medication errors due to misread prescriptions, prescription forgery, and drug interactions through the use of the prescription history available to the prescriber and pharmacist (U.S. Dept. of Health. Office of the National).

A pilot study of e-Rx was conducted in 2004 at the direction of the General Assembly.

In 2002, the General Assembly enacted House Bill 26, which authorized a pilot study of e-Rx. The pilot was conducted over the course of 2004 using the e-Rx vendor Veriscrip and was evaluated by the University of Louisville. The evaluation made several key points:

- Participants were unanimously enthusiastic about the potential for the system.
- The prescribers were not enthusiastic about the time and costs involved in adopting and using the system.
- The system has the potential to reduce drug diversion and enhance patient care.
- Veriscrip did not provide hard evidence that its system could easily expand to statewide application.
- The Web-based eKASPER system was not considered when comparing Veriscrip with KASPER.

Office of Inspector General officials view e-Rx as a potential enhancement rather than an alternative to KASPER.

Office of Inspector General officials stated that they do not perceive e-Rx as an alternative to KASPER, but they are open to the concept as a potential enhancement. The primary area of improvement would be to prevent the forging or altering of prescriptions. KASPER already contains a history of controlled substance prescriptions, and e-Rx would add nothing to that. If eKASPER is successful in obtaining real-time access to pharmacy transactions, it will operate on a similar timeframe to e-Rx. Some value might be added by e-Rx obtaining information at the time the prescription is written rather than filled. This might aid in the initial identification of the patient, but it would not prevent drugs from being intercepted by a third party at the pharmacy. Thus, the major benefits of e-Rx are medical and not related to drug enforcement.

Controlling Out-of-state and Internet Pharmacies

A significant issue in the diversion of controlled substances is the role played by illegitimate out-of-state and Internet pharmacies. Such pharmacies do not report to KASPER. A national cooperative effort is required.

One recurring theme concerning the diversion of controlled substances was the role played by out-of-state and Internet pharmacies. All pharmacies shipping controlled substances into Kentucky are required to register with the Kentucky Board of Pharmacy and to report transactions to KASPER. A number of legitimate online and out-of-state pharmacies do register with the board and report controlled substance prescriptions to KASPER. However, Office of the Attorney General and Office of Inspector General officials commented that the problematic pharmacies are those that do not register and/or report to KASPER. The officials noted that the Internet pharmacies not registering and reporting are generally "fly-by-night" operations with little medical purpose.

At its May 10, 2006, meeting, the Kentucky Board of Pharmacy took steps to strengthen the application process for out-of-state pharmacies, including Internet pharmacies. The new application form requires owners and officers to report their Social Security numbers, dates of birth, and all business and home addresses and telephone numbers. The pharmacy must submit a pharmacy permit verification form, part of which must be completed by the Board of Pharmacy in the state in which the applicant is located. In addition, the pharmacist-in-charge and the owner must submit a notarized memorandum of understanding and agreement acknowledging that they have read, understand, and agree to abide by applicable state laws and regulations, which are listed on the agreement. As a result, each pharmacy that registers with the board will know about the KASPER reporting requirements in KRS 218A.202.

Officials with the Office of Attorney General noted that law enforcement has intercepted some diverted controlled substances by working with package shippers. One example of such cooperation was the confiscation of 58 packages in August 2005 of diverted prescriptions at the Lexington FedEx Distribution Center. FedEx employees alerted the Kentucky Bureau of Investigation of a potential problem (Alessi).

As an Office of Inspector General official commented, illegitimate Internet pharmacies and the diversion they facilitate are national problems that require a national course of action. Combating such activity requires cooperation among states and with shipping companies.

Chapter 3

Medicaid Management Information System

The Medicaid Management Information System supports management of Medicaid and adjudicates claims. The new MMIS and related systems are integral to Kentucky's Medicaid modernization plan.

A Medicaid Management Information System is a software and database system that provides computer support for the state Medicaid agency. State employees and contractors use the MMIS to manage the Medicaid program and to carry out their other duties. Information stored in the MMIS includes provider enrollment, recipient eligibility, benefit plan coverage rules, prior service authorizations, and health care service claims. The software tools process and pay claims and allow Medicaid personnel to update information and manage the Medicaid enterprise. The new MMIS and related systems are an integral part of Kentucky's ambitious Medicaid modernization plan.

Department for Medicaid Services officials did not answer several of Program Review staff's questions. Another study would be needed to cover unresolved issues.

This chapter reviews the role of information systems. First, the basic structure and functions of an MMIS are explained. Then, the process of building a new MMIS is described. Next is a summary of the systems involved in Kentucky's Medicaid modernization, followed by an assessment and recommendations. The assessment is limited because many questions asked by Program Review staff remained unanswered by the Kentucky Department for Medicaid Services. Another study of the MMIS and related systems would need to be conducted to cover the unresolved issues in this chapter.

Eleven recommendations address concerns about plans for the new MMIS and related systems.

The chapter's 11 recommendations relate to information systems and encompass specific concerns about

- the physical location of Medicaid data,
- MMIS inclusion of other vendors' claims information,
- potential duplication of effort and resources,
- prevention and detection of improper payments,
- measurement of cost savings and health care outcomes, and
- additional federal funding that may be available.

Status of the System

Two key parts of Medicaid modernization were 1) hiring experts to improve quality of care and control costs and 2) replacing the existing MMIS.

In 2004, the Kentucky Department for Medicaid Services embarked on a plan for Medicaid modernization. One key element of the plan was hiring two specialized contractors to improve the quality of medical care and to control costs. Another key element was building a replacement for the existing Medicaid Management Information System.

Three contracts have been awarded:
- Pharmacy Benefit Administrator (First Health Services),
- Kentucky Medicaid Administrative Agent (First Health Services), and
- MMIS (Electronic Data Systems).

The first request for proposals (RFP) issued was for a pharmacy benefit administrator to manage prescription usage, pay pharmacy claims, and contain costs. The contract was awarded to First Health Services Corporation in August 2004; First Health took over the pharmacy benefit on December 4, 2004.

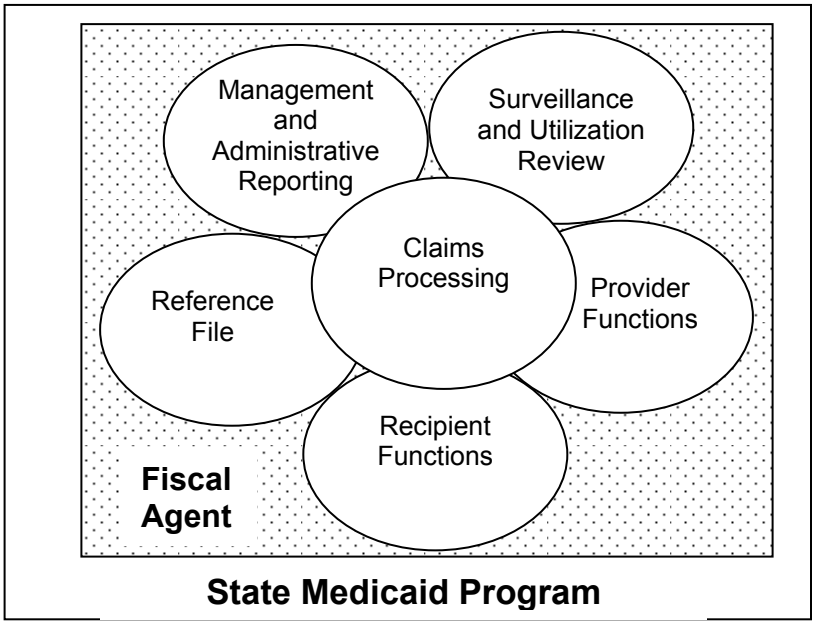
An RFP was issued for the Kentucky Medicaid administrative agent to manage health care utilization, contain costs, and perform other services. It was issued in September 2004 and also awarded to First Health Services Corporation in June 2005. First Health has taken over some of the administrative functions of the Medicaid program and was scheduled for full operation by January 1, 2006. Its systems may not be implemented fully until later in 2006.

The MMIS RFP also was issued in September 2004. It was awarded to Electronic Data Systems in June 2005, which took over operation of the existing MMIS in November 2005. It is scheduled to have a new MMIS in full operation by November 1, 2006.

Structure and Functions of an MMIS

The *State Medicaid Manual* from the U.S. Centers for Medicare and Medicaid Services (CMS) lists the functions that the MMIS must perform. Each functional area is called a subsystem, and CMS lists a number of requirements for each. The six subsystems are shown in Figure 3.A and described in Table 3.1.

Figure 3.A
Medicaid Management Information System and Users: Traditional Model



Source: Adapted by Program Review staff from U.S. Dept. of Health. Centers. "Medicaid" slide 23.

Table 3.1
Description of MMIS Subsystems

Subsystem	Description
Provider	This subsystem contains a database of Medicaid providers. Functions include enrolling, certifying, and updating provider information.
Recipient	This subsystem contains member eligibility data and third-party payer information. It supports the Medicare Part B buy-in program, and it performs Early and Periodic Screening, Diagnosis, and Treatment functions.
Reference File	This subsystem contains a reference library of information and code sets needed to run the MMIS, including billing, diagnosis, and formulary codes for health services. It maintains the file of reasonable and customary charges and all other reference information needed by other subsystems. It also provides access to claims history for detecting duplicate claims and access to listings of suspended claims.
Claims Processing	This subsystem receives claims for health care services and processes them; checks to see whether the service is covered for a member who was eligible at the time of service; determines whether other insurance should pay instead of Medicaid; checks that the provider was properly enrolled at the time of service; verifies that the claim meets program rules, such as prior authorization, amount billed, or number of allowable services; and determines whether a claim should be paid, denied, or suspended for further review. The subsystem then pays the payable claims in a timely manner and issues remittance advice forms. It handles credits, adjustments, and corrections to claims. The subsystem keeps audit trails and historical records and provides access to information to handle inquiries about claims and member eligibility.
Surveillance and Utilization Review	This subsystem provides reporting, statistical analyses, and other tools to ensure quality of services and to detect improper payments.[1] The subsystem supports efforts to identify and correct misutilization of services and to monitor the level of care and quality of services; provides access to reports and data for medical review and fraud control units; and keeps a history of adjudicated claims from which reporting and analyses are done.
Management and Administrative Reporting	This subsystem supports overall Medicaid program administration. It provides information for budgeting and fiscal control, for evaluating policy and regulation, for monitoring claims and payments, and for reviewing provider and member activity to develop more effective programs. This subsystem produces federally required reports and performs several other tasks.

Source: Program Review staff's summary of U.S. Dept. of Health. Centers. *State Medicaid Manual*, §§11310-11340.

[1] In this report, improper payments are defined as overpayments and include amounts that should not have been paid or were paid for the wrong amount.

A fiscal agent generally has the responsibility for operating the MMIS and often uses the MMIS to perform other tasks.

In most states, a vendor called the fiscal agent has the responsibility for operating the MMIS and often handles provider relations and other functions. State Medicaid program staff use the MMIS to perform their jobs. The line between the fiscal agent and state staff varies from state to state. In some states, the vendor does no more than build and house the MMIS; state staff operate the system. In other states, the fiscal agent operates the system and provides its own personnel to carry out various administrative tasks. State staff mostly monitor the vendor's performance.

Changing Views of the MMIS

Traditionally, the MMIS was seen as a self-contained system with subsystems that performed all the required functions. As technology advanced and state and federal agencies gained more experience, CMS recognized that separate software systems can perform some MMIS functions.

The definition of MMIS is changing toward a set of tasks that can be performed by a number of related software components. Some separate systems can now be counted as MMIS related.

CMS recognizes that data warehouses and decision support systems are important to the surveillance and utilization review subsystem. A data warehouse is a separate copy of data from one or more systems kept in one place, often with additional information included. A decision support system manipulates information to answer questions about the enterprise. Even when a data warehouse or decision support system is not directly part of MMIS, CMS counts it as satisfying some surveillance and utilization review functions.

CMS officials have expressed openness to viewing other software systems as MMIS related, including pharmacy benefit systems and possibly other vendors' systems.

In the past, the claims processing subsystem was seen as the core of the MMIS, with all other subsystems performing support functions. This was consistent with Medicaid's emphasis on paying claims.

Federal and state emphasis has shifted from paying claims to purchasing quality medical services at the lowest reasonable cost. The importance of care and cost management has increased.

Federal and state emphasis has shifted from paying claims to purchasing quality medical services at the lowest reasonable cost. As a result, more emphasis has been placed on the role of the surveillance and utilization review subsystem and management and administrative reporting subsystem to promote quality and efficiency in providing health care.

New Division of Labor

States have utilized a number of specialized vendors in order to bring experts to many Medicaid administrative tasks.

Most states are approaching the MMIS division of labor in a new way to take advantage of experts in various areas. Most states include some or all of the following vendors:

- Managed care organizations take on the full risk of the cost of health care in exchange for a fixed annual payment per member. They perform all MMIS functions, including paying claims. The state MMIS, however, double-checks managed care claims for errors. Further, an External Quality Review Organization is required to ensure that managed care members have proper access to medical care.
- Pharmacy benefit administrators can be responsible for handling and paying pharmacy claims, managing pharmacy usage, negotiating drug rebates, and handling pharmacy provider relations. Typically, they use their own software and transfer information to the MMIS.
- Program administrators or administrative agents can perform a number of functions, such as provider enrollment and relations, member relations, utilization review, and care and disease management. They may use the MMIS or their own software.
- Fraud and abuse investigators specialize in uncovering fraud and abuse by Medicaid recipients and providers to recover improper payments and forward cases for possible prosecution.
- Medical management vendors provide medical professionals to review patient care. They can advise providers and recipients in the best ways to manage chronic diseases and coordinate care among multiple providers.
- Third-party liability vendors look for alternate payers, such as insurers who also cover Medicaid recipients. Other sources of payment include child medical support orders; estates; trusts; and accident insurance payments, settlements, or awards.
- Cost optimization vendors specialize in identifying program, policy, or procedure changes that could result in equally good or better care at the lowest reasonable cost.
- Rate-setting vendors use statistical and other methods to establish reimbursement rates for covered health services.
- Quality improvement organizations perform a variety of functions, including prior authorization of services and review of medical records to verify documentation of billed health services.

Software for Surveillance, Utilization Review, and Detection of Fraud and Abuse

Specialized software has come to the market for surveillance, utilization review, and fraud and abuse detection.

Several kinds of specialized software supplement the basic MMIS for surveillance and utilization review functions and detection of fraud and abuse. These include data warehouses, decision support systems, and fraud and abuse detection systems.

Decision support systems condense mountains of data to target health care improvement, cost avoidance, and identification and recovery of improper payments.

Any system that summarizes, categorizes, and/or analyzes data can be considered a decision support system. As part of surveillance and utilization review, a decision support system might classify providers according to their specialty and location, then compare them on such measures as how many patients they see each day or how expensive their services are. Similarly, such a system might classify recipients according to their diagnoses, identifying those who have serious or chronic conditions needing special attention.

"Data mining" is a term for the ability of a decision support system to pick out individual pieces of information that make up a classification or profile. For instance, a surveillance and utilization review analyst might want to look at specific providers or recipients or claims that contribute to a potential problem or a potential opportunity for improvement.

Most Medicaid decision support system products include benchmark information, such as the per-member-per-month cost of care from other states or from private insurers. Because Medicaid recipients in Kentucky probably have different health care needs than do Medicaid recipients in other states or members of private health plans, these benchmarks can be adjusted to account for known differences. The decision support system vendor may also provide other standard information such as disease treatment protocols.

Fraud and abuse detection systems often use specially built decision support system products. "Rule-based" products are most common. A fraud and abuse detection system contains rules describing patterns of claims that might indicate fraud or abuse. The vendor supplies many rules, often thousands, from the start. Medicaid analysts can add rules over time. "Model-based" systems are not yet common. These fraud and abuse detection systems use sophisticated statistical models to detect unusual or unexpected patterns among claims. So far, model-based systems appear to be experimental or exploratory.

Fraud and abuse detection systems have to be updated constantly and require much human intervention.

Over time, unscrupulous providers adapt to known detection methods, so the analysts have to study claims patterns to identify

new methods of submitting improper claims. In addition to trying to anticipate these methods, the fraud and abuse detection system vendor usually provides updated rules based on the experience of other Medicaid and private programs. The Medicaid analysts also can create new rules based on reading relevant news articles, keeping up with insurance industry and CMS alerts, receiving tips from whistle-blowers, and networking via antifraud organizations.

Managing health care utilization and detecting fraud and abuse are labor-intensive tasks. Although good software is essential, adequate numbers of trained staff are necessary to interpret the volumes of generated information. Case managers must follow up on the information about health care utilization. Fraud and abuse investigators must verify whether each suspected problem is a real case of improper payment.

The MMIS Life Cycle

The process of building, operating, upgrading, and replacing an MMIS involves federal approval at several stages. Kentucky's Medicaid modernization vendors are at different stages.

Like all software systems, an MMIS has to be built, operated, upgraded, and eventually replaced. Because Medicaid is a federal program, CMS is involved at several steps. And because Medicaid is a state-run program, the MMIS usually requires a procurement process to select a vendor to build the system and often to operate it as the state's fiscal agent. The steps of a typical MMIS life cycle are listed below. These steps apply to the traditional fiscal agent as well as to any other vendor building a system that performs some of the MMIS functions.

1. State Medicaid agency conducts an MMIS procurement with CMS approval at the beginning and at several other stages.
2. Fiscal agent and state Medicaid officials conduct the design, development, and implementation (DDI) phase of the project.
3. Fiscal agent operates, maintains, and modifies the system.
4. Shortly after operations begin, CMS reviews and certifies the new MMIS and determines the level of federal financial participation.
5. For various reasons—including program changes and technological advances that render the MMIS obsolete, a desire to restructure the program, or a need to re-bid in order to ensure lowest cost—state Medicaid agency initiates another procurement with step 1.

The Kentucky pharmacy benefit administrator has been in the operations, maintenance, and modification stage since December 2004. The administrative agent is implementing functions on different timelines; some tasks are already in

operation, while some others are still in the DDI phase. The new MMIS is in the design portion of the DDI phase of the project.

Design, Development, and Implementation

The design and development process for a new MMIS is labor intensive and time consuming. Thousands of detailed rules about Medicaid benefits have to be written down and entered into the new system.

Few, if any, states are now developing a new MMIS from the ground up. Most states receive a system already in use by another state or by a private insurer. Because each state's program is unique, these "transfer systems" still have to be customized for other states.

Whether new or transferred, the new MMIS requires an extensive building phase prior to operations. The design process describes all the rules of the Medicaid program that the MMIS must support. During development, the MMIS vendor makes any necessary modifications to the MMIS to work for the state Medicaid program. Additional software, such as a claims checking package or a decision support system, is installed and connected to the MMIS. Finally, the pieces are put together and tested in the implementation of the MMIS.

The initial step after executing the contract is called joint application design. State and vendor staffs meet to write down in detail exactly how the Medicaid operation works and what the MMIS will have to do to support each business process. Because of the complexity of Medicaid rules, this step is a massive undertaking. Wisconsin officials stated that they identified about 5,000 detailed items to implement. Ohio officials reported more than 4,000 items. Several states reported that the entire process took from four to six months and involved from 15 to 25 staff members full time.

After joint application design, state staff members continue to work to oversee MMIS development and implementation. Officials from several states emphasized that the state needs to be in control of the work plan rather than depending on status reports from the vendor. Development and implementation can consume as many resources as the joint application design phase. Virginia officials reported dedicating 80 full-time staff, including contractors, to the DDI phase.

Other states provided advice regarding timelines and strategies to obtain a quality outcome.

Officials from some states observed that the time allowed for DDI in a contract often is too short to build a high-quality system, leading to problems. West Virginia officials suggested allowing some schedule flexibility to ensure everything works properly.

Officials from other states that recently acquired a new MMIS all agreed that the DDI process is intensive and places severe strains on the state Medicaid agency. They recommended that staff members who are involved in the design process should not have other responsibilities. They and the staff members who have to take over their workload should be recognized, even if they cannot be compensated monetarily.

Work overload and workplace changes can severely strain a Medicaid agency, and steps should be taken to mitigate the effects of this strain.

Officials from other states pointed out that the stresses on the state agency go beyond the staff workload. Implementing a new system means changes in how staff members perform their jobs. Usually, the Medicaid program itself will change and the agency may restructure in order to streamline operations. West Virginia and Washington state officials said some staff and resources should be dedicated to cultural change management. Massachusetts officials advocated for a budget line item to cover this task.

No matter how effective the cultural change management, some turnover will result from the changes and staff's reaction to them. Valuable knowledge and experience will be lost while the agency is struggling to get all its work done. Agency officials need to be aware of and plan for this.

Recipients and providers have concerns about Medicaid program changes. These groups need information and reassurance. Some states have included them in their application design process.

A new MMIS and changes in the Medicaid program affect recipients and providers too. Officials from other states highly recommended a cultural change management plan for recipients and providers. A few states, notably Texas and Georgia, included provider representatives in the joint application design workgroups. West Virginia implemented a weekly teleconference with provider groups to keep them up to date on the new system.

Many states have hired consultants to help manage the design, development, and implementation of a new MMIS.

Because an MMIS is a complex system, some states have used a consulting vendor to help oversee the design, development, and implementation. The term "independent verification and validation" vendor has been used by CMS and the states to include management consulting at any time from before the contract award through the implementation of a new MMIS. Nevada officials suggested bringing in an independent verification and validation vendor prior to awarding the MMIS contract. Iowa successfully used such a vendor to manage its DDI and to ensure that system testing was done properly. Officials from Virginia, West Virginia, and Georgia highly recommended independent verification and validation vendors.

Operations, Maintenance, and Modification

Operations begin after the MMIS has been completed. The system also has to be maintained to resolve any processing errors. Modification refers to changes in program rules and to software enhancements.

Before the new MMIS begins operation, all necessary information must be stored in its database. This includes provider information, recipient eligibility, reference data, claims history and claims adjudication rules, the specifications for the surveillance and utilization review reporting and management and administrative reports, and other information. When the system is judged ready, it is turned on. The old system may be turned off or operated in parallel for a time. The goal is a smooth transition from the old MMIS to the new one.

The transition between an old and new MMIS is subject to errors. Historically, such errors have been expensive.

Officials in other states indicated that the period of initial operations often uncovers errors in the software or in the rules that describe the Medicaid program to the software. A Vermont official described a claims processing problem that resulted from an incorrect understanding of a single program benefit rule. Other problems can arise if the MMIS itself has a flaw.

Any subsystem may have errors that cause serious problems. Failure of a new MMIS can affect many people. If the recipient subsystem is flawed, providers may have trouble verifying coverage. If the provider subsystem has problems, the system may deny all claims for some providers or pay providers who are not enrolled. If the claims subsystem malfunctions, it is possible that no claims will be paid or that claims will be paid improperly.

Kentucky historically has experienced problems with paying claims when transitioning to a new MMIS. Similarly, a Georgia official reported that its new MMIS had such serious problems that it was unable to pay a significant number of claims. Before its MMIS was operating properly, Georgia had to make $1.5 billion in estimated payments to providers, based on previous billing patterns, to make up for unpaid claims. This action led to a long and complex process of offsetting the estimated payments against actual services provided. The reconciliation was still incomplete two years later.

Some states have reported excellent results and few problems in the transition to a new MMIS.

Other states have reported excellent results, with few problems in the initial operations phase. Officials from Iowa, Oklahoma, and Virginia were pleased with the transitions to their new systems.

For maintenance and modification, officials from other states have recommended a sound change management process that is documented clearly. Any changes requested should be prioritized and scheduled by a group of state decision makers with vendor participation. State staff should be involved in the testing process and have sign-off authority on the changes.

Federal Certification and Funding

Federal funds pay 50 percent of most Medicaid administrative costs, but enhanced funding of 75 or 90 percent is available for some aspects of building and operating an MMIS. In order to obtain enhanced funding, the MMIS must pass federal certification.

Shortly after operations begin, CMS examines the MMIS to verify that it performs all the required functions. Once CMS certifies the MMIS, it becomes eligible for enhanced federal funding. Enhanced funding is available for the design, development, and implementation phase and the operations, maintenance, and modification phase.

As a joint federal-state program, federal funds are available for most Medicaid program activities. Federal funding of the MMIS and related systems is provided at different levels, depending on the type of function and the stage of development. The federal funding rate is called the federal financial participation. For the MMIS, three levels of funding can apply. The first two are called "enhanced" participation because they are higher than the 50 percent typically provided for Medicaid administration.

- A rate of 90 percent is paid for the cost of hardware, software, and personnel in the design, development, and implementation of a new MMIS. It also covers the cost of procurement of a new MMIS.
- A rate of 75 percent is paid for the cost of operating, maintaining, and modifying the MMIS. It also covers the cost of procurement of a new vendor to operate an existing MMIS and the cost of proprietary MMIS-related software.
- A rate of 50 percent is paid for other costs, such as the cost of using the MMIS to administer the Medicaid program. Most Medicaid administrative costs are covered at 50 percent, even if unrelated to the MMIS.

Kentucky's Medicaid Modernization

Kentucky Medicaid will continue to operate mostly as a fee-for-service program with some managed care features. A fully managed care region was created in 1997.

Prior to Medicaid modernization, Kentucky had a traditional MMIS built and run by Unisys Corporation. As the fiscal agent, Unisys ran the MMIS, ran the Medicaid call center, and enrolled providers. Department for Medicaid Services staff and other contractors used the MMIS to administer the Medicaid program.

Most Kentucky Medicaid recipients have been covered under the fee-for-service KenPAC program. Providers submit claims to the fiscal agent and are paid according to a reimbursement schedule. In addition, KenPAC includes primary care case management. Each recipient's assigned primary care provider receives a monthly fee. In exchange, the provider is expected to coordinate the recipient's medical care among any other providers.

In 1997, Kentucky Medicaid established a managed care organization in Jefferson and 15 surrounding counties. The department pays the organization a fixed amount per member from which the organization covers recipient care. An external quality review contractor monitors the organization to ensure that recipient care is appropriate.

The KyHealth Choices plan calls for a variety of benefit packages to improve health care and manage costs more effectively.

In order to improve recipient health care and manage costs more effectively, Kentucky Medicaid proposed an overhaul—called KyHealth Choices—of the Medicaid program. It includes a number of distinct health plans tailored to the needs of recipients, increased recipient cost sharing, and individual health care accounts for some recipients. Through authority granted in Section 1115 of the Social Security Act to suspend certain laws or regulations, CMS gave preliminary approval to a proposal in January 2006. Changes to federal law under the Deficit Reduction Act of 2005 have since allowed Kentucky Medicaid to proceed without a waiver for three of the four KyHealth Choices plans.

Overview of the Medicaid System Modernization Plan

In support of Medicaid modernization, Kentucky Medicaid has contracted with a number of vendors for new systems and additional expertise in care management and cost optimization.

