LEGISLATIVE RESEARCH COMMISSION

PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Medicaid Prescription Drug Benefit Fraud, Abuse, and Cost Management

Research Report No. 351

Prepared by

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Medicaid Prescription Drug Benefit Fraud, Abuse, and Cost Management

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Foreword

In completing this report, numerous individuals provided valuable assistance. The authors of this report want to thank staff from the Cabinet for Health and Family Services' Department for Medicaid Services, Office of the Inspector General, Department for Community Based Services, Department for Disability Determination Services, Office of the Ombudsman, and Office for Human Resource Management; First Health Services Corporation; Electronic Data Systems; the Office of the Attorney General's Medicaid Fraud Control Unit; the Justice and Public Safety Cabinet's Office of Drug Control Policy; Administrative Office of the Courts; Passport Health Plan; the Kentucky Board of Medical Licensure; the Kentucky Board of Pharmacy; the Kentucky Board of Nursing; the Kentucky Injury Prevention and Research Center; and the federal Centers for Medicare and Medicaid Services for sharing their knowledge. Within the law enforcement community, the authors would like to express appreciation to officers of the Kentucky Bureau of Investigation; the Kentucky State Police Drug Enforcement Branch; the U.S. Drug Enforcement Agency (Louisville Office); Operation UNITE; the Louisville Metro Police Department Prescription Drug Squad; and the Lexington-Fayette Urban County Division of Police, Bureau of Investigation, Narcotics Squad for their helpful information on prescription drug diversion in Kentucky. Among Legislative Research Commission staff, the authors also want to recognize Jonathan Roenker for his help.

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Robert Sherman
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Legislative Research Commission
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Summary

Among many factors driving up the cost of health care, prescription drug costs have been among the fastest growing. In recent years, public and private insurers have taken steps to rein in the costs of their pharmacy benefits. It appears that some of these steps have succeeded in slowing the rapid growth in pharmacy costs, at least temporarily.

This report has 11 main conclusions.

1. It is not possible to make a good estimate of the amounts lost to fraud and abuse. For every case found, there is an unknown number of other cases.

2. The greatest opportunity for savings lies in aggressive management of the Medicaid prescription drug benefit to reduce costs while ensuring quality health care. The factors that determine these costs are many and complex. So far, KyHealth Choices benefit plans and the pharmacy benefit administrator have made strides in several areas. However, some programs have yet to be implemented and there remains potential for significant additional savings.

3. The cost of the prescription drug benefit should not be expected to decline. The costs of medications needed for optimal health care probably will continue to rise. Better drugs will be developed and should be used when appropriate. New drugs cost more than older drugs with generic equivalents. Other factors, such as inflation, inevitably increase costs. The challenge for all insurers, including Medicaid, is to address every area of waste, abuse, and fraud to minimize the increase while providing quality health care. Medicaid's success in this area should be measured in comparison with other, comparable programs over time.

4. Within fraud and abuse, probably the greatest opportunity for returns is drug pricing and marketing fraud. The next greatest opportunity probably is nonfraudulent overpayments to pharmacies, including agency errors.

5. It is better to prevent fraudulent and abusive payments from being made than to attempt to recover them afterward. Aggressive prevention systems can save significant dollars. However, accounting systems are not designed to give credit for cost avoidance in the budget. Policy makers need to be aware of these factors in order to determine appropriate funding for prevention.

6. While fraud itself probably does not represent the greatest cost, combating fraud usually returns more dollars than are invested. Other states and commercial insurers routinely report recovering $10 or more for each dollar spent on enforcement. In addition, prosecuting fraud can create a deterrent effect. It is arguable that as a crime, fraud should be prosecuted even if it results in a net loss to the state.

7. Nationally, the Centers for Medicare and Medicaid Services acknowledge that fighting Medicaid fraud and abuse was not a federal priority until passage in 2006 of the Deficit Reduction Act of 2005. Until then, many, if not most, states placed little emphasis on fighting fraud and abuse.

8. With federal emphasis lacking, Kentucky Medicaid has performed minimal detection of provider fraud for many years and has not actively sought abuse by pharmacies since 2003. However, Medicaid has developed a commendable request for proposals for a program integrity vendor.

9. Medicaid followed a traditional process to identify fraud and abuse by recipients until May 2007 and plans to resume soon. The Cabinet for Health and Family Services has implemented a commendable recipient eligibility fraud prevention program. The planned program integrity vendor would assist with recipient fraud and abuse, which would be a commendable development.

10. Several agencies conduct fraud and abuse prevention and detection for the Department for Medicaid Services. Some of the agencies' activities are poorly coordinated, sometimes overlapping and sometimes leaving gaps. The department has not taken an assertive role in overseeing and planning program integrity functions for the Medicaid program.

11. The Department for Medicaid Services has experienced an unusually heavy workload because of Medicaid modernization in the past 4 years. With new federal initiatives focusing on Medicaid processes as well as program integrity, the workload is unlikely to decrease much in the near future. Turnover in many key positions revealed a lack of documentation and a staffing level that makes program management difficult.

Addressing fraud and abuse is one of many strategies that help manage the cost of health care. No one knows how much is spent on claims for services that were not provided, were not necessary, or were misrepresented, but the National Health Care Anti-Fraud Association cites estimates that from 3 percent to 10 percent of all paid claims are attributable to fraud alone. Unfortunately, these figures are guesses and apply to all types of claims, not just prescriptions. Beyond fraud, additional practices that constitute abuse result in overpayments, some of which can be recovered.

Kentucky's Department for Medicaid Services has addressed the challenge of increasing health care costs through a modernization program. In addition to developing a new computerized information system, Medicaid is implementing a new set of benefit packages—KyHealth Choices—designed to contain costs while purchasing quality health care services.

Kentucky Medicaid placed a priority on managing the prescription drug benefit by soliciting bids for a pharmacy benefit administrator in May 2004, months before soliciting other Medicaid modernization vendors. The contract was awarded to First Health Services Corporation in August 2004, and First Health took over administration of the prescription drug benefit on December 4, 2004.

Within the Cabinet for Health and Family Services, the Department for Community Based Services handles Medicaid applications and the Office of Inspector General (OIG) houses the Medicaid program integrity function. The OIG investigates provider and recipient fraud and abuse. When provider fraud and abuse are documented, OIG takes administrative action and refers the cases to the attorney general for possible prosecution.

The Kentucky attorney general operates the federally required Medicaid fraud control unit. The Office of the Attorney General is responsible for prosecuting fraudulent providers and any recipients who might be involved in assisting such providers. In addition, the attorney general's office may file or participate in lawsuits against pharmaceutical manufacturers for deceptive and fraudulent pricing practices.

Other agencies are involved in fraud and abuse prevention and detection. The Department for Community Based Services conducts Medicaid eligibility determinations. The cabinet's Office of the Ombudsman is responsible for eligibility quality control. Professional licensing boards regulate prescribers and pharmacists. Law enforcement agencies and prosecutors handle prescription drug diversion cases. DMS is responsible for coordinating Medicaid program integrity and should work with all agencies involved with Medicaid fraud and abuse.

This report has 29 recommendations.

1.1 If it is the intent of the General Assembly to provide the most effective tools for recovering losses caused by Medicaid fraud, then after receiving input from the Office of the Attorney General and other interested parties, the General Assembly may wish to consider passage of a state false claims act that meets the requirements outlined in the Deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud.

1.2 The Department for Medicaid Services should develop a process to ensure that the documentation of policies and procedures is comprehensive and kept up to date. The department should work with all vendors, both governmental and private, to ensure that they also maintain comprehensive and up-to-date documentation of their policies and procedures.

1.3 The Department for Medicaid Services should ensure that an adequate staffing resource plan is developed and maintained. To the extent possible, such planning also should be implemented by the department's vendors, both governmental and private. The Cabinet for Health and Family Services should present an adequate staffing plan in its budget proposals to the governor and the General Assembly.

1.4 The Department for Medicaid Services, in consultation with all involved agencies and vendors, should ensure that a comprehensive Medicaid program integrity plan is developed, maintained, and followed. The plan should delineate responsibility for all aspects of program integrity: prevention, detection, and recovery of fraud, abuse, and other overpayments related to recipients, providers, Medicaid contractors, state employees, and pharmaceutical and other medical supply manufacturers. The plan should include funding and staffing considerations. The plan should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers.

1.5 As part of its overall program integrity plan, the Department for Medicaid Services should explore ways to implement concurrent fraud, abuse, and overpayment detection within the pharmacy point-of-sale system as well as the medical-claims processing system.

1.6 If it is the intent of the General Assembly to assist the Kentucky Medicaid program in seeking more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs, the General Assembly may wish to consider a resolution asking Congress to provide such relief.

1.7 The Department for Medicaid Services should implement a comprehensive program to evaluate the performance and outcomes of Medicaid as a whole and of each vendor and each benefit program. To the extent possible, the program should attempt to measure the outcomes and calculate a return on investment for each agency and vendor activity and each benefit plan change and innovation.

1.8 The Cabinet for Health and Family Services should reconstitute the Drug Management Review Advisory Board and ensure that it fulfills its duties under federal and Kentucky law. If the cabinet believes that the board's duties and those of the Pharmacy and Therapeutics Committee could be combined, it should propose to the General Assembly legislation that is consistent with federal law.

1.9 The Department for Medicaid Services should ensure that the annual drug use review report is prepared and sent to the federal government. In addition, the department should provide copies of the last five such annual reports and all future reports to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission.

1.10 If it is the intent of the General Assembly to more fully empower the Office of Inspector General to combat Medicaid fraud and abuse, then the General Assembly may wish to consider the changes requested by that office as embodied in Senate Bill 223 of the 2005 Regular Session.

2.1 The Department for Medicaid Services should review Medicaid eligibility procedures, and the Department for Community Based Services should ensure that all caseworkers understand and follow the procedures for verifying an applicant's statements. The Department for Medicaid Services should consider whether it is desirable that caseworkers ask adult Medicaid applicants for information about expenses and attempt to balance income, resources, and expenses. If so, the departments together should develop such a procedure and incorporate it into caseworker training.

2.2 The Department for Medicaid Services, the Office of Inspector General, and the Department for Community Based Services should develop a plan to expand the Determining Eligibility Through Extensive Review program to additional local offices. The plan should address local office acceptance of the program, office space, funding, and the role of claims workers.

2.3 The Department for Community Based Services should ensure that referrals for suspected fraud in adult Medicaid cases are being made correctly to the Office of Inspector General. The department should implement procedures to reduce the error rate in adult Medicaid cases.

2.4 The Department for Community Based Services should determine a staffing level adequate to ensure quality results in the Division of Family Support. The department should develop a staff retention plan to reduce turnover. To the extent that either an adequate staffing level or a retention plan requires additional positions or funding, the department should include the needed resources in its budget requests.

3.1 Recognizing that the Recipient Utilization Review Committee does not exist, the General Assembly may wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable. If the statute is not so modified, the Department for Medicaid Services should operate the committee as defined in the law.

3.2 The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine whether fair and reasonable limitations could be placed on filling phone-in prescriptions.

3.3 The General Assembly may wish to consider options to remove potential conflicts among KRS 218A.020-130, related administrative regulations, and the federal controlled substance schedule.

3.4 The Cabinet for Health and Family Services should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling.

3.5 If it is the intent of the General Assembly to clarify the permitted and prohibited uses of data in the Kentucky All Schedule Prescription Electronic Reporting system, then the General Assembly may wish to consider amending KRS 218A.202 and KRS 218A.240 to remove possible ambiguities and inconsistencies.

3.6 As part of its overall program integrity plan, the Department for Medicaid Services should reissue a program integrity request for proposals substantially similar to the one canceled in October 2007 and award a contract as soon as it is prudent to do so. The new vendor and program integrity staff should implement as soon as possible a review of all Medicaid claims, with special priority on prescription claims submitted since June 2003.

3.7 As part of its overall program integrity plan, the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and develop an ongoing cost-benefit analysis of the program. The department should modify the program over time to optimize costs and benefits.

3.8 If it is the intent of the General Assembly that the Kentucky Medicaid fraud hotline statute be consistent with federal regulation 42 CFR 455.14, then the General Assembly may wish to consider amending KRS 205.8483(2) to allow the Office of Inspector General to conduct a preliminary investigation to determine if a sufficient basis exists for a full investigation, prior to referring the case to the Office of the Attorney General.

3.9 As part of its overall program integrity plan, the Department for Medicaid Services should work with the Office of Inspector General and Office of the Attorney General to establish protocols for preliminary investigation of all potential provider fraud cases by the Office of Inspector General and for timely referral to the Office of the Attorney General for full investigation, consistent with federal regulations.

3.10 The Office of the Attorney General should develop a budget request for state funding necessary to cover the costs of investigating and prosecuting all the anticipated criminal Medicaid fraud cases referred as well as performing the other duties of the Medicaid fraud control unit. The attorney general should provide a justification for the funding request and a range of estimated recoveries.

4.1 The Department for Medicaid Services should estimate the amount by which the Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual-eligible recipients if they had remained in the Medicaid prescription drug benefit. The department should report its estimate to the Program Review and Investigations Committee by September 2008.

4.2 When measuring the performance of the Medicaid prescription drug program, the Department for Medicaid Services and all its vendors should consider the effects of Medicare Part D and the clawback. When presenting any performance information to the public, and particularly to the General Assembly, the department should explain these effects.

4.3 The Department for Medicaid Services should conduct a complete cost-benefit analysis of the behavioral health drug use review program, including historical trend data by drug class and the effect of the agreement on the preferred drug list and supplemental rebates. The department should ensure that a tracking system is in place to monitor the results of the program and should compare actual with expected results. The department should report to the Program Review and Investigations Committee

- the cost-benefit analysis by September 2008 and
- the results after the 2-year program.

4.4 The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine effective and acceptable education regarding best practices for prescribing and dispensing.

4.5 The Department for Medicaid Services should consider whether to implement counter-detailing to provide unbiased prescribing information to physicians and other prescribers. The department also should consider Medication Therapy Management by pharmacists as a means of improving care and reducing costs. If either program appears to be effective and feasible, the department should request any necessary enabling legislation and should implement the program.