The system vendors almost invariably have their own copy of MMIS data and use their own software to support their activity. Program Review staff determined that, because these vendors are performing MMIS functions in parallel with the MMIS, they should be considered in the study. Primarily, staff focused on the MMIS, pharmacy benefit administrator, and Kentucky Medicaid administrative agent.

EDS will operate the existing MMIS while transferring a new MMIS from Oklahoma and Wisconsin.

Fiscal Agent. The fiscal agent, Electronic Data Systems (EDS), will operate the existing MMIS and supply a new MMIS that should be capable of meeting all the federal requirements for an MMIS. Like most states, Kentucky will receive a transfer system from another state. In this case, EDS proposed to transfer the

Oklahoma MMIS to Kentucky, with some additional features from the Wisconsin MMIS. Oklahoma and Wisconsin Medicaid officials have expressed confidence in the ability of EDS to implement a high-quality MMIS. Other vendors, however, will actually carry out many MMIS functions.

The pharmacy benefit administrator manages the pharmacy benefit, processes and pays pharmacy claims, and performs related tasks. The vendor does not enroll pharmacy providers.

Pharmacy Benefit Administrator. Kentucky, like many states, has separated the management of the pharmacy benefit. First Health, as the pharmacy benefit administrator, performs many of the MMIS functions related to pharmacy services, including processing and paying claims. The vendor conducts drug utilization reviews, handles pharmacists' questions, and performs a number of other pharmacy-related administrative functions. However, the vendor does not enroll pharmacy providers.

The Medicaid administrative agent enrolls and manages providers and performs other tasks with the goals of improving patient care and optimizing costs.

Administrative Agent. In the Kentucky Medicaid modernization plan, provider enrollment, provider and member management, case and disease management, quality management, and several other administrative functions will be performed by the Kentucky Medicaid administrative agent. Primary objectives of the agent are improving patient care and optimizing costs. First Health is also the administrative agent vendor.

The managed care organization and nonemergency human services transportation system manage their own care and costs and perform their own claims processing. Details of how the managed care organization and the new vendors will interact are unclear.

Managed Care Organization. An earlier step toward Medicaid modernization was the Medicaid managed care organization (MCO). Passport Health Care Plans is the MCO for Jefferson and 15 surrounding counties. AmeriHealth Mercy of Pennsylvania and its pharmacy benefit administrator, PerformRx, administer the plan. They perform all MMIS functions for the MCO's covered members and covered services, which do not include behavioral health and long-term care. Federal regulations require the state Medicaid program to monitor the MCO's claims; the fiscal agent does so as part of its MMIS operation. In addition, federal regulations require an independent review of Medicaid MCO operations. To meet this requirement, Kentucky has contracted with Island Peer Review of New York.

Appendix A shows how the managed care region systems operate. The roles of the pharmacy benefit administrator and MMIS are tentative because the requests for proposals were not clear and the department has not provided clarification. This process applies to the Medicaid program in the MCO region for services covered by the MCO. A process similar to the MCO model exists for nonemergency human services transportation brokers. It was not included in this report.

Program integrity operations are now in the Office of Inspector General with the assistance of two specialized vendors.

Program Integrity. The program integrity operation has been transferred to the Division of Fraud, Waste, and Abuse/ Identification and Prevention in the Office of Inspector General. The office oversees two vendors that are central to Medicaid cost avoidance and recovery. The third-party liability vendor, Public Consulting Group, assists the MMIS in identifying other insurance coverage and uses its own systems to identify and recover payments from other sources, such as accident settlements and estates. The fraud and abuse recovery vendor, Myers and Stauffer, works closely with the Office of Inspector General to study claims patterns, identify possible provider fraud and abuse, assist in recovery of improper payments, and develop new edit/audit rules for the MMIS to prevent similar payments in the future.

Medicaid System Modernization Timelines

Detailed timelines were not made available. A rough timeline is presented here.

A number of timelines have been presented. The most recent available information, when final work on this study was concluded, was from an October 14, 2005, report by the Department for Medicaid Services to the Legislative Research Commission's Interim Joint Committee on Appropriations and Revenue. Detailed timelines were not made available.

As noted before, the pharmacy benefit administrator began adjudicating and paying pharmacy claims on December 4, 2004. Some time prior to October 2005, the administrator had implemented "point-of-sale edits to prevent duplication, interactions and excessive dosing" (Commonwealth of Kentucky. Cabinet. Department. "Medicaid Update.")

The MMIS schedule involves two major activities: taking over the existing MMIS and building a new MMIS.

- EDS was scheduled to take over the Unisys system on December 1, 2005, and actually took over on November 28.
- EDS is scheduled to implement the new MMIS on October 1, 2006.
- According to a department official, the new MMIS is scheduled for solo operation on November 1, 2006. Program Review staff understood that during the month of October 2006, the new MMIS will be operational but the existing system will be available in case of problems.

As of December 2005, the Kentucky Medicaid administrative agent had begun to take over some tasks and was to assume more over time, with all services implemented by January 2006 (Commonwealth of Kentucky. Cabinet. Department. "Medicaid

Update."). However, unpublished documentation indicated there probably were some delays and additional system milestones that fell later in 2006.

The published draft of the KyHealth Choices plan states that all Medicaid members except those in the Passport program will be moved into KyHealth Choices during May to July 2006. (Commonwealth of Kentucky. Cabinet. Department. "KyHealth" 59) The plan calls for several new benefit packages, which will impact the new Medicaid information systems. According to vendor proposals, this should present no major difficulty for the new MMIS and other systems. The challenge is to ensure that the program rules for each benefit package are translated accurately for the MMIS and pharmacy benefit administrator systems.

If KyHealth Choices is implemented before the new MMIS is operational, changes to the existing MMIS will be required.

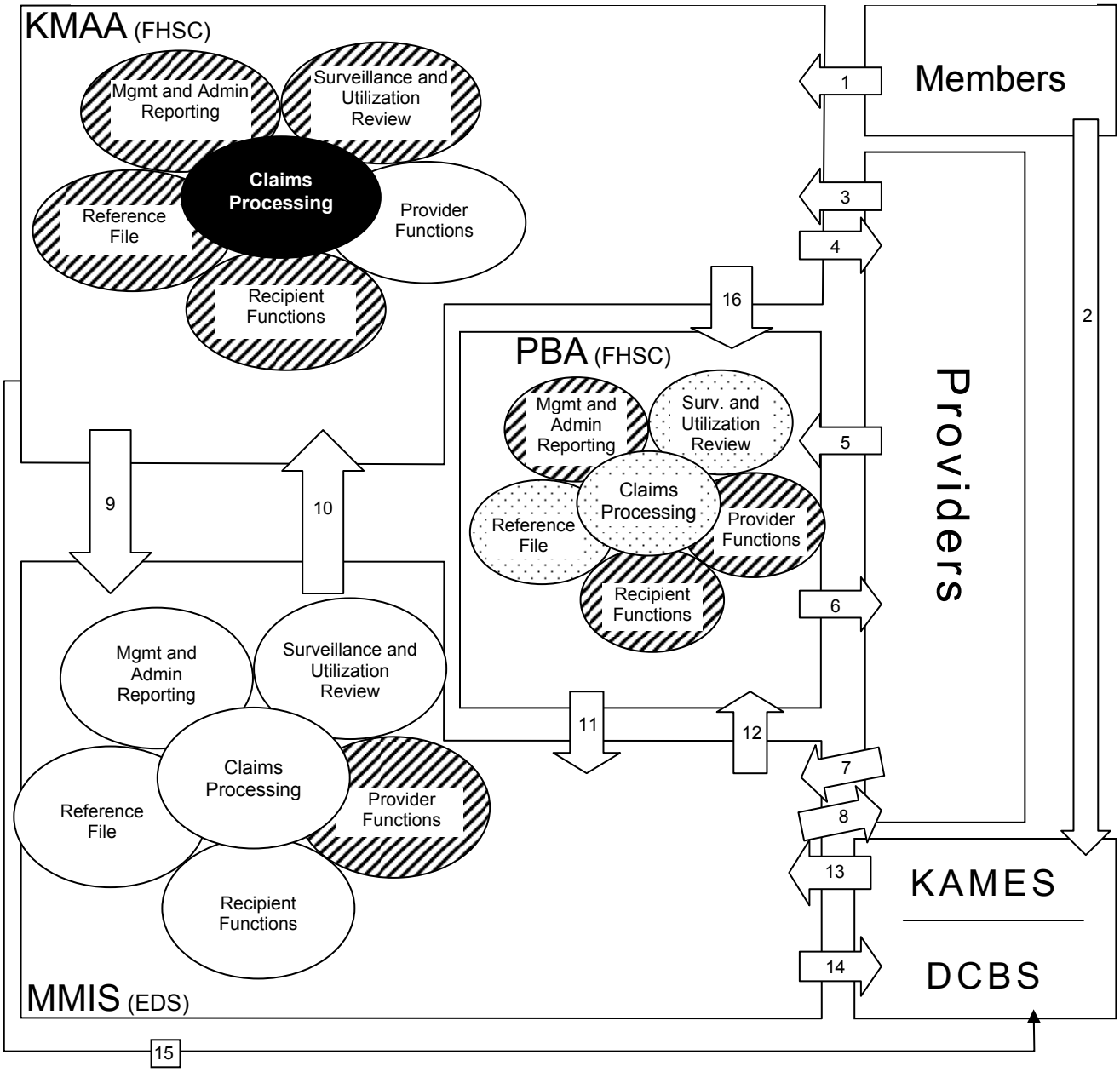
However, because Kentucky Medicaid hopes to have KyHealth Choices implemented before the new MMIS is operational, the existing MMIS would have to support the new packages for some time. This will require EDS to implement some changes to the existing MMIS (the former Unisys system).

Details of Information Systems in Medicaid Modernization

Figure 3.B shows how the three major vendors—the pharmacy benefit administrator (PBA), Kentucky Medicaid administrative agent (KMAA), and the MMIS—work together. This process applies to the Medicaid program outside the managed care region and applies to services provided within the managed care region that are not covered by managed care, such as behavioral health services and long-term care. Program Review staff attempted to show the likely relationships using available information. Items marked with "?" are uncertain.

In Figure 3.B, diagonal stripes indicate functions shared with another vendor or a state agency. Dots indicate pharmacy functions that the PBA handles exclusively. The dark oval indicates that the KMAA does not perform any claims processing tasks.

Figure 3.B
Medicaid Modernization Overview: Fee for Service



Descriptions of paths are on the following page.

Figure 3.B Continued
Descriptions of Paths

1 Members' complaints and questions
2 Members' applications, reviews to Department for Community Based Services offices (KAMES is the Kentucky Automated Management Eligibility System.)
3 Provider applications, inquiries, prior authorization requests, prior authorization override requests, appeals of claim denials
4 Provider approvals and disenrollments, prior authorization approvals/denials, primary care provider member rosters
5 Claims, provider inquiries, prior authorization requests, prior authorization override requests
6 Payments, denials, prior authorization approvals/denials
7 Claims
8 Payments, denials
9 Provider enrollment data, payment rules (including member-specific), provider inquiries from call center
10 Member eligibility file including third-party liability data, access to all MMIS data (including update screens in some cases), provider inquiries that still need the KMAA's attention, reference data
11 Pharmacy encounter information (paid only or all?), (?) prior authorization records
12 Member eligibility data, provider enrollment data, nonpharmacy claims, (?) failed encounters, reference data
13 Member eligibility data, primary care provider selection (KenPAC)
14 (?) Primary care provider lock-in updates, provider enrollment data
15 (?) Provider data online access for Department for Community Based Services offices
16 Pharmacy payment rules (including member-specific), (?) member inquiries from call center

Source: Information compiled by Program Review staff from Program Review staff's summary of U.S. Dept. of Health. Centers. *State Medicaid Manual* and Kentucky Medicaid procurement documents.

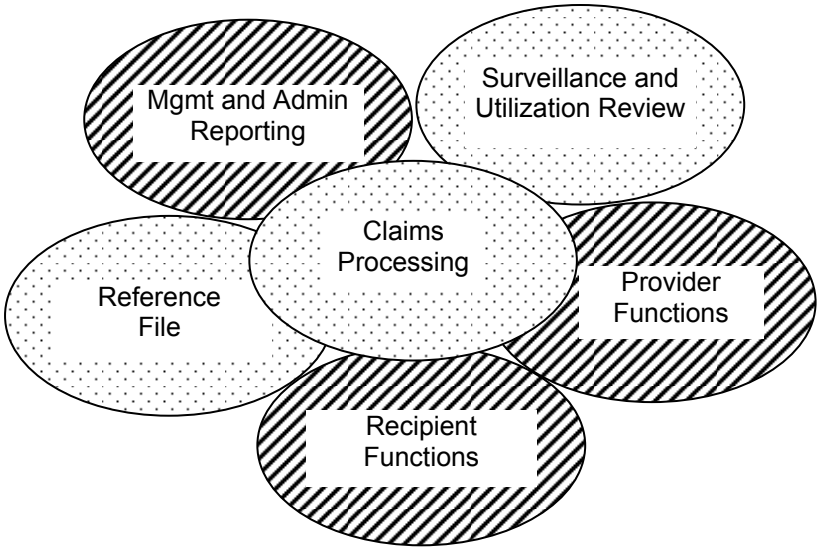
Pharmacy costs have increased more than other health costs. The PBA was the first contract, and First Health has been in operation since December 2004. The PBA performs certain MMIS functions for the pharmacy benefit.

Pharmacy Benefit Administrator. The first request for proposals was for the PBA. The pharmacy benefit has been the focus of cost control in all states because of the rapid increases in pharmacy expense. The PBA was intended to provide greater control over the pharmacy benefit, bring in pharmacy benefit expertise, and optimize drug utilization to improve recipients' health and lower costs.

Because the PBA would begin operations while the existing Unisys MMIS was still in place, the PBA request for proposals clearly carved out certain tasks. The PBA would be responsible for handling pharmacy claims from the point of service through payment and remittance advice. It would handle pharmacy prior authorization and pharmacists' questions about Medicaid. It would also perform drug utilization review—the pharmacy equivalent of surveillance and utilization review—using both pharmacy claims

and claims for other health services sent through the MMIS. Figure 3.C shows how the PBA performs most MMIS functions for the pharmacy benefit.

Figure 3.C
Pharmacy Benefit Administrator Functions

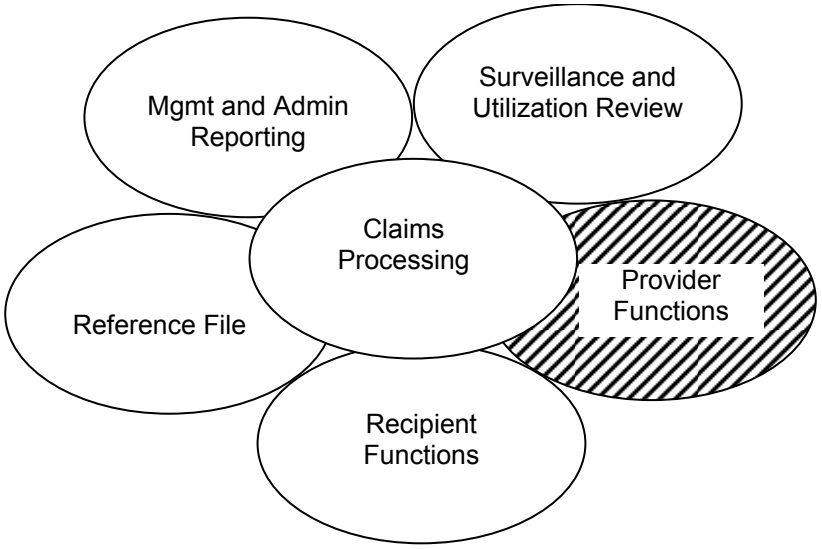


Diagonal stripes indicate functions shared with another vendor or state agency.
Dots indicate functions the PBA handles exclusively for pharmacy.
Source: Program Review staff's analysis of procurement documents and interviews with agency officials.

EDS took over the existing MMIS on November 28, 2005. EDS will build a new MMIS that will meet all federal requirements; although, not all of its subsystems will be fully utilized.

MMIS. Electronic Data Systems took over operation of the existing Unisys MMIS on November 28, 2005. While operating the existing MMIS, EDS will build a new MMIS that will perform all federally required functions. Figure 3.D shows the new MMIS in a simplified form. Although the new MMIS will have a provider subsystem that meets federal requirements, the Kentucky Medicaid administrative agent will actually use its own system and transmit provider information to the MMIS. Therefore, the MMIS provider subsystem will serve primarily as a reference for claims processing and other subsystems.

Figure 3.D
Medicaid Management Information System Functions



Diagonal stripes indicate functions shared with another vendor or state agency.
Source: Program Review staff's analysis of procurement documents and interviews with agency officials.

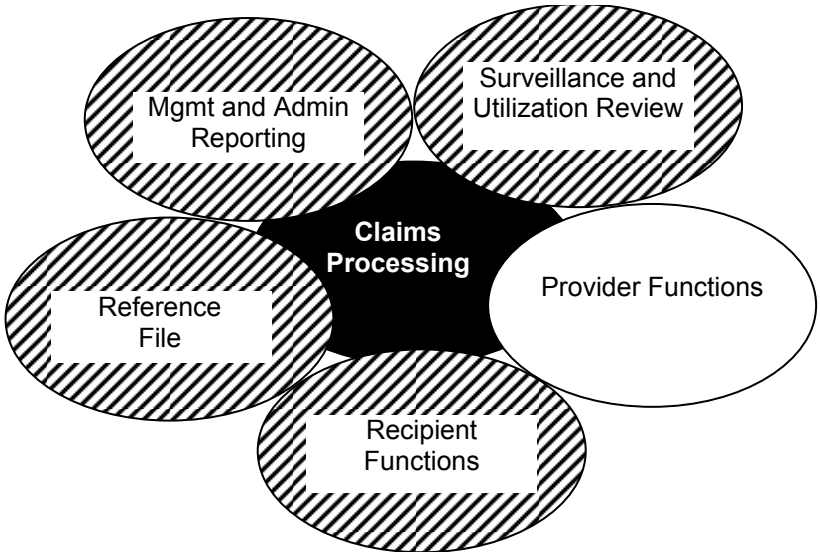
The KMAA performs many tasks related to Medicaid administration, using its own software instead of the MMIS.

Kentucky Medicaid Administrative Agent. Figure 3.E depicts the MMIS functions and shows those performed in whole or in part by the KMAA. In addition to traditional MMIS functions, the KMAA takes on many of the tasks that might use the MMIS to administer the Medicaid program. Table 3.2 shows how the administrative agent's tasks correspond to MMIS functions. The KMAA will use its own software for most of its tasks.

The KMAA performs all the tasks related to provider enrollment and management and serves as the single point of contact for Medicaid provider questions, except for pharmacy providers. Pharmacy providers contact the pharmacy benefit administrator directly for claims-related questions. The administrative agent also serves as the single point of contact for recipients who have questions about their Medicaid benefits.

The KMAA is also responsible for prior authorization of services, utilization and medical review, case and care management, and disease management. It also reviews medical policy and benefits to make recommendations to the Department for Medicaid Services regarding benefit plans and rules.

Figure 3.E
Kentucky Medicaid Administrative Agent Functions



Diagonal stripes indicate functions shared with another vendor or state agency.
The administrative agent does not perform any claims processing tasks.
The pharmacy benefit administrator handles some pharmacy provider relations.
Source: Program Review staff's analysis of procurement documents and interviews with agency officials.

Table 3.2
Kentucky Medicaid Administrative Agent Tasks Compared With MMIS Subsystems

Administrative Agent Task	MMIS Subsystem
Utilization management Prior authorization Medical review Medical policy Case management Care management Disease management	Surveillance and Utilization Review
Benefits administration	Management and Administrative Reporting Reference File
Provider management Call center management	Provider Functions
Member management Call center management	Member Functions

Source: Program Review staff's comparison of procurement documents with federal requirements.

The three major vendors have to share many kinds of data among themselves and other systems. The vendors have complex interactions.

System Interfaces. Figure 3.B shows that the three major vendors have to share many kinds of data. In general terms, the MMIS and its enterprise data warehouse are the central repository of data. However, the information comes from and goes to other systems. What follows is a general description of the major kinds of information. There are many more types of data and many more interfaces than are listed here.

- Provider enrollment information comes to the MMIS from the KMAA and is sent to the PBA and the Department for Community Based Services.
- Recipient eligibility information comes from the Department for Community Based Services to the MMIS and is sent to the KMAA and PBA.
- Prior service authorizations are created by the KMAA and PBA and sent to the MMIS.
- Pharmacy claims are sent from pharmacies to the PBA electronically via the point-of-service network. Pharmacy denials are sent from the PBA to the pharmacies the same way.
- Claims are sent from nonpharmacy providers to the MMIS. Pharmacy claims are sent from the PBA to the MMIS. Managed care claims are sent from the managed care organization to the MMIS.[2] Claims information is sent from the MMIS to the KMAA, PBA, managed care organization, and other vendors.
- Payments and remittance advice forms are sent from the MMIS, PBA, and managed care organization to providers.
- KMAA systems require access to MMIS data for many administrative tasks.
- PBA systems require access to MMIS data for many pharmacy claims processing and administrative tasks.
- Third-party liability information is sent to the MMIS from the Department for Community Based Services, the third-party liability vendor, and other sources. The MMIS sends related claims and other information to the third-party liability vendor.

To manage the many data transfers among numerous independent systems, the Department for Medicaid Services chose the Microsoft® BizTalk® server system as the standard tool. The BizTalk server provides a means for each vendor's system to send and receive information. It minimizes the need to build special interface software between systems for every data exchange. Appendix B contains a diagram supplied by the department showing how the systems will be linked.

[2] For simplicity, the term "claims" in this section also refers to managed care organization and pharmacy encounters.

Concerns With the Medicaid Modernization Information System

The major requests for proposals were written to give vendors flexibility in proposing solutions. The exact details of their interaction will be worked out during the design phase of the projects. Program Review staff's concerns might be addressed during that phase, but another study might be valuable after all systems are in place.

Department for Medicaid Services officials—both in the wording of the requests for proposals and in interviews—indicated that the MMIS, administrative agent, and pharmacy benefit administrator vendors would have to work out many of the details regarding the division of labor. The requests for proposals were intentionally ambiguous about several functions to allow the greatest flexibility on the part of the bidders. During the design, development, and implementation process, the three major vendors will negotiate the boundaries of their tasks.

For certain areas of functionality, however, Program Review staff raised some concerns that department officials did not adequately resolve. Many of the concerns involved apparent duplication of software or duplication of effort. Other concerns were not related to the tasks themselves but rather to the proposed schedule and project management.

It is possible that most of staff's concerns will be addressed in the design, development, and implementation process. However, because of the enormity of the Medicaid information systems, staff recommend that another study be conducted after all the new information systems are in place. With the information available today, the earliest date for such a study to commence would be mid-2007.

Timeline

Timelines may be too tight, particularly for the new MMIS. The effect of the KyHealth Choices plan on the existing MMIS is another concern.

A number of outside experts have questioned the MMIS implementation time frame of October-November 2006 as being too aggressive. Experts have stated that if a vendor succeeds in meeting an aggressive deadline, the system often will barely meet basic requirements and will need costly improvements later. Experts also have stated that it is better to set a realistic time frame to receive a quality result and to avoid the strained relations that come with unrealistic expectations. Kentucky Medicaid officials assured Program Review staff that the timeline was realistic.

Program Review staff questioned how the KyHealth Choices plan might affect the operation of the existing MMIS. These questions were based on the reputation of the existing MMIS as being difficult to modify. Furthermore, the proposed start-up date for the plan allowed little time to modify the existing system. Kentucky Medicaid officials indicated that the existing MMIS could be

modified at no additional cost using the change requests built into the EDS contract.

Physical Location of Data and Processing

Data and processing can occur anywhere. Physical possession of the data, however, remains an issue. The Department for Medicaid Services should take steps to alleviate any problems related to the location of data and processing.

EDS proposed to maintain data and processing in its regional data center in Florida. First Health as pharmacy benefit administrator proposed to process pharmacy claims in Virginia and maintains the pharmacy claims data there.

First Health as Kentucky Medicaid administrative agent proposed to maintain data and processing in Arizona and Virginia, although the proposal also mentioned server location in Louisville. It was not clear from the First Health proposal, or from discussions with Kentucky Medicaid officials, where administrative agent data will be stored and where the processing will occur.

Kentucky Medicaid officials pointed out that Kentucky's Medicaid data have been processed and stored in Utah and California in the past. They stated that telecommunications technology allows for efficient processing and storage of data in out-of-state locations.

Program Review staff are concerned about the degree of control over the Commonwealth's Medicaid data. The MMIS procurement does include provisions requiring EDS to turn over the data and operating software on termination of the contract. The pharmacy benefit administrator procurement requires First Health to "cooperate" with the new vendor but is not specific about the transfer of data. The Kentucky Medicaid administrative agent procurement is even less clear about the transfer of data at the end of the contract.

Recommendation 3.1

The Department for Medicaid Services should evaluate whether it would be feasible and desirable to maintain in Kentucky a duplicate copy of Medicaid data stored by vendors outside Kentucky. The department should ensure that adequate contractual obligations are in place for vendors to transfer all Medicaid-related data to the Commonwealth upon termination of the contracts.

Project Management

The Kentucky design and development team appears to be of typical size. Concerns include strain on other staff, possible lack of outside expertise, and management of providers and recipients.

Department for Medicaid Services officials stated that they have dedicated about 20 full-time equivalent positions to the design, development, and implementation process. Other subject-matter experts are available as needed. Some information technology staff from the Medicaid Information Technology Branch and some Commonwealth Office of Technology staff are assisting. Compared with other states, Kentucky's staffing of the project appears to be in the middle of the range.

Department officials stated they have not hired any additional personnel or contractors to perform DDI functions or to fill in for dedicated employees. Program Review staff did not hear of a plan to provide incentives for agency employees who must work extra hours under high levels of stress.

Unlike other states, Kentucky Medicaid officials stated that they had not hired a project management consultant or independent verification and validation vendor for the DDI process.[3] Department officials did not describe a plan or process for management of cultural change or management of personnel to assure effective performance during this time of stress on the agency's staff.[4]

Change management for providers and recipients was considered a best practice, along with including provider and recipient input in DDI. The Kentucky Medicaid administrative agent will be working to educate providers and recipients about changes in the program. The First Health proposal also indicated that the administrative agent will gather feedback from providers and recipients. It is not clear, however, whether that process will allow provider and recipient input into DDI.

[3] The MMIS proposal and contract state that an EDS subcontractor, Accenture, will manage the project and facilitate joint application design sessions, but Department for Medicaid Services officials did not respond to questions about the role of Accenture. It appears that Accenture is not a truly independent consultant in this project.

[4] Navigant has a contract to assist the Department for Medicaid Services to manage the design, development, and implementation of the Kentucky Medicaid administrative agent's systems and to produce a new organizational structure and transition plan for department staff. Department officials did not respond to questions about the role of Navigant. It is not known whether a staff transition plan exists or how extensive it is.