Chapter 1

Overview and General Findings on Medicaid Prescription Drug Fraud and Abuse

Introduction

Prescription drug costs have been one of the fastest growing health care factors. The rate of growth has slowed recently.

Prescription drug costs have been among the fastest growing factors driving up the cost of health care. In recent years, public and private insurers have taken steps to rein in the costs of their pharmacy benefits. Some of these steps may have succeeded in slowing the rapid growth in pharmacy costs, at least temporarily.

The amount of fraud and abuse is unknown. Staff found no estimates specific to prescription drugs.

Addressing fraud and abuse is one of many strategies that help manage the cost of health care. No one knows how much is spent on claims for services that were not provided, were unnecessary, or were misrepresented, but the National Health Care Anti-Fraud Association cites estimates that from 3 percent to 10 percent of all paid claims are attributable to fraud alone. Unfortunately, these figures are guesses and apply to all types of claims, not just prescriptions. Beyond fraud, practices that constitute abuse result in overpayments, some of which can be recovered.

Prescription drug benefit fraud and abuse can involve pharmaceutical manufacturers, pharmacies, physicians, state employees, and recipients.

Prescription drug benefit fraud potentially takes a number of forms. Pharmaceutical manufacturers might conceal discounts available to other insurers. Pharmacists might submit fake claims or bill for more medication than was dispensed. Doctors might write unneeded prescriptions and buy them back from their patients for reuse or resale. State employees or contractors might provide billing information to providers who want to defraud the system. Recipients might fake symptoms to obtain controlled substances to sell on the street. Applicants might qualify for Medicaid based on false or erroneous information.

Overpayments made because of abuse probably exceed those made because of fraud.

Abuse is a gray area between fraud and waste. It covers overpayments made because of careless billing practices and innocent errors. Total overpayments attributable to abuse in this broad definition probably exceed the amount of loss from fraud, except for the most extreme fraud cases.

Description of This Study

On December 14, 2006, the Program Review and Investigations Committee voted to initiate a study of losses caused by fraud and abuse in Kentucky Medicaid's prescription drug program. Staff examined several types of fraud and abuse, including eligibility, benefit use, drug diversion, billing, and drug pricing and marketing. The study also examines prescription drug benefit cost management.

How This Study Was Conducted

Staff reviewed relevant state and federal statutes and regulations; agency policies and procedures; existing financial and performance audits; and research literature on fraud, abuse, and prescription drug programs. Staff analyzed available data and reviewed agency documents and reports. Staff obtained information from agency officials and personnel.

Staff interviewed officials in the Cabinet for Health and Family Services' Office of Inspector General, Department for Medicaid Services, Department for Community Based Services, Department for Disability Determination Services, Office of Human Resource Management, and pharmacy benefit administrator. Staff interviewed officials in the Office of the Attorney General and licensing boards. Staff interviewed eligibility caseworkers, agency staff, and law enforcement officers. Staff interviewed and obtained information from officials of the Centers for Medicare and Medicaid Services. Staff interviewed and visited Passport Health Plan and commercial health insurers.

Staff interviewed seven individuals and three physicians convicted of prescription drug fraud. Staff conducted three focus groups with physicians from the Lexington Medical Society, the Greater Louisville Medical Society, and the Kentucky Society of Interventional Pain Physicians. Staff conducted a focus group with pharmacists in Pikeville.

Staff also conducted two Web-based surveys: one targeting Kentucky Medicaid physicians and one targeting Kentucky pharmacists.

Organization of the Report

This report has four chapters. The first three chapters discuss Medicaid program integrity, defined as any process that protects the Medicaid program from losses caused by fraud, abuse, or agency error. The final chapter reviews cost management.

The remainder of this chapter presents the major conclusions of the study; basic definitions of "fraud," "abuse," and "waste"; overall functional and financial descriptions of the Medicaid prescription drug benefit; a brief description of the federal laws and regulations affecting the Medicaid prescription drug benefit and program integrity; a listing of types of fraud and abuse; a listing of Kentucky agencies and their respective roles in the Medicaid process and in handling fraud and abuse; a general description of Medicaid program integrity; and general findings.

Chapter 2 describes fraud and abuse in Medicaid eligibility. Highlighted are agency descriptions and roles, types of eligibility fraud and abuse, quality control, and eligibility findings.

Chapter 3 describes fraud and abuse related to prescription drug claims. Recipient benefit misuse and prescription drug diversion and provider billing fraud and abuse are described. Program integrity countermeasures are described and evaluated.

Chapter 4 describes prescription drug benefit cost management in terms of the ways that costs can be managed, a trend analysis, and physician prescribing patterns and how they can be influenced.

Appendix A contains a list of topics staff selected as deserving further study. Appendix B is a compilation of ways that fraud and abuse have been perpetrated on prescription drug programs generally. Appendix C displays the results of the Program Review staff survey of pharmacists. Appendix D displays the results of the Program Review staff survey of Medicaid physicians. Appendix E describes the research methods for conducting and analyzing the surveys and other data analyses conducted by staff. Appendix F contains the federal report on the Kentucky Medicaid program integrity unit. Appendix G contains the Cabinet for Health and Family Services' response to this report. Appendix H contains the Office of the Attorney General's response to this report.

Major Conclusions

This report has 11 major conclusions.

1. It is not possible to make a good estimate of the amounts lost to fraud and abuse. For every case found, there is an unknown number of other cases.

2. The greatest opportunity for savings lies in aggressive management of the Medicaid prescription drug benefit to reduce costs while ensuring quality health care. The factors that determine these costs are many and complex. So far, KyHealth Choices benefit plans and the pharmacy benefit administrator have made strides in several areas. However, some programs have yet to be implemented and there remains potential for significant additional savings.

3. The cost of the prescription drug benefit should not be expected to decline. The costs of medications needed for optimal health care probably will continue to rise. Better drugs will be developed and should be used when appropriate. New drugs cost more than older drugs with generic equivalents. Other factors, such as inflation, inevitably increase costs. The challenge for all insurers, including Medicaid, is to address every area of waste, abuse, and fraud to minimize the increase while providing quality health care. Medicaid's success in this area should be measured in comparison with other, comparable programs over time.

4. Within fraud and abuse, probably the greatest opportunity for returns is drug pricing and marketing fraud. The next greatest opportunity probably is nonfraudulent pharmacy overpayments, including agency errors.

5. It is better to prevent fraudulent and abusive payments from being made than to attempt to recover them afterward. Aggressive prevention systems can save significant dollars. However, accounting systems are not designed to give credit for cost avoidance in the budget. Policy makers need to be aware of these factors in order to determine appropriate funding for prevention.

This report has 11 major conclusions.

1. It is not possible to make a good estimate of the amounts lost to fraud and abuse.

2. The greatest opportunity for savings lies in aggressively reducing prescription drug benefit costs while ensuring quality health care. So far, strides have been in several areas. However, there remains potential for significant additional savings.

3. The cost of the prescription drug benefit should not be expected to decline. Medication costs will continue to rise. Other factors, such as inflation, inevitably increase costs. The challenge is to address every area of waste, abuse, and fraud to minimize the increase while providing quality health care. Medicaid's success in this area should be measured in comparison with other, comparable programs over time.

4. Within fraud and abuse, probably the greatest opportunity for returns is drug pricing and marketing fraud. The next greatest opportunity probably is nonfraudulent pharmacy overpayments, including agency errors.

5. It is better to prevent fraudulent and abusive payments from being made than to attempt to recover them afterward. Aggressive prevention systems can save significant dollars. However, accounting systems are not designed to give credit for cost avoidance in the budget. Policy makers need to be aware of these factors in order to determine appropriate funding for prevention.

6. While fraud itself probably does not represent the greatest cost, combating fraud usually returns more dollars than are invested. Other states and commercial insurers routinely report recovering $10 or more for each dollar spent on enforcement. In addition, prosecuting fraud can create a deterrent effect. It is arguable that as a crime, fraud should be prosecuted even if it results in a net loss to the state.

7. Nationally, the Centers for Medicare and Medicaid Services acknowledge that fighting Medicaid fraud and abuse was not a federal priority until passage in 2006 of the Deficit Reduction Act of 2005. Until then, many, if not most, states placed little emphasis on fighting fraud and abuse.

8. With federal emphasis lacking, Kentucky Medicaid has performed minimal detection of provider fraud for many years and has not actively sought abuse by pharmacies since 2003. However, Medicaid has developed a commendable request for proposals for a program integrity vendor.

9. Medicaid followed a traditional process to identify fraud and abuse by recipients until May 2007 and plans to resume soon. The Cabinet for Health and Family Services has implemented a commendable recipient eligibility fraud prevention program. The planned program integrity vendor would assist with recipient fraud and abuse, which would be a commendable development.

10. Several agencies conduct fraud and abuse prevention and detection for the Department for Medicaid Services. Some of the agencies' activities are poorly coordinated, sometimes overlapping and sometimes leaving gaps. The department has not taken an assertive role in overseeing and planning program integrity functions for the Medicaid program.

11. The Department for Medicaid Services has experienced an unusually heavy workload because of Medicaid modernization in the past 4 years. With new federal initiatives focusing on Medicaid processes as well as program integrity, the workload is unlikely to decrease much in the near future. Turnover in many key positions revealed a lack of documentation and a staffing level that makes program management difficult.

6. While fraud itself probably does not represent the greatest cost, combating fraud often returns $10 or more for each dollar spent on enforcement. Also, prosecuting fraud can create a deterrent effect. Arguably, criminal fraud should be prosecuted even at a net loss.

7. Fighting Medicaid fraud and abuse was not a federal priority until 2006. Until then, many, if not most, states placed little emphasis on fighting fraud and abuse.

8. With federal emphasis lacking, Kentucky Medicaid has performed minimal provider fraud detection for many years and has not actively sought abuse by pharmacies since 2003. However, Medicaid has developed a commendable request for proposals for a program integrity vendor.

9. Medicaid followed a traditional process to identify fraud and abuse by recipients until May 2007 and plans to resume soon. The Cabinet for Health and Family Services has implemented a commendable recipient eligibility fraud prevention program. The planned program integrity vendor would assist with recipient fraud and abuse.

10. Several agencies conduct fraud and abuse prevention and detection for the Department for Medicaid Services. Some of the agencies' activities are poorly coordinated. The department has not taken an assertive role in overseeing and planning program integrity functions for the Medicaid program.

11. The Department for Medicaid Services has experienced an unusually heavy workload in the past 4 years. With new federal initiatives, the workload is unlikely to decrease much in the near future. Documentation and staffing are inadequate to handle turnover and program management.

Definitions of Fraud, Abuse, and Waste

It is difficult to separate into categories the actions that result in costs to the prescription drug benefit. Fraud may seem clearly defined but usually depends on intent. Abuse is a gray area typically involving unintentional error or carelessness. Waste represents spending that could be curtailed with proper management. Some actions may not fit clearly into a single category.

Fraud is an intentional and knowing effort to obtain an unauthorized benefit.

This report uses the definition of "fraud" as it appears in federal Medicaid regulations:

> *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

Abuse is failure to follow sound fiscal, business, or medical practices so that Medicaid experiences an unnecessary cost. This report considers errors to be abuse because they could be avoided in principle.

Similarly, this report uses the definition of "abuse" as it appears in federal Medicaid regulations:

> *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2).

One example of abuse of the prescription drug benefit is prescribing a brand-name medication when a generic version is appropriate. While it is impossible to eliminate human error, this report considers abuse to include innocent errors, on the assumption that proper diligence could have prevented any specific error.

Waste is any program expense that would be unnecessary under efficient medical and fiscal management. This report considers agency errors separately from waste.

In this report, staff consider "waste" to be expenditures that would be unnecessary under efficient medical and fiscal management by the Medicaid program. Examples include prescriptions that could be reduced with care management and claims system payment errors that could be eliminated with correct programming. Waste includes outstanding overpayments that could be reduced or collected more quickly with better recovery methods. Waste will be addressed under the topic of cost management.

Agency error is a source of overpayments that is considered separately in this report. Staff also refer to these as erroneous

payments. Agency error can occur while determining eligibility and when processing claims.

Definition of Program Integrity

Program integrity refers to the process of combating fraud, abuse, and agency error.

The process of combating fraud, abuse, and agency error in Medicaid is called "program integrity." This report will use the term to refer to efforts by several agencies and vendors to ensure the financial integrity of the Medicaid program.

Medicaid Prescription Drug Benefit Structure

Medicaid is financed jointly by the federal and state governments and operated by the states.

The Medicaid program was established in 1965 by Title XIX of the Social Security Act. The Act provides that the federal and state governments share the cost of Medicaid. Each state has a federal matching rate that can vary from year to year and is based on the per capita income in the state. States have wide latitude in determining eligibility rules and what services will be covered.

States must cover certain "categorically needy" people and may choose to cover others.

Federal rules designate as "categorically needy" the group of people that the state Medicaid program must cover. The rules designate additional "categorically related" people whom states may cover at their discretion. These are the two groups that can receive federal funds for their coverage. States also have the option of extending coverage to "state-only" groups using state funds without a federal match.

States must provide at least certain health coverage. Other coverage, including prescription coverage, is optional.

Federal law also sets minimum coverage for the categorically needy group. States may provide less than this minimum for categorically related and state-only groups.

Federal funds are available for some kinds of optional coverage beyond the minimum. States may opt to provide any of these and receive matching federal dollars. The prescription drug benefit is one kind of optional coverage. Kentucky, along with most states, has chosen to provide prescription drug coverage.

KyHealth Choices Prescription Drug Benefit

KyHealth Choices, as the Kentucky Medicaid benefit plans are called, includes the prescription drug benefit. Cost containment measures were implemented in 2005 and 2006.

KyHealth Choices, as the Kentucky Medicaid benefit plans are now called, includes a prescription drug benefit for Medicaid recipients. KyHealth Choices plans were not initiated until 2006, although some major cost containment measures were implemented in 2005 under the new pharmacy benefit administrator (PBA).