System Interactions

Contracts did not clearly state how the three major vendors will work together. Many of these issues will be resolved during the design phase. Some areas seemed especially problematic.

The systems of the three major contractors will have to work together seamlessly. Comparing the documents from the three procurements, Program Review staff found several cases of system interactions that were unclear. Appendix C outlines the major MMIS subsystem requirements from the *State Medicaid Manual* and shows how the MMIS, pharmacy benefit administrator, and Kentucky Medicaid administrative agent relate to the requirements. It points out some of the uncertainties about system interactions.

It seems likely that system interaction issues will come up during joint application design. The Department for Medicaid Services and the affected vendors will have an opportunity to resolve these issues at that time. A few examples are given below. Department officials did not respond to questions about these issues.

Prior service authorization is an important aspect of medical management and claims processing. In order to adjudicate claims, the MMIS must know whether certain services were authorized prior to being performed. The administrative agent has been given the task of handling prior authorizations. However, the MMIS and KMAA contracts actually contained conflicting statements on prior authorization. The MMIS contract indicated that First Health would use MMIS screens to enter prior authorization data, but the KMAA proposed to use its own software.

The KMAA has the task of provider enrollment and has proposed to perform this task using its own systems. First Health will send the MMIS daily updates to the provider data. However, the MMIS request for proposals requires the MMIS to deactivate providers meeting certain criteria. If so, it will be necessary for the KMAA to receive this information and not accidentally reverse these deactivations. The KMAA contract does not appear to mention this interaction.

Department for Community Based Services workers need to have information about Medicaid providers in order to assist applicants in selecting a primary care provider. The MMIS and KMAA requests for proposals appear to contain conflicting or redundant requirements for sending provider information to the department. The MMIS request for proposals requires the MMIS to transmit a daily provider update to the department. The KMAA request for proposals requires the KMAA to provide the department with interactive access to provider information.

The Medicaid program has a "lock-in" process for recipients who appear to be abusing their access to medical care. When a recipient is locked in, he or she is limited to receiving services from specific providers. The KMAA determines the lock-in status of recipients. PBA and MMIS, however, have to ensure that claims from other providers are not paid. It was not clear how lock-in status would be communicated to the PBA and MMIS.

Contracts were not clear about the amount of information that would be in the MMIS and enterprise data warehouse regarding claims from the pharmacy benefit administrator and managed care organization. All claims-related information should be available in the MMIS and its data warehouse.

The PBA and MMIS procurements clearly indicate that the PBA will send pharmacy claims data to the MMIS. Kentucky Medicaid officials and the two contracts were not clear about the amount of claims information included. The fraud and abuse literature indicates that full information about claims—prior authorizations, denials, resubmissions, adjustments, and so on—is important for program integrity investigators. These items help investigators detect efforts on the part of a few unscrupulous providers to probe the claims system for weaknesses.

Similarly, Program Review staff were not able to determine whether the managed care organization sends complete claims data to the MMIS. This information could be important in utilization review and program integrity, as recipients move in and out of the managed care region.

Recommendation 3.2

The Department for Medicaid Services should ensure that the MMIS and enterprise data warehouse contain full information about pharmacy and managed care claims, including all claims data fields, attempted claims that were denied, resubmissions, prior authorizations, adjustments, and corrections.

Possible Duplication of Effort and Resources

An MMIS is capable of supporting all federally required Medicaid functions. States have to decide whether to use this system alone or with other vendors' systems. Iowa uses the core MMIS as much as possible.

In a traditional model, state Medicaid staff would use the MMIS and its associated decision support system to perform all their job functions. With Medicaid modernization, a number of vendors might combine resources to replace state Medicaid staff in many of those tasks.

Iowa as an Example. Perhaps the most ambitious division of labor was recently adopted in Iowa. Iowa Medicaid divided the MMIS and related work into nine categories and requested vendors to bid on each category. The procurement description stated, "[Iowa's] objective … is to develop a contract environment where Iowa Medicaid is a cohesive … [e]nterprise, with 'Best of Breed'

contractors co-located with State staff at a common … facility" (Gessow). In addition, Iowa emphasized cooperation among the vendors in the use of software.

Eight vendors were selected. In addition, Iowa hired an independent verification and validation vendor to manage the overall process of building the systems and to ensure that the systems were properly designed and tested. In August 2005, an Iowa official stated that the vendors and systems were working well together after six weeks of full operation.

Where possible, all the Iowa Medicaid vendors use the same software systems. One vendor operates the MMIS, which state staff and other vendors use to perform various functions, such as provider enrollment and prior authorization of services. All vendors and state staff use the same data warehouse and decision support system. An Iowa official indicated that only two additional systems were provided by vendors. The pharmacy benefit vendor brought its own point-of-service claim system, and the medical services vendor brought its own clinical database to supplement the data warehouse.

The Kentucky Medicaid systems plan may have unnecessary duplication of effort and resources.

Kentucky's Division of Labor. The Kentucky Medicaid modernization plan, on the other hand, appears to have significant duplication of effort and resources. Appendix C outlines the major MMIS subsystem requirements from the *State Medicaid Manual* and shows how the MMIS, pharmacy benefit administrator, and Kentucky Medicaid administrative agent relate to the requirements. It points out some potential duplication of effort and resources.

The major concerns related to duplication of software are additional costs and difficulty in synchronizing data. The additional costs of licensing and adapting software could be significant. Even with modern systems such as the BizTalk server, having separate databases that need to be synchronized can lead to problems.

There are several points of possible duplication between the pharmacy benefit administrator and MMIS. These may have been necessary at the time the pharmacy benefit administrator contract was awarded, and there may be other justifications. Kentucky Medicaid should consider whether any duplications can be eliminated.

Potential Pharmacy System Duplication. In its MMIS proposal, EDS stated that its system has point-of-service capability to handle both pharmacy claims and other medical services. In addition, the MMIS should be able to handle prior authorizations and adjudicate and pay pharmacy claims. Many states have contracted with a pharmacy benefit administrator in order to obtain leading-edge pharmacy point-of-service capability, but it is unclear how many states require the PBA to pay claims. In Vermont, for example, the

PBA does not pay pharmacy claims. Instead, the Vermont PBA sends claims to the MMIS for payment.

In order to perform its drug utilization review functions, the PBA maintains its own data warehouse and decision support software. These appear to be duplications of the utilization review subsystem, enterprise data warehouse, and decision support system provided by EDS.

The PBA procurement did not ask vendors to provide a cost for the start-up phase of the project. Therefore, Program Review staff were unable to estimate the cost of the PBA software or its customization to the Kentucky Medicaid program.

The Department for Medicaid Services presumably issued the PBA request for proposals first because pharmacy costs were such a large part of the Medicaid budget and have increased more rapidly than other costs. In addition, prescriptions are notoriously difficult to manage for individual patients. The urgency to manage these costs and to improve the health of recipients through pharmacy management would support contracting with a PBA before replacing the MMIS. This might justify some duplication of functionality. In addition, Program Review staff were unable to determine whether the PBA systems are specialized to support pharmacy claims in a way that the EDS system could not easily match.

Recommendation 3.3

The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's pharmacy benefit software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the pharmacy benefit administrator should use EDS software to perform their tasks.

There are several points of possible duplication between the Kentucky Medicaid administrative agent and MMIS. These may have been necessary because of timing, and there may be other justifications. Kentucky Medicaid should consider whether any duplications can be eliminated.

Potential Administrative Agent Duplication. The EDS MMIS along with its enterprise data warehouse and decision support system can perform or support the following Kentucky Medicaid administrative agent functions:

- provider enrollment/management;
- prior authorization of services;
- surveillance and utilization review (including, but not limited to, medical management, lock-in, clinical review, and program integrity);

- management reporting (including, but not limited to, quality management and benefits administration); and
- ad hoc inquiry, reporting, and data mining in support of any of the above functions.

There is no obvious need for the KMAA to bring its own software, which amounts to purchasing portions of a second MMIS and decision support system. The MMIS and KMAA requests for proposals were unclear about this delineation. Based on the agency's responses to vendor questions, however, it was clear that Kentucky Medicaid wanted the KMAA to have its own data warehouse and decision support system. There was a lack of clarity on whether the KMAA should enroll providers and perform prior service authorizations using the EDS MMIS or its own software. Nevertheless, First Health proposed to utilize its own software to perform all the KMAA functions.

First Health did not quote a cost for the start-up phase of the KMAA. Therefore, Program Review staff were unable to estimate the cost of the KMAA software or its customization to the Kentucky Medicaid program. However, First Health did charge $5.4 million more for the first year of operations than for the second year. It seems likely that some of that increased charge included the costs of licensing and customizing First Health's software.

There is some possible overlap related to interactive voice response phone systems. The MMIS Master Agreement states that EDS will maintain the interactive voice response system. However, the KMAA request for proposals states that the KMAA will have its own interactive voice response system. These systems are designed to route callers, typically providers or recipients, to the appropriate vendor staff. It is unclear whether these documents refer to the same interactive voice response system or two separate systems.

It is possible that during the joint application design process, some of the potential duplication will be eliminated. However, the KMAA was scheduled to begin operations before the new MMIS, which limited its ability to use the MMIS to carry out its tasks. As with the PBA, potential cost savings and care improvements from the KMAA's utilization review and care and disease management functions might offset the cost of having duplicated systems. In addition, Program Review staff were unable to determine whether the KMAA systems are specialized to support KMAA tasks in a way that the EDS system could not easily match.

Recommendation 3.4

The Department for Medicaid Services, EDS, and First Health should consider the costs and benefits of using First Health's administrative agent software versus the systems supplied by EDS. When feasible and cost effective in the long term, staff of the Kentucky Medicaid administrative agent should use EDS software to perform their tasks.

A number of distinct data warehouses and decision support systems appear to exist or to be proposed. There may be sound reasons for the apparent duplication, but officials did not respond to questions on this issue. Kentucky Medicaid, the Office of Inspector General, and the vendors should consider whether any of these systems can be consolidated.

Multiple Data Warehouses and Decision Support Systems. A data warehouse provides a central repository for information from many sources so that users can easily find all information related to a given item. A data warehouse often will contain additional statistical or benchmark information. For instance, the Medicaid enterprise data warehouse might allow a program analyst to inquire about a recipient and see all pharmacy and medical claims, the provider certifications, prior authorizations, denied claims, the recipient's rank in terms of number of claims per month among all recipients (statistical information), and the recipient's rating in terms of cost of care compared with recipients across the health care industry (benchmark information). One important use of a data warehouse is to supply data to decision support systems and other software tools for data analysis.

The Medicaid modernization procurements appear to include three distinct data warehouses and decision support systems. EDS will support the Medicaid enterprise data warehouse and provide a decision support system. As the administrative agent, First Health will maintain its own data warehouse and use its own decision support system. It appears that as the pharmacy benefit administrator, First Health, will maintain a separate pharmacy data warehouse, which will include nonpharmacy claims, and may operate a separate version of its decision support system.

This reading of the procurements points to three distinct data warehouses containing much of the same information and three distinct decision support systems—two of which are the same software package—that perform similar functions. Although there might be some specialized information added to the administrative agent's and pharmacy benefit administrator's data warehouses, it also would be possible to add that information to the enterprise data warehouse. In fact, it might be preferable for all parties to have access to the specialized information about all the different kinds of claims, recipients, and providers.

Beyond the three major contracts, it appears that significant copies of the MMIS data exist with other vendors. It seems likely that the

following vendors have copies of the MMIS data, which have to be updated periodically:

- Third-party liability: Public Consulting Group;
- Fraud and abuse: Myers and Stauffer;
- Rate-setting: Navigant; and
- External Quality Review Organization: Island Peer Review.

There may be good reasons for having multiple copies of Medicaid data. However, Kentucky Medicaid officials did not respond to questions about this issue.

In addition, the Office of Inspector General has a number of investigative databases. Officials there stated they were in the process of consolidating these into a single investigative database. It might be feasible and cost effective to include investigative data in the enterprise data warehouse.

Recommendation 3.5

The Department for Medicaid Services, the Office of Inspector General, and Medicaid vendors should review the need for multiple data warehouses and decision support systems. When feasible and cost effective, the enterprise data warehouse and decision support system should be used rather than having additional copies of the Medicaid data and additional decision support software.

Prevention and Detection of Improper Payments

An improper payment can occur accidentally when a claim has the wrong procedure code or other information. It can occur when unnecessary medical care is provided or when a recipient is not eligible for the service. It also can occur when an unscrupulous provider intentionally bills for a procedure that was not performed.

Stopping an improper payment before it is made is the best practice. The trends toward automated claims approval and rapid payment may lead to more improper payments. The Department for Medicaid Services should ensure claims are aggressively edited before they are paid and should consider how to balance manual review of suspect claims against automated systems and rapid payment.

Prospective Utilization Review. Some improper payments can be detected before the claim is paid. The process is known as "prospective utilization review" or "cost avoidance." It is more desirable to avoid paying an improper claim in the first place than to attempt to recover the funds later. Primarily, this is done by applying edits and audits to the claims to make sure the claims meet program rules and do not fit patterns known to indicate likely improper claims. Edits are rules that apply to a single claim, making sure the information on the claim is self-consistent. Audits are rules that compare the current claim against the history of claims and other information for that recipient or provider, making

sure the claim is consistent with the medical history or provider practice.

Pharmacy claims are checked at the point of service. The pharmacy submits the claim electronically and receives an immediate pay or deny response. As EDS pointed out in its proposal, existing software systems could provide point-of-service edits and audits for many kinds of medical claims. In the current batch claims system, however, most medical claims are adjudicated after a delay of several days.

Although there is pressure to decrease turnaround time, faster payment can make it harder for Medicaid to detect and verify improper payments before making them. In a point-of-service system, a claim will either pay or deny. In today's batch claims system, a claim may be paid, denied, or suspended. Suspended claims may be reviewed by hand to determine whether they should be paid, or they may be reprocessed automatically after a certain time that allows for supporting information to be entered into the system.

Human intervention remains superior to computer software in determining whether a claim should be paid. Having the option to suspend claims for review allows the system to identify suspicious claims that are not clearly improper. A person can then verify whether the claims should be paid. This process furnishes an opportunity to cut off a number of improper claims before they are paid.

Prospective edits and audits enforce basic program rules and incorporate the collective experience of the health care industry. A few unscrupulous providers continue to invent new ways to increase their income at the expense of health plans, including Medicaid. Experts in the insurance industry combat these methods by creating new edits and audits. In Kentucky, the Kentucky Medicaid administrative agent, pharmacy benefit administrator, MMIS, other vendor staff, and the Office of Inspector General work to improve the system of edits and audits.

Adding an edit or audit is a balancing act. A good edit or audit can prevent many dollars of improper payments. If it results in unfair denials of claims or too many suspended claims, providers will complain and attempt to reverse the new rule.

Recommendation 3.6

The Department for Medicaid Services and the Office of Inspector General should take as aggressive a stance as possible to implement effective edits and audits and prevent improper payments. Both organizations should evaluate the benefits and disadvantages of point-of-service claims processing versus traditional batch processing, including manual review of suspended claims.

Edits and audits can be disabled under certain conditions. This usually leads to improper payments. The Department for Medicaid Services should exercise high-level control and review over all decisions to disable edits and audits, should reactivate them quickly, and should recover promptly all resulting improper payments.

Managing Edits and Audits. At times, it may be necessary to turn off or disable an edit or audit. For example, officials from other states described system problems, such as a breakdown in the transfer of recipient eligibility data to the MMIS. In the absence of up-to-date eligibility data, it might be necessary temporarily to disable audits related to eligibility and allow claims to be paid regardless of eligibility. However, all claims paid while an edit or audit is disabled should be flagged or placed in a special file for reprocessing later. Any resulting improper payments should be recovered as soon as possible.

Disabling an edit or audit can lead to significant improper payments that are difficult to recover. It is important to have a procedure to ensure that the decision to disable an edit or audit is reviewed and authorized by high-level Medicaid officials. When an edit or audit has been disabled, it is crucial to have a management procedure to monitor the situation and ensure that the edit or audit is reactivated or replaced as soon as possible. Kentucky Medicaid officials did not respond to Program Review staff's questions about these procedures.

Recommendation 3.7

The Department for Medicaid Services should document and follow edit/audit management procedures that require high-level management control over any request to change or disable an edit/audit, that require immediate corrective action to reactivate the edit/audit, and that require prompt review of all affected payments and prompt recovery of all resulting improper payments.

Complete information about recipient health care and claims filings should be available to all vendors to allow optimal care management and detection of improper payments.

Retrospective Surveillance and Utilization Review. The surveillance and utilization review process does not end when claims have been adjudicated. Afterward, a more thorough and time-consuming process of retrospective review takes place. The Office of Inspector General, the pharmacy benefit administrator, Kentucky Medicaid administrative agent, and other vendors all have roles in this process.

Surveillance and utilization review staff use a variety of software tools to sift through the voluminous claims information in a data warehouse. The data warehouse often includes statistical profiles: information such as the rank of a provider in number of dollars or procedures per day, or the rank of a recipient in number of emergency room visits per month. Software tools can display providers and recipients who are outside the norm of their peers and can allow the analyst to see the claims information related to these outliers. Other software tools can perform sophisticated analyses of the data to detect unusual patterns of claims submission. In all cases, analysts or investigators review the most likely suspects to determine whether the payment was correct or an improper payment was made.

The pharmacy benefit administrator and Kentucky Medicaid administrative agent review health service utilization to optimize patient care and costs. If either vendor discovers improper payments, it informs the appropriate officials. In addition, the pharmacy benefit administrator has a contractual responsibility to produce reports identifying potentially fraudulent pharmacy providers.

The primary responsibility for surveillance and utilization review belongs to the Office of Inspector General's Division of Fraud, Waste, and Abuse/Identification and Prevention. The division administers two related contracts with the third-party liability vendor and the fraud and abuse vendor. Division staff work with the vendors to identify and recover improper payments. Each vendor has its own specialized software tools, and the division has reviewed fraud detection software that it may purchase.

Complete information about recipient care is important for the most effective surveillance and utilization review. The Kentucky Medicaid administrative agent, pharmacy benefit administrator, other vendors, and the Office of Inspector General should have access to and use the full range of information from all sources.

Recommendation 3.8

For surveillance and utilization review, the Kentucky Medicaid administrative agent, pharmacy benefit administrator, related vendors, and the Office of Inspector General should include and analyze all available data from the MMIS and pharmacy benefit and managed care systems.

Field audits of randomly selected claims are a best practice for supporting the surveillance and utilization review function. It was unclear to what degree the Department for Medicaid Services or the Office of Inspector General will conduct field audits.

Provider Audits. The fraud and abuse literature recommends audits of randomly selected claims to verify that services were performed as described in the claims. Field audits require auditors to visit the provider's office and physically review the medical records and other documentation. These are more time-consuming than, but superior to, desk audits. Desk audits, often called medical review audits, are based on copies of records sent by the provider.

Although CMS has instituted a random audit in its demonstration project to measure payment error rates, these will be desk audits. Field audits, which would verify that the service was actually performed, are not required (U.S. Office of the Federal Register. 42325). An Oklahoma Medicaid official stated that Oklahoma will continue its own audits because of their value in quality control.

The pharmacy benefit administrator proposed to conduct 60 desk audits and 24 field audits annually. These audits did not appear to be required by the request for proposals, but the proposal is included by reference in the contract. The Kentucky Medicaid administrative agent and MMIS proposals did not appear to include any desk or field audits. Kentucky Medicaid officials did not address Program Review staff's questions about this issue.

Measurement of Outcomes

The pharmacy benefit administrator, Kentucky Medicaid administrative agent, and KyHealth Choices plan were intended to improve health care and control costs. They should be held accountable for their outcomes. Measurements need to be defined and a person or agency needs to be identified to carry out the measurements.

The pharmacy benefit administrator and Kentucky Medicaid administrative agent were hired in order to save Kentucky Medicaid dollars while improving the quality of health services. The two requests for proposals required the bidders to estimate the savings that would result from their efforts.

Pharmacy benefit cost savings are difficult to quantify but were projected to be significant—in the neighborhood of $200 million per year. The amount would depend on which strategies were used. First Health pointed out that under the most aggressive strategy, "program constituents would be substantially disrupted" (Cost Proposal Summary). In any case, pharmacy savings should represent a significant portion of the Medicaid budget.

The cost savings projected by First Health for the Kentucky Medicaid administrative agent were insignificant. The cost proposal showed $5.6 million in total savings over a five-year period. This amount barely offsets $5.4 million of apparent start-up costs. The value of the administrative agent's services will have to be judged by measuring the actual impact on costs.

The KyHealth Choices plan also proposes to deliver higher-quality care and to control costs. A Medicaid 1115 waiver requires a program evaluation, and the waiver proposal included a list of research questions to address cost effectiveness and measurement of outcomes. Kentucky Medicaid stated in strong terms that it intended to evaluate the impact on participants' lives and to show whether the program achieved lower costs.

Now that most of KyHealth Choices has been authorized under the Deficit Reduction Act, there is no federal requirement for program evaluation. A Kentucky Medicaid official stated that "we will continue to monitor and evaluate our programs in the same way as we did prior to our modernization efforts" (Cornwall). It is important that the evaluation of such a dramatic modernization be substantial and thorough, using both point-in-time and longitudinal measures.

Recommendation 3.9

The Department for Medicaid Services should report the following information to the Program Review and Investigations Committee by December 2006:

- **What measurements will be used to determine the health improvements and cost effectiveness of the pharmacy benefit administrator? Who will conduct the assessment and when will it be done?**
- **What measurements will be used to determine the health improvements and cost effectiveness of the Kentucky Medicaid administrative agent? Who will conduct the assessment and when will it be done?**
- **What measurements will be used to determine the health improvements and cost-effectiveness of the KyHealth Choices program? Who will conduct the assessment and when will the assessment be done?**

Possible Enhanced Federal Financial Participation

Enhanced federal funding might be available for some parts of the pharmacy benefit administrator system.

In order to accommodate states in their efforts to improve management of their Medicaid programs, CMS has broadened its definition of systems that qualify for enhanced federal financial

participation (FFP). For instance, in its approval letter for the Kentucky pharmacy benefit administrator, CMS approved an FFP of only 50 percent. However, the letter stated that Kentucky could submit a "cost distribution plan" that described the functions of the PBA that are "qualifying [MMIS] functions" as defined in the *State Medicaid Manual* (Murray). If approved, such a plan would result in an FFP of 90 percent for the purchase and development of systems and 75 percent for operations, prorated to the specified functions.

The highest level of enhanced funding probably is not available because the Pharmacy Benefit Administrator contract did not grant software rights to Kentucky.

Program Review staff's examination of the PBA procurement suggested that many of its functions do correspond to MMIS functions in the *State Medicaid Manual*. To qualify for the 90 percent FFP, however, the state must obtain rights to the software. It appears that the PBA contract does not grant software rights to Kentucky. It seems likely that none of the PBA design, development, and implementation costs would qualify for 90 percent FFP. However, the cost of procurement might qualify for 90 percent FFP, and the cost of the proprietary First Health software systems related directly to MMIS functions might be reimbursable at the 75 percent FFP.

It was not be possible to estimate enhanced funding for the pharmacy benefit administrator start-up phase because no start-up costs were quoted in the contract. Some aspects of its operations probably would qualify for enhanced federal funding.

Program Review staff were unable to estimate the start-up costs because the pharmacy benefit request for proposals cost proposal guide only requested annual operating costs and did not include a cost for design, development, and implementation. The pharmacy benefit administrator's invoices during the start-up period prior to December 4, 2004, totaled more than $466,000. However, the invoices did not appear to include the cost of software licenses.

It appears likely that some aspects of pharmacy benefit system operations would qualify for the 75 percent FFP. If this enhanced FFP was approved just for the claims processing function, Program Review staff estimated additional FFP might amount to a few hundred thousand dollars per year, based on First Health's cost proposal.

Enhanced funding for Kentucky Medicaid administrative agent systems is less clear, but CMS might consider such funding. The contract did not grant software rights to Kentucky and did not include any start-up costs. If start-up costs could be identified, some enhanced funding might be available. A limited amount of enhanced funding for operations might be available.

Similarly, a CMS official told Program Review staff that CMS is open to considering some of the functions of other kinds of systems for enhanced funding. Staff's review of the Kentucky Medicaid administrative agent procurement suggested that many of its functions, as shown in Table 3.2, might qualify for enhanced FFP.

Because First Health proposed to use its own proprietary software for the KMAA and did not break out start-up costs, the 90 percent FFP would not apply. In the First Health proposal, however, the first year's cost of operations was $5.4 million higher than the second year's cost. This unexplained expense might represent the start-up cost, including software licenses and hardware. If the start-up cost could be broken out, some of it might qualify for 75 percent FFP. For the operations and maintenance phase, a 75 percent FFP might pay for a few tasks—that is, for the direct maintenance and operation of the software, direct entry of provider and prior authorization data, and generation of reports.[5] Enhanced FFP would depend on approval by CMS. Program Review staff were unable to estimate this amount.

Department for Medicaid Services officials stated that no request for enhanced funding had been submitted. The department should consult with CMS and if so advised should submit cost distribution plans for the pharmacy benefit administrator and Kentucky Medicaid administrative agent systems.

As of November 4, 2005, Department for Medicaid Services officials stated that no cost distribution plan had been submitted to CMS for pharmacy benefit administrator or administrative agent funding. They stated, however, that the department would submit cost distribution plans in the future. Department officials were confident that CMS would pay any approved enhanced FFP retroactively. Program Review staff's reading of the *State Medicaid Manual*, however, suggested that the enhanced FFP for start-up is not available retroactively, unless CMS has changed the regulations.

Recommendation 3.10

The Department for Medicaid Services should consult with the Centers for Medicare and Medicaid Services about potential enhanced federal financial participation for the development and operational phases of the pharmacy benefit administrator and Kentucky Medicaid administrative agent contracts. If CMS so advises, the department should submit to CMS cost distribution plans for the systems in an effort to obtain enhanced federal financial participation. The department should report the CMS response to the Program Review and Investigations Committee by December 2006.

A clause in the MMIS contract that might affect enhanced federal funding seemed ambiguous and should be reviewed.

Program Review staff identified a potentially problematic clause in the MMIS contract related to a specific software tool. A review by a staff attorney suggested the interpretation of the contract clause was open to question. As written, it might be interpreted to mean that EDS retains full rights to all software developed for the

[5] Program Review staff were informed that the KMAA is reimbursed 75 percent for the Quality Improvement Organization task, but this is not an MMIS-related function.

Commonwealth, including the MMIS itself. In order to qualify for the 90 percent FFP, the rights to the MMIS must belong to Kentucky. As a precautionary measure, staff recommended that Kentucky Medicaid obtain a legal opinion on the interpretation of this clause.

Recommendation 3.11

The Department for Medicaid Services should obtain a legal opinion on the rights of the Commonwealth to MMIS software developed under the MMIS contract, particularly pages 6-7 of the Master Agreement. If necessary, the contract language should be modified to ensure compliance with requirements of the Centers for Medicare and Medicaid Services. The department should report the opinion and any action taken to the Program Review and Investigations Committee by December 2006.