The Deficit Reduction Act of 2005, signed into law on February 8, 2006, emphasized changes in Medicaid policy with an eye toward program expenditure reductions. It allowed KyHealth Choices to implement new options related to benefits, cost sharing, and long-term care.

Medicare Part D

The Medicaid prescription drug benefit no longer covers those eligible for both Medicaid and Medicare, called "dual eligibles."

Many "dual-eligible" Medicaid recipients also receive Medicare. In January 2006, Medicare's prescription drug benefit, Medicare Part D, began to cover almost all prescriptions for dual-eligible recipients. Medicaid now covers only a small number of prescriptions that federal law left with Medicaid for dual eligibles.

Kentucky Medicaid Managed Care

The Medicaid managed care organization's prescription coverage is not part of KyHealth Choices.

Federal rules allow states to request waivers to implement managed care for Medicaid. Kentucky has created a managed care region in Jefferson and surrounding counties. University Health Care, Inc., formed Passport Health Plan to provide Medicaid services in the region. Passport receives a lump-sum payment from Kentucky Medicaid to provide those services. Passport provides a prescription drug benefit that is separate from KyHealth Choices. Passport is responsible for its own program integrity function and cost management.

The finances and operations of Medicaid managed care organizations are separate from the regular Medicaid program. This report does not consider program integrity in the Passport prescription drug benefit. Passport's budget is not included in the discussion of the Kentucky Medicaid prescription program.

Financial Summary of the Kentucky Medicaid Prescription Drug Benefit

In the following and all other discussions of finances, the cost of the Passport Health Plan managed care prescription drug benefit is not included.

Federal and State Funds

Most dollar figures shown for Medicaid include the 70 percent federal share and the 30 percent Kentucky share.

In almost all instances, cost figures shown for Medicaid include both federal and state funds. The federal match rate for medical and prescription claims in Kentucky is close to 70 percent, based

on per capita income. State dollars account for 30 percent of the amounts spent on Medicaid in Kentucky.

Effect of Rebates

Many dollar figures shown for Medicaid do not show the benefit of drug rebates.

The federal Medicaid program negotiates rebates with drug manufacturers and allows states to negotiate supplemental rebates. Each state receives rebates after paying claims by invoicing the manufacturers quarterly. The state then remits the federal portion and retains the state portion. The actual cost of the prescription drug benefit is the reported expenditures less the rebates invoiced for each quarter.

Effects of Medicare Part D

When Medicare Part D began paying for prescriptions for all Medicaid-Medicare dual eligibles in January 2006, the apparent cost of the program fell by more than $194 million per year. This is not a real drop in overall cost; it represents the cost of prescriptions for dual-eligible recipients.

Medicare took over the prescription drug benefit for dual-eligible Medicaid recipients in January 2006. This made the apparent cost of the Medicaid benefit fall dramatically. States do have to repay Medicare for this difference through a "clawback" calculation.

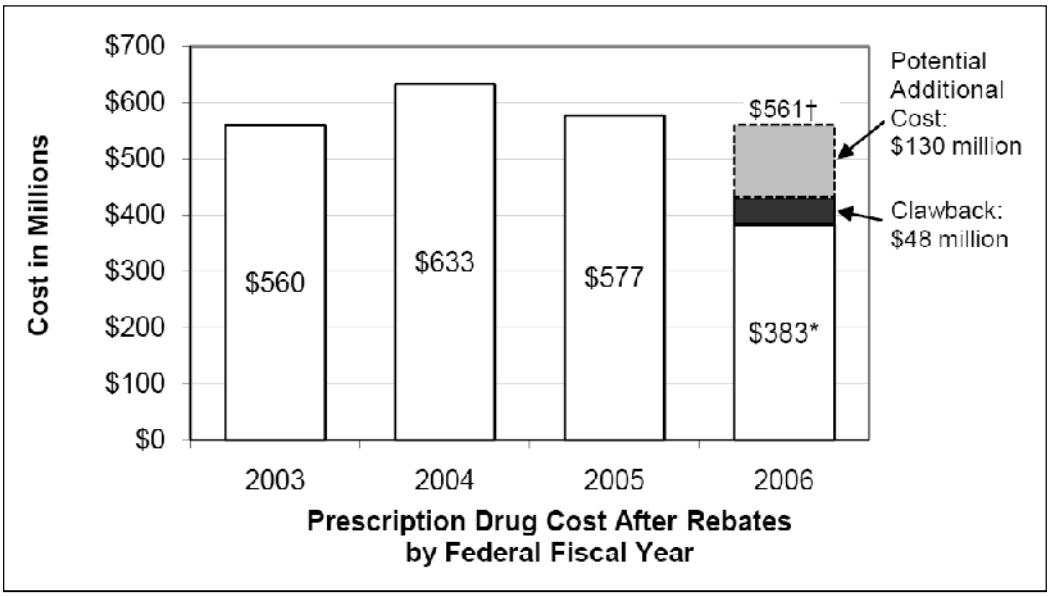
However, state Medicaid programs have to pay the federal Medicare program an estimated amount to cover the state share of most of that difference. This repayment is known as the Medicare Part D "clawback." Initially, it is 90 percent of the estimated Medicare expense, but it will decline in stages to 75 percent by 2015. Any accounting of the cost of the prescription drug benefit must at least include the actual clawback amount paid. Any analysis of trends in Medicaid expenditures must take into account the loss of dual eligibles and the amount of clawback.

Financial Summary

Figure 1.A shows the prescription drug benefit expenditures over federal fiscal years (FFYs) 2003-2006.[1] For 2006, Program Review staff estimated the effect of Medicare clawback on overall prescription drug expenditures.

[1] A federal fiscal year begins on October 1 and ends September 30 of the next calendar year.

Figure 1.A
Annual Kentucky Medicaid Prescription Drug Cost
Federal Fiscal Year 2003 to Federal Fiscal Year 2006

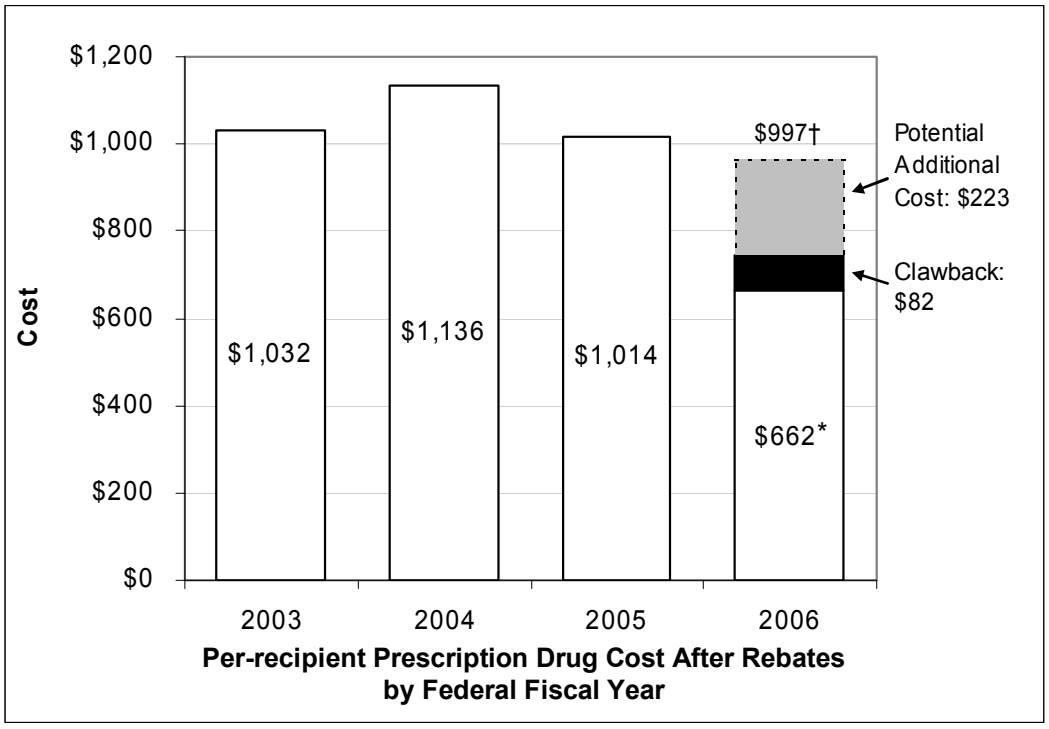


Note: *The drop between FFY 2005 and FFY 2006 is mostly attributable to Medicare Part D.
†The actual cost to the state of clawback was $55 million, prorated for the first three quarters of calendar year 2006. Staff estimated and removed the clawback paid for Passport Health Plan, leaving $48 million. The potential additional cost is what would have appeared in the budget if Medicaid prescriptions of that amount had been paid, including the federal share.
Sources: Program Review staff's compilation of data from the Centers for Medicare and Medicaid Services; Henry. "Estimated"; and First Health Services Corporation.

Medicare clawback is calculated for calendar years. In calendar year 2006, Kentucky's clawback payment was approximately $73 million (Henry. "Estimated"). If dual eligibles had been part of the Medicaid prescription program, there would have been a federal match of $171 million, for a total of $244 million. Because the clawback is calculated as 90 percent of the estimated Medicare cost, the actual estimated cost is $271 million. Staff prorated those numbers so that Figure 1.A shows the clawback amounts for the portion of 2006 that falls within FFY 2006. If the dual eligibles had been part of the benefit, the total expenditures for FFY 2006 would have been approximately $587 million.

Because expenditures depend on the number of recipients and other factors, it can be more useful to look at the cost per recipient. For Figure 1.B, staff calculated the average monthly cost per recipient and from that calculated the average annual cost.[2]

Figure 1.B
Annual Kentucky Medicaid Prescription Drug Cost Per Recipient
Federal Fiscal Year 2003 to Federal Fiscal Year 2006



Note: *The drop between FFY 2005 and FFY 2006 is mostly attributable to Medicare Part D. †The actual cost to the state of clawback, prorated for the first three quarters of calendar year 2006, was $95 per recipient. Staff estimated and removed the clawback paid for Passport Health Plan, leaving $82 per recipient. The potential additional cost is what would have appeared in the budget if Medicaid prescriptions of that amount had been paid, including the federal share.
Sources: Program Review staff compilation of data from the Centers for Medicare and Medicaid Services; Henry. "Estimated"; and First Health Services Corporation.

Costs of the Medicaid prescription drug benefit overall and per recipient rose until early in federal fiscal year 2005 when cost containment measures began. Costs began to rise again in 2006, perhaps at a slightly lower rate.

From both perspectives, prescription drug benefit expenses were rising between FFY 2003 and FFY 2004. Early in FFY 2005, First Health Services Corporation began operation as Kentucky Medicaid's PBA. During that year and continuing into FFY 2006, the Kentucky Department for Medical Services (DMS) and the PBA implemented several cost containment measures that appear

[2] Staff obtained the number of Medicaid recipients—not including Passport Health Plan members—from the Department for Medical Services. First Health Services Corporation, Kentucky Medicaid's pharmacy benefit administrator, has included Passport members when computing the per-recipient cost. As a result, First Health shows lower costs per recipient than staff's calculation.

to have reduced overall expenditures and the cost per recipient. According to PBA data, beginning early in calendar year 2006, prescription expenditures began to rise again, perhaps at a lower rate than before.

Legal Framework for Medicaid Prescription Drug Benefits and Program Integrity

There are several federal laws and regulations affecting Medicaid prescription drug benefits and Medicaid program integrity efforts. Examples are the Social Security Act, which created the Medicaid program; the Deficit Reduction Act of 2005, which created and funded new program integrity initiatives in Medicaid; the Stark Law, which makes it illegal for physicians to refer patients to health service providers in which they have a financial interest; and the Anti-Kickback Statute, which prohibits bribes, kickbacks, or rebates for expenses reimbursed by government health care programs.

There are several federal laws and regulations affecting Medicaid prescription drug benefits and Medicaid program integrity efforts. These include the Social Security Act, the Deficit Reduction Act of 2005, the Stark Law, the Anti-Kickback Act, and the False Claims Act.

Social Security Act

Title XIX of the Social Security Act is the federal law outlining the provisions for state Medicaid programs. Title XIX is administered by the Centers for Medicare and Medicaid Services (CMS). It appears in the United States Code as Title 42 §§1396-1396v. The provisions for the optional Medicaid prescription drug benefit and drug rebates are found in 42 USC 1396r-8. Regulations relating to Medicaid are contained in Title 42 and Title 45 subtitle A of the Code of Federal Regulations (U.S. Social. *Compilation*).

Deficit Reduction Act

The Deficit Reduction Act of 2005 was signed into law in 2006. It is an attempt to reduce the cost of federal entitlement programs, including Medicaid, over a 5-year period. The Act established the Medicaid Integrity Program, which is administered by CMS. The relevant federal regulations are 42 CFR 430-498. The program is a national strategy by CMS to detect and prevent Medicaid fraud and abuse. The Act provided funding and resources, "which will reach a total of $75 million annually by [federal] fiscal year 2009 and each year thereafter." (U.S. Dept. of Health. Centers. Center. Medicaid. *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FY 2006* 2). In addition, the Act created a program to combine Medicare and Medicaid databases to assist detection of fraud and abuse. The Medicaid Transformation Grants were created and funded by this Act.

Stark Law

> [T]he Stark Law prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of designated health services… if the physician (or a member of the physician's immediate family) has a direct or indirect financial relationship with the entity (Lebowitz 31).

Pharmacies are included among those entities.

Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987 as amended (42 USC §1320a-7b) is known as the Anti-Kickback Statute. It established as criminal acts practices such as providing bribes, kickbacks, or rebates to individuals for health services and medical goods that are reimbursable under government health care programs (Manning).

Federal False Claims Act

The federal False Claims Act (FCA) applies when someone falsely requests payment from the federal government, including Medicaid claims. It allows whistleblowers, called "relators," to file lawsuits on their own on behalf of the government, which is called a "*qui tam*" action. Relators receive a percentage of the recovery plus expenses.

The federal False Claims Act (FCA) (31 USC 3729 *et seq*.) imposes liability on any person who submits a claim to the federal government that he or she knows or should know is false. The penalty is not less than $5,000 and not more than $10,000, plus three times the amount of damages that the government sustains because of the person's act.