Officials at the Office of Inspector General discussed the possibility of enhanced FFP for investigative databases and other program integrity systems. The officials stated they would ask CMS about enhanced FFP for these systems.

Future Challenges for Medicaid Systems

National Provider Identifier

The National Provider Identifier will be required as of May 23, 2007. The Kentucky vendors appear to be aware of and preparing for this change.

The National Health Information Technology initiative includes a National Provider Identifier (NPI). The program will create a unique identifier for all health care and health service providers in the country.

The deadline for implementing the program is May 23, 2007. A Virginia Medicaid official recommended placing a high priority on this change. Because the NPI will affect all Medicaid providers and vendors, it will be important to develop a clear plan to implement it.

Program Review staff did not find any reference to NPI in the pharmacy benefit administrator procurement. Staff found that Kentucky Medicaid did include NPI compatibility in the MMIS and Kentucky Medicaid administrative agent requests for proposals. EDS responded that the new MMIS should be capable of handling the NPI. First Health responded that its analysts were studying the program to see how it should be implemented.

Medicaid Information Technology Architecture

The federal Medicaid Information Technology Architecture will transform the way each MMIS is designed and certified. The new Kentucky MMIS and related systems should be in place before a certification is required. The Kentucky vendors appear to be aware of and preparing for this initiative.

Every MMIS must meet certain requirements in order to be certified by CMS. Until now, CMS certification has used a checklist approach based on the *State Medicaid Manual*, ensuring that every MMIS has the required subsystems and can perform the listed functions. In response to changing technology and changing needs, CMS has developed the Medicaid Information Technology Architecture (MITA) model to describe how any future MMIS should be built and certified. The model is in the conceptual stage. CMS, states, and vendors are working to flesh out the standard and show how it can be used.

MITA encourages states and vendors to take advantage of system design principles, looking at the agency's overall business objectives and breaking them down into the actual business activities or processes that will meet those objectives. MITA describes how computer systems should be built to support business objectives and processes using the latest technology. Going further, the model promotes modernization of the agency's objectives, processes, and procedures themselves, regardless of the computer systems being used. Each state will develop its own Medicaid business process plan using the MITA model as a guide.

When using MITA for certification, CMS will replace the traditional checklist with a checklist based on the state's Medicaid business process plan. Certification will verify that the MMIS and related systems actually meet the needs identified in that plan.

CMS expects to pilot the new MMIS assessment process based on MITA in 2006 and to begin implementing certifications based on MITA no earlier than 2007 (Bazemore). Based on the current development schedule, it will not be necessary for the new Kentucky MMIS to undergo a MITA certification. Nevertheless, as MITA matures, CMS will expect all states and vendors to move toward MITA business process plans and MITA-aligned systems.

Both EDS and First Health have MMIS and MMIS-related systems in a number of states. Both are members of the Medicaid Private Sector Technology Group, an industry group that advises CMS on issues such as MITA. It seems reasonable to assume they will keep their systems consistent with MITA as the model develops.

Chapter 4

Medicaid Fraud, Abuse, and Other Improper Payments

The Program Review and Investigations Committee previously considered the issue of improper payments in a 2004 report, which stated:

> Kentucky's Medicaid program is at high risk for making improper payments. Improper payments include inadvertent errors, such as duplicate payments and calculation errors; payments for unsupported or inadequately supported claims; payments for services not actually received by Medicaid recipients or rendered to ineligible recipients; and payments resulting from outright fraud and abuse (Commonwealth of Kentucky. Legislative. *Uncollected* 27).

When a payment is made that is not in accordance with Medicaid law, regulation, or policy, it is an improper payment and should be recovered.

The U.S. Government Accountability Office has designated Medicaid a high-risk program for improper payments.

In 2003, the U.S. Government Accountability Office designated Medicaid a high-risk program for improper payments, in part because of concerns about the quality of fiscal oversight needed to prevent inappropriate program spending (*Health Care Fraud and Abuse* 1). A 2005 U.S. Office of Management and Budget study of improper payments in other federal programs determined that approximately 92 percent are overpayments (ii). In this Program Review report, improper payments are defined as overpayments.

A 2005 federal law creates a new Medicaid Integrity Program and provides incentives for states to enact and enforce false claims statutes.

The federal Deficit Reduction Act of 2005 includes provisions designed to eliminate fraud, waste, and abuse in Medicaid. The Act creates a new Medicaid Integrity Program and provides incentives for states to enact and enforce false claims statutes. House Bill 735, which was introduced in the 2006 Regular Session of the General Assembly but did not pass, would have created a false claims statute in the Commonwealth.

This chapter describes examples of improper payments made by the Medicaid program. Where possible, the chapter specifies whether the underlying problems were or could have been discovered through review and analysis of information in

computerized systems. Eight recommendations are made. Two address funding of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division. Others address Medicaid's ability to avoid paying claims that are the responsibility of third parties, the limited ability of the Office of Inspector General to pursue administrative action in allegations of Medicaid fraud and abuse, the need for a cost-benefit analysis by the Office of Inspector General on new activities related to detecting Medicaid fraud and abuse, the need for a coordinated state plan to control Medicaid fraud and abuse, the need for a false claims statute in Kentucky, and the effect of unfulfilled dependent medical support orders on Medicaid program expenses.

Definitions

"Improper payments" are defined in this report as overpayments and include amounts that should not have been paid, were paid for the wrong amount, or were otherwise not paid according to Medicaid law, regulation, or policy.

"Improper payments" are defined in this report as overpayments and include amounts that should not have been paid; were paid for the wrong amount; or were otherwise not paid according to Medicaid law, regulation, or policy.

KRS 205.8451 provides additional definitions for the Medicaid program:

- "Provider" means an individual, company, corporation, association, facility, or institution that is providing or has been approved to provide medical services, goods, or assistance to recipients under the Medicaid program.
- "Recipient" means any person receiving or who has received Medicaid benefits.
- "Provider abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the Medicaid program, that result in reimbursement for services that are not medically necessary or are excessive, or that fail to meet professionally recognized standards for health care.
- "Recipient abuse" means recipient practices that result in unnecessary cost to the Medicaid program or the obtaining of goods, equipment, medicines, or services that are not medically necessary, are excessive, or constitute flagrant overuse or misuse of Medicaid benefits for which the recipient is covered.
- "Fraud" means an intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law.

The glossary on page xvii includes more definitions. Except where specifically noted, this chapter does not attempt to distinguish between fraud, abuse, and error in describing improper payments. The preliminary review and analysis of information in computerized systems can show suspicious patterns that may indicate potential improper payments. Investigators must gather additional information to determine whether criminal charges of fraud or abuse should be pursued, administrative actions should be undertaken, or honest mistakes were made. Those determinations often involve legal and medical issues that are beyond the scope of this report.

Other States Have Reported on Medicaid Improper Payments

A Texas study found potential overpayments in 13.7 percent in a sample of Medicaid fee-for-service payments.

The Texas Office of the Comptroller is required by statute to study that state's Medicaid overpayments every two years. The results show that potential overpayments have increased over the last five years. In the 2005 study, the office found potential overpayments in 13.7 percent of the Medicaid fee-for-service sample with a margin of error of plus or minus 0.2 percent (1). In the 2003 study, the office found potential overpayments in 13.5 percent of the fee-for-service sample with a margin of error of plus or minus 2 percent (1). In the 2001 study, potential overpayments were found in 7.24 percent of the fee-for-service sample with a margin of error of plus or minus 3 percent (1).

The methodology of the Texas studies uses a random sample of Medicaid clients' health care services for a quarter based on date of service. The study sample includes the selected client's sample service and all other services performed by the provider on the sample date. Each claim is examined to determine if the overpayment amount is the entire dollar amount of the claim, an adjusted dollar amount, or zero. If the service is classified as an error because the service was not documented in the medical record, the entire dollar amount of the service was counted as an overpayment error. If the service was documented in the medical record but was not coded correctly, the amount of the error is the difference between the amount paid and the amount that should have been paid. The dollar amount of the error is zero if the service was documented in the medical record and the error was an incorrect date or some other clerical error.

A Florida study found that between 5 and 10 percent of Medicaid payments were overpayments.

Research in other states has focused on the extent to which identified overpayments are collected rather than on measuring the extent of overpayments. For example, a Florida study found that

between 5 percent and 10 percent of payments were overpayments, and the state recovered only 2.3 percent to 4.5 percent of the Medicaid funds lost to fraud and abuse over a five-year period (State of Florida 4).

Massachusetts reported that more than $1.5 billion in losses due to fraud and abuse may remain undetected.

Massachusetts reported that it recovered only 1 cent of every hundred dollars expended, while more than $1.5 billion in losses due to fraud and abuse may remain undetected if the overpayment rate was 10 percent (Commonwealth of Massachusetts ii).

Federal Government Studies Emphasize the Importance of Strong Fraud Control Systems

Common themes in federal studies include the vulnerability of the Medicaid program to exploitation, the difficulty of detecting wrongful acts, the broad scope of health care fraud and abuse, and the extent of health care fraud.

The following paragraphs provide examples from federal government studies of the prevalence of fraud and abuse in the nation's health care system. Appendix D provides a more extensive list. Program Review staff reviewed 177 reports from federal government agencies including the Government Accountability Office, the Department of Health and Human Services' Office of Inspector General, and the Office of Management and Budget. The reports dated from March 1992 through April 2006. Common themes include the vulnerability of the Medicaid program to exploitation; the difficulty of detecting wrongful acts that are committed by criminals using myriad improper billing practices; the broad scope of health care fraud and abuse, which can cross state lines and require collaboration among federal, state, and local law enforcement officials; and the extent of health care fraud, which is estimated to be billions of dollars nationally.

The U.S. Government Accountability Office has concluded that Medicaid is inherently vulnerable to exploitation.

In a 2000 report, the U.S. Government Accountability Office (GAO) concluded that Medicaid is inherently vulnerable to exploitation.

> Fraud schemes often cross state lines and enforcement jurisdictions, entailing a number of federal, state, and local agencies that may have different or competing priorities in their efforts to investigate, prosecute, and enforce compliance. Experience shows that coordinating the efforts of the multiple players, investing in preventive strategies, and dedicating adequate resources to fraud control units are essential components of an effective program integrity strategy (*Medicaid: Federal and State* 1).

Examples of fraud and abuse abound. The targets include both government programs and private health insurers. Few of the GAO examples refer specifically to Kentucky, primarily because GAO normally targets large states in its studies. However, in the absence of evidence to the contrary, it is likely that the same problems occur in Kentucky, especially those involving national and international corporations.

The U.S. Government Accountability Office has found that vulnerabilities within the health insurance system allow unscrupulous providers to cheat companies and programs out of billions of dollars a year.

GAO has found that vulnerabilities within the health insurance system allow unscrupulous providers to cheat health insurance companies and programs out of billions of dollars a year (*Health Insurance: Vulnerable* 1). "Insurers have difficulty discerning wrongful acts amidst the multiple activities that take place at the time of processing claims" (*Health Insurance: More* 1).

In 1999, GAO reported:

> Improper payments can result from incomplete or inaccurate data used to make payment decisions, insufficient monitoring or oversight, or other deficiencies in agency information systems and weaknesses in internal control. This risk is inherently increased in programs involving (1) complex program regulations, (2) an emphasis on expediting payments, and (3) a significant volume of transactions (*Financial* 7).

GAO's work suggests that Medicare and Medicaid are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system (*Medicare and Medicaid* 1).

Decisions on whether and how to pursue fraud and abuse against Kentucky's Medicaid program are made by various agencies, including the Office of the Attorney General; the Office of Inspector General; and prosecutors at the federal, state, and local levels.

GAO initially focused much of its work on the Medicare program. A 1998 report concluded:

> Fraud and abuse encompass a wide range of improper billing patterns that include misrepresenting or overcharging for services delivered. Both result in unnecessary costs to Medicare, but a fraud conviction requires proof of intent to defraud. Abuse typically involves actions that are inconsistent with Medicare billing rules and policies. Practically, whether and how a wrongful act is addressed depends on the size of the financial loss incurred and the evidence establishing intent. For example, small claims are generally not pursued

> as fraudulent because of the cost involved in investigation and prosecution (*Medicare: Fraud and Abuse* 4).

The same concepts apply to the Medicaid program. In Kentucky, decisions are made and investigations are conducted by various agencies, including the Office of Inspector General in the Cabinet for Health and Family Services; the Office of the Attorney General; and other law enforcement officials and prosecutors at the federal, state, and local levels.

Other federal agencies also report on health care fraud and abuse. The U.S. Department of Health and Human Services' (HHS) Office of Inspector General issues a semiannual report on its investigations and related activities. For example, in its report for the first half of federal fiscal year 2005, the office reported on the case of Gambro Healthcare, Inc. Gambro, which owns and operates renal dialysis clinics across the United States, agreed to pay more than $350 million in fines and penalties and entered a comprehensive corporate integrity agreement with the Office of Inspector General. The global settlement resolved civil and criminal allegations of health care fraud with the Medicare, Medicaid, and TRICARE programs. As part of the global resolution, Gambro agreed to pay $310.5 million to resolve its civil liability and must allocate $15 million for potential liability to state Medicaid programs. A subsidiary, Gambro Supply Corporation, pleaded guilty to health care fraud, agreed to pay a $25 million criminal fine, and was permanently excluded from Medicare and other federal health care programs (U.S. Dept. of Health. Centers. *Semiannual* 15).

The federal Health Insurance Portability and Accountability Act of 1996 established a national Health Care Fraud and Abuse Control Program under the joint direction of the U.S. Attorney General and HHS, acting through the HHS Office of Inspector General. The program is designed to coordinate federal, state, and local law enforcement activities related to health care fraud and abuse. The program uses "a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect program beneficiaries" (U.S. Dept. of Health and Human Services and Dept. of Justice).

The federal government won or negotiated more than $1.8 billion in health care fraud judgments and settlements in fiscal year 2003.

HHS and the Department of Justice issue a joint report each year. The report covering federal fiscal year 2003 stated that the federal government won or negotiated more than $1.8 billion in health care fraud judgments and settlements.

Hundreds of defendants were convicted and thousands of providers were excluded from participating in the Medicaid and Medicare programs in 2003.

The same report also states:

> Federal prosecutors filed 362 criminal indictments in health care fraud cases in 2003. A total of 437 defendants were convicted for health care fraud-related crimes during the year. There were also 1,277 civil matters pending, and 231 civil cases filed in 2003. HHS excluded 3,275 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocations.

These examples and those in Appendix D illustrate the extent of the problem of improper payments and the importance of strong fraud control systems in the Medicaid program.

The Office of the Attorney General and the Department for Medicaid Services Share Responsibility for a Medicaid Fraud Control System in Kentucky

Medicaid fraud controls in Kentucky are the joint responsibility of the Office of the Attorney General and the Department for Medicaid Services. Many of the department's responsibilities are delegated to its contractors, including the Cabinet for Health and Family Services' Office of Inspector General and the operator of its MMIS, Electronic Data Systems. In simplified terms, the contractors are charged with preventing and detecting fraud, abuse, and errors, whereas the Office of the Attorney General's Medicaid Fraud and Abuse Control Division is responsible for investigating and prosecuting fraud.

Allegations of Medicaid Fraud Are Investigated by the Office of the Attorney General's Medicaid Fraud and Abuse Control Division

In Kentucky, many allegations of provider fraud are investigated by the Office of the Attorney General's Medicaid Fraud and Abuse Control Division.

Many allegations of provider fraud in Kentucky are investigated by the Medicaid Fraud and Abuse Control Division of the Office of the Attorney General. The division director provided an e-mail in August 2005 that summarized several closed cases for inclusion in this report. Program Review staff have grouped the case summaries into three categories: 1) those in which Medicaid fraud

was or could have been discovered by analyzing information from the MMIS, 2) those for which information in the MMIS was used to calculate overpayments related to cases identified from other sources, and 3) those that were identified by means independent of the information in the MMIS. The summaries illustrate that Kentucky's Medicaid program is not immune to fraud and abuse.

Some Medicaid fraud can be discovered by analyzing information from the MMIS.

Table 4.1 illustrates incidents of Medicaid fraud in Kentucky that were or could have been discovered by analyzing information from the MMIS. Since the cases involved fee-for-service provider billings, the relevant information would be the claims submitted by the providers for payment. Information from the provider claims is stored in the MMIS. Trend reports often are used to identify providers whose levels of service differ significantly from those of their peers.

Medicaid fraud due to patient neglect cannot be discovered by analyzing information from the MMIS, but the information is used to determine improper payments due to services not provided.

Table 4.2 describes two incidents in which Medicaid fraud due to patient neglect was initially reported by other sources but for which analysis of claims information from the MMIS was later used to determine liability to the Medicaid program because the provider billed for health care services not provided. Both cases involve nursing homes that received multiple Type A citations, the most serious kind of deficiency, from the Division of Health Care Facilities and Services within the Cabinet for Health and Family Services' Office of Inspector General. The roles of the Office of Inspector General and other agencies in such situations are covered in a 2004 Program Review and Investigations Committee report, *Kentucky Can Improve the Coordination of Protective Services for Elderly and Other Vulnerable Adults*. The specific procedures are not replicated in this report.

Table 4.1
Examples of Cases in Which Information From the MMIS Could or Did Help Identify Medicaid Fraud and Abuse in Kentucky

Provider	Type of Fraud and/or Abuse	Outcome
Optometrist (2003)	▪ Upcoded services ▪ Billed for services allegedly provided on defective or inoperative equipment ▪ Double billed for numerous office visits	▪ Pleaded guilty to seven felony counts, including devising a scheme to defraud Medicaid ▪ Sentenced to 10 years' imprisonment and ordered to pay more than $43,000 in restitution ▪ Later was granted shock probation
Physician (2003)	▪ Billed for patient office visits when physician assistants actually saw the patients ▪ Some billings were for dates the physician was not in Kentucky or even in the United States.	▪ The physician's corporation entered a guilty plea to two counts of theft by deception. ▪ Paid restitution of $65,000, paid a $5,000 fine, and reimbursed Attorney General investigative costs of more than $19,000
Pharmacist (2000)	▪ Billed for excessive quantities of two drugs claimed to have been provided to nursing home patients when lesser amounts had been provided	▪ Sentenced to 10 years' imprisonment ▪ Ordered to make restitution of $575,000 and reimburse investigative costs of $15,000 ▪ After serving 120 days, was granted shock probation
Dentist (2001)	▪ Billed for juvenile root canals when those services were not provided	▪ Entered a guilty plea to a Class A misdemeanor ▪ Sentenced to 12 months in jail and ordered to make restitution of more than $143,000 ▪ Received a probated sentence for 2 years or until restitution was paid in full
Derma-tologist (2002)	▪ Allowed a physician assistant to perform procedures alone when the procedures require a physician's presence ▪ Several patients suffered injuries and permanent scarring from the procedures.	▪ Entered a guilty plea to devising a plan or scheme to defraud Medicaid of more than $300 and one count of filing false claims more than $300 ▪ Sentenced to 10 years' imprisonment and ordered to make restitution of $10,000
Durable Medical Equipment (2002)	▪ Arranged for an out-of-state supplier to ship disposable nebulizer circuits with a value of about $1 to the recipients but billed Medicaid for nondisposable circuits at the rate of $25 each ▪ Most of the supplies were never provided. Therefore, the provider incurred no actual expenses while billing Medicaid as much as $10,000 a month for those supplies.	▪ Entered a guilty plea to one count of the Class C felony of devising a plan or scheme to defraud Medicaid of $10,000 or more ▪ Sentenced to 5 years' imprisonment and ordered to make restitution in the amount of $100,000

Source: Compiled by Program Review staff from information obtained from the Office of the Attorney General (Murphy. "LRC").

Table 4.2
Two Cases in Which Information From the MMIS Could Not Detect Fraud or Abuse but Was Used To Determine the Amount of Provider Overpayments

Kindred Nursing Facilities	Pavilion Health Care Center
Background Seven Kindred facilities were cited for patient neglect. One facility was closed by the cabinet. Patient neglect constitutes Medicaid fraud because Medicaid was paying for services to properly care for residents, but the services were not rendered by the provider. There were several examples of patient neglect at the facilities: • A resident suffered a fatal fall after many previous falls were ignored by the facility. • A resident lost both feet to amputation because of inadequate care by the facility. • A resident died because of the facility's failure to attend to a severely impacted bowel. • A resident suffered a broken neck when she fell from a toilet after being left alone there for 15 minutes by staff. • At least five residents died from severe dehydration and untreated infections. • A resident was brought to the hospital with his mouth caked shut from dried mucous and old bits of food. **Outcome** Kindred agreed to pay more than $357,000 to the Medicaid program, $500,000 to the Kentucky Nursing Incentive Scholarship Fund, $300,000 a year to enhance training of staff at its Kentucky facilities, and more than $96,000 to the Attorney General's Medicaid Fraud and Abuse Control Division for its investigative costs. The total amount of the agreement, finalized on February 21, 2004, was more than $3.6 million. Monitoring of the agreement continues.	**Background** A three-year investigation of Pavilion Health Care led to the seizure of hundreds of pages of patient charts and other documents. Interviews were conducted with former employees, family members, hospital personnel, expert witnesses, corporate officials, and state regulators. Billing information for more than 40 of the 186 residents was analyzed to determine time periods of fraud relating to neglect. Other documents, such as cost reports and staffing patterns, also were analyzed. **Outcome** Pavilion's managing organization, Diversified Health Services, pleaded guilty to criminal Medicaid fraud in the neglect of 24 patients. The defendant was ordered to pay restitution for fraudulent billings of more than $254,000, the amount billed during the period the 24 residents were victims of criminal neglect. The defendant also was ordered to pay $500,000 to the Kentucky Nursing Scholarship Fund, a fine of $20,000, and $43,000 in investigation costs to the Office of the Attorney General. In a separate agreement with the U.S. Department of Justice and the U.S. Department of Health and Human Services' Office of Inspector General, the defendant agreed to pay $386,000 in additional restitution. The successor company was obligated to hire a monitor to oversee quality-of-care compliance in the remaining 22 facilities it owned or managed.

Source: Compiled by Program Review staff from information obtained from the Office of the Attorney General (Murphy. "LRC").

A review of information from the MMIS cannot identify patient neglect. However, if the facility neglects patients, the associated claims for service can be analyzed to determine how much the facility must repay the Medicaid program because of services billed but not provided.

Other fraudulent acts normally are discovered through whistle-blower lawsuits and involve multiple Medicaid programs in many states.

Some fraudulent acts cannot be discovered by analyzing information from the MMIS. These cases involve entities that report inaccurate information to the Medicaid program to increase profits. Such cases normally come to light from whistle-blower lawsuits filed under the federal False Claims Act and involve multiple Medicaid programs in many states. These cases illustrate that computerized systems are one tool but are not a panacea in preventing and detecting Medicaid fraud and abuse. They also illustrate the millions of dollars of fraud perpetrated against Medicaid that cannot be detected by normal surveillance and utilization review procedures.

An e-mail received by Program Review staff in October 2005 from the director of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division described the case against Serono, the manufacturer of Serostim, an antiwasting growth hormone used to treat AIDS patients (Murphy. E-mail). The company was charged with illegally paying kickbacks to doctors to prescribe Serostim. Kentucky's part of the settlement was more than $473,000. Program Review staff learned of additional cases from a review of the Office of the Attorney General's Web site on October 5, 2005. Table 4.3 shows examples of these multi-million dollar closed cases.

Kentucky's Medicaid Fraud Control Unit Does Not Receive All Federal Funding for Which It Qualifies

Adequate funding is essential in the fight against Medicaid fraud. However, the Medicaid Fraud and Abuse Control Division in the Office of the Attorney General does not receive all federal funding for which it qualifies.

Given the importance of the efforts of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division, adequate funding is essential. The state Medicaid Fraud Control Units are reimbursed by the federal government for 75 percent of their costs. That is, for each dollar spent, the federal government reimburses states 75 cents. No state accesses all the federal funds available. In Kentucky, approximately 88 percent ($9.2 million) of available federal funding was not drawn down in 2004. Approximately $3 million in state funds would have been required to increase federal funding by this amount.

Table 4.3
Examples of Cases in Which Information From the MMIS
Was Not Useful in Determining Medicaid Fraud and Abuse Overpayments

Pharmaceutical Manufacturers		
Provider	**Alleged Fraud and/or Abuse**	**Outcome**
Schering-Plough	▪ Charged with underpayment of drug rebates on Claritin ▪ Alleged that Schering, when negotiating with two HMOs to keep Claritin on formulary in lieu of a competitor product, provided the HMOs with certain discounts, concessions, and incentives, which were not reported to CMS as part of the "best price" used to calculate the drug rebate	▪ Schering-Plough pleaded guilty to federal anti-kickback charges. ▪ Kentucky recovered more than $5.7 million in a settlement with the company (Commonwealth of Kentucky. Office. "Attorney General Announces").
Parke-Davis	▪ Accused of off-label marketing of the drug Neurontin that is used to treat epilepsy ▪ Accused of providing kickbacks to physicians to prescribe Neurontin for off-label use	▪ Kentucky recovered more than $1 million (Commonwealth of Kentucky. Office. "Attorney General Stumbo").
GlaxoSmithKline and Bayer	▪ Accused of violating the Medicaid drug rebate law ▪ Alleged that the drug companies sold several highly prescribed medications to HMOs at deeply discounted prices, repackaging the drugs under the HMO's private label, but not reporting discounted sales to CMS as part of the best price	▪ Kentucky's Medicaid program recouped nearly $10 million from the settlement (Commonwealth of Kentucky. Office. "$10 Million").
Bristol-Myers Squibb; Watson Pharmaceuticals, Inc.; and Danbury Pharmacal, Inc.	▪ Accused of violating antitrust laws by keeping generic competitor drugs out of the hands of consumers	▪ Kentucky's Medicaid program recouped more than $2 million (Commonwealth of Kentucky. Office. "Chandler").
Healthcare Corporation		
Columbia/HCA	▪ Accused of billing for services never rendered and of upcoding ▪ It was alleged that between 1987 and 1997, HCA and its hospitals sought reimbursement for costs stated to have been incurred as a result of treating Medicaid recipients. Many of the costs were billed to Medicaid but were never actually incurred, were incurred in lesser amounts, and/or were otherwise not fully allowable.	▪ Kentucky's part of the settlement was more than $1 million (Commonwealth of Kentucky. Office. "$1 Million").
Columbia/HCA	▪ Accused of billing for services not needed and billing for services not provided at its hospitals and home health agencies ▪ Alleged to have billed for outpatient lab tests that were not medically necessary, were not ordered by physicians, or resulted from billing violations and home health visits for patients who did not qualify to receive them or the services were not performed	▪ Kentucky's share of the settlement was more than $2 million (Commonwealth of Kentucky. Office. "Former").

Federal reimbursements are made quarterly. Under the formula used to determine available federal funding, each state is guaranteed at least $125,000 each quarter. The maximum reimbursement amount is equal to one-quarter of 1 percent of total Medicaid expenditures for a state. For example, if Kentucky's total quarterly Medicaid expenditures were $1 billion, the state could receive $2.5 million in federal reimbursement. To receive this amount, Kentucky would have to spend $833,333 in state funds.

Federal reimbursements for the Medicaid Fraud and Abuse Control Division have increased only marginally and have not kept pace with the growth in Medicaid expenditures.

Kentucky's federal reimbursements increased from about $1 million in 2000 to $1.4 million in 2005. This increase has not kept pace with the overall growth in Medicaid expenditures. In 2000, federal reimbursement equaled 0.032 percent of total Medicaid expenditures, the same as in 2005. The maximum federal reimbursement is set at 0.25 percent. This means that approximately 89 percent (1-[0.032 ÷ 0.25] × 100) of available federal funding was not accessed in both 2000 and 2005. The same pattern continued in each of the following years. Kentucky's expenditures and percentage of available federal funding accessed are shown in Table 4.4.

Table 4.4
Office of the Attorney General's Medicaid Fraud and Abuse Control Division's Expenditures
(State Fiscal Years 2000 to 2005)

State Fiscal Year	Total Division Expenditures	Total Medicaid Expenditures	Federal as % of Total Medicaid (0.25% Max.)	% of Federal Grant Unaccessed
2000	$1,319,398	$3,135,703,586	0.032	87.4
2001	1,454,807	3,398,140,533	0.033	87.0
2002	1,392,325	3,861,368,158	0.027	89.2
2003	1,123,015	3,978,738,396	0.021	91.7
2004	1,542,358	4,287,019,087	0.027	89.4
2005	1,888,955	4,411,633,270	0.032	87.3

Source: Kentucky budget and accounting data and Program Review staff's analysis.

The amount of federal funding foregone and the additional state expenditures required by Kentucky to obtain maximum federal reimbursement can be determined using total Medicaid expenditures and the maximum federal reimbursement rate for the fraud control units. The federal funds not accessed for six fiscal years are shown in Table 4.5.

Table 4.5
Unaccessed Federal Medicaid Fraud and Abuse Control Funds and State Expenditure Needed To Draw Down These Funds (State Fiscal Years 2000 to 2005)

State Fiscal Year	Federal Money Unaccessed	State Expenditure Required To Access Federal Funds
2000	$6,849,887	$2,283,296
2001	7,386,775	2,462,258
2002	8,608,846	2,869,615
2003	9,119,126	3,039,709
2004	9,578,589	3,192,863
2005	9,629,989	3,209,996

Source: Program Review staff's analysis.

Kentucky spent fewer state dollars on its Medicaid fraud control program in 2005 than it did in 2000 relative to total Medicaid expenditures.

The amount of federal reimbursement foregone has steadily increased, indicating that Kentucky is spending fewer state dollars on its Medicaid fraud control program in 2005 than it did in 2000 relative to total Medicaid expenditures, even though state spending increased during the period.

The federal government will approve incremental increases in funding with proper justification, including the need for more staff to investigate and prosecute Medicaid fraud and patient abuse cases. The Office of the Attorney General's Medicaid Fraud and Abuse Control Division is experiencing an increased load, particularly of cases of patient abuse. To qualify for additional federal funding, the Office of the Attorney General need only demonstrate that state matching funds are available. Table 4.6 compares the division's case statistics for calendar years 2003 and 2005.

Table 4.6
Office of the Attorney General's Medicaid Fraud and Abuse Control Division's Provider Fraud and Patient Abuse Case Statistics (Calendar Years 2003 and 2005)

		Year	
Statistic		**2003**	**2005**
Complaints reviewed		1,075	2,002
Cases opened:	Abuse	74	51
	Fraud	39	82
Cases pending at year-end:	Abuse	85	104
	Fraud	43	105

Source: Compiled by Program Review staff from information provided by the Office of the Attorney General's Medicaid Fraud and Abuse Control Division.

Recommendation 4.1

The Office of the Attorney General should consider requesting additional state funding from the General Assembly to more fully access the federal funds to operate its Medicaid Fraud and Abuse Control Division. The office should allocate state appropriations to the division in amounts necessary to maximize access to the federal funds. If at any time the office believes additional state funds are necessary to access federal matching funds for operation of the Medicaid Fraud and Abuse Control Division, an emergency appropriation increase should be requested for the division utilizing unused or discretionary funds from other budget units within the Office of the Attorney General. This action by the office should be utilized to the greatest extent possible without significantly impairing other legal, investigative, and administrative functions. When requesting additional funds from the General Assembly during the budget process, the Office of the Attorney General should present a comprehensive plan with the request outlining how the new funds will be used and the expected results from the increased expenditures.

Recommendation 4.2

The General Assembly should consider appropriating additional state funds to the Office of the Attorney General for the specific purpose of accessing a larger amount of federal funds to operate its Medicaid Fraud and Abuse Control Division only after the office has shown that appropriation increases provided through fund transfers from other budget units within the office are insufficient to obtain the specified goals of the Medicaid Fraud and Abuse Control Division. Additional funding by the General Assembly should be made as a specific line-item appropriation for the purpose of accessing larger amounts of federal funds to operate the Medicaid Fraud and Abuse Control Division. Specified appropriations by the General Assembly should be contingent upon demonstrating, to an appropriate legislative committee, by the Office of the Attorney General actual results produced by the Medicaid Fraud and Abuse Control Division and obtaining a determination by the General Assembly that the results warrant the additional funding requested.

The Extent of Improper Payments Made by the Medicaid Program Has Not Been Measured

The extent of Medicaid's improper payments has not been measured.

Having shown that Medicaid improper payments do happen in Kentucky, the next step should be to report the extent of the problem. However, the extent of Medicaid's improper payments has not been measured at the state or national level.

The Centers for Medicare and Medicaid Services has measured the Medi*care* improper payment rate since 1996. CMS recently began a similar initiative with the Medi*caid* program through the Payment Accuracy Measurement demonstration project and the Payment Error Rate Measurement pilot project. Both projects examined information on paid claims and recipient eligibility in computerized systems.

Payment Accuracy Measurement Project

The purpose of the federally funded Payment Accuracy Measurement demonstration project was to determine the accuracy of payments made by Medicaid and the Children's Health Insurance Program.

CMS initiated the Payment Accuracy Measurement demonstration project in October 2000. The purpose of the project was to determine the accuracy of payments made by Medicaid and the Children's Health Insurance Program. State participation in the project was voluntary and 100 percent federally funded. The Cabinet for Health and Family Services chose to participate in the project to measure Medicaid's payment accuracy.

Under the federal Improper Payments Information Act of 2002, large federal agencies are required to provide an annual estimate of improper payments made from federal funds. CMS, as part of the Department for Health and Human Services, is required to provide such an estimate for the Medicaid program but has not yet been able to do so. The Payment Accuracy Measurement demonstration project was a first step in determining how to measure the national error rate.

Kentucky's Medicaid program participated in the third year of the project and issued a report in January 2005.

Kentucky's Medicaid program participated in the third year of the demonstration, beginning its work in October 2003 and completing the project in January 2005. Cabinet staff with the Department for Medicaid Services and the Office of Inspector General worked with contractor Myers and Stauffer to complete most of the work.

In its January 31, 2005, report to CMS, the Kentucky Department for Medicaid Services stated that it examined a sample of Medicaid and Children's Health Insurance Program payments to 1) identify potential problems or enhancements to claims payment systems; 2) identify the cause of identified claims processing problems; and 3)

critically analyze internal controls (Commonwealth of Kentucky. Cabinet. Department. *Payment Accuracy* 3). Samples from Medicaid's fee-for-service model and its managed care model were tested.

Samples of Medicaid's fee-for-service claims were tested for medical, processing, and eligibility accuracy.

Under the fee-for-service model of the Medicaid program, a random sample of more than 1,000 Medicaid fee-for-service claims was reviewed for medical and processing accuracy.[1] A subsample of 50 claims was reviewed for eligibility accuracy.

Medicaid payments to service providers were tested to address the following questions:

- Was the amount, scope, and duration of the service provided (as indicated on the claim) consistent with the patient's medical needs and documentation within the patient's medical chart?
- Was the provider's Medicaid claim consistent with the service provided, and did the claims processing system appropriately adjudicate the claim in accordance with Medicaid policies, regulations, and statutes?
- Were the recipients in the subsample of claims eligible for the provided service? (4).

Each claim was reviewed for medical, coding, and payment process accuracy. Fifty claims were reviewed by verifying eligibility as of the application or re-determination date prior to the date of service by using recipient information and documentation from the case file.

Samples of Medicaid's managed care claims were tested for processing and eligibility accuracy.

Under the managed care model of the Medicaid program, a sample of more than 1,100 managed care claims was reviewed for processing accuracy.[2] A subsample of 50 claims was reviewed for eligibility accuracy.

Medicaid payments to managed care contracted health plans were tested to answer the following questions:

- Was the recipient enrolled in the health plan that received the capitation payment?

[1] The random sample of 1,067 claims was selected from the universe of paid claims for one quarter, October through December 2003. Unpaid claims were not included in the sample. The sample was drawn without replacement to obtain an estimate of the payment accuracy rate within +/- 3 percentage points of the true population error rate with 95 percent confidence.

[2] The sample of 1,162 paid capitation claims was reviewed for one quarter, October through December 2003. An estimate of the payment accuracy rate within +/- 3 percentage points of the true population rate with 95 percent confidence was computed.

- Was the correct rate cell applied (was the proper capitation rate used)?
- Did the health plan receive the correct capitation rate?
- Were any inappropriate fee-for-service payments made for the recipient? (9)

Fifty capitation claims were reviewed to determine eligibility for the months in which the capitation payment applied.

The project measured an overall payment accuracy rate of 94 percent with a total dollar error of $48 million for underpayments and overpayments. The estimated error amount does not imply that the Medicaid program could immediately collect overpayments of $48 million from providers.

Results. The Payment Accuracy Measurement project found an overall payment accuracy rate of 94 percent. The payment accuracy rate is the dollar value of Medicaid claims paid correctly divided by the total dollar value of Medicaid payments (Commonwealth of Kentucky. Cabinet. Department. *Payment Error* 2). The accuracy rate for managed care was 100 percent compared to 93.6 percent for fee-for-service claims. The reported total dollar error was more than $48 million. The federal methodology required the state to add the absolute value of overpayments and underpayments to determine the total dollar error. Using this methodology, if three overpayment errors totaling $100 and three underpayment errors totaling $100 were discovered, the number of payment errors would be six, and the dollar amount in error would be $200. The results are depicted in Table 4.7.

Table 4.7
Fee-for-Service and Managed Care Payment Accuracy Rates

	Fee for Service	Managed Care	Total
Total cases reviewed	1,067	1,162	2,229
Dollar value of cases reviewed	$1,204,166	$347,380	$1,551,546
Number of overpayment errors	74	0	74
Dollar value of overpayment errors	$21,597	$0	$21,597
Number of underpayment errors	7	0	7
Dollar value of underpayment errors	$1,340	$0	$1,340
Total number of errors	81	0	81
Absolute dollar value of errors	$22,937	$0	$22,937
Overall accuracy rate	**93.6%**	**100.0%**	**94.4%**

Source: Commonwealth of Kentucky. Cabinet. Department. *Payment Accuracy* 12.

Three types of accuracy review were performed in this project: processing, medical, and eligibility. The processing review of claims found an accuracy rate of 99.98 percent compared to the medical review, which found an accuracy rate of 97.02 percent. No errors were found in the eligibility review. Table 4.8 shows the results by type of review.

Table 4.8
Processing, Medical, and Eligibility Accuracy Rates

	Processing	Medical	Eligibility
Total cases reviewed	1,067	1,067	100
Dollar value of cases reviewed	$1,204,166	$1,204,166	$60,834
Number of overpayment errors	3	71	0
Dollar value of overpayment errors	$108	$21,489	$0
Number of underpayment errors	3	4	0
Dollar value of underpayment errors	$158	$1,181	$0
Total number of errors	6	75	0
Absolute dollar value of errors	$266	$22,670	$0
Overall accuracy rate	**99.98%**	**97.02%**	**100.00%**

Source: Commonwealth of Kentucky. Cabinet. Department. *Payment Accuracy* 12.

The most significant issue affecting the payment accuracy rate was the inability to obtain patient records from some providers.

The following passage from page 16 of Kentucky's Payment Accuracy Measurement (PAM) report explains the project results:

> The most significant issue affecting the accuracy rate for Kentucky was the inability to obtain patient records from some providers. In many situations, the PAM request was the first such request received by the provider. Categories such as physician, long-term care, and school-based health services were especially difficult, as many providers in these categories historically have not been required to submit such documentation. As such, it appears as though their documentation practices have deteriorated.
>
> . . . [A] significant portion of the final error, 38%, was related to missing and incomplete documentation.

The estimated dollar amount of error suggests that increased claim auditing that examines medical chart information may result in additional findings.

> [The Payment Accuracy Measurement] report includes the projected total dollars in error based on the findings of the reviews.... It is important to note that this estimated error amount does not imply that the Department could immediately collect overpayments of this amount from providers.... The

estimated dollar amount of error does suggest that increased claim auditing that examines medical chart information may result in additional findings.

Payment Error Rate Measurement Project

The goal of the Payment Error Rate Measurement project was to calculate an error rate of payments made incorrectly.

On the heels of the PAM project, Kentucky's Department for Medicaid Services chose to voluntarily participate in CMS's Payment Error Rate Measurement (PERM) pilot project. PERM sought to measure a payment error rate, which was defined as the dollar value of payments made incorrectly divided by the total dollar value of payments (Commonwealth of Kentucky. Cabinet. Department. *Payment Error* 2).

The sample size was too small to allow the results to be generalized to the population.

The sample of 150 claims drawn for the PERM project was too small to allow the results to be generalized to the entire population. For this reason, the results are not presented in this Program Review and Investigations Committee report.

Weaknesses in the Federal Methodology

A false claim can be defined as a claim that contains a material falsehood but is billed correctly, processed correctly, and paid by Medicaid. The falsehood may be accidental or deliberate.

The methodology used in the PAM and PERM projects does not consider that medical documentation can be fabricated. The issue of false claims is discussed in detail by Dr. Malcolm Sparrow, a nationally recognized expert in health care fraud, in his book *License to Steal: How Fraud Bleeds America's Health Care System*. Sparrow used the term "false claims" in a nonlegal sense to mean claims that contain a material falsehood and which are nevertheless "billed correctly, processed perfectly, and paid" (83). The falsehood may be accidental or deliberate. The false claim may contain a false diagnosis, represent services that were not provided, or list procedures that were upcoded to something more expensive.

The methodology in the federal projects was not designed to detect false claims.

The methodology required by the federal government in the PAM and PERM projects essentially replicates that used in the annual projection of Medicare's improper fee-for-service payments. That methodology is not designed to detect fraud in the form of false claims.

The methodology used to estimate the extent of Medicare improper payments includes drawing a random sample of Medicare beneficiaries and reviews all the claims submitted on their behalf during a three-month period. Claims are reviewed for processing accuracy, and providers are asked to provide copies of medical records supporting the services billed. Medical professionals assess

the medical records to determine whether, based on the submitted claims, the services billed were reasonable, medically necessary, documented adequately, and coded correctly (92).

The medical review audit methodology followed in the federal projects accepts all documents as true and focuses on their medical significance. To detect false claims, a fraud audit to contact patients or relatives is needed.

This methodology is essentially a medical review audit. Such an audit accepts all documents as "true" and focuses on their medical significance. However, a medical review audit will seldom reveal false claims.

> Only a more rigorous *fraud audit* could do that. A fraud audit would have to include, at a minimum, substantial efforts to contact patients or their relatives to verify the services were delivered. Preferably, the patient interviews would be done before any approach to the provider. If the patient disputed the services, a rigorous audit protocol would call for an unannounced visit to the provider's offices to examine medical and billing records, minimizing their opportunity to tinker with them (93).
>
> The false claims phenomenon shows the principal remaining weaknesses in the fee-for-service structure . . . (83).
>
> Fraud perpetrators understand the dynamics of false claims extremely well: They lie about diagnoses, falsify the record of services, and in some cases fabricate entire medical episodes for patients they have never seen. They bill their lies correctly, aiming for the sweet spot—smack in the middle of medical orthodoxy, policy coverage, and price. Then, having found combinations that pay, they replicate them (electronically) thousands of times, spreading the activity across hundreds of patients' accounts, and preferably across different insurers, to evade detection... When the perpetrators are caught, they quickly pay back the claims in question, apologize profusely for the filling error, and continue to steal (84).

Only a small number of fraud audits should be required, focusing on providers who appear to have submitted false claims.

Program Review staff recognize the potential problems with implementing a fraud audit protocol. Contacting patients or relatives would be time consuming, labor intensive, and expensive. Some patients may not have the cognitive ability to remember, and relatives may not know what services have been provided.

Unannounced provider visits could raise questions in patients' minds about their providers. However, the number of such actions should be small and focused on providers that appear to have submitted false claims.

The fiscal year 2004 Medicare fee-for-service report showed a net overpayment error rate of more than 9 percent. False claims might add another 10 percent or more to that rate.

The fiscal year 2004 Medicare fee-for-service report showed net overpayments (overpayments less underpayments) of $19.9 billion and a net overpayment error rate of 9.3 percent (U.S. Department. Centers. *FY* 7). Referring to the Medicare fee-for-service improper payment studies, Sparrow stated:

> Because the OIG [HHS Office of Inspector General] measurement studies fail to capture the majority of fraudulent claims that might have fallen into the samples, the series of overpayment error rates these studies have produced *do not cover fraudulent claims*. Fraud might add another 10 percent (or 20 percent, or 30 percent) on top of the estimated overpayment rate. Nobody knows exactly how much because the *fraud* rate has not yet been measured (91).

Cabinet for Health and Family Services' Office of Inspector General

The Cabinet for Health and Family Services' Office of Inspector General helps prevent and detect errors, fraud, and abuse against the Medicaid program.

Several initiatives of the Kentucky Cabinet for Health Services' Office of Inspector General attempt to address these issues. The divisions that are involved in preventing and detecting errors, fraud, and abuse against the Medicaid program are Fraud, Waste and Abuse/Identification and Prevention; Special Investigations; and Audits and Detection. An overview of each division follows. The information was provided by the Office of Inspector General and three division directors. Flowcharts showing the details of fraud and abuse complaint investigations, referrals, and dispositions are shown in Appendix E: Figures E.1 and E.2.

Division of Fraud, Waste and Abuse/Identification and Prevention

The Division of Fraud, Waste and Abuse/Identification and Prevention collects and analyzes information to prevent improper payments and to detect and recover improper payments already made.

The Division of Fraud, Waste and Abuse/Identification and Prevention acts as an "intelligence area," collecting and analyzing information to prevent improper payments and to detect and recover improper payments already made. Importantly, the director of this division has years of experience with Kentucky's Medicaid

program integrity function and has the authority to require an edit to be implemented in the MMIS to prevent improper payments.

The division directed the work of the contractor on the federal projects. The contractor also analyzes patterns of Medicaid usage and recommends policy changes and prepayment system edits for preventing improper payments.

The work of the contractor Myers and Stauffer on the PAM and PERM projects was coordinated by the division. Under the division's direction, Myers and Stauffer also performs postpayment reviews of Medicaid claims to detect outliers—providers or recipients whose usage patterns lie outside the norm. The outliers are identified by the contractor through the analysis of information from the MMIS and are investigated by Office of Inspector General staff.

Myers and Stauffer recommends policy changes and prepayment computer system edits for preventing improper payments. The contractor's contingency fee for this part of its work is based on calculated savings from the avoided costs. Preventing improper payments during prepayment review saves the effort of identifying overpayments during postpayment review and attempting to recover them from the provider or recipient. Three recent cost avoidance studies using computerized algorithms by Myers and Stauffer are described in Table 4.9. The three studies resulted in new policies designed to save the Medicaid program more than $11 million over two years.

The division administers the contract for identifying third-party liability for claims presented to Medicaid for payment.

The division also administers Medicaid's contract with Public Consulting Group. That contract involves identifying third-party liability for claims presented to Medicaid for payment. Details of the third-party liability function are described in more detail in the Program Review and Investigations Committee report *Uncollected Revenues and Improper Payments Cost Kentucky Millions of Dollars a Year*.

Table 4.9
Examples of Medicaid Cost Avoidance Studies and Projected Savings
(Projects Completed Since June 2005)

Bed Reserve Reimbursement Methodology	Outpatient Services Provided 3 Days Prior to Inpatient Stay (Different Diagnoses)	Root Canals on Primary Teeth
Prior policy: When a resident left a nursing facility for an inpatient hospital admission or a therapeutic leave, the facility was paid the full nursing facility per diem to hold the bed until the resident returned.	**Prior policy:** No system edit was in place to deny outpatient diagnostic services prior to an inpatient stay for claims with different inpatient and outpatient diagnosis codes.	**Prior policy:** Medicaid was paying for root canals on primary teeth.
New policy: Residents are subject to an annual limit of 14 hospital day stays and 10 therapeutic leave days. In addition, for a bed reserve paid stay, the per diem is limited to 50% of the nursing facility rate if the facility's occupancy is less than 95%. If the occupancy rate is equal to or greater than 95%, then the bed reserve rate is equal to 75% of the nursing facility rate.	**New policy:** Outpatient diagnostic services provided up to three days prior to an inpatient acute care stay for the same recipient and provider are denied for claims with different inpatient and outpatient primary diagnoses. A system edit has been implemented to deny these claims.	**New policy:** Root canals should be limited to permanent teeth only. If a root canal is performed on a primary tooth, the appropriate procedure code is a therapeutic pulpotomy, which results in a substantially lesser fee. The claims payment system had no pulpotomy fee established. An edit has been proposed to deny claims for root canals on primary teeth.
Projected savings: It is estimated that $10,540,945 in cost over two years will be avoided.	**Projected savings:** It is estimated that $597,198 in cost over two years will be avoided.	**Projected savings:** It is estimated that $67,318 in cost over two years will be avoided.

Source: Developed by Program Review staff from information provided by the Office of Inspector General.

Much third-party liability is determined by comparing information in the MMIS to information obtained from other insurers, such as Medicare and private insurance companies. Table 4.10 shows the costs avoided by Kentucky Medicaid by making sure that other liable third parties are billed before Medicaid pays. The majority of avoided costs are paid by the federal Medicare program.

Table 4.10
Components of Medicaid Third-party
Liability Cost Avoidance (in $ millions)

	FY 2003	FY 2004	FY 2005
Medicare	$624.9	$665.3	$664.0
Private Insurance	$63.1	$84.1	$91.4
Total	$688.0	$749.4	$755.4

Note: The amounts include both federal and state dollars.
FY is state fiscal year, July 1 through June 30.
Source: Compiled by Program Review staff using data obtained from the Office of Inspector General.

If a liable third party is identified after a claim is paid or if benefits become available from a third party after a claim is paid, Medicaid must seek recovery from the third party. When Medicaid receives the recovery, the state keeps 100 percent of the money. CMS will withhold its share from future payments to the state (Commonwealth of Kentucky. Legislative. *Uncollected* 29-31).

KRS 205.623 requires insurance companies to provide coverage information and data on claims paid on behalf of Medicaid-eligible policyholders and dependents but does not include a penalty for noncompliance.

Kentucky's relevant statute (KRS 205.623) is insufficient to ensure that Medicaid is able to maximize its ability to discover third-party coverage through matching electronic data with the eligibility files of all insurers. According to statute, insurance companies must provide to the Cabinet for Health and Family Services, upon request, coverage information and data on claims paid on behalf of Medicaid-eligible policyholders and dependents. This information is to be sent electronically in the format prescribed by the cabinet. However, the statute provides no penalty for not complying with the cabinet's request. For Program Review's 2004 report, cabinet officials stated that draft legislation to strengthen the statute had been considered. A recommendation from that report is repeated here (Commonwealth of Kentucky. Legislative. *Uncollected* 31).

Recommendation 4.3

To maximize Medicaid's ability to avoid paying claims that are the responsibility of a liable third party, the General Assembly may wish to consider amending KRS 205.623 to include a penalty for noncompliance.

Collections and avoided costs due to third-party liability are increasing. In FY 2005, more than $755 million in cost was avoided, and more than $42 million was collected.

Similar to the cost-avoidance trend, the amount of improper payments collected due to third-party liability has been increasing over the past three fiscal years. As illustrated in Table 4.11, the amount of improper payments prevented due to third-party liability has far exceeded the amount being collected through "pay and chase," in which claims are paid and then the Department for Medicaid Services attempts to recover the overpayment. In fiscal year 2005, Kentucky Medicaid saved more than $755 million by preventing improper payments, and more than $42 million was subsequently collected in overpayments.

Table 4.11
Medicaid Third-party Liability Cost Avoidance and Collections (in $ millions)

	State Fiscal Year		
	2003	**2004**	**2005**
Cost Avoidance	$688.0	$749.4	$755.4
Collections	$23.3	$34.5	$42.5
Total	$711.3	$783.9	$797.9

Note: The amounts include both federal and state dollars.
Source: Compiled by Program Review staff using data obtained from the Office of Inspector General.

Total collections of more than $46 million were credited to the Medicaid Claims and Recovery Fund in fiscal year 2005.

Third-party liability collections are credited to the Medicaid Claims and Recovery Fund. The collections are combined with those attributable to the work of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division and other miscellaneous sources. More than $46 million was credited to the fund in fiscal year 2005. Activity in the fund for the last five fiscal years is shown in Table 4.12.

Table 4.12
Medicaid Claims and Recovery Fund (in $ millions)

	State Fiscal Year				
	2001	**2002**	**2003**	**2004**	**2005**
Balance Forward	$18.0	$18.1	$14.7	$13.9	$17.1
Plus: Current Receipts	$25.6	$14.9	$25.3	$41.1	$46.1
Less: Budget Reduction/Stability Initiative	$0	$0	$0	($2.0)	$0
Total Available	**$43.6**	**$33.0**	**$40.0**	**$53.0**	**$63.2**
Less: Administration	($12.5)	($17.6)	($14.8)	($17.6)	($20.5)
Less: Benefits	($13.0)	($0.7)	($11.3)	($18.3)	($29.9)
Total Expenditures	**$25.5**	**$18.3**	**$26.1**	**$35.9**	**$50.4**
Balance Forward	**$18.1**	**$14.7**	**$13.9**	**$17.1**	**$12.8**

Source: Compiled by Program Review staff using data from the Office of State Budget Director.

The Office of the Attorney General's Medicaid Fraud and Abuse Control Division investigates allegations of provider fraud only and may decline some of those cases. The Office of Inspector General's Division of Fraud, Waste and Abuse/ Identification and Prevention coordinates with law enforcement and prosecutors on the provider cases declined by the Office of the Attorney General and all recipient cases.