The FCA says that private whistleblowers, called "relators," may file a civil lawsuit on behalf of the United States government, known as a "*qui tam*" action. The government has the option of intervening in the action. Whether or not the government intervenes, the relator may share in a percentage of the proceeds from an award or settlement under the FCA. If the government proceeds with the action, it has the primary responsibility for prosecution and, with some exceptions, the *qui tam* relator receives between 15 percent and 25 percent of the proceeds depending on the extent to which the relator substantially contributed to the prosecution. If the government decides not to proceed, the whistleblower has the right to continue independently and receives between 25 percent and 30 percent of the proceeds, determined by the court. The relator also receives reasonable expenses plus attorneys' fees, to be paid for by the defendant.

The FCA provides protection to *qui tam* relators from being discharged, demoted, suspended, threatened, harassed, or discriminated against at their place of employment as a result of their action under the Act.

State False Claims Acts

The federal FCA has resulted in billions of dollars in federal Medicaid recoveries. The federal government has created an incentive for states to pass their own false claims acts.

Several billion dollars have been recovered in recent years for Medicaid at the federal level via the FCA (Moorman). The Deficit Reduction Act of 2005 provides a financial incentive for states to enact false claims acts that establish liability to the state for the submission of false or fraudulent claims to a state's Medicaid program. If a state has a false claims act that meets four federal requirements, the state is entitled to an increase of 10 percentage points in its share of any amounts recovered under a state action brought under such a law. The effective date was January 1, 2007 (P.L. 109-171, §6031; 42 USC 1396h).

To qualify for the federal incentive, a state FCA must
- establish liability for false or fraudulent claims against state Medicaid plans,
- contain *qui tam* provisions at least as effective as federal provisions,
- require the initial action be filed under seal with the Attorney General for review, and
- provide a civil penalty not less than that of federal law.

To qualify for the incentive, federal law requires that a state's false claims act must
- establish liability to the state for false or fraudulent claims described in the federal False Claims Act with respect to any expenditures related to state Medicaid plans described in section 1903(a) of the Social Security Act, which delineates how sums are to be appropriated to each state;
- contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in the federal FCA;
- contain a requirement for filing an action under seal for 60 days with review by the state attorney general; and
- contain a civil penalty that is not less than the amount of the civil penalty authorized under the federal FCA.

Nineteen states and the District of Columbia have FCAs. Thirteen states have applied for and eight have received certification for federal incentives.

Nineteen states and the District of Columbia have passed some form of false claims act (Taxpayers). Thirteen of these states have applied for Deficit Reduction Act certification from the federal government that their acts meet the requirements for the incentive. Eight state false claims acts have been certified, including Tennessee, Illinois, and Virginia (U.S. Dept. of Health. Office. "State").

Texas reported a return of about $10 for every $1 spent on state FCA cases.

Staff interviewed an official of the Texas Office of the Attorney General, who indicated that the office has recovered about $10 for every $1 spent on litigation under the Texas FCA. As of April 2007, the office had a backlog of 150 cases, with a new case arriving each week, and there was a plan to expand staffing from 9 attorneys to 37.

For Kentucky, the federal incentive would increase the state's share of recoveries from 30 percent to 40 percent. The incentive should more than make up for the requirement to reward the relator.

Kentucky must return to the federal government approximately 70 percent of any Medicaid-related recoveries and keep only 30 percent because federal funds pay about 70 percent of spending on Medicaid claims. If Kentucky had a false claims act, the federal government would receive only 60 percent of the recoveries for cases brought under the false claims acts. Kentucky's share would increase to 40 percent for those cases. The requirement to reward the relator might consume some of the federal incentive, but the incentive in most cases will more than cover this cost.

According to representatives of the Pharmaceutical Research and Manufacturers of America, an industry group, the relator's share for cases brought under a state FCA often amounts to 20 percent of the state funds recovered. In a case that recovered a total of $100, Kentucky's share with the federal incentive would be $40. The relator's share of that would be $8. Kentucky would recover $32. Without a state FCA, the Kentucky share would be $30 with no relator to pay. The difference with a state FCA is in Kentucky's favor but is far less than the federal incentive might suggest.

States without FCAs currently receive negotiated settlements in most federal FCA cases and do not pay the relator. With a state FCA, the settlement amount might be higher, and the federal incentive would offset the relator's share.

According to an official of the U.S. Department of Justice, the federal FCA technically does not create a means for states to recover their share of false claims (Anderson 20). This also means that the relator receives no reward for any state recoveries. Staff observed that most federal Medicaid FCA cases seem to include settlements for the states, negotiated by the National Association of Medicaid Fraud Control Units. Because these are negotiated settlements, it is possible that they do not cover the entire loss to the Medicaid program, even though there is no reward to the relator. If Kentucky had an FCA, it might be more likely to obtain a full recovery and, as pointed out above, the federal incentive would offset the relator's reward.

Officials with the Kentucky attorney general's Medicaid fraud control unit (MFCU) stated that they would ask the court in state FCA settlements to require the defendants to pay the relator's fee in addition to the recovery to the Medicaid program. If the judge agreed, the amount of the fee would be based on the amount recovered but would not come from the Medicaid recovery. This practice would not apply to cases that go to trial.

A state FCA can encourage reporting of smaller cases and allows the state attorney general to move forward more quickly on cases filed under both the state and federal FCA.

Potentially, a state FCA might encourage whistleblowers to come forward in smaller cases, particularly those that involve only Kentucky. Although a relator can file such a case under the federal FCA, the U.S. Department of Justice has such a backlog of cases that it might be years before it decides whether or not to intervene

in a local case. A state FCA would allow Kentucky to move forward more quickly and assist the federal case. An official with the Virginia Office of the Attorney General stated that the office has been overwhelmed with FCA cases and has hired additional staff. However, its FCA has provided the office with information on cases it otherwise would not have known about. In addition, a state can pursue a case that the federal prosecutors are not interested in.

Kentucky law, according to the MFCU, provides little opportunity to pursue fraudulent activity through civil lawsuits. A state FCA would provide a civil course of action for the office. Another advantage described by the MFCU is that a state FCA would give the MFCU access to the relator's evidence. Access to evidence in federal FCA cases is limited to the federal prosecutors.

It is possible that the state might not recover more than is spent to prosecute some smaller cases. However, the state has the option of turning down cases that do not appear profitable. Alternately, the state could choose to prosecute fraud regardless of the dollar amount in order to enforce the law and create a deterrent.

A 2006 Program Review and Investigations Committee report recommended that the Attorney General and Office of Inspector General evaluate the passage of a Kentucky FCA and report to the Program Review and Investigations Committee and other committees (Commonwealth. Legislative. Program. *Information* 96). They did not present such a report. House Bill 477 in the 2007 Regular Session of the General Assembly would have created a Kentucky FCA, but the bill did not pass. An official of the MFCU told staff that the federal Department of Health and Human Services conducted a preliminary review of House Bill 477 and indicated that it would have met the federal requirements for certification.

Staff now recommend that the General Assembly consider a false claims act after weighing information from the Office of the Attorney General and other interested parties.

Recommendation 1.1

Recommendation 1.1 is that the General Assembly, after receiving input from the attorney general and interested parties, may wish to consider passage of a state false claims act that qualifies for the federal incentive.

If it is the intent of the General Assembly to provide the most effective tools for recovering losses caused by Medicaid fraud, then after receiving input from the Office of the Attorney General and other interested parties, the General Assembly may wish to consider passage of a state false claims act that meets the requirements outlined in the Deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud.

Summary of Methods of Fraud and Abuse

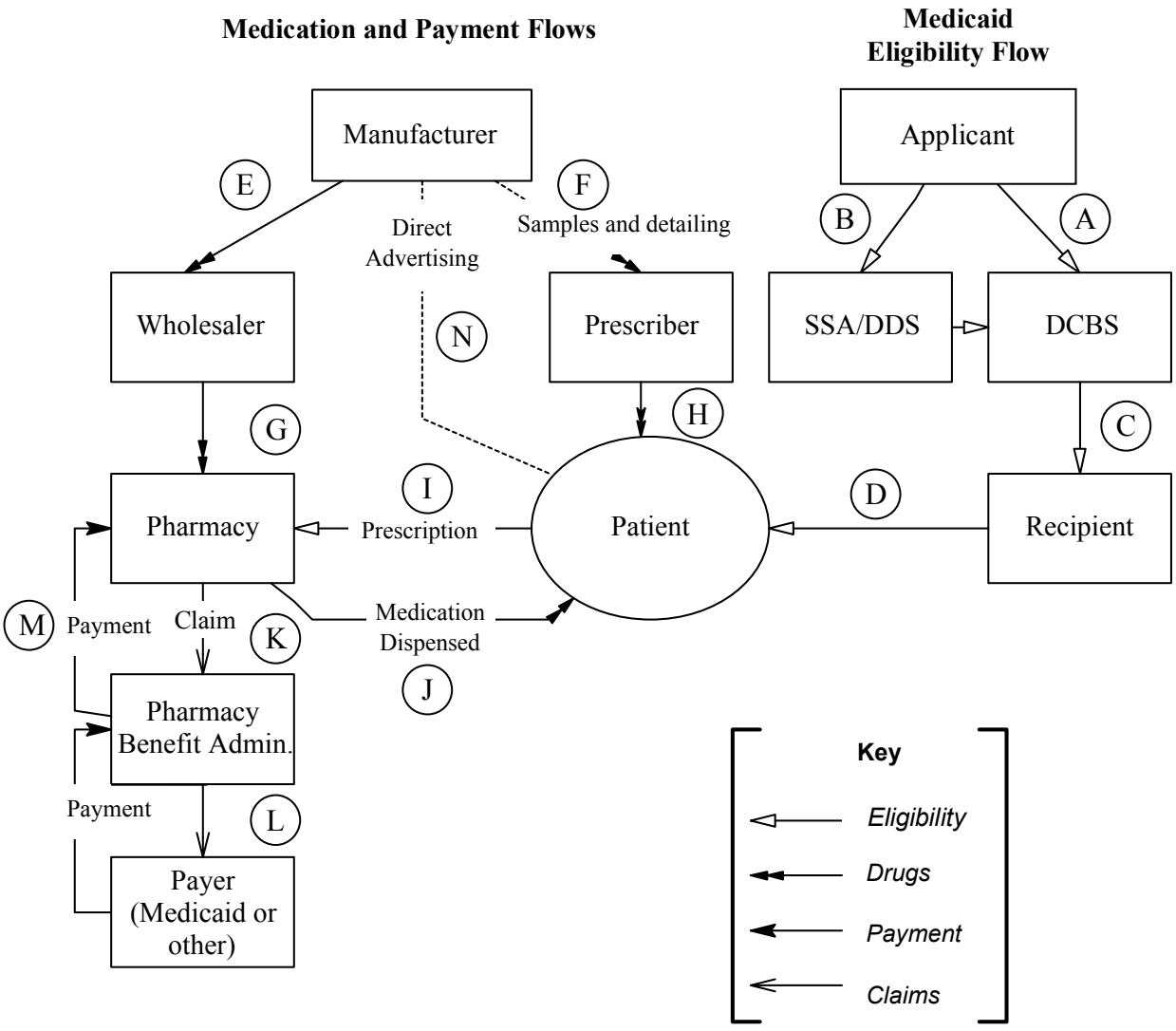
Three major areas are vulnerable to fraud and abuse: determining eligibility, providing the drugs, and paying for the drugs.

The three major processes that are vulnerable to prescription drug benefit fraud and abuse are

- determining eligibility,
- providing drugs to the recipient, and
- billing and receiving payment for those drugs.

Figure 1.C illustrates these processes. Connections between the parties and steps in the process are indicated by the circled letters A through N in the figure. The letters correspond to the letters used in the following tables. Table 1.1 lists the fraud and abuse types applicable to each party. Table 1.2 gives examples of fraud and abuse at each point in the process; Appendix B provides more examples of fraud and abuse.

Figure 1.C
Pharmaceutical Distribution, Eligibility, Prescribing, and Billing Processes



Note: SSA is the United States Social Security Administration. DDS is the Kentucky Department for Disability Determination Services. DCBS is the Kentucky Department for Community Based Services.
Circled letters A-N correspond to types of fraud and abuse described in Table 1.1 and Table 1.2.
Source: Compiled by Program Review staff from interviews and literature review.

Table 1.1
Fraud and Abuse Types by Party

Party	Eligibility	Benefit	Pricing, Marketing, Medication	Billing
Recipient	A, Ba	D, Ha, Ia, Ja		
Medical Provider	Bb	Hb		
Eligibility Worker	C			
Manufacturer			E, F, Ga, N	
Wholesaler			Gb	
Prescriber		Hc	Gc, Ib, Jb	
Pharmacy		Jc	Gd	K
Pharmacy Benefit Administrator				L, M

Note: Capital letters correspond to the labeled steps in the prescription drug process shown in Figure 1.C and to the sections of Table 1.2. Lower-case letters correspond to specific examples in Table 1.2. If a type of fraud and abuse is unlikely or inapplicable for a particular party, the space is blank.
Source: Compiled by Program Review staff from interviews and literature review.

Table 1.2
Examples of Fraud and Abuse Methods

A. Fraud: Falsifying information on application, intentionally withholding information about changes after being approved. Abuse: Accidentally providing incorrect or incomplete information at the time of application or later.

B. Eligibility related to disability
   a. Recipient—Fraud: Faking symptoms, using fake medical records, pressuring physician to document symptoms implying disability. Abuse: Insisting on medications or specific brands when not medically necessary.
   b. Medical provider—Fraud: Knowingly documenting false symptoms of disability; providing false medical records, including images and lab results. Abuse: Failing to exercise vigilance in verifying symptoms.

C. Fraud: Obtaining benefits for self or others by falsifying information on applications and circumventing system safeguards.

D. Fraud: Sharing Medicaid card with someone else, faking symptoms in order to obtain medications for someone else or for diversion, doctor shopping, other diversion methods.

E. Fraud: Various methods of hiding the true cost of medications from federal government.

F. Fraud: Illegal marketing schemes, misrepresenting or hiding effects of medication, kickbacks to prescribers. Abuse: Providing gifts, meals, and other incentives to prescribers; using information on their prescribing habits to target prescribers.

G. Drug supply fraud and abuse into the pharmacy:
   a. Manufacturer (typically a sales representative acting without knowledge of the manufacturer)—Fraud: Providing drug samples for repackaging and sale.
   b. Wholesaler—Fraud: Inserting counterfeit or black market (previously diverted or stolen) medications into the supply chain, hiding or misrepresenting true costs.
   c. Prescriber—Providing drug samples for repackaging and sale.
   d. Pharmacy—Obtaining sample, counterfeit, or black market medications for repackaging and sale.

H. Prescribing fraud and abuse: a. Recipient—Fraud: Doctor shopping, presenting false medical records, participating in diversion schemes with prescribers. Abuse: Refusing to accept medical advice and diagnosis, overemphasizing symptoms, insisting on medication for relief, insisting on brand-name medications. b. Medical provider (other than prescriber)—Fraud: Providing false medical records, including images and lab results, to the recipient. c. Prescriber—Fraud: Knowingly writing prescriptions for no medical purpose (pill mill), colluding with recipients or pharmacies in diversion schemes. Abuse: Outdated or ill-informed prescribing habits, acquiescing to prescribe unnecessary brand-name or other medications at a patient's request.
I. Presenting prescriptions: a. Recipient—Fraud: Altering or forging prescriptions for personal use (addiction) or for diversion, sharing Medicaid card with someone else or filling a prescription obtained for someone else by faking symptoms, failing to use or inform Medicaid of other insurance resources. b. Prescriber—Fraud: Referring the patient to a pharmacy in exchange for a kickback or in which the prescriber or family member has a financial interest.
J. Filling prescriptions: a. Recipient—Fraud: Using drugs for addiction or selling them to others. Abuse: Failing to follow prescription instructions, leading to additional medical costs. b. Prescriber—Fraud: Writing and presenting prescriptions for patients who were never seen. c. Pharmacy—Fraud: Knowingly filling an altered or forged prescription or any prescription intended for diversion.
K. Fraud: False claims based on forged prescription records, short-filling, substituting drugs, not reversing claims for abandoned prescriptions, many other methods. Abuse: Accidentally billing for the wrong drug or wrong amount, failing to maintain adequate documentation of prescriptions.
L. Fraud: Presenting false or altered claims to the payer client. Abuse: Erroneously presenting claims that could have been denied or corrected, erroneously calculating pharmacy reimbursement.
M. Fraud: Intentionally underpaying pharmacies for claims. Abuse: Erroneously underpaying pharmacies for claims.
N. Direct advertising to the consumer can create inappropriate demand and lead to unnecessary costs to the insurer; this might be considered a cost-management issue.

Source: Compiled by Program Review staff from interviews and literature review.

Prescription Drug Benefit Losses Caused by Fraud and Abuse Cannot Be Estimated

Some recipients and health care providers traditionally have committed fraud and abuse. Also, pricing and marketing fraud and abuse by manufacturers and distributors are relevant for the prescription drug benefit.

There are two primary ways that fraud and abuse affect the prescription drug benefit. Traditionally, some recipients and health care providers have committed health care fraud and abuse. For prescription drugs specifically, sometimes pharmaceutical manufacturers and distributors commit fraud and abuse in the pricing and marketing of drugs.

Recipient and Provider Fraud

There are no good estimates of prescription drug fraud, and it is not possible to know what fraud remains undiscovered. There are no estimates that divide the cost among recipients, providers, and manufacturers. Opinions of those in the field are contradictory.

Most experts speculate that the amount of recipient and provider fraud involved in health care systems in general is from 3 percent to 10 percent. Others think it could be higher. However, it seems likely that the figure for the prescription drug benefit would be different from health care generally. Many of the officials and experts interviewed for this report said that compared with the medical benefit, recipient prescription drug fraud might be more significant and prescription drug provider fraud might be less significant. Others disagreed. The only consensus was that estimating the amount of the loss is impossible. The difficulty is that no one knows the amount of fraud that remains undiscovered.

Similarly, there are no reliable estimates for the amount of fraud that can be attributed separately to recipient eligibility and benefit use, prescription drug diversion, and provider billing. Persons interviewed for their expertise in each area had diverse views. Some stated that there was very little fraud and others stated that there was significant fraud.

Based on Kentucky court records, it appears there is little prosecution of fraud related to eligibility, benefit use, and provider billing. By comparison, there is a great deal of prosecution of prescription drug diversion. However, it is impossible to estimate diversion's cost to Medicaid. Again, law enforcement and other officials interviewed had varying opinions on how much diversion might be billed to Medicaid and other insurers, but there was some agreement that most diverted prescription drugs are paid for with cash.

In the Program Review staff surveys, physicians and pharmacists expressed the opinion that recipient fraud and abuse is by far a more serious problem than fraud and abuse by providers, manufacturers, and others. It is unclear whether they meant serious in frequency or cost. Although there may be many more

perpetrators of recipient fraud and abuse, the actual cost to the Medicaid program in each instance is far less than that caused by a typical fraudulent provider.

Furthermore, it is not helpful to look at the amount of fraud identified by Medicaid and recovered through court or other means. Kentucky Medicaid has not conducted an aggressive or comprehensive program integrity process for many years. As a result, little fraud has been identified through the program integrity unit. Some fraud has been reported to Medicaid through hotline tips and other sources such as law enforcement investigations of other crimes; however, these sources probably represent a small portion of the fraud actually occurring.

Fraud in Pharmaceutical Distribution, Pricing, and Marketing

Fraud in the distribution of drugs could involve counterfeit medications and stolen or black-market drugs. Counterfeit drugs have not been reported in the U.S. Black-market drugs do not appear to have been a major problem in Kentucky. The federal drug pedigree program should reduce this threat by documenting the chain of custody of a drug product as it moves through the supply chain.

One area of possible fraud is the introduction of counterfeit drugs into the drug supply chain. To combat counterfeit drugs, recently the Food and Drug Administration introduced a drug pedigree system to document the chain of custody of a drug product as it moves through the supply chain. Staff found no evidence that counterfeit drugs have been introduced into the legitimate supply chain in the United States. However, there have been many instances of counterfeit drugs being supplied via illegitimate Internet pharmacies and in other parts of the world.

Stolen or diverted drugs can make it back into the drug supply chain via the black market. In some sense, the repackaging and dispensing of samples is a form of black-market activity. Black-market drugs can be dangerous because they often have not been kept in climate-controlled conditions or may have expired. It does not appear that black-market drugs are a significant problem for Kentucky. The drug pedigree program should help reduce the black market further.

Fraud and abuse in pharmaceutical pricing and marketing affect Medicaid nationally. Kentucky has joined many lawsuits with the federal and other state governments and has initiated a few cases on its own. It is not possible to know how much fraud in this area remains undiscovered.

Fraud and abuse in pharmaceutical pricing and marketing typically are issues that affect Medicaid nationally. Kentucky has joined in many lawsuits brought by states and the federal government against pharmaceutical manufacturers, even initiating a few. As a result of such lawsuits, pharmaceutical manufacturers have paid federal and state Medicaid programs billions of dollars in settlements and court awards. Kentucky's share is outlined in a later section of this chapter. Unfortunately, it is not possible to determine how much remains undiscovered.

Abuse and Agency Error

Abuse is a gray area between clearly fraudulent activities and innocent error. The agency also can make errors in billing. Total recoveries attributable to abuse and agency error may be much larger than those from fraud. It was not possible to determine an amount.

Abuse is a gray area between clearly fraudulent activities and innocent error. In addition, the claims processing system can make errors in favor of Medicaid or the provider. Program integrity is responsible for identifying and recovering overpayments and refunding underpayments attributable to abuse and agency error. The DMS and Office of Inspector General program integrity units have not proactively sought prescription claims abuse since 2003, so there is no track record on which to base an estimate.

Staff were unable to determine the likely portion of overpayments caused by abuse and agency error versus that caused by fraud. Because abuse often is unintentional, it seems likely that such overpayments occur more often than fraud. However, the dollar amount of billing fraud per case probably is far larger.

Return on Investment Combating Fraud and Abuse

For fraud and abuse that is discovered, many reports have shown a return of $3 to $15 for every $1 spent to identify, investigate, and prosecute the cases.

Although the amount lost because of fraud and abuse cannot be known, there are many instances in which efforts to combat fraud and abuse have been measured in terms of return on investment. In almost all cases, the return on a dollar spent has been from $3 to $15, with many, if not most, provider fraud efforts returning $10 for each dollar invested. Staff are unaware of any states that have reached a point of diminishing returns.

Value of Criminal Prosecution

In some cases, prosecution of criminal fraud might cost the state more than the restitution recovered. It can be argued that these criminal cases should be prosecuted anyway.

In addition to financial return on investment, true fraud is a criminal offense. The Office of the Attorney General is responsible for prosecuting Medicaid criminal fraud and, through the Kentucky Bureau of Investigation, may also prosecute recipients involved in prescription drug diversion. The Cabinet for Health and Family Services' Office of Inspector General seeks prosecution of recipient fraud cases that come to its attention.

It is possible that the total cost of prosecution in court exceeds the amount recovered for fraudulent Medicaid claims or benefits, at least in the smaller cases. However, there probably is a deterrent effect from ensuring that as many cases as possible are prosecuted, regardless of the immediate cost. Arguably, criminal fraud should be prosecuted even if there is a net loss to the state.

Kentucky Agencies Related to Medicaid Program Integrity

The Department for Medicaid Services is Kentucky's single state agency for administering Medicaid, but it enlists the assistance of other agencies and vendors.

Federal laws and regulations require that each state designate a single agency to operate the Medicaid program. The federal Centers for Medicare and Medicaid Services refers to this agency as the "single state agency," which is permitted to contract some of the tasks to other agencies or vendors.

In Kentucky, the Department for Medicaid Services is the single state agency. DMS has agreements with a number of other agencies and vendors to carry out its mission to administer the Medicaid program. Other agencies that are not contracted to Medicaid become involved in program integrity in the course of carrying out their duties. Table 1.3 shows how the many agencies and vendors are related to loss-prevention issues. Administrative agencies are those directly involved in the day-to-day operation of a Medicaid activity and may have a role in preventing and detecting losses. Enforcement agencies are the ones that attempt to detect and recover losses. Support agencies provide expertise and software tools to assist other agencies in preventing, detecting, and recovering losses.

Table 1.3
State Agencies and Contractors Involved in the Medicaid Prescription Drug Benefit

	Type of Activity (Letter References to Steps in Figure 1.C)					
Agency or Contractor **(ADM=Administrative role, ENF=Enforcement role, SPT=Support role)**	**Prescription Drug Pricing and Marketing Fraud (E, F, G, I, J, N)**	**Eligibility Fraud and Abuse (A, B, C)**	**Benefit Fraud and Abuse (D, H, I, J)**	**Prescription Drug Diversion (D, H, I, J)**	**Billing Fraud and Abuse (K, L, M)**	**Cost Management**
Cabinet for Health and Family Services						
Department for Community Based Services						
• Division of Family Support*		ADM				
• Division of Protection and Permanency		ADM				
Department for Disability Determination Services		ADM				
Department for Medicaid Services			ADM	ADM	ADM	ADM
• Drug Use Review Board (Drug Management Review Advisory Board)			ADM	ADM	ADM	ADM
• Eligibility Policy Branch		ENF				
• Pharmacy and Therapeutics Committee			ADM	ADM	ADM	ADM
Office of Contract Oversight	ENF					ADM
Office of Human Resource Management		ENF				
Office of Inspector General						
• Division of Fraud, Waste and Abuse/Identification and Prevention*			ENF	ENF	ENF	
• Drug Enforcement and Professional Practices Branch				ENF		
• Division of Special Investigations*		ENF	ENF	ENF	ENF	
Office of Ombudsman's Quality Control Branch*		ENF				
Office of the Attorney General						
• Kentucky Bureau of Investigation				ENF		
• Medicaid Fraud and Abuse Control Division†	ENF				ENF	
Office of Drug Control Policy				SPT		
Law enforcement				ENF		
Licensing boards				ENF	ENF	SPT
Electronic Data Systems*						
• performing lock-in review			SPT	SPT		
• performing surveillance and utilization review services			SPT	SPT	SPT	
• SHPS (subcontractor in Louisville)						SPT
First Health Services Corporation*						
• as Medicaid Administrative Agent					SPT	SPT
• as Pharmacy Benefit Administrator			ADM	ADM	ADM	ADM
• as operator of National Medicaid Pooling Initiative						ADM

Note: *agencies or contractors with agreements with the Kentucky Department for Medicaid Services; †agency contracting with the federal government and coordinating with the Kentucky Department for Medicaid Services.
Source: Compiled by Program Review staff from agency information.

Medicaid Program Integrity

Program integrity encompasses all types of overpayments—fraud, abuse, agency error—from all sources. The Department for Medicaid Services (DMS) is the single agency responsible for program integrity. DMS coordinates with the Office of the Attorney General's independent Medicaid fraud control unit.

The program integrity function comprises activities that detect all types of overpayments. These overpayments may be caused by fraud, abuse, or agency error in recipient eligibility and benefit use and in provider service provision and claim submission. In addition, CMS appears to consider the pricing of prescription drugs by manufacturers as part of Medicaid program integrity (U.S. Dept. of Health. Centers. Center. Medicaid. *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FY 2006* 14).

As the federally required single Kentucky agency administering Medicaid, DMS is responsible for all Medicaid activities, including program integrity. DMS has entered into contracts with vendors and memoranda of agreement with other state agencies to conduct the program integrity function. The sole exception is that the Office of the Attorney General's Medicaid fraud control unit operates under a direct federal contract but has a memorandum with DMS to establish their relationship.

Four areas of the program integrity function are discussed below: Medicaid recipient eligibility, Medicaid recipient benefit use, Medicaid provider billing, and pharmaceutical manufacturer pricing and marketing.