The Division of Fraud, Waste and Abuse/Identification and Prevention also coordinates with law enforcement agencies when the Office of Inspector General pursues criminal cases independently from the Office of the Attorney General. KRS 205.8483(2) requires the Office of Inspector General to immediately refer all hotline complaints to the Office of the Attorney General and other agencies and boards of jurisdiction. In fiscal year 2005, the Office of Inspector General referred 610 cases to the Office of the Attorney General, about 72 percent of which were complaints of recipient fraud and abuse. The role of the Attorney General's Medicaid Fraud and Abuse Control Division is limited to investigating allegations of provider fraud. Officials in

the Office of the Attorney General review the complaints of recipient fraud and abuse to determine if the recipient appears to be involved in an ongoing provider fraud or prescription drug case. After review, the Office of the Attorney General returns all recipient-related allegations to the Office of Inspector General.

In addition, if the Office of the Attorney General declines to pursue an allegation of potential provider fraud, the case is returned to the Office of Inspector General. Reasons for declining potential cases include insufficient evidence of a crime or a lack of showing of criminal intent. In these cases, the Office of Inspector General can pursue an administrative recovery.

If the allegation involves a recipient, the Division of Fraud, Waste and Abuse/Identification and Prevention takes the case to local prosecutors for potential action. If it involves a provider, a United States attorney is contacted. Two administrative actions against providers are shown in Table 4.13. Both cases included an analysis of information in the MMIS.

Table 4.13
Examples of Administrative Actions Taken by the Office of Inspector General on Improper Payments From the Medicaid Program

Case 1	Case 2
Complaint ▪ A complaint was received in 2003 alleging that a physician provider group (serving numerous hospitals throughout the state) had been systematically billing Medicaid for physician-level services when in actuality the services were provided by a physician assistant. ▪ The physician assistant reimbursement rate is approximately 25% less than the physician rate. **Investigation** ▪ The OIG's Special Investigations Division conducted a preliminary investigation involving extensive interviews with hospital staff and the physicians under whom the services were billed, plus a full analysis of the Medicaid policy and paid claims at issue. ▪ The completed investigation substantiated significant overbilling and medical documentation that supported the fact that the physicians had not seen the patients. **Referral to Medicaid Fraud and Abuse Control Division** ▪ The case was then referred to the Attorney General's Medicaid Fraud and Abuse Control Division in early 2004. ▪ The division returned the case to the OIG in early 2005, declining to prosecute. **Outcome** ▪ The OIG partnered with the U.S. Attorney's Office, Eastern District, and began the process of negotiating a settlement for Medicaid, which includes interest on the overpayment and recovery of OIG's investigative costs. ▪ With the threat of formal false claim proceedings and the substantiated findings by the OIG, the provider quickly responded to the settlement opportunity. ▪ Through the settlement, Medicaid recovered approximately $275,000. Through this process, OIG was able to determine that the provider has been billing appropriately since 2004 and OIG will continue to periodically monitor claims.	**Complaint** ▪ A complaint was received through the OIG hotline in 2002 alleging the provider (a physician affiliated with a large provider group in the state) was upcoding certain office visit procedures, even though the medical documentation did not support that level of service. **Investigation** ▪ The OIG's Special Investigations Division conducted a preliminary investigation, interviewing the provider and staff, reviewing policy and claims, and performing other procedures. ▪ The investigation (which involved a sampling of claims over a three-month period) substantiated the billing practice and that the provider billing representatives were unaware of the billing codes at issue. ▪ The provider has a clear obligation to be aware of policy, under the contract signed with the Department of Medicaid Services. **Referral to Medicaid Fraud and Abuse Control Division** ▪ The case was referred to the Attorney General's Medicaid Fraud and Abuse Control Division in September 2003. ▪ The case was eventually returned to the OIG for administrative proceedings in early 2005. **Outcome** ▪ OIG took the original findings, extrapolated them across a five-year retroactive period and included all physicians in the provider group. This resulted in a significant extrapolated overpayment. ▪ OIG sent a demand letter to the provider asking the provider to repay the extrapolated amount, conduct a self-audit, and report the findings to OIG. Failing that, OIG would conduct a full-scale audit of all provider billing practices. ▪ The provider has acknowledged a $400,000 overpayment and is considering the additional findings to add to that overpayment. OIG is awaiting a formal proposal from the provider for final settlement and anticipates this amount to be more than $500,000. This case is pending but is close to full resolution.

OIG is the Cabinet for Health and Family Services' Office of Inspector General.
Source: Compiled by Program Review staff from information provided by Ramsey.

Division of Special Investigations

The Division of Special Investigations conducts preliminary investigations of providers and recipients accused of Medicaid fraud.

The Division of Special Investigations works closely with the Division of Fraud, Waste and Abuse/Identification and Prevention. The two examples in Table 4.13 involved preliminary investigations of providers by the Division of Special Investigations, including a review of paid claims from the MMIS.

The Division of Special Investigations has 39 employees, 22 of whom are field investigators in Carter, Daviess, Franklin, Graves, Jefferson, Kenton, Laurel, Montgomery, Nelson, and Trigg Counties. The division operates the Office of Inspector General hotline, conducts preliminary investigations of allegations against providers and recipients, and serves as the direct contact to law enforcement, prosecutors, and judges. In addition, the division has recently created an administrative civil enforcement team to pursue cases administratively and to recover overpayments through civil settlements. Administrative actions include disenrolling a provider and withholding payments in anticipation of a criminal conviction. As of April 2006, the division had worked with the U.S. Attorney's Office to resolve a provider case in which approximately $280,000 was recovered. Information concerning another provider is being reviewed by the U.S. Attorney's Office, and division officials expect the office to be involved in another investigation soon.

Federal regulations at 42 CFR 455.15 require the state Medicaid program to conduct a full investigation if there is reason to believe a recipient has abused the program. Allegations against recipients most often result from calls to the Division of Special Investigations' hotline. Investigations involving recipients are conducted by the Division of Special Investigations, under the authority of the Office of Inspector General in KRS 194A.020(5) and a memorandum of agreement between the Department of Medicaid Services and the Office of Inspector General.

The work of the Division of Special Investigations is crucial in developing a case against a recipient.

Such investigations are crucial to developing a case against a recipient, since the federal government does not fund any investigations of recipients by the Office of the Attorney General. However, the information in such referrals may be used by the Office of the Attorney General in prescription drug diversion and provider investigations.

The work of the Division of Special Investigations also is crucial to developing a case against a provider. However, the Office of Inspector General's options are limited in pursing such cases.

The division's investigations also are crucial to developing a case against a provider since the federal government does not fund preliminary investigations by the Office of the Attorney General. Instead, the Office of Inspector General is expected to examine

MMIS claims, gather evidence, and present a case to the Office of the Attorney General's Medicaid Fraud and Abuse Control Division.

If the Medicaid Fraud and Abuse Control Division declines to pursue a case against a provider, the case is returned to the Office of Inspector General. However, the Office of Inspector General is limited in its ability to independently pursue the case. The office must enlist the aid of a U.S. attorney for criminal prosecution, or it can attempt to apply an administrative action, such as disenrolling the provider. The office's options are limited because it does not have administrative subpoena power and is limited in its ability to impose civil penalties.

Senate Bill 223 was filed in the 2005 Regular Session of the General Assembly to enhance the ability of the Office of Inspector General, acting on behalf of the Department for Medicaid Services, to detect and prevent fraud and abuse against the Medicaid program by recipients, providers, and others, including cabinet employees. The bill did not pass and was not filed in the 2006 Regular Session. The Inspector General plans to submit it for the 2007 session.

Recommendation 4.4

The General Assembly may wish to consider amending KRS 194A.020(5) to enhance the ability of the Office of Inspector General to pursue administrative actions in allegations of fraud and abuse against the Medicaid program, including the ability to issue administrative subpoenas and impose civil penalties.

Division of Audits and Detection

The goal of the Division of Audits and Detection is to perform internal audits of the programs in the Cabinet for Health and Family Services.

The goal of the Division of Audits and Detection is to perform internal audits of the Cabinet for Health and Family Services' programs to increase program efficiency and effectiveness. The division's transition from primarily accounting functions to internal audit activities was completed in December 2005. Because of the short time frame, few results are available for discussion in this report. One completed audit involved a survey of a personal care home that uncovered suspicious accounting practices. The results of the division's review produced evidence that ultimately led to a grand jury indictment on a charge of embezzlement. Division staff also have met with the U.S. attorney regarding a

county attorney who is alleged to have misappropriated cabinet funds. This case has been accepted for criminal prosecution.

The division plans to concentrate on high-risk areas and conduct preliminary reviews. The division's work will supplement the work performed by contractors.

The division seeks to provide assurances to the secretary of the Cabinet for Health and Family Services that program policies and procedures are operating as mandated. The secretary must approve the division's annual audit plan. The division will conduct a risk assessment and analysis of cabinet operations but first will focus on requests from the secretary and undersecretaries; then the division will perform additional risk assessments, concentrating its resources on high-risk areas determined by the assessments. The internal auditors will conduct prepayment reviews, analyzing denied claims and unusual patterns. An analysis of denied claims can help detect instances of trial-and-error billing schemes designed to find and exploit weaknesses in Medicaid's claims payment system. The division has purchased several licenses for a commercial software package that will allow its auditors to analyze submitted claims (including denied claims) and identify potential violations of Medicaid program rules, which will be referred to the Division of Special Investigations. The work of the Division of Audits and Detection will supplement rather than duplicate work performed by other divisions and Medicaid contractors.

Because some fraud prevention and detection activities of the Office of Inspector General are new, little evidence is available to demonstrate their efficiency and effectiveness.

Recent initiatives by the Division of Audits and Detection and the Division of Special Investigations hold promise for preventing and detecting improper payments made by Kentucky's Medicaid program. However, because of the newness of these activities, little evidence is available to demonstrate their efficiency and effectiveness.

Recommendation 4.5

The Office of Inspector General should conduct a cost-benefit analysis of the initiatives of its Division of Special Investigations and its Division of Audits and Detection and report the results to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

Seven Levels of Health Care Fraud

The Department for Medicaid Services normally does not know whether a service billed by a provider was actually performed or was billed in the correct amount.

Medicaid is different from some other federal programs. For example, in the federal Food Stamps program, the state provides a service in the form of an electronic benefits transfer card directly to the recipient. In the Medicaid program, the state does not provide a direct service to a recipient. Instead, a provider renders a service to a recipient, and the provider then bills Medicaid. The Department for Medicaid Services normally does not know whether the billed service was actually performed or was submitted in the correct amount.

When potential fraud is addressed at each of seven levels by the Medicaid program, a strong fraud control strategy should be in place.

This situation is addressed in Sparrow's book *License to Steal*, which summarizes the seven levels of health care fraud relating to fee-for-service claims (232-252). The levels also translate into a model fraud control strategy. When potential fraud at each level is addressed by the Medicaid program, a strong fraud control strategy should be in place. Each level is described below.

Level 1 occurs at the claim or transaction level and involves claims that would be suspicious purely from information contained in the claim. Examples include men receiving hysterectomies and infants receiving psychotherapy.

Level 2 concerns the relationship between one provider and one patient and examines the overall volume and nature of services delivered to that patient by that provider. At this level, detection systems would compare service frequency with reasonable norms for the provider's specialty and the patient's diagnosis. In an actual example, one state Medicaid agency paid for more than 142 lab tests for one patient in 18 days.

Level 3 involves patient-level and provider-level fraud, looking at a) the patient's entire history, aggregating claims across all providers and b) the provider's overall practice patterns across all patients. An example of patient-level monitoring would include detecting more than one appendectomy in a lifetime. An example of provider-level monitoring would include detecting unusually high levels of service, such as the case of a California pharmacist who billed Medicaid for improbably high volumes of prescription drugs, some involving recipients receiving more than 20 prescriptions a day.

Level 4 addresses two sides of the same problem. One side involves a patient group with one provider, and the other side involves one patient and a practice group of providers. The first

side recognizes that several patients may be covered by the same policy (such as Medicaid) and that one practitioner may distribute fraudulent or abusive activity across several patients. For example, the owner of a medical supply company in New York billed Medicaid for more than $1.2 million for services that were never provided to patients. The other side recognizes that one patient's account may be abused by a practice, acknowledging that frauds may be perpetrated by billers who deliberately distribute fraudulent activity across several practitioners, perhaps without knowledge of the acts by related practitioners. For example, an internal or external billing agent may submit claims for services never provided to a Medicaid recipient by physicians, labs, and physical therapists in a group practice.

Level 5 represents the relationship between a policy and the provider's practice. It considers the overall use of a policy (which may cover several patients) by a practice (which may include several providers). For example, a corporation that operates hospital, laboratory, and home health services facilities in several states, having access to all recipients' Medicaid billing information, could bill for services not provided at any level for any number of patients in numerous states.

Level 6 considers misuse of a particular group of patients, perhaps by many different providers; it also concerns patterns of claims activity by groups of practitioners affiliated with one another through practices, clinics, or other cooperative business arrangements. For example, practitioners may bill for services not provided to residents of a nursing home or intermediate care facility for persons with mental retardation or developmental disability. In another example, several practitioners may work in the same location, referring patients among themselves for needless services.

Level 7 represents multiple-party criminal conspiracies. These situations involve the operation of criminal networks in which the pattern of fraudulent activity is broader than that of a restricted set of recipients or providers. To detect fraud at this level requires watching for broad patterns of coincidence or connection between hundreds or thousands of otherwise innocuous transactions. An example of this type of conspiracy is a prescription drug diversion or recycling scheme.

Some potential fraudulent situations are being addressed. Others are not, but they may be considered in the future when the final responsibilities of Department for Medicaid Services contractors are determined.

Some of these potential situations are being addressed by the Department for Medicaid Services through its contracts and agreements with vendors and the Office of Inspector General.

Others do not appear to be addressed currently but may be considered in the future when the final responsibilities of the department's contractors are determined. Chapter 3 of this report noted that some final contractor responsibilities are not yet determined.

Recommendation 4.6

The Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General should work with Medicaid contractors to develop a plan for controlling fraud against Kentucky's Medicaid program. The plan should consider the roles of the Department for Medicaid Services, the Office of Inspector General, the Office of the Attorney General, and each relevant contractor, and should provide a timeline for implementing a cohesive fraud control strategy. The Department for Medicaid Services should report the plan to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

Federal False Claims Act

Under the federal False Claims Act, a prosecutor does not have to prove criminal intent on the part of a provider that submits false claims. Rather, a prosecutor only has to prove that an entity knowingly made a false claim or presented false information to a federal agency to obtain payment.

The False Claims Act (31 USC §§ 3729-3733) is used by federal prosecutors to pursue civil actions involving false claims against the federal government, including its Medicaid and Medicare programs. Under the Act, a prosecutor has only to prove that an entity knowingly made a false claim or presented false information to a federal agency to obtain payment. In other words, the entity knew or should have known that the claim or information leading to a payment from the federal government was false. The prosecutor does not have to prove criminal intent to defraud the government to obtain a False Claims Act judgment.

These cases often come to light through the efforts of whistle-blowers, typically persons who work for or have previously worked for the corporations charged under the Act. Examples of judgments and settlements in such cases were provided earlier in this chapter, including Kentucky's recoveries from Columbia/ HCA, Serono, Schering/Plough, GlaxoSmith Kline, and others. The Office of the Attorney General's Medicaid Fraud and Abuse Control Division participates in such cases on behalf of the Commonwealth.

Almost all of the top 20 recoveries under the False Claim Act are from corporations involved in the health care system. Prosecutors have obtained $16 billion in judgments and settlements.

The Taxpayers Against Fraud Education Fund reports that, since 1986, False Claims Act judgments and settlements have totaled more than $16 billion (Taxpayers. "Statistics"). Program Review staff reviewed the top 20 recoveries as of November 2005 from the group's Web site. Table 4.14 lists the top 20 cases. The amounts in the table include only those recovered under the False Claims Act, not the entire payment made by the corporation. For example, the first entry for Columbia/HCA shows more than $731 million recovered under the False Claims Act. The total amount the corporation agreed to pay, including criminal fines, civil penalties, and damages, was more than $840 million. The False Claims Act applies to all federal government programs. Of the corporations listed in the table, only BankAmerica and United Technologies are not involved in health care.

Table 4.14
Top 20 Federal False Claims Act Judgments and Settlements

Corporation	Amount
1. Columbia/HCA	$731,400,000
2. Columbia/HCA	$631,000,000
3. Serono	$567,000,000
4. TAP Pharmaceutical Products	$559,483,560
5. Abbott Labs	$400,000,000
6. Fresnius Medical Care of North America	$385,000,000
7. SmithKline Beecham Clinical Laboratories, doing business as GlaxoSmith Kline (tie)	$325,000,000
7. Health South (tie)	$325,000,000
8. National Medical Enterprises	$324,200,000
9. Gambro Healthcare	$310,000,000
10. Schering-Plough	$292,969,482
11. AstraZeneca Pharmaceuticals	$266,127,844
12. Bayer Corporation	$257,200,000
13. First American Health Care of Georgia	$225,000,000
14. BankAmerica	$187,500,000
15. Laboratory Corporation of America	$182,000,000
16. Beverly Enterprises	$170,000,000
17. Pfizer/Warner-Lambert	$152,000,000
18. United Technologies	$150,000,000
19. Blue Cross Blue Shield Illinois	$140,000,000
20. Caremark Rx	$137,500,000

Source: Compiled by Program Review staff from information obtained from the Taxpayers Against Fraud Education Fund's "Top 20 Cases."

Fifteen states also have false claims statutes, but Kentucky is not one of them.

Fifteen states and the District of Columbia also have false claims statutes (Taxpayers. "State"). However, the extent to which those states have provided the necessary resources and have prosecuted cases under such statutes is unknown. Program Review staff discussed the issue of a potential false claims statute for Kentucky with the director of the Office of the Attorney General's Medicaid Fraud and Abuse Control Division and with the Cabinet for Health and Family Services' Inspector General. Both officials agreed that a statute could be useful in clarifying the state's authority in civil litigation. However, the proper resources must be provided to evaluate, investigate, and prosecute such cases. A formal analysis of the costs and potential benefits would be required. No such analysis has been performed for Kentucky.

The federal Deficit Reduction Act of 2005 will provide financial incentives to states that enact and enforce false claims statutes.

The Deficit Reduction Act of 2005 will provide additional resources to states that have a false claims statute that satisfies federal requirements. When the state brings an action under its statute and recovers Medicaid funds related to false or fraudulent claims, the federal government will decrease by 10 percent the amount that must be returned. In Kentucky, the federal Medical Assistance percentage is about 70 percent, which means that the federal government pays 70 percent of Medicaid benefit costs and Kentucky pays 30 percent. When improper payments are recovered, Kentucky must return the federal government's 70 percent share. With a false claims statute, the amount that must be returned to the federal government would decrease to about 63 percent.

Recommendation 4.7

The Office of the Attorney General's Medicaid Fraud and Abuse Control Division and the Cabinet for Health and Family Services' Office of Inspector General should work together to explore the feasibility of implementing a false claims statute in Kentucky. Issues to be considered include required staffing of all agencies, required monetary resources, and a cost-benefit analysis of implementing such a statute. The two agencies should present a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, the Health and Welfare Committee, and the Judiciary Committee.

Unfulfilled Medical Support Orders

Unfulfilled dependent medical support orders cause the Medicaid program to make unnecessary payments.

Unenforced medical support orders do not constitute improper payments by the Medicaid program but are unnecessary payments. Noncustodial parents who do not provide health insurance as ordered increase the number of dependent children who are eligible to receive medical care through the Medicaid program and the Kentucky Children's Health Insurance Program. Enforcement of child support orders, including medical support orders, is administered by the Department for Community Based Services in the Cabinet for Health and Family Services.

In fiscal year 2005, if dependent coverage had been provided as ordered by the courts, Kentucky's Medicaid program could have saved between $10 million and $46 million.

In a 2004 report, Program Review staff estimated that $2.4 million to $11 million in state Medicaid costs could be saved if noncustodial parents who have access to health insurance and can afford to pay for dependent coverage provided insurance as ordered (Commonwealth of Kentucky. Legislative. *Uncollected* 51). That estimate has been updated for this report, showing that $3.1 million to $13.8 million in state Medicaid costs could have been saved in fiscal year 2005. Including the federal share, total savings are estimated at $10.3 million to $46 million.

The 2004 report included three recommendations to improve enforcement of medical support orders and save money for Kentucky's Medicaid program. Those recommendations have not been implemented. Two of the recommendations are combined, summarized, and amended into this report's final recommendation.

Recommendation 4.8

The Cabinet for Health and Family Services should a) reexamine the costs and benefits of providing greater financial incentives to county child support offices for improving enforcement of medical support orders and b) determine whether noncustodial parents who cannot provide dependent health insurance should be required to provide some financial assistance for dependent medical care through the Medicaid program and the Kentucky Children's Health Insurance Program. The cabinet's Department for Medicaid Services and Department for Community Based Services should provide a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee.

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Appendix A

Overview of Medicaid Modernization: Managed Care Organization

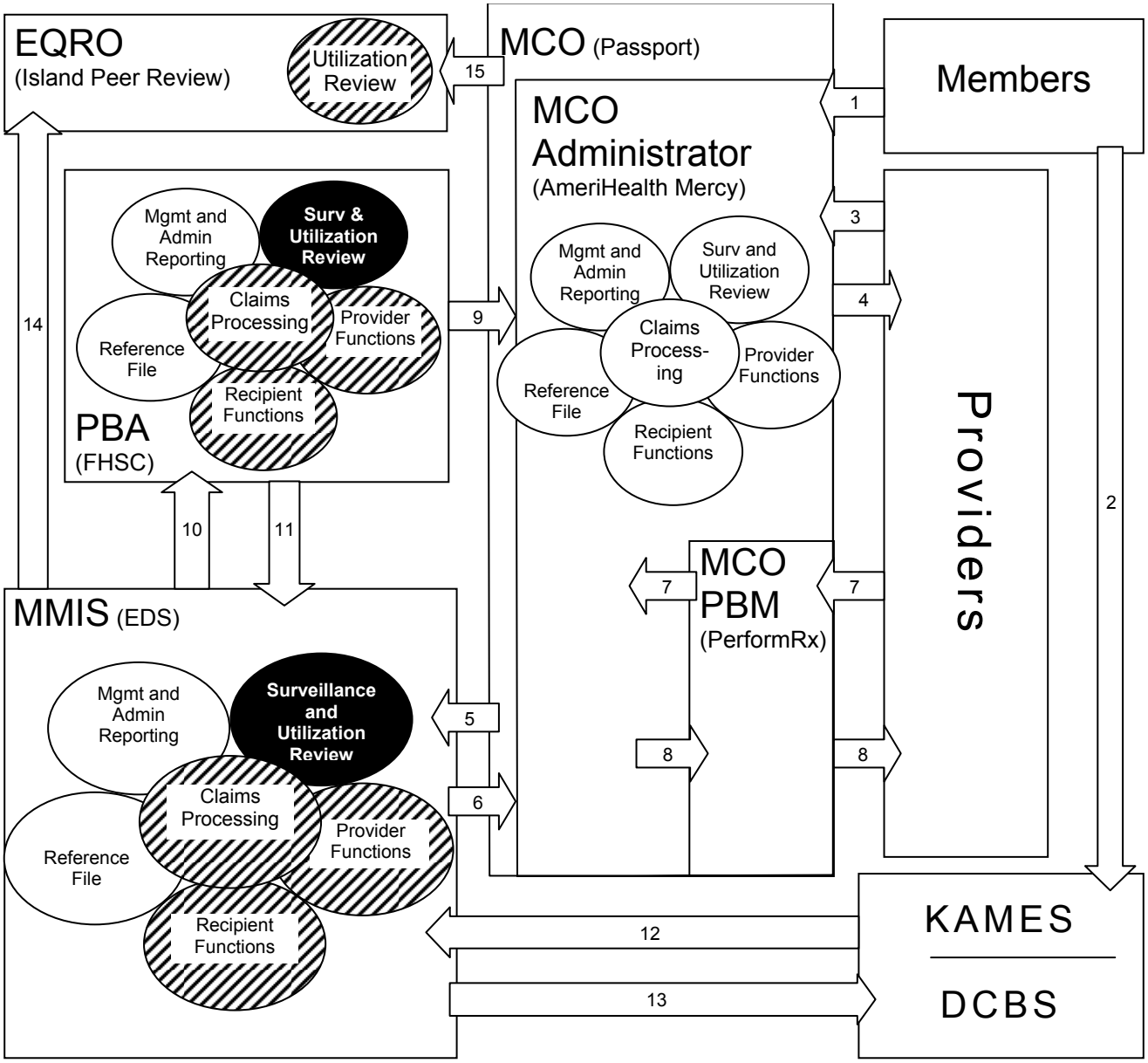
The following diagram shows how the systems operate in relation to the managed care organization (MCO). This process applies to the Medicaid program in the managed care region for services covered by Medicaid managed care (excluding behavioral health services and long-term care).

The roles of the pharmacy benefit administrator (PBA) and Medicaid Management Information System (MMIS) are tentative because the requests for proposals were not clear and the Department for Medicaid Services has not provided clarification. Program Review staff attempted to show the likely relationships using available information. Items marked "?" are uncertain.

In the diagram, diagonal stripes indicate functions shared with another vendor or a state agency. The dark ovals indicate that the MMIS and PBA do not perform surveillance and utilization review for managed care.

The diagram was prepared by Program Review staff using information from the Centers for Medicare and Medicaid Services' *State Medicaid Manual*, Kentucky Medicaid procurement documents, and the Passport Health Care and related Web sites.

Overview of Medicaid Modernization: Managed Care



Abbreviations

DCBS	Department for Community Based Services
EQRO	External Quality Review Organization
FHSC	First Health Services Corporation
KAMES	Kentucky Automated Management Eligibility System
MCO	Managed care organization
PBM	Pharmacy benefit manager

Descriptions of Paths

Items marked with "?" are uncertain.