Eligibility of Medicaid Recipients

The Department for Community Based Services and the Ombudsman's Quality Control Branch perform eligibility program integrity for DMS.

DMS has a memorandum of agreement with the Department for Community Based Services (DCBS) to perform Medicaid eligibility determinations. One goal of the process is to screen out applicants who present inaccurate or false information on their applications.

DCBS has an internal process by which some applications are reviewed by supervisors to ensure they were handled properly. In addition, the Department for Medicaid Services contracts with the Quality Control Branch of the Cabinet for Health and Family Services' Office of the Ombudsman to conduct quality reviews of a targeted sample of cases.

The Department for Disability Determination Services is independent of Medicaid, but its decisions affect Medicaid eligibility.

The Department for Disability Determination Services carries out the disability determination process by which some Kentuckians become eligible for Medicaid. The department also performs some program integrity functions. The Social Security Administration funds and monitors disability determinations. The process,

therefore, is independent of the federal and state Medicaid programs.

Use of Benefits by Medicaid Recipients

Recipient drug misuse and overuse are handled by the Cabinet for Health and Family Services' Office of Inspector General (OIG), which conducts surveillance and review.

For many years, the DMS program integrity unit used the surveillance and utilization review subsystem of the Medicaid Management Information System to help identify recipients who may be overusing or misusing Medicaid services. DMS used information from the Medicaid fraud hotline and other sources when it reviewed the cases and determined what action to take.

In 2004, DMS moved its program integrity unit to the Cabinet for Health and Family Services' Office of Inspector General (OIG) under a memorandum of agreement. Since then, OIG has continued the review of recipient surveillance and utilization and fraud referrals.

The Medicaid pharmacy benefit administrator has systems in place that prevent many fraudulent and abusive prescription claims from being paid.

Medicaid Provider Billing

The Office of the Attorney General handles most provider criminal cases. OIG is responsible for identifying provider overpayments, referring criminal cases to the attorney general, and pursuing recovery in other cases.

Medicaid providers are medical clinics, hospitals, pharmacies, and other entities that provide services to Medicaid recipients. Provider program integrity is divided between criminal and administrative activity. The Office of the Attorney General's Medicaid Fraud and Abuse Control Division handles most criminal investigations and prosecutions. The DMS program integrity unit, which moved in 2004 to OIG, is responsible for identifying fraud, abuse, and other overpayments; referring criminal cases to the attorney general; and pursuing recovery of overpayments in other cases.

DMS and OIG have performed minimal provider fraud detection for many years. They have focused on provider abuse and agency errors.

Although DMS and OIG have hired vendors to assist them in collecting overpayments from providers, both program integrity units have performed only minimal fraud detection for many years. The vendors have focused on identifying provider abuse. The program integrity units also have identified agency errors and other kinds of overpayments.

The Medicaid PBA has systems in place that can prevent payment of claims in some of the more common instances of provider fraud and abuse.

Pricing and Marketing by Pharmaceutical Manufacturers

Pharmaceutical manufacturer fraud and abuse may offer the greatest potential recoveries. The Office of the Attorney General is responsible for monitoring and pursuing these cases.

Perhaps the largest single area of potential recovery for program integrity is fraud and abuse by pharmaceutical manufacturers in the pricing and marketing of prescription drugs. Most such recoveries are the result of settlements and court judgments in federal lawsuits called "global cases." States typically receive a portion of the recovered funds. States also may file such lawsuits on their own and may join other states in their lawsuits. For example, in October 2007, the Kentucky Attorney General filed a lawsuit against Purdue Pharma to recover damages related to inappropriate marketing of Oxycontin. At about the same time, Iowa filed a pricing lawsuit against 79 manufacturers (InvesTrend Research).

In Kentucky, the Office of the Attorney General's Medicaid Fraud and Abuse Control Division is responsible for monitoring lawsuits against pharmaceutical manufacturers and determining when to initiate or join lawsuits.

Fraud and Abuse in Pricing and Marketing by Drug Manufacturers

Billions of dollars have been recovered nationally in pharmaceutical manufacturer fraud and abuse cases. Kentucky has shared in many of the recoveries. Most manufacturers have maintained their innocence in the settlements.

This section describes some of the ways the prescription drug sector is vulnerable to fraud and abuse and what has been done to combat it. When fraud and abuse occur in pricing and marketing, the effects usually are nationwide and substantial. Nationally, recoveries from drug manufacturers in the past few years have been in the billions of dollars. Kentucky Medicaid has shared in many of these cases. Few of the drug manufacturers in these cases have acknowledged guilt. Most have settled the cases while maintaining innocence.

Vulnerabilities in the Medicaid drug rebate process have been exploited.

The federal Medicaid drug rebate program requires a drug manufacturer to have a national rebate agreement with the U.S. Department of Health and Human Services in order to be reimbursed by Medicaid prescription drug plans. The program also authorizes the states to enter into supplemental rebate agreements with manufacturers. These programs are intended to allow Medicaid to negotiate prices similar to those of other customers. However, there are vulnerabilities in the negotiation system that have been exploited by drug manufacturers to charge Medicaid more than some other customers.

Allegations of pricing fraud include hiding best-price discounts, reporting false average wholesale and other prices, and providing kickbacks for favorable treatment.

One of the requirements is that drug manufacturers report their "best price": the lowest price at which they sell drugs to any customer. Manufacturers identified a potential loophole in the law called the "nominal price exclusion." The intent of the law was to protect charities, nonprofit clinics, and other organizations that receive highly discounted drugs. If those prices were reported as the best price, the manufacturers might have to stop providing the discounts. However, the law was vague, and the Centers for Medicare and Medicaid Services adopted a rule of thumb that any price less than 10 percent of the average price that manufacturers charge wholesalers would be considered nominal. Some manufacturers began to offer 90 percent discounts to large customers without reporting them as the best price. The law has been changed to clarify the entities that can receive drugs at a nominal price.

Pricing information also enters into the amount Medicaid reimburses pharmacies. State Medicaid programs attempt to set reimbursement rates by determining the amount pharmacies pay for medications. Most states use an industry figure called the average wholesale price. Many lawsuits have been filed alleging that manufacturers inflate this price and that it does not represent the true average wholesale price.

In some cases, drug manufacturers have attempted to influence price negotiations by providing kickbacks to pharmacy benefit administrators or other purchasers.

Drug manufacturing fraud—placing less than the labeled amount into the medication or using an unapproved process—was found in at least one case.

It is possible for drug manufacturers to reduce their costs by putting less than the labeled amount of active ingredient into the medication or using unapproved manufacturing processes to cut costs. In at least one case, a drug manufacturer was found guilty of the latter crime.

Influence by drug manufacturer sales representatives has been criticized as inappropriate and sometimes illegal. Purdue Pharma pleaded guilty to providing false or misleading information about Oxycontin.

Drug manufacturers also attempt to gain market share by influencing prescribers, primarily physicians. Drug representatives known as "detailers" visit prescribers and offer information about the drugs they promote. Drug manufacturers also hire speakers to make presentations about treating diseases related to the drugs they manufacture. In both cases, the information is supposed to be scientific and unbiased. Some manufacturers have been found guilty of providing false or misleading information, most notably Purdue Pharma in its marketing of Oxycontin.

Drug manufacturers also have been accused of offering meals, free medical education credits, travel, and other enticements to prescribers. In some cases, they have provided kickbacks and similar incentives to prescribers.

Drugs are approved by the Food and Drug Administration for specific uses. Any other use is called "off label." Prescribers have the authority to prescribe a drug for any purpose, but it is illegal for a drug manufacturer to promote a drug for off-label use.[3] Some drug manufacturers have violated this rule.

Direct-to-consumer marketing can create pressure to prescribe drugs that otherwise might not be prescribed.

Direct-to-consumer advertising might have an impact on what is prescribed. When a patient comes to the prescriber with a specific drug in mind, the prescriber faces the choice of offending the patient or going along with the request—assuming the drug is at least not harmful and will address a medical condition of the patient.

Appendix B presents a more detailed list of drug manufacturer fraud and abuse methods.

Combating Fraud and Abuse by Drug Manufacturers

Most pricing and marketing fraud is discovered through whistleblowers. State Medicaid fraud control units, through their national association, coordinate state claims in federal cases.

Because most pricing and marketing fraud affects the Medicaid program nationally, the federal government has taken the lead in prosecuting and obtaining restitution in these cases. There are no obvious ways to detect pricing and marketing fraud, so most of the cases are discovered through whistleblowers who file cases under the federal False Claims Act.

At the state level, the Medicaid fraud control units are responsible for joining or initiating lawsuits. The National Association of Medicaid Fraud Control Units coordinates the interests of state MFCUs in most federal cases. The association coordinates the claims of the states and the distribution of restitution to them. Some states have their own false claims acts, and whistleblowers can file cases under both state and federal laws.

States can file lawsuits on their own. Kentucky's Office of the Attorney General has four active cases involving drug manufacturers.

States also are free to file lawsuits on their own. The Kentucky Office of the Attorney General has four active lawsuits against drug manufacturers. The grounds for these lawsuits are that the citizens of Kentucky as a whole were damaged either by paying inflated prices or by using drugs off label as a result of illegal

[3] From 1997 through September 2006, it was permissible for a drug manufacturer under certain conditions to provide physicians with reprints of peer-reviewed medical articles about off-label uses for their medications.

marketing practices. The grounds include the Medicaid program's additional expenses, even though in three of the cases there are active federal False Claims Act cases as well. In the fourth case, the Attorney General decided that Kentucky's share of the federal Purdue Pharma case on the marketing of Oxycontin was not adequate and filed a separate lawsuit.

From 2002 to 2006, Kentucky recovered $9.7 million in state Medicaid funds.

From 2002 through 2006, Kentucky's MFCU participated in 12 national settlements, and the Office of the Attorney General also recovered Medicaid funds in a consumer protection case. From these cases, Kentucky recovered about $28 million, of which $9.7 million was returned to the state. The remainder was the federal share. Table 1.4 provides examples of recent major settlements from which Kentucky received monetary recoveries.

Table 1.4
Examples of Kentucky's Share of Recent National Pharmaceutical Settlements

Date Case Closed	Kentucky Settlement Amount	State Share	Circumstances of Case
12/31/2003	$2,818,221	$945,186	GlaxoSmithKline sold the drugs Paxil and Flonase to large HMOs at deeply discounted prices then failed to report the sales to the federal government under the Medicaid rebate law. Under this law, pharmaceutical companies must disclose the best price offered to a commercial buyer.
1/12/2004	$7,034,464	$2,383,191	Bayer failed to report discounts offered under its private labeling program for the drug Cipro in violation of the Medicaid rebate law. Under this law, pharmaceutical companies must disclose the best price offered to a commercial buyer.
3/24/2006	$3,023,059	$971,056	King Pharmaceuticals failed to report accurate average manufacturer prices and best prices used to calculate rebate payments to states and to determine ceiling payments for drugs purchased under certain state and federal programs.
12/19/2006	$3,710,226	$1,068,287	Omnicare Corporation allegedly switched dosage forms of the drug Zantac (tablets for capsules) for nursing home patients to avoid federal price limitations.

Note: The state share was the amount returned to Kentucky after the federal share was repaid.
Source: Compiled by Program Review staff from information provided by the Office of the Attorney General.

Drug manufacturer fraud and abuse may be declining in response to the intense litigation in federal and state courts. It is likely that many millions of dollars of potential recoveries remain.

Drug manufacturer fraud and abuse may be declining in response to the intense litigation in federal and state courts. However, it remains likely that many millions of dollars of potential recoveries remain. These lawsuits provide perhaps the greatest return on investment of any program integrity activity.

General Findings

This section describes some general findings about Kentucky Medicaid and its program integrity function that do not fall under the subject area of other chapters. Some of these findings are not specific to the prescription drug benefit, while others broadly cover 8program integrity rather than specific types of fraud and abuse.

Plan To Participate in Medicare-Medicaid Data Sharing Is Commendable

Kentucky's effort to join the Medicare-Medicaid data sharing project is commendable.

Kentucky has requested and obtained permission to be one of the next states in the federal "Medi-Medi" project to share data between Medicare and the state Medicaid programs. The Medi-Medi program has been implemented in 10 other states so far and has shown promise for identifying significant new cases of fraud (Wachino 13). Staff commend DMS and OIG for their leadership on this initiative.

Documentation of Medicaid Prescription Drug Policies and Procedures Is Inadequate

The basic rules for the prescription drug benefit are in legal documents and manuals, but Program Review staff found little evidence of policy and procedure documentation at DMS. Policies and procedures appear to be passed along verbally rather than in written form. DMS staff turnover has made it difficult for new employees to become effective.

Many of the rules guiding the prescription drug benefit reside in federal and state laws and regulations. In addition, the PBA maintains a provider manual and preferred drug list. Other sources of information about how the program should operate are the state Medicaid plan (the document submitted to CMS) and vendor contracts.

Staff found that little documentation was available that centrally indexed the rules of the program and described the procedures for regular operation of the program. The current interim and former prescription drug benefit directors confirmed that program procedures are difficult to find and sometimes are not documented. Much of the knowledge of the program appears to reside with individuals rather than in documents. Departmental staff turnover has led to a loss of institutional memory and has made it difficult for new employees to become effective.

As one example, staff attempted to learn how Kentucky meets the federal requirement for a drug use review board. Not only were no current cabinet officials aware of such a board when interviewed, officials were unable to identify any documentation of policies and procedures related to the board and the submission of annual drug use review reports to CMS.

DMS documentation seems disorganized and inadequate compared to Passport Health Plans' comprehensive policy and procedure process.

In contrast, the annual quality review of Passport Health Plans described a comprehensive process for maintaining its policy and procedure documentation. Passport is responsible for Medicaid services in the Kentucky Medicaid managed care region. The review noted that Passport had some lapses in maintaining documentation, but there was a centralized system for tracking updates to them. Interviews with individuals familiar with both DMS and Passport documentation indicated that DMS documentation is disorganized and inadequate by comparison.

DMS officials pointed out that the process of self-assessment for the new Medicaid Information Technology Architecture (MITA) began on November 1, 2007. MITA is a federal initiative intended to ensure that all states follow a compatible model for using information technology in Medicaid systems. The self-assessment requires the states to develop complete documentation of their business processes and the technology used if any. Future phases include developing a Medicaid-wide technology plan and implementing progressively more advanced technology tools to manage Medicaid.

DMS officials pointed to a self-assessment process required by Centers for Medicare and Medicaid Services (CMS) that should result in improve documentation. DMS should ensure that such documentation occurs and is maintained, both for DMS and for all vendors.

To the extent that MITA requires documentation of policies and procedures, both manual and automated, MITA may resolve the documentation issue at DMS. MITA also should include DMS vendors and their processes. Even if MITA does not require a comprehensive documentation of policies and procedures, DMS should take steps to ensure such documentation exists and is maintained.

Similarly, it is important that all vendors of DMS have complete and current documentation of their policies and procedures. DMS contracts with other state government agencies and private companies. Major DMS vendors are listed earlier in this chapter.

Recommendation 1.2

Recommendation 1.2 is that DMS should ensure that policies and procedures are documented adequately and should work with all vendors, governmental and private, to ensure they also maintain adequate documentation.

The Department for Medicaid Services should develop a process to ensure that the documentation of policies and procedures is comprehensive and kept up to date. The department should work with all vendors, both governmental and private, to ensure that they also maintain comprehensive and up-to-date documentation of their policies and procedures.

Medicaid Staffing May Be Inadequate

DMS staffing appears to be inadequate. One person directs the prescription drug program, and support for the director seems limited.

In addition to having incomplete written procedures, DMS has assigned one director to manage the prescription drug benefit. That person can call on policy staff, finance staff, information technology staff, and vendor staff for support but has no direct staff. A previous director expressed the opinion that a full-time assistant would make the job more manageable, although one person might be able to handle the job with adequate support from the vendor and DMS as a whole. The current interim director expressed the opinion that one person could handle the job if the procedures are thoroughly documented and the information systems are stabilized.

Program Review staff question whether DMS can provide adequate support to the prescription drug benefit director with the current level of Medicaid staffing overall. Staff noted the following points that suggest staffing issues: DMS

- was unable to find required federal drug use review reports;
- was unable to answer policy and procedure questions from staff in a timely manner, and several remain unanswered;
- has used the PBA's self-report of performance without an independent evaluation;
- was unable to provide definitive information on the amount of supplemental rebates received prior to the PBA contract;
- was unable to locate a document from the PBA that proposed a solution to the technical difficulty of identifying providers in the PBA system;
- provided PBA invoices and other financial information only after considerable delay, up to 6 months for some information; and
- has not kept the state Medicaid plan, required by CMS, fully up to date.[4]

Staff turnover and several major projects have contributed to the burden on DMS staff. Hiring a vendor to coordinate other vendors, while reasonable, illustrates the staffing difficulties at DMS.

Some of the difficulty may have been attributable to staff turnover and to the significant extra work load required to bring in and implement three new vendors: the fiscal agent, the Medicaid administrative agent, and the pharmacy benefit administrator.[5] The new Medicaid Management Information System, the main project of the new fiscal agent, has required a great deal of input from DMS and OIG staff and remains unfinished. Coordination among the three vendors has been difficult, and DMS recently hired a

[4] For instance, §4.26, Drug Utilization Review Program, was last updated in 1993 and fails to indicate that Kentucky uses an electronic point-of-sale system.
[5] The fiscal agent is Electronic Data Systems. The administrative agent and PBA are different entities within First Health Services Corporation.

fourth vendor to provide this coordination as the Kentucky Medicaid Operation Support Services provider.[6] Staff found this to be a reasonable decision.

Demands on DMS staff will not cease after the major projects are completed.

The creation of Kentucky Medicaid Operation Support Services does not address the long-term staffing issue because it appears to be implementation-related and not intended as an ongoing management activity. The new MITA process will require a continuous commitment to documenting and refining all the procedures used in DMS. The MITA assessment process alone will require additional staff resources. However, MITA should help develop departmental performance assessment procedures and identify areas that need additional staffing.

OIG faces significant staffing challenges in the next year. A new program integrity vendor and CMS audits may greatly increase the workload. Passage of a state false claims act also would add work.

Office of Inspector General. Several anticipated events are likely to place significant additional burdens on OIG in its roles of identifying, investigating, and recovering funds overpaid because of fraud, abuse, and agency error.

- OIG plans to procure a vendor to initiate a comprehensive, modern Medicaid program integrity function and to train OIG staff to perform this function. A comprehensive program integrity function probably will result in a significant increase in the number of cases requiring investigation and recovery.
- CMS has initiated the Medicaid Payment Error Rate Measurement Program. Based on comments by the states and CMS, it appears likely that audits performed under this program will identify additional cases that OIG will have to handle.
- CMS has initiated a Medicaid Integrity Program that includes audits of state Medicaid claims. Based on comments by the states and CMS, it appears likely that this program will identify additional cases that OIG will have to handle.
- If the General Assembly were to pass a false claims act, the OIG probably would receive requests to provide evidence in the resulting cases.

The same factors facing OIG also have the potential to greatly increase the workload of the Office of the Attorney General.

Office of the Attorney General. The attorney general probably will experience additional demands based on all the events identified above for the OIG. Any provider fraud or recipient drug diversion cases arising from improved program integrity or CMS initiatives would add to the attorney general's caseload.

The passage of a false claims act probably would place greater demands on the Office of the Attorney General than on OIG. It would be the responsibility of the office to determine whether to

[6] The operation support services provider is Accenture.

intervene in false claims cases and to investigate and prosecute those in which it intervenes.

Medicaid program integrity nationwide is underfunded, according to a CMS advisory committee.

Comments From Other States. The CMS Medicaid Integrity Program Advisory Committee consists of state representatives. In 2007, the committee requested that CMS adopt a goal of "[a]ssisting States in getting additional State funding. Every State lacks resources (e.g., staffing, technology, training)…" (U.S. Dept. of Health. Centers. Center. Medicaid. *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FY 2007* 17)

Recommendation 1.3

Recommendation 1.3 is that DMS should develop and maintain an adequate staffing resource plan. To the extent possible, all vendors, governmental and private, should do the same. The cabinet should present an adequate staffing plan in its budget proposals.

The Department for Medicaid Services should ensure that an adequate staffing resource plan is developed and maintained. To the extent possible, such planning also should be implemented by the department's vendors, both governmental and private. The Cabinet for Health and Family Services should present an adequate staffing plan in its budget proposals to the governor and the General Assembly.

Pharmacy Benefit Administrator Is Underused for Combating Fraud and Abuse

The pharmacy benefit administrator (PBA) has tools, expertise, and an unenforced contractual requirement to perform program integrity tasks. The PBA has claims processing rules and has implemented benefit changes that should reduce the opportunity for fraud and abuse at the front end..

First Health Services Corporation has been Kentucky Medicaid's PBA since December 2004. Staff reviewed the PBA role in preventing and detecting fraud and abuse.

Prevention of Fraud and Abuse. Using effective claims processing rules to identify and deny fraudulent and abusive claims is a cornerstone of program integrity. These rules operate in conjunction with the preferred drug list and the prior authorization process. PBA officials explained some of the rules that stymie some common schemes. The rules prevent payment for duplicate claims, claims for similar drugs, claims for unusually high dosages, and several other claims situations.

Similarly, some of the benefit changes since 2004 were in line with First Health's advice and probably reduced the opportunity for fraud and abuse. For instance, reducing the number of prescriptions and the number of brand-name prescriptions that Medicaid will cover without prior authorization reduced the opportunity for fraud and abuse.

Fraud and abuse detection programs also provide information that could be useful for prevention. Such reviews have not been done.

Another source of prevention is feedback from fraud and abuse detection programs. Such programs can suggest ways to prevent fraud and abuse that they discover. As described earlier, the Office of Inspector General's surveillance and utilization review program has not conducted a prescription fraud and abuse detection program in several years and therefore has not provided feedback to First Health. First Health itself has experience with other state Medicaid programs and may suggest changes based on that experience. However, First Health has not conducted a fraud and abuse detection program specific to Kentucky. When one or both of these programs is in place, there should be an effort to adjust claims processing rules based on fraud and abuse detection.

Effectiveness of First Health's Claims Processing System. The Program Review staff's survey of pharmacists asked them to rate the effectiveness of First Health's Medicaid point-of-sale system at preventing Medicaid recipient drug diversion, Medicaid card sharing, errors in claims submission, and fraudulent or abusive claims submission.[7] The results are shown in Table 1.5. These percentages only include pharmacists whose primary payer is KyHealth Choices, not Passport Health Plan.

Table 1.5
Effectiveness of the First Health Claims Processing System
at Preventing Fraud and Abuse as Reported by Surveyed Kentucky Pharmacists

Aspect of Prevention	Somewhat or Very Effective	Neither Effective nor Ineffective	Somewhat Ineffective or Not Effective
Medicaid Recipient Drug Diversion	40%	21%	39%
Medicaid Recipient Card Sharing	41%	28%	31%
Errors in Claims Submission	56%	22%	22%
Fraudulent or Abusive Claims Submission	46%	28%	26%

Note: These percentages only include pharmacists whose primary payer is KyHealth Choices, not Passport Health Plan. The number of respondents ranged from 420 to 423.
Source: Program Review staff analysis of Kentucky physician and pharmacist surveys.

In the opinion of pharmacists surveyed, the PBA claims system is most effective at preventing erroneous claims and less effective at preventing fraud.

First Health's point-of-sale system received its highest approval rating from pharmacists for preventing erroneous claims, which is the system's main task. It received the lowest approval ratings in the areas of preventing Medicaid recipient drug diversion and card sharing, suggesting an opportunity for improvement. It is not clear

[7] Nine percent of physicians and 16.5 percent of pharmacists who were sent questionnaires responded. Because of the low response rates, results should be interpreted as representing only those who completed questionnaires, not Kentucky physicians and pharmacists in general.

why pharmacists were split in their opinions on recipient fraud prevention.

Effectiveness of First Health's Prior Authorization Process. The Program Review staff survey of pharmacists also asked them to rate the effectiveness of First Health's prior authorization process at preventing Medicaid recipient drug diversion and Medicaid card sharing, as well as preventing unnecessary use of brand-name or nonpreferred drugs. The results are shown in Table 1.6. These percentages only include pharmacists whose primary payer is KyHealth Choices, not Passport Health Plan.

Table 1.6
Effectiveness of the First Health Prior Authorization Process at Preventing Fraud and Abuse as Reported by Surveyed Kentucky Pharmacists

Aspect of Prevention	Somewhat or Very Effective	Neither Effective nor Ineffective	Somewhat Ineffective or Not Effective
Medicaid Recipient Drug Diversion	36%	22%	42%
Medicaid Recipient Card Sharing	41%	27%	32%
Unnecessary Use of Brand-name or Nonpreferred Drugs	57%	13%	30%

Note: These percentages only include pharmacists whose primary payer is KyHealth Choices, not Passport Health Plan. The number of respondents ranged from 423 to 428.
Source: Program Review staff analysis of Kentucky physician and pharmacist surveys.

In the opinion of pharmacists surveyed, the PBA prior authorization process is most effective at managing the use of brand-name or nonpreferred drugs and less effective at preventing fraud.

First Health's prior authorization process received its highest approval rating from pharmacists for preventing the unnecessary use of brand-name or nonpreferred drugs, which is the process's primary task. It received lower ratings for preventing Medicaid recipients' drug diversion and card sharing, similar to the ratings that First Health's point-of-sale system received on the same measures. It is not clear why pharmacists were split in their opinions on all these matters.

Practically all prescription drug benefit plans, including Medicaid, use a point-of-sale system that tells the pharmacy within minutes whether the claim will be paid. The lack of time for review with such systems makes it difficult to do concurrent detection, which is detecting fraud and abuse before the claim is paid.

Concurrent Detection of Fraud and Abuse. A 2006 Program Review and Investigations Committee report pointed out an issue with immediate adjudication of claims. Practically all prescription drug benefit plans, including Medicaid, use a point-of-sale system that tells the pharmacy within minutes whether the claim will be paid. Traditionally, medical claims have been handled on a time-delay basis that allowed human reviewers a chance to look at claims before promising payment. The report recommended that Kentucky Medicaid do as much as possible to detect and prevent improper payments (Commonwealth. Legislative. Program.

Information 52-53). Detecting fraud and abuse before paying the claim is called "concurrent detection."

Program Review staff saw a presentation about a prepayment review system for medical claims. In this system, all claims are assigned a fraud suspicion score. Claims with the highest scores are set aside for manual review. The insurer's analysts review these suspended claims within 24 hours and determine whether they should be paid. Using this system, the insurer estimated that each full-time analyst could save about $500,000 per year in fraud and overpayment avoidance. The number of analysts required to reach a point of diminishing return depends on the total number of claims handled by the insurer.

No concurrent detection systems are in use in prescription point-of-sale systems, but DMS specified a similar process in the request for proposals for a program integrity vendor. Staff encourage DMS to pursue concurrent detection with the prescription point-of-sale system and the medical claims system.

Such concurrent fraud and abuse detection systems are not in use yet for prescription claims. However, methods could be developed to assign a fraud suspicion score to each prescription claim and to reverse true fraud and overpayments before issuing the check. According to vendors who sell such systems, a procedure could be designed that would review many of the suspect claims before the patient returns to pick up the prescription.

In its request for proposals for a program integrity vendor, DMS specified a prepayment review activity. Staff encourage the department to pursue such a process for both medical providers and pharmacies. Following up on the 2006 recommendation, staff now recommend that DMS actively explore ways to incorporate concurrent fraud and abuse detection into the prescription claims processing system and more generally into the medical claims processing system.

The PBA contract includes a section specifying fraud and abuse activities. DMS has never enforced this provision.

Retrospective Detection of Fraud and Abuse. A review of procurement and contract documents shows that DMS did not include fraud and abuse detection and prevention services in the PBA request for proposals. However, First Health proposed to perform fraud and abuse detection, and the department did include some requirements in the contract. Section E.18.1 of the contract states:

> The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

> The Contractor shall provide monthly reports to DMS that describe pharmacy provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns. Additionally, the Contractor will provide specific recommendations to DMS, via a plan of correction that will eliminate the potentially fraudulent, abusive or wasteful dispensing patterns of these specific pharmacy providers.