1 Members' complaints and questions

2 Members' applications, reviews to DCBS

3 Provider applications, inquiries, prior authorization requests, prior authorization override requests, claims, appeals of claim denials

4 Provider approvals and disenrollments, prior authorization approvals/denials, primary care provider member rosters, payments, claim denials

5 Encounters, provider enrollment/disenrollment data, third-party liability resource information

6 Capitated payments, member enrollment data, verified third-party liability resource information, failed encounters, (?) reference data

7 (?) Provider inquiries, prior authorization requests, prior authorization override requests, claims, appeals of claim denials

8 (?) Pharmacy prior authorization approvals/denials, (?) primary care provider member rosters, payments, claim denials, (?) non-MCO pharmacy encounters from the pharmacy benefit administrator

9 (?) Non-MCO pharmacy claims data for MCO members

10 (?) MCO pharmacy encounters

11 (?) Other MCO data transfers

12 (?) Members eligibility data, primary care provider selection

13 (?) Provider enrollment data

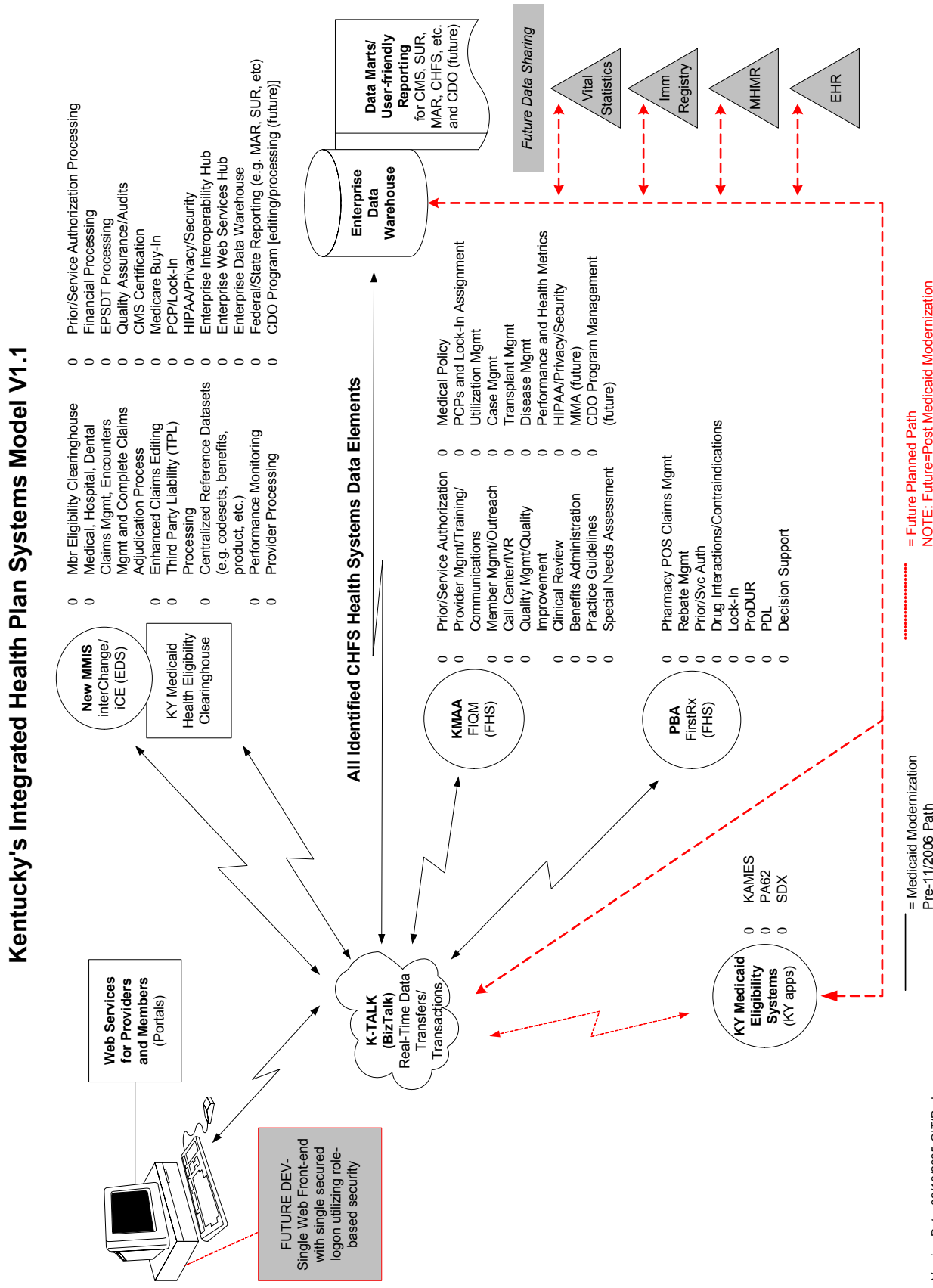
14 (?) Claims, eligibility, etc.

15 (?) Encounters, medical records

Appendix B

Medicaid Integrated Health Plan Flowchart

The following diagram was supplied by the Department for Medicaid Services (Commonweath of Kentucky. Department. "Kentucky's"). It shows how the department expects the various information systems to interact.


Kentucky's Integrated Health Plan Systems Model V1.1
Web Services for Providers and Members (Portals)
FUTURE DEV- Single Web Front-end with single secured logon utilizing role-based security
New MMIS interChange/ iCE (EDS)
KY Medicaid Health Eligibility Clearinghouse
0 Mbr Eligibility Clearinghouse
0 Medical, Hospital, Dental Claims Mgmt, Encounters Mgmt and Complete Claims Adjudication Process
0 Enhanced Claims Editing
0 Third Party Liability (TPL) Processing
0 Centralized Reference Datasets (e.g. codesets, benefits, product, etc.)
0 Performance Monitoring
0 Provider Processing
0 Prior/Service Authorization Processing
0 Financial Processing
0 EPSDT Processing
0 Quality Assurance/Audits
0 CMS Certification
0 Medicare Buy-In
0 PCP/Lock-In
0 HIPAA/Privacy/Security
0 Enterprise Interoperability Hub
0 Enterprise Web Services Hub
0 Enterprise Data Warehouse
0 Federal/State Reporting (e.g. MAR, SUR, etc)
0 CDO Program [editing/processing (future)]
K-TALK (BizTalk) Real-Time Data Transfers/ Transactions
All Identified CHFS Health Systems Data Elements
KMAA FIQM (FHS)
0 Prior/Service Authorization
0 Provider Mgmt/Training/ Communications
0 Member Mgmt/Outreach
0 Call Center/IVR
0 Quality Mgmt/Quality Improvement
0 Clinical Review
0 Benefits Administration
0 Practice Guidelines
0 Special Needs Assessment
0 Medical Policy
0 PCPs and Lock-In Assignment
0 Utilization Mgmt
0 Case Mgmt
0 Transplant Mgmt
0 Disease Mgmt
0 Performance and Health Metrics
0 HIPAA/Privacy/Security
0 MMA (future)
0 CDO Program Management (future)
PBA FirstRx (FHS)
0 Pharmacy POS Claims Mgmt
0 Rebate Mgmt
0 Prior/Svc Auth
0 Drug Interactions/Contraindications
0 Lock-In
0 ProDUR
0 PDL
0 Decision Support
KY Medicaid Eligibility Systems (KY apps)
0 KAMES
0 PA62
0 SDX
Enterprise Data Warehouse
Data Marts/ User-friendly Reporting for CMS, SUR, MAR, CHFS, etc. and CDO (future)
Future Data Sharing
Vital Statistics
Imm Registry
MHMR
EHR
= Medicaid Modernization Pre-11/2006 Path
= Future Planned Path
NOTE: Future=Post Medicaid Modernization Implementation after 11/2006
Version Date: 09/16/2005-OIT/Redmon
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Appendix C

Medicaid Management Information System Requirements

This table shows most of the MMIS requirements defined in the *State Medicaid Manual* issued by the Centers for Medicare and Medicaid Services. Numbers in the table in brackets [ ] refer to explanatory notes.

Abbreviations

DCBS Department for Community Based Services
EDS Electronic Data Systems
EOB Explanation of benefits
EPSDT Early and Periodic Screening, Diagnosis, and Treatment
KAMES Kentucky Automated Member Eligibility System
KASPER Kentucky All Schedule Prescription Electronic Reporting
KMAA Kentucky Medicaid administrative agent
MAR Management and administrative reporting
MCO Managed care organization
PA Prior authorization
PA62 Public assistance database
PBA Pharmacy benefit administrator
POS Point of service/sale
RFP Request for proposals
SDX Social Security data exchange
SUR Surveillance and utilization review
TPL Third-party liability

	MMIS (EDS)	PBA (First Health)	KMAA (First Health)
Provider Functions:			[1]
Enroll providers	✓ (MMIS will maintain a database of providers)		✓
Certify providers	✓ (MMIS will maintain a database of providers)		✓
Handle changes	✓ (MMIS will allow online update and will accept changes from KMAA) [2]		✓
Maintain database	✓	PBA will have a copy of the provider database	✓
Review provider data	✓ (MMIS will deactivate providers meeting criteria)		It is unclear whether KMAA does this
Recipient Functions:			
Keep eligibility list [3]	✓ (MMIS receives eligibility data from KAMES, SDX, PA62)	✓ (PBA probably receives eligibility file from MMIS)	KMAA receives eligibility file from MMIS (used for prior authorization, etc.)

	MMIS (EDS)	PBA (First Health)	KMAA (First Health)
Maintain positive control of all eligibility data	✓	✓ (Not mentioned in any procurement documents but appears to apply)	✓ (KMAA performs PA and SUR functions, which need member data)
Maintain member data for other subsystems	✓	✓	✓ (KMAA's PA and SUR functions may be "other subsystems")
Distribute data	✓	Probably not	Probably not
Support Medicare Part B Buy-In [4]	✓	✓ (POS system denies claims for drugs covered by Medicare)	This may apply to KMAA
Support TPL [4]	✓	✓ (POS system denies drug claims covered by TPL)	This may apply to KMAA
Perform EPSDT functions	✓ (Does this include MCO and pharmacy encounters?)	Does PBA track and/or report on EPSDT treatment?	This may apply to KMAA
Reference File / Code Sets:			
Maintain procedure and diagnosis files	✓	✓ (PBA will receive this information from MMIS) [5]	KMAA will need a copy of or access to this information
Maintain formulary file	✓ (It appears MMIS will receive this from PBA)	✓ (It appears PBA will maintain this and send to MMIS)	KMAA may need a copy of or access to this information
Maintain reasonable and customary charges	✓ (Some reimbursement rates are set in Provider Functions)	It is unclear whether PBA does this	KMAA will need a copy of or access to this information
Report on files	The only report specified is an audit trail of changes	It is unclear whether PBA does this	Presumed that KMAA will be able to obtain as needed
Maintain long-term claims history	✓ (MMIS keeps 60 months of active claims data)	✓ (PBA keeps 60 months of offline history) [6]	KMAA may need a copy of or access to this information
Report on suspended claims	✓ (These are specified in claims processing and MAR functions) [7]	It does not appear that the PBA system suspends any pharmacy claims	
Maintain claims processing support data	✓ (presumed)	✓ (presumed)	
Claims Processing:			
Claims transactions	✓[8]	✓	
Verify providers	✓[8]	✓	
Verify eligibility	✓[8]	✓	
Verify charges	✓[8]	✓	
Prior authorization	✓ (MMIS will have a file of prior authorizations from KMAA [9], maybe PBA [10])	✓ (PBA will have its own PA system and might transmit information to MMIS [10])	✓ (KMAA will have its own PA system and will transmit information to MMIS)
Make timely payments	✓	✓	

	MMIS (EDS)	PBA (First Health)	KMAA (First Health)
Keep audit trails	✓	✓ (Audit trails are not mentioned in RFP/contract but seem to be required)	
Keep historical records	✓ (It is unclear whether this includes pharmacy claims)	✓	
Respond to queries on member eligibility and benefits	✓ (MMIS will maintain data necessary to perform this function and will handle claim-specific inquiries)		KMAA will operate the call center and respond to these inquiries (querying its own database or MMIS)
Process credits and adjustments	✓	✓	
Suspend erroneous transactions	✓	It does not appear that PBA system suspends any pharmacy claims	
Correct erroneous transactions	✓	✓[11]	
Respond to queries on claims status	✓	✓[12]	KMAA will transfer claims status calls to EDS
Issue remittance advice	✓	✓	
Provide EOB[13]	✓ (Generates EOB)	✓ [14]	[15]
Identify claims having TPL coverage	✓	✓ [16]	
Surveillance and Utilization Review:	[17]	[18]	[19]
Profile patterns of health care delivery and utilization	✓ (default)	✓ (PBA uses its own system)	KMAA uses a copy of MMIS data to support this task
Identify misutilization	✓ (default)	✓ (PBA uses its own system)	KMAA uses a copy of MMIS data to support this task
Monitor level of care and quality of services	✓ (default)	[20]	KMAA uses a copy of MMIS data to support this task
Provide data/reports for med. review, Fraud Control Units [21]	✓ (default)	✓ (PBA uses its own system)	KMAA uses a copy of MMIS data and its own clinical database to support this task
Profile use of covered services by specific providers and members	✓ (default)	✓ (PBA uses its own system)	✓(22]
Perform exception processing	✓ (default)	✓ (PBA uses its own system)	It is unclear whether KMAA will analyze this information, or what system would be used

	MMIS (EDS)	PBA (First Health)	KMAA (First Health)
Maintain history of adjudicated claims	✓ (default)	✓ (PBA uses its own system)	KMAA uses a copy of MMIS data to support this task
Produce required reports	✓ (default)	It is unclear whether PBA will produce or analyze any of the required reports	It is unclear whether KMAA will analyze this information, or what system would be used
Support ad hoc access to all data elements	✓ (default)	✓ (PBA uses its own system)	✓ (KMAA uses its own systems)
Management and Administrative Reporting:	[17]	[23]	
Provide information for fiscal planning and control	✓ (presumed)		
Provide information for policy and regulation	✓ (presumed)		
Monitor claims processing and payment activity	✓ (presumed)		
Review provider performance	✓ (presumed)		It appears KMAA will analyze this information; it is unclear whether MMIS or KMAA will produce reports
Review member participation to develop more effective programs	✓ (presumed)		
Support required reporting	✓ (presumed)		
Prepare budget allocations	✓ (presumed)		
Project future costs	✓ (presumed)		
Analyze cash flow	✓ (presumed)		
Compare expenditure with budget	✓ (presumed)		
Determine cost benefit	✓ (presumed)		
Review utilization and relative cost by type of member	✓ (presumed)		
Analyze Medicare buy-in and break-even between Medicare and Medicaid	✓ (presumed)		

	MMIS (EDS)	PBA (First Health)	KMAA (First Health)
Review availability of services	✓ (presumed)	It is unclear whether PBA will analyze this information for pharmacy services	It appears KMAA will analyze this information; it is unclear whether MMIS or KMAA will produce reports
Monitor timeliness of reimbursement	✓ (presumed)		
Analyze provider and other claims processing errors [24]	✓ (presumed)		[25]
Monitor TPL avoidance and collections	✓ (presumed)		
Provide data for institutional and capitation rate setting	✓ (presumed)		
Analyze provider claim filings	✓ (presumed)		It appears KMAA will analyze this information; it is unclear whether MMIS or KMAA will produce reports
Analyze drug use for cost and abuse [26]	✓ (presumed)	It appears PBA will analyze this information; it is unclear whether MMIS or PBA will produce reports	
Provide geographic analysis of costs and member participation	✓ (presumed)		

[1] KMAA proposes to have its own independent provider database.
[2] It is unclear who will use the MMIS online update. If KMAA has its own provider database, the two have to be kept in sync.
[3] DCBS enrolls members and keeps member data in KAMES. Other eligibility information comes from SDX and PA62.
[4] TPL contractor uses this information.
[5] Per PBA RFP §30.051(b)
[6] Per PBA Proposal §7.5.9.a
[7] Per MMIS RFP §§30.090.007.003.25, 30.090.012.003.6
[8] Claims processing and verification include MCO and PBA claims (encounters) to double-check the MCO and PBA adjudication processes.
[9] Per MMIS RFP §30.050.005.001.9
[10] It is unclear whether PBA will transmit prior authorizations to the MMIS although this information is necessary if the MMIS is to verify PBA edits and audits or if the data warehouse is to include prior authorizations for SUR functions.
[11] Per PBA RPF §30.043

[12] PBA RFP §30.049(i) states PBA will do this, but MMIS and KMAA procurement documents are not consistent with this. Kentucky Medicaid officials were unclear about this. Based on the fact that pharmacy claims are handled as they are submitted, most (if not all) pharmacy provider inquiries probably will go directly to the PBA provider help desk. It is unclear how member calls related to pharmacy claims will be handled.

[13] The purpose of EOB is to obtain feedback from recipients on the accuracy of claims, so tracking and review of EOB responses is a necessary function. There does not appear to be such a function specified in any documents from the three procurements. It is unclear whether one of the vendors or Kentucky Medicaid will perform this task.

[14] EOB is not mentioned in the PBA RFP, but the PBA proposal includes "Verification of Benefits" sent to selected members.

[15] Per the KMAA RFP § 30.010.016, KMAA will mail the EOB.

[16] Identifying third-party coverage is not mentioned in the PBA RFP but is included in the PBA Contract §A.2.2.3(k).

[17] The MMIS is required by federal regulations to support all these functions. The MMIS procurement appears to meet these requirements. However, under Medicaid Modernization, other vendors likely will carry out the tasks and may use information from their own systems rather than or in addition to the MMIS.

[18] In general, the PBA will perform Drug Utilization Review tasks using its own information system.

[19] In general, the KMAA is responsible for many SUR functions related to medical care utilization. It is unclear to what extent First Health will use its own software rather than the MMIS and its data warehouse/decision support system.

[20] Although PBA data should be available to support this task, it is unclear whether the PBA or someone else will perform this task for the pharmacy benefit.

[21] This requirement covers both utilization review and program integrity. The utilization review tasks will be performed by the PBA and KMAA, but program integrity will be performed by the Office of Inspector General and the fraud/abuse contractor. The requirement also refers to the Attorney General's Medicaid Fraud Control Unit. The Inspector General will refer cases to the Attorney General, but it is unclear how the Attorney General's staff will access data from the various vendors' systems.

[22] KMAA RFP §30.020.003.002 states that KMAA will provide this information to the MMIS vendor's data warehouse/decision support system.

[23] The division of responsibility for MAR between the MMIS and PBA is unclear. The absence of MAR requirements in the PBA procurement suggests that most pharmacy MAR will be accomplished by the MMIS using data from the PBA. MMIS RFP §30.090.012.002.10 does mention "prescription" data related to one of kind of reporting, but pharmacy reporting does not seem to be required by the MMIS procurement. The EDS proposal indicated that the MMIS would support pharmacy reporting.

[24] Analysis of errors covers both utilization review and program integrity. It seems likely that KMAA would be interested in errors as part of utilization review. The Office of Inspector General and the fraud/abuse contractor do have some responsibility to handle these reports.

[25] It is unclear whether this falls within the KMAA's responsibility. If KMAA will analyze this information, it is unclear whether MMIS or KMAA will produce reports.

[26] Technically, federal regulations appear to require the MMIS to produce these reports. The MMIS RFP did not specifically require reports to support drug use analysis but did require the vendor to meet federal regulations. The PBA is responsible for analyzing drug use for cost management, and the PBA contract includes a requirement to produce reports that identify potentially fraudulent providers. PBA contract wording suggests the PBA will use its own system. Analysis of drug use for abuse is a program integrity function and also is performed by the Office of Inspector General in conjunction with KASPER. The division of labor between the PBA and Office of Inspector General is unclear.

Source: Information compiled by Program Review staff from the Centers for Centers for Medicare and Medicaid Services' *State Medicaid Manual* and Kentucky Medicaid procurement documents.

Appendix D

Examples of Health Care Fraud and Abuse Schemes Reported by the U.S. Government Accountability Office

A "pill mill" involves a doctor's office, a clinic, or a pharmacy in which a principal business of the facility is the illegal diversion of prescription drugs. In a typical scheme, a physician enrolled in the Medicaid program provides a medically unnecessary prescription to a Medicaid recipient. Depending on the scheme, the recipient may sell the prescription to a pharmacist or intermediary for cash or merchandise, or the recipient or pharmacist may sell the drugs on the street (U.S. Government. *Health Care Fraud: Schemes* 2).

Other problems involving prescription drug diversion include pharmacists who routinely add medications to customers' orders and keep the extras for sale or personal use. Participants in drug diversion schemes frequently face additional charges of fraud, false claims, or other legal violations. "Blatant examples included a doctor writing 2,000 prescriptions a month; a pharmacist billing for more than 20 prescriptions a day for a single recipient; a patient who, in one four-day period, had the same three lab tests and filled six prescriptions for Zantac, which he subsequently sold on the street; and an organized network of colluding physicians, pharmacists, patient brokers, and other middlemen" (U.S. Government. *Medicaid Drug Fraud* 3-4).

"The drop box scheme uses a private mailbox facility as the fraudulent health care entity's address, with the entity's 'suite' number actually being its mailbox number. The fraudulent health care entity then uses the address to submit fraudulent Medicare, Medicaid, and other insurance claims and to receive insurance checks. For example, while the insurer sends payments to 'Suite 478' at a certain address, payments are actually going to 'Box 478' at a privately owned mailbox facility. The perpetrator then retrieves the checks and deposits them into a commercial bank account that he/she has set up" (U.S. Government. *Health Care Fraud: Schemes* 2).

The "rolling labs" insurance fraud scheme ultimately involved hundreds of physicians and numerous medical laboratories and an estimated $1 billion in fraudulent claims to public and private insurers. Physicians certified false diagnoses for kickbacks, or nonmedical administrative staff made up fictitious diagnoses. The laboratories then performed the unnecessary tests and billed Medicare for them (U.S. Government. *Medicare: One* 1-2).

"The third-party billing scheme revolves around a third-party biller—who may or may not be part of the scheme—who prepares and remits claims to Medicare or Medicaid (electronically or by paper) for health care providers. It is possible, however, for a third-party biller to defraud Medicare, Medicaid, and others by adding claims without the providers' knowledge and keeping the remittances or by allowing fraudulent claims to be

billed to Medicare or Medicaid through its service" (U.S. Government. *Health Care Fraud: Schemes* 2-3).

"Under the rent-a-patient scheme, criminals pay 'recruiters' to organize and recruit beneficiaries to visit clinics owned or operated by the criminals. . . . In other words, for a fee, recruiters 'rent,' or 'broker,' the beneficiaries to the criminals. Recruiters often enlist beneficiaries at low-income housing projects and retirement communities and drive them to area clinics. There the beneficiaries receive cursory examinations and testing, treatment, or durable medical equipment (DME) referrals. Recruiters generally receive $100 or more for each beneficiary they bring to the clinic. In turn, recruiters often pay a portion of their fee to each cooperating beneficiary. Cooperating beneficiaries participate to 'make a few bucks' and understand that if the need 'a real doctor,' they are to go elsewhere. Medicare, Medicaid, or other insurance companies are later billed for the services that were provided and for other services or equipment that was not provided" (U.S. Government. *Health Care Fraud: Schemes* 3).

"Investigators found evidence of 'bump and run' schemes, in which individuals bill for a few months for services that are not rendered, stop being detected, and then start again under a new name. They also found evidence of 'wholesalers' who give pharmacies and suppliers false invoices to substantiate false claims" (U.S. Government. *Medicaid: State* 10).

"[C]riminal groups have created interstate health care fraud schemes and have used associates in foreign countries to transfer ill-gotten proceeds out of the United States. For example, a group with ties to a New Jersey scheme purchased a lab in Illinois and began billing Medicaid and Medicare there. In another case, two individuals investigated for Medicaid fraud in south Florida were tied to three individuals in North Carolina who used a similar scheme to falsely bill Medicare. Proceeds from this scam were laundered through associates in Mexico" (U.S. Government. *Medicaid: Federal and State* 6).

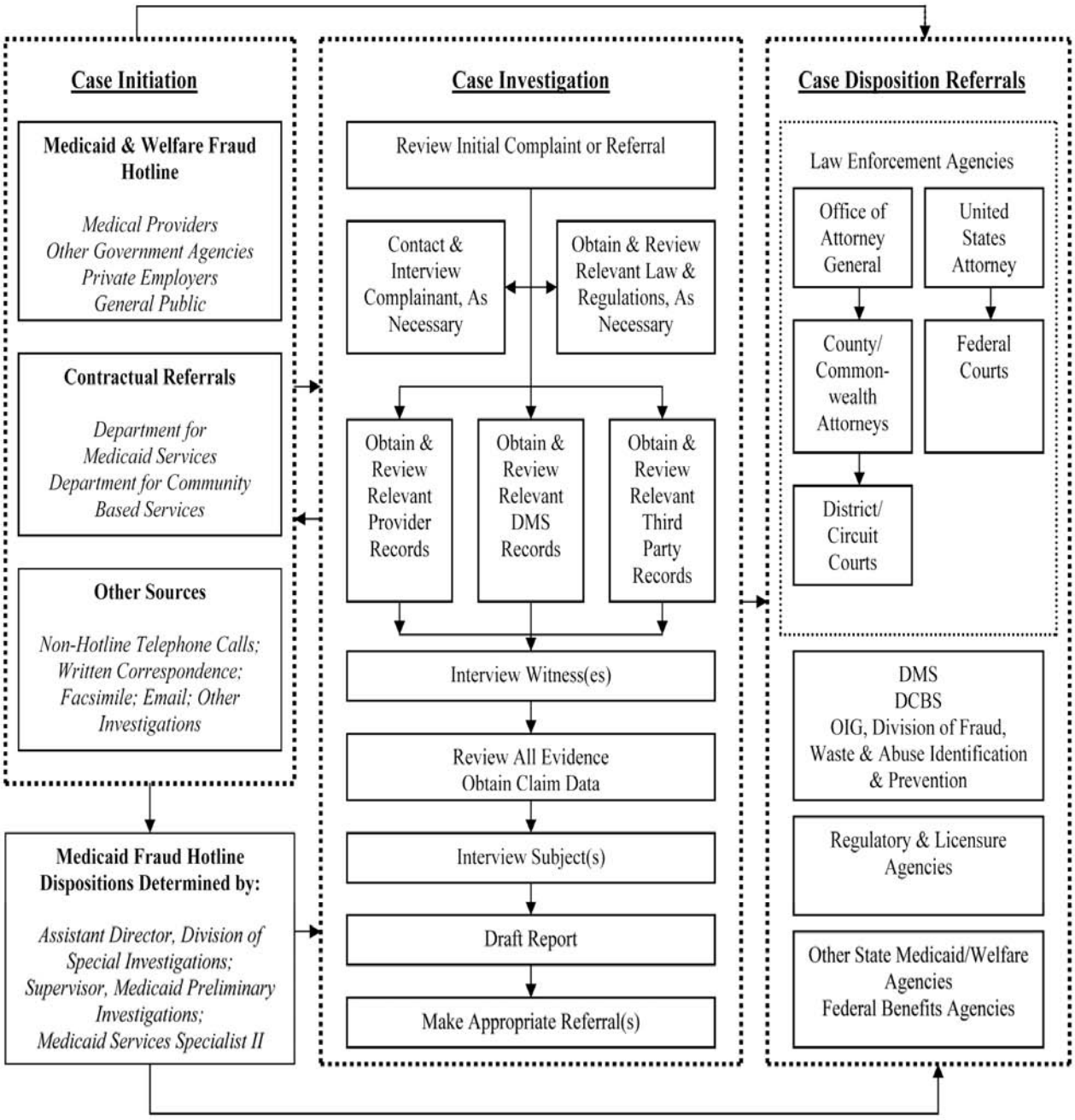
Appendix E

Office of Inspector General

Abbreviations used in the figures are:

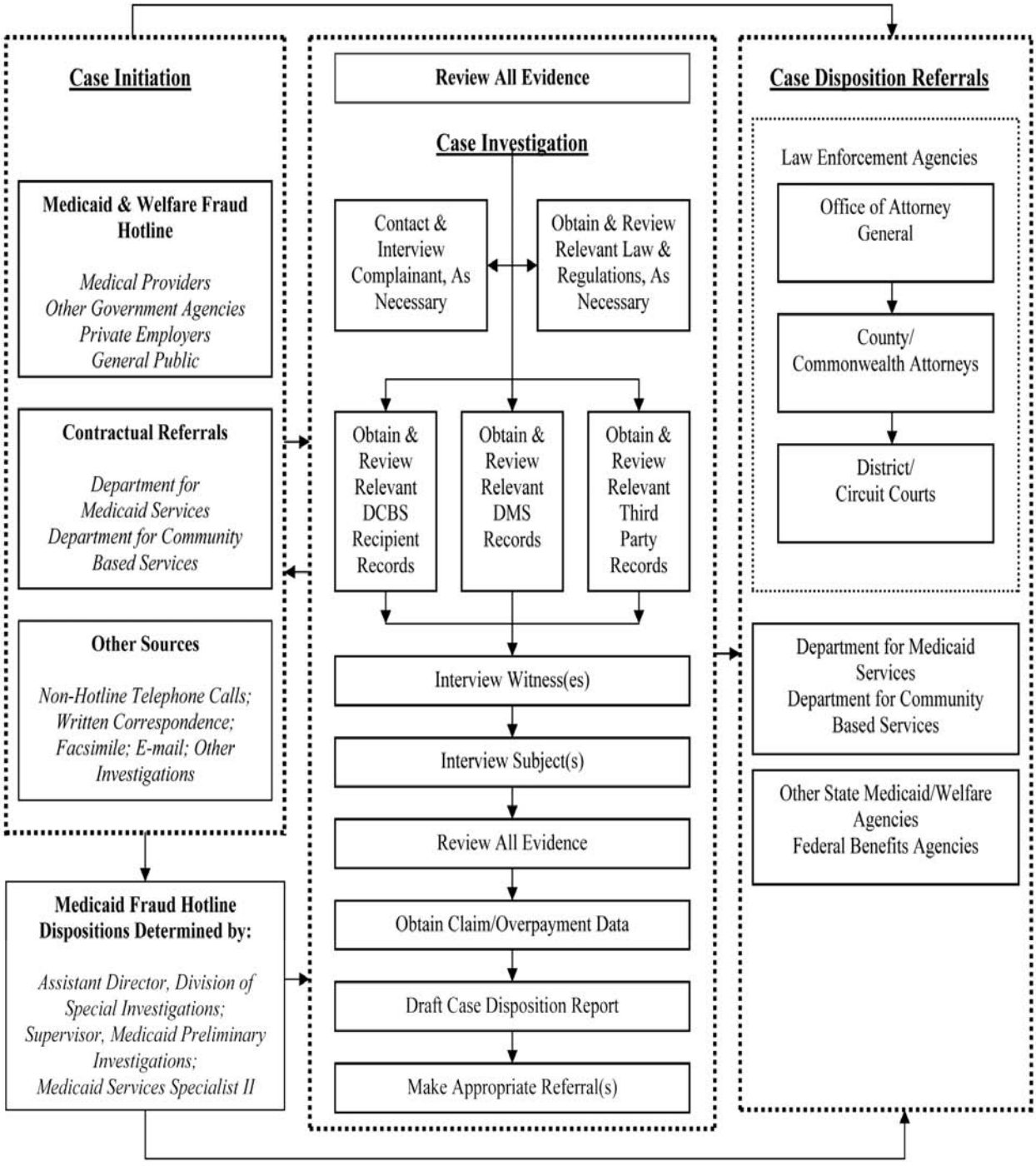
DCBS	Department for Community Based Services
DMS	Department for Medicaid Services
FWAIP	Fraud, Waste and Abuse/Identification and Prevention Division (Office of Inspector General)
MFCU	Medicaid Fraud Control Unit (Office of the Attorney General's Medicaid Fraud and Abuse Control Division)
NEMT	Nonemergency Medical Transportation
OAG	Office of the Attorney General
OIG	Office of Inspector General (Health and Family Services Cabinet)
U.S. HHS	United States Department of Health and Human Services

Figure E.1
OIG Medicaid *Provider* Fraud and Abuse Complaint Investigation and Referral



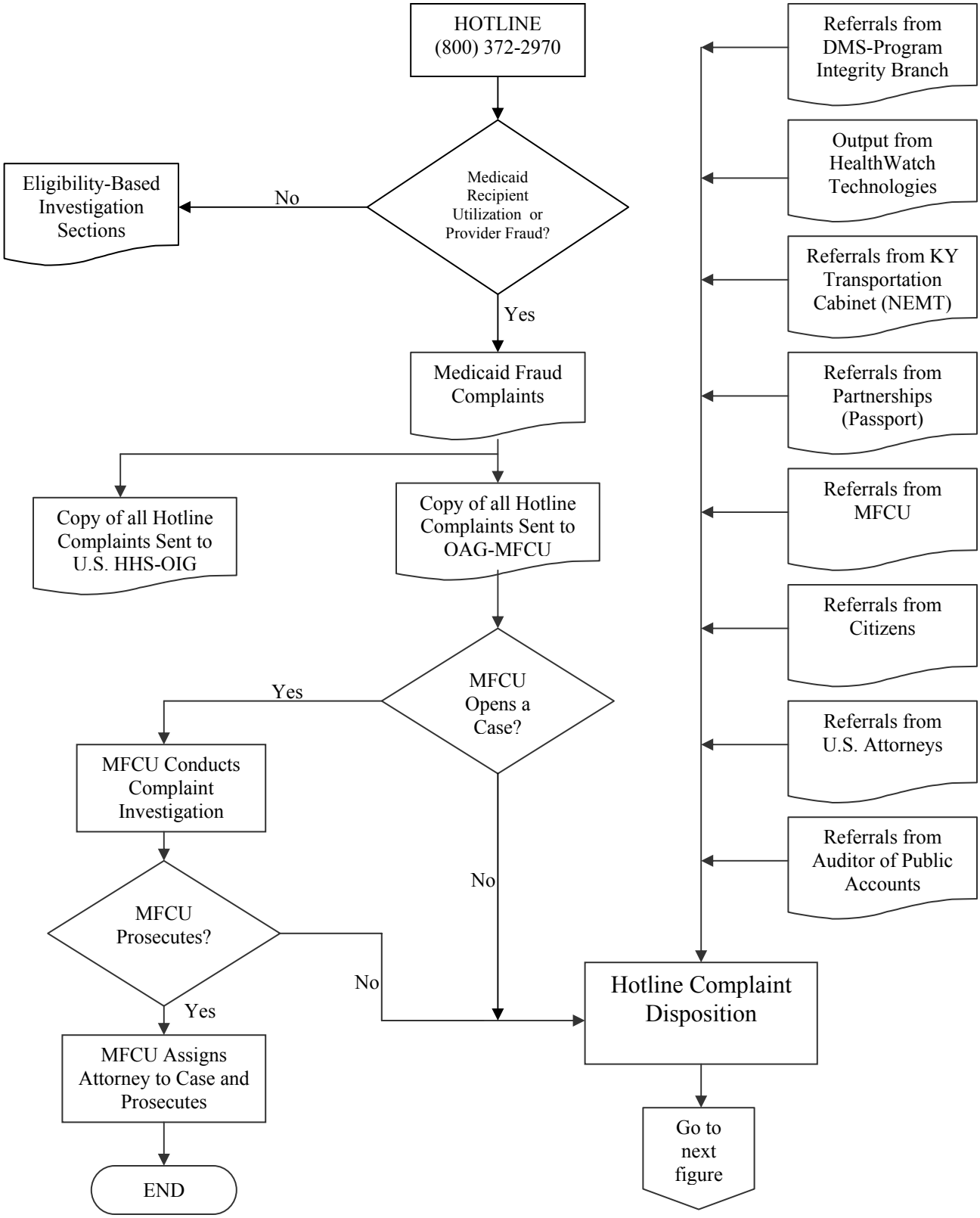
Source: Revised version of flowchart provided to staff by Office of Inspector General officials at a meeting on November 3, 2005.

Figure E.2
OIG Medicaid *Recipient* Fraud and Abuse Complaint Investigation and Referral



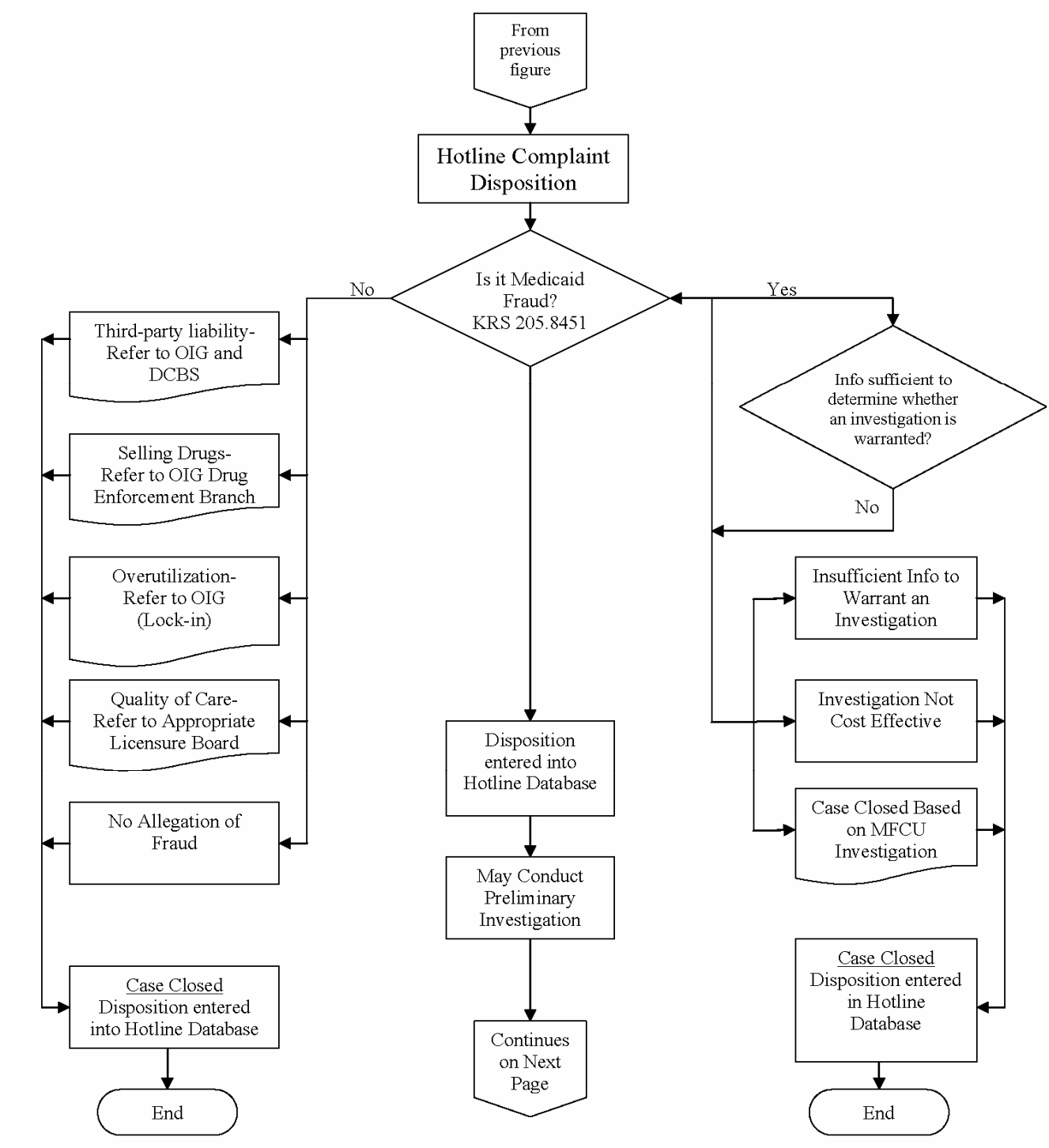
Source: Revised version of flowchart provided to staff by Office of Inspector General officials at a meeting on November 3, 2005.

Figure E.3
OIG Hotline Referral Process



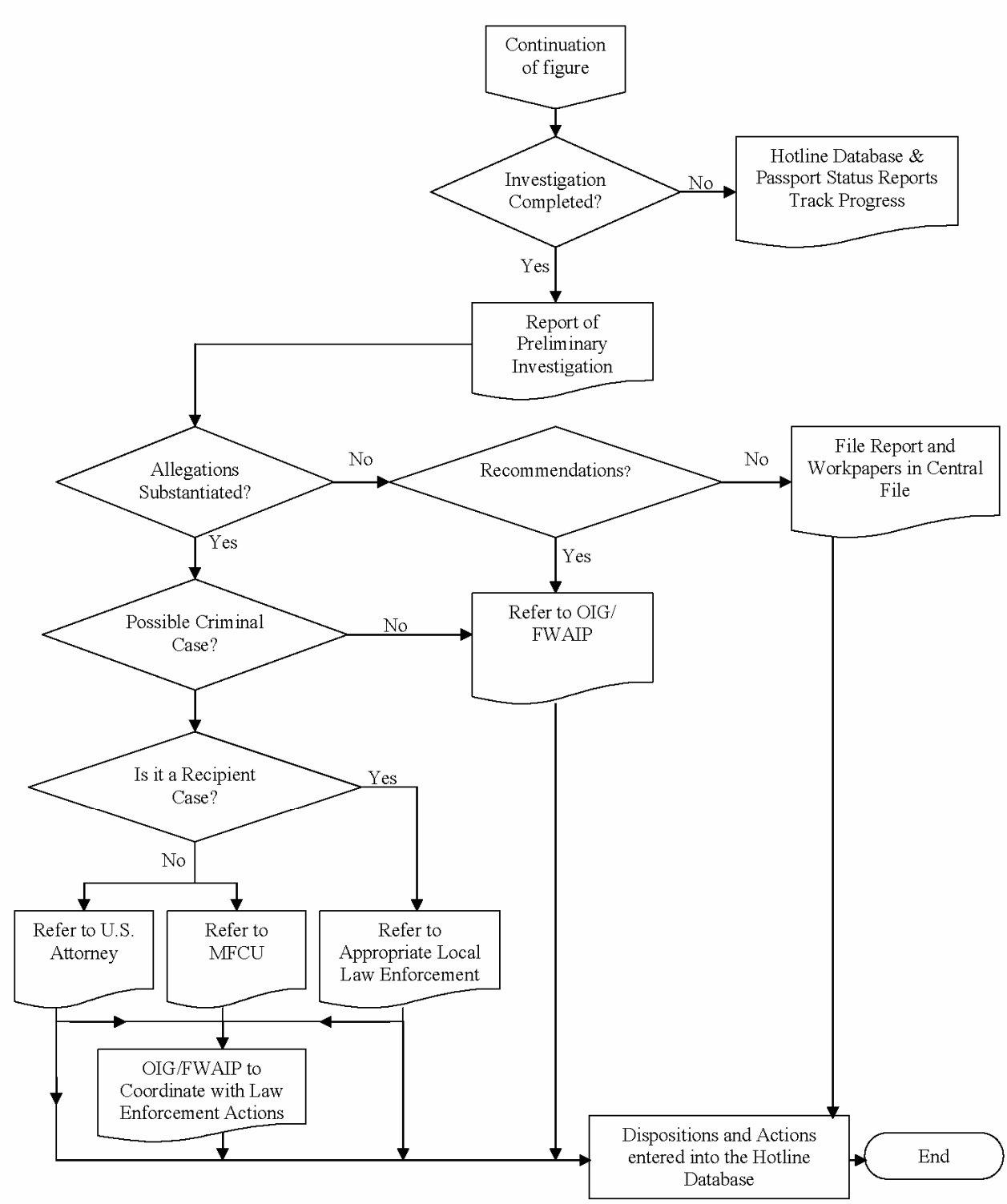
Source: Revised version of flowchart provided to staff by Office of Inspector General officials at a meeting on November 3, 2005.

Figure E.4
OIG Hotline Complaint Disposition



Source: Revised version of flowchart provided to staff by Office of Inspector General officials at a meeting on November 3, 2005.

Figure E.4 Continued
OIG Hotline Complaint Disposition



Source: Revised version of flowchart provided to staff by Office of Inspector General officials at a meeting on November 3, 2005.

Appendix F

Response From the Office of the Attorney General

Proposed Responses to Selected Recommendations; Submitted June 26, 2006

Recommendation 4.1
"The Office of the Attorney General should consider requesting additional state funding from the General Assembly to more fully access the federal funds to operate its Medicaid Fraud and Abuse Control Division. The office should allocate state appropriations to the division in amounts necessary to maximize access to the federal funds. If at any time the office believes additional state funds are necessary to access federal matching funds for operation of the Medicaid Fraud and Abuse Control Division, an emergency appropriation increase should be requested for the division utilizing unused or discretionary funds from other budget units within the Office of the Attorney General. This action by the office should be utilized to the greatest extent possible without significantly impairing other legal, investigative, and administrative functions. When requesting additional funds from the General Assembly during the budget process, the Office of the Attorney General should present a comprehensive plan with the request outlining how the new funds will be used and the expected results from the increased expenditures."

OAG COMMENT
The Office of the Attorney General (OAG) regularly requests additional general funds for the Medicaid Fraud program to make full use of available federal funds. We requested and the 2005 General Assembly provided an additional $359,800 in general funds in FY06 for the Medicaid Fraud program. As a result, we were able to increase the overall Medicaid budget by approximately 45% in FY06.

Due to the overall general fund situation, we limited our additional general fund request for Medicaid Fraud in the FY06-08 budget request. Those funds were denied even though the general fund portion would have been only about $25,000. Additionally, the 2006 General Assembly included a fund transfer from the OAG to the general fund from agency funds in the amount of $521,200, which significantly reduced the chance of using excess agency funds for the Medicaid program.

The budget ultimately approved by the 2006 General Assembly for the Office of the Attorney General (general funds and restricted funds excluding the Uninsured Employer's Fund) is down 5.11% in FY 07 and down 6.38% in FY 08. Even with budget reductions, base funding for the Medicaid Fraud program will increase approximately 2% in FY07 while most programs will face significant reductions. Additionally, due to a greater carryforward in agency funds than anticipated, the OAG has requested authorization to expend an additional $75,000 in agency funds for the Medicaid Fraud program which will (if approved) generate an additional $225,000 in federal funds for the

program for FY 07. This office plans to continue our requests for additional funds to maximize federal funds whenever possible.

Comprehensive Plan Components

The mission of the Medicaid Fraud and Abuse Control Division is prosecutorial in nature. Investigating fraud perpetrated against the Medicaid program and crimes committed against vulnerable adults in health care facilities are the Division's main focus. Often, providers who are convicted of fraud against the Medicaid program are ordered to make full restitution as part of their sentences. The Medicaid Fraud and Abuse Control Division always seeks such an order. The providers are excluded from participation in the program for a minimum of five (5) years, ensuring that the program will be protected from fraud for that period of time. Frequently professional providers face administrative sanctions by their licensing or certifying bodies.

Examples of Fraud Convictions Restitution and Loss-avoidance (Extrapolated)

Provider	Restitution*	5 year loss-avoidance	Career duration loss-avoidance**
Clear	$18,176	$90,878	$127,230
Wright	$168,913	$422,283	$2,364,787
Hamilton	$40,000	$200,000	$920,000
Andrews	$180,000	$150,000	$600,000
Tumey	$8,504	$7,086	N/A
Caudill	$143,633	$179,541	$502,715
Hamlin	$575,000	$1,437,500	$1,725,000
Eades	$43,499	$108,747	$652,480

*Total restitution ordered may cover multiple years
**This figure presumes career lasting until age 65
*** It should be noted that the figures shown above assume a constant rate of fraud over time. Experience has shown, however, that unscrupulous providers nearly always increase their fraudulent billings year by year. Thus, both loss-avoidance columns are extremely conservative estimates.

The best measure of expected results from increased expenditures is past performance. In gauging performance, several predicates must be understood:

- Prosecution, not revenue collection, is the Unit's first mission.
- New employees require 18-24 months on the job before they are independently functional. Therefore, when new staff is hired, recovery statistics will be down pending staff and case development.
- National standing based upon recovered funds should be measured by federal dollars per Unit employee.
- Due to the complex nature of these cases recoveries cannot be accurately predicted from year to year.

- Each of the nation's 49 units is unique, with varying state Medicaid budgets, regulations, statutes, employee powers and healthcare challenges, making comparison among the states statistically invalid.
- Some units have both criminal and civil litigation authority, making it easier to collect stolen revenue. Kentucky's unit does not have civil authority. Our burden of proof is always the highest. We do work closely with the United States Attorneys for the Eastern and Western Districts of Kentucky when our cases appear to sustain less than the criminal standard. These efforts still require a significant investment of unit resources.

Year	Recovery/ Federal $	Recovery/ Staff	National Rank
2002	$2.92	$183,130	14th/16th
2003	$1.40	$ 98,468	23rd/24th
2004	$14.49	$1,016,932	1st/2nd
3 year Average	$6.27	$423,427	10th/10th

Recommendation 4.2

"The General Assembly should consider appropriating additional state funds to the Office of the Attorney General for the specific purpose of accessing a larger amount of federal funds to operate its Medicaid Fraud and Abuse Control Division only after the office has shown that appropriation increases provided through fund transfers from other budget units within the office are insufficient to obtain the specified goals of the Medicaid Fraud and Abuse Control Division. Additional funding by the General Assembly should be made as a specific line-item appropriation for the purpose of accessing larger amounts of federal funds to operate the Medicaid Fraud and Abuse Control Division. Specified appropriations by the General Assembly should be contingent upon demonstrating, to an appropriate legislative committee, by the Office of the Attorney General actual results produced by the Medicaid Fraud and Abuse Control Division and obtaining a determination by the General Assembly that the results warrant the additional funding requested."

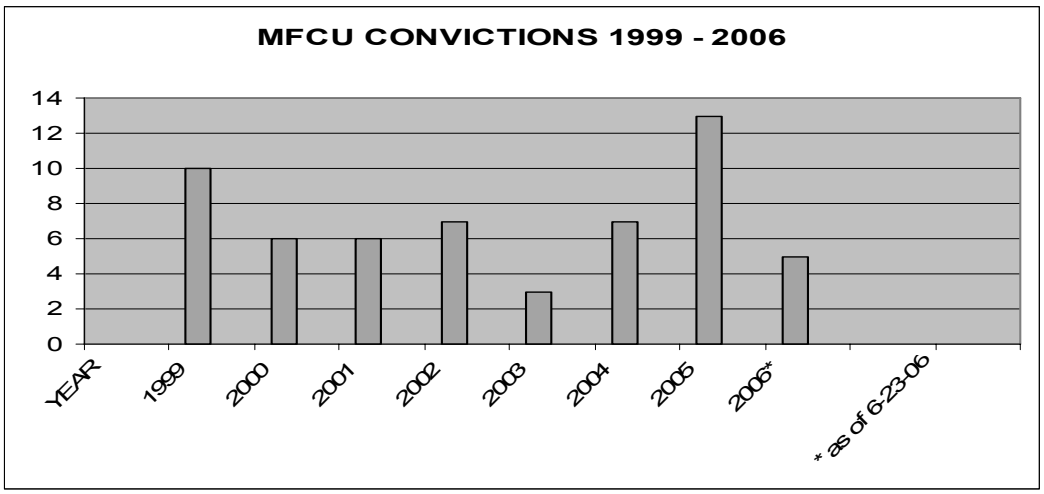
OAG Comment

The Medicaid Fraud and Abuse Control Division handles cases of abuse, neglect, and exploitation of vulnerable adults as well as fraud by unscrupulous providers. While it recovers substantial revenues lost due to fraud against the Medicaid program, the division is primarily an investigative and prosecutorial unit. Measurement of the unit's "results" must include consideration of the deterrent effect of investigations and prosecutions, the loss-avoidance effect of specific prosecutions, and the immeasurable value of convicting those who perpetrate crimes against vulnerable adults.

Cases of fraud are complicated to investigate, prepare for trial, and prosecute. Due to the unique nature of healthcare fraud, the learning curve for new employees is steep. Regardless of the past experience of investigator and attorneys who come into the unit, it takes 18 to 24 months for the average employee to work independently on healthcare fraud cases.

See the response to Recommendation 4.1 for additional information.

The following chart represents the unit's conviction levels since 1999. In reviewing this information, it is important to realize that extremely complex cases will utilize the majority of the unit's resources, causing lower conviction rates for the following year.



Recommendation 4.6
"The Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General should work with Medicaid contractors to develop a plan for controlling fraud against Kentucky's Medicaid program. The plan should consider the roles of the Department for Medicaid Services, the Office of Inspector General, the Office of (the) Attorney General, and each relevant contractor and should provide a timeline for implementing a cohesive fraud control strategy. The Department for Medicaid Services should report the plan to the Program Review and Investigations Committee, the Medicaid Oversight Committee, and the Health and Welfare Committee."

OAG Comment
The Office of Attorney General has worked with the other named entities in developing efforts to control fraud against the Medicaid Program and will continue to do so. The Medicaid Fraud and Abuse Control Division has learned of various "loopholes" or weaknesses in the claims review process and has discussed with OIG and DMS personnel ways to close those loopholes or eliminate weaknesses. For example, the OAG's investigation and prosecution of an oral surgeon has revealed the need to have "audits" in place at EDS to cross check dental and oral surgery claims, preventing a provider from billing twice for the same service or for services not rendered at all. Likewise, our prosecution of a transportation company revealed the need to have managed care brokers require placing pick up and drop off times on claims in order to reduce the fraudulent practice of billing for higher reimbursed "single person runs" when in fact multiple persons were transported at the same time at what should have been a significantly reduced rate. The OAG has also worked with DMS and OIG personnel in efforts to restructure certain blood panel components to avoid unbundling practices, which will result in significant savings to the Medicaid Program.

Recommendation 4.7
"The Office of the Attorney General, Medicaid Fraud (and Abuse) Control Division, and the Cabinet for Health and Family Services, Office of Inspector General, should work together to explore the feasibility of implementing a false claims statute in Kentucky. Issues to be considered include required staffing of all agencies, required monetary resources, and a cost-benefit analysis of implementing such a statute. The two agencies should present a joint report to the Program Review and Investigations Committee, the Medicaid Oversight Committee, the Health and Welfare Committee, and the Judiciary Committee."

OAG Comment
During the 2006 Regular Session, OAG developed just such a legislative proposal specifically crafted to meet Kentucky's needs. OAG and OIG are in agreement about the need for a state False Claims or Qui Tam statute. OAG will continue its work in refining and updating this important legislative initiative. OAG will continue the dialogue it initiated with the Inspector General and DMS personnel to ensure that any enactment satisfies federal requirements in order to make the Commonwealth eligible for a 10% reduction in the payback of captured Medicaid overpayments. While passage would clearly require the hiring of additional attorney personnel, the experiences in Texas, Florida and other states with False Claims statutes suggest that over time the increased recoupment will far exceed the state general fund appropriation.