Staff interviews with DMS and First Health staff indicated that the department never asked First Health to conduct a comprehensive fraud and abuse detection program and that First Health has not done so. The only known request is a single report that ranks pharmacies according to two measures that might be related to fraud and abuse. Such a report does not represent an adequate fraud and abuse detection program.

In addition to the contract provisions, First Health proposed to perform recipient and provider profiling in order to identify suspicious prescription drug usage, prescribing, and billing patterns. The proposal describes a typical program integrity data mining operation focused on the prescription drug benefit.

Kentucky and other states have struggled to identify the prescriber on prescription claims. That difficulty has limited the ability of the PBA and OIG to look for fraud and abuse and to conduct an important review activity.

Identifying the Prescriber on Claims. In order to conduct a prescription fraud and abuse data mining operation fully, it is necessary to know the prescriber as well as the recipient and the pharmacy. In Kentucky and other states, there is no reliable way to identify the prescriber. Because non-Medicaid providers can write prescriptions for Medicaid recipients, the Medicaid provider number is not always available. Similarly, some prescribers do not have Drug Enforcement Administration numbers. Some states have opted to use the Drug Enforcement Administration number anyway because that does capture a high percentage of prescribers.

Staff could not determine when Kentucky decided to use the prescriber's professional license number, but it appears to have been during or before the 1990s. The prescriber license number presents problems in two ways.

Within Kentucky, the various licensing boards use sequential numbers. Therefore, a physician and a dentist can have the same license number. The Medicaid Management Information System (MMIS) and point-of-sale system do not distinguish the different professions, so the point-of-sale system cannot tell the two apart.

Outside Kentucky, some medical professionals write prescriptions for Kentucky Medicaid recipients. Their license numbers can duplicate Kentucky prescribers' numbers.

Retrospective drug utilization review can help identify and reduce recipient and provider fraud and abuse. The program was stopped soon after it began because the prescriber could not be uniquely identified.

The inability to identify a prescriber with confidence in many cases limits the ability of First Health and OIG to look for patterns suggesting fraud and abuse in the prescription claims. In addition, it has prevented First Health from conducting an important cost and care management task, retrospective drug utilization review, or retroDUR. RetroDUR can impact fraud and abuse in two ways. First, retroDUR identifies patients with unusual prescription patterns and informs the prescriber; this might allow the prescriber to take action to stop fraud or abuse if there is any. Sending a letter to the wrong prescriber is a violation of health information privacy laws. Second, retroDUR identifies prescribers with unusual prescribing patterns; First Health is responsible for discussing these patterns with the prescribers, which can identify prescriber fraud and abuse or improve the prescriber's ability to notice and prevent recipient fraud and abuse.

The National Provider Identifier should solve the prescriber identification problem in the future.

The National Provider Identifier should resolve the prescriber identification problem. It was scheduled for implementation in May 2007, but CMS delayed it until May 2008. There is no guarantee that the identifier will be implemented even then.

The PBA proposed a solution to the retrospective drug utilization review problem, but DMS has not taken action on it. Staff urge DMS to take action without waiting for the National Provider Identifier.

A former DMS commissioner told staff that First Health had offered a written proposal to work around the existing prescriber identification problem. However, after repeated requests, DMS did not provide a copy of the proposal nor did DMS indicate its status. As part of its overall program integrity plan, DMS should take whatever interim steps are possible to implement a retroDUR program without waiting for the National Provider Identifier.

The Medicaid Management Information System needs to have more information about prescription claims in order to support program integrity operations.

Pharmacy Claims Representation in MMIS. Staff examined a small sample of claims in the prescription point-of-sale system and in MMIS. The examination identified three potentially important pieces of information that MMIS does not have.

- MMIS does not have the codes the pharmacist uses to override certain kinds of claims denials.
- MMIS sometimes has the denial reason code for denied claims and sometimes does not.
- MMIS does not have prior authorization information.

To the extent OIG and its vendor will look for patterns of prescription fraud and abuse, these items could greatly expand their options. The 2006 Program Review and Investigations

Committee report recommended that MMIS have all the information necessary to conduct a thorough fraud and abuse review (Commonwealth. Legislative. Program. *Information* 54-55).

Overall Planning for Medicaid Program Integrity

Coordination among agencies and vendors is inconsistent. The main entities involved are DMS; OIG; the PBA; Electronic Data Systems, which is the fiscal agent responsible for the Medicaid Management Information System and lock-in reviews; the Department for Community Based Services; the Ombudsman's Quality Control Branch; and the Office of the Attorney General.

The preceding sections illustrated some of the difficulties facing Kentucky Medicaid's program integrity function. Several entities are involved in this function. In many cases, coordination among the agencies appears to work well. In other cases, there have been apparent breakdowns.

The primary agencies and vendors identified by staff are

- the Cabinet for Health and Family Services' (CHFS) Department for Medicaid Services (management responsibility);
- the CHFS's Office of Inspector General's Division of Fraud, Waste and Abuse/Identification and Prevention;
- First Health Services Corporation, which is the pharmacy benefit administrator;
- Electronic Data Systems, which is the fiscal agent responsible for the Medicaid Management Information System and lock-in reviews;
- the CHFS's Office of Inspector General's Division of Special Investigations;
- the CHFS's Department for Community Based Services' Division of Family Support;
- the CHFS's Office of the Ombudsman's Quality Control Branch; and
- the Office of the Attorney General's Medicaid Fraud and Abuse Control Division.[8]

DMS planning for program integrity appears fragmented, and DMS management seems unaware of some program integrity activities. Key positions turned over in 2007, and DMS has been stretched since 2004 with Medicaid modernization. There appears to be no central, written, comprehensive plan.

Planning for program integrity appears to be fragmented, and DMS management does not appear to be aware of all the activities being carried out on its behalf. Some of the difficulty is attributable to turnover in many key positions during the past few years and particularly in 2007. Some is attributable to the heavy workload required to implement Medicaid modernization since 2004. Some is attributable to lack of a centralized planning function. There

[8] The Office of the Attorney General operates Kentucky's Medicaid fraud control unit under a contract with the U.S. Department of Health and Human Services' Office of Inspector General. Funding is provided under that contract. DMS has a memorandum of agreement with the Office of the Attorney General to delineate the relationship between them, but DMS does not exercise control or provide funding.

appears to be no central, written, comprehensive plan for conducting program integrity in Kentucky Medicaid.[9]

Coordination of OIG and PBA in program integrity could be helpful.

Although DMS has contracted with OIG to provide fraud and abuse detection for all types of claims, it may be beneficial to take advantage of the specialized expertise of the PBA in prescription fraud and abuse detection. The PBA contract includes fraud and abuse detection. OIG officials indicated that they had expected the PBA to take over some of the program integrity responsibilities. On the other hand, DMS officials have expressed some concern that asking the PBA to conduct a fraud and abuse program could cause it to exceed the federal cost match.

New federal Medicaid program integrity requirements probably will guide planning in the states. DMS is in the process of reissuing a program integrity procurement based on the federal plans.

The federal Comprehensive Medicaid Integrity Plan process probably will guide Kentucky and other states in planning their program integrity function. DMS is in the process of reissuing a program integrity request for proposals. The procurement is based largely on the Comprehensive Medicaid Integrity Plan and on a CMS review of Kentucky's program integrity unit. Staff found the procurement to be commendable.

The 2006 Program Review report recommended that DMS and other agencies and vendors develop a comprehensive fraud plan (Commonwealth. Legislative. Program. *Information* 94). Staff reiterate that recommendation.

Recommendation 1.4

Recommendation 1.4 is that DMS should work with involved agencies and vendors to develop a comprehensive program integrity plan and ensure it is maintained and followed. The plan should delineate responsibility for all aspects of program integrity and should include funding and staffing considerations. It should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers.

The Department for Medicaid Services, in consultation with all involved agencies and vendors, should ensure that a comprehensive Medicaid program integrity plan is developed, maintained, and followed. The plan should delineate responsibility for all aspects of program integrity: prevention, detection, and recovery of fraud, abuse, and other overpayments related to recipients, providers, Medicaid contractors, state employees, and pharmaceutical and other medical supply manufacturers. The plan should include funding and staffing considerations. The plan should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers.

[9] The federally required State Medicaid Plan does not contain a sufficient plan for Kentucky's program integrity operation and probably is not the proper repository for such a detailed plan.

Recommendation 1.5

Recommendation 1.5 is that DMS should explore ways to implement concurrent detection of improper payments within the pharmacy point-of-sale system as well as the medical-claims processing system.

As part of its overall program integrity plan, the Department for Medicaid Services should explore ways to implement concurrent fraud, abuse, and overpayment detection within the pharmacy point-of-sale system as well as the medical-claims processing system.

Medicaid Program Integrity Disincentives

The federal requirement that states refund the federal portion of any overpayments within 60 days of their discovery creates a cost burden and disincentive to seek fraud and abuse actively.

When a Medicaid program integrity unit discovers a potential overpayment of any kind, federal regulations require the state Medicaid program to repay the federal portion of the overpayment within 60 days. The 60-day rule applies no matter how long the state takes to recover the overpayment. Because Kentucky's federal match rate is approximately 70 percent, a large portion of these overpayments comes out of the Medicaid budget before the recovery occurs. State Medicaid programs across the country have the same problem.

In the long term, costs balance out. Eventually the overpayment may be recovered and the state keeps the federal share. If the state establishes that an overpayment is not recoverable, CMS will return the amount paid under the 60-day rule. However, the process of recovery can last months or years, during which the state has lost the interest that would have been earned on those funds.

The federal payment for claims is 70 percent, but the federal budget support for program integrity units is only 50 percent. Kentucky pays half the cost of finding and recovering overpayments but keeps only 30 percent.

Another factor that discourages states from seeking aggressive recovery of overpayments is the federal funding formula for program integrity units. Although federal funds pay 70 percent of Medicaid claims, the federal share of most administrative costs, including program integrity, is 50 percent. Because most states have a federal claims match rate well above 50 percent, states find themselves paying half the cost of recovery while receiving a far lower percentage of return—30 percent in Kentucky's case.

Upcoming Unbudgeted Program Integrity Costs

The Medicaid Integrity Program and the Payment Error Rate Measurement project both involve audits of Medicaid claims. These audits could result in discovery of significant overpayments. If so, Kentucky would have to pay the 70 percent federal share within 60 days while it attempts to recover the overpayments. The extra burden on OIG and Office of the Attorney General staff might delay the recoveries further.

Part of the federal Medicaid Integrity Program, which is expected to begin in 2008, is an audit of every state's Medicaid claims. These audits have the potential to uncover a large number of overpayments, including fraud and abuse. There have been concerns that the federal auditors will not understand the states' differing program rules and thus erroneously identify even a larger number of overpayments (Atlantic).

CMS also is proceeding with the Payment Error Rate Measurement project, the first stages of which already have begun in Kentucky. It involves the review of a sample of claims to identify payment errors and it, too, has the potential to uncover a large number of overpayments.

State Medicaid programs have pointed out that the objectives and methods of Medicaid Integrity Program audits and Payment Error Rate Measurement review overlap. Despite this, CMS has persisted in conducting them concurrently. If so, the number of overpayments they identify will be larger than a combined review.

Kentucky may be more vulnerable than some other states because DMS and OIG have never conducted comprehensive fraud and abuse detection. Such a process probably would have cleaned out a significant portion of fraud, abuse, and other overpayments.

The implications are twofold. First, Kentucky will have to repay the 70 percent federal share of any overpayments discovered by Medicaid Integrity Program audits and Payment Error Rate Measurement review within 60 days. The amount involved is unknown but could be large. Second, DMS, OIG, and the attorney general probably will not have adequate staff to handle the sudden increase in cases, some of which may require criminal prosecution.

The General Assembly might be able to influence these federal issues through a resolution to Congress.

States have no direct control over federal policy. However, states do have influence. State Medicaid agencies have lobbied CMS and Congress about these issues, so far with no success. The General Assembly may wish to add its voice to their efforts.

Recommendation 1.6

Recommendation 1.6 is that the General Assembly may wish to consider a resolution asking Congress for more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs.

If it is the intent of the General Assembly to assist the Kentucky Medicaid program in seeking more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs, the General Assembly may wish to consider a resolution asking Congress to provide such relief.

Accountability and Measurement of Outcomes Are Inadequate

DMS does not have a comprehensive process for evaluating vendors or for evaluating the effects of specific KyHealth Choices innovations. DMS did not follow recommendations related to evaluations in a 2006 Program Review and Investigations Committee report.

DMS does not appear to have an independent means of evaluating the performance of First Health Services Corporation as PBA. The department has used First Health's self-evaluations rather than independently measuring performance. In addition, there does not appear to be an effort to measure the effectiveness of Medicaid modernization in general.

A 2006 Program Review and Investigations Committee report noted that the original proposal for KyHealth Choices included an extensive plan for measuring outcomes and performance. The report explained that the plan was required by the CMS waiver process. When the Deficit Reduction Act of 2005 gave states more flexibility to create benefit plans, the waiver was no longer necessary for three of the four KyHealth Choices plans. At that point, the outcome and performance measurement plan was dropped. The report recommended that DMS explain how it would evaluate the significant program changes in KyHealth Choices (Commonwealth. Legislative. Program. *Information* 55-56). DMS did not provide an explanation.

The same report recommended that OIG conduct a cost-benefit analysis and report to the Program Review and Investigations Committee (91). No cost-benefit analysis was reported to the committee.

Even when DMS adopts a benefit rule or innovation that has been used effectively elsewhere, it is important to measure its effects. An innovation may work differently in Kentucky than elsewhere. It may turn out not to be cost effective and even might be counterproductive. Staff now recommend that DMS create a comprehensive Medicaid performance evaluation process.

Recommendation 1.7

Recommendation 1.7 is that DMS should evaluate the performance and outcomes of Medicaid as a whole and each vendor and each benefit program. To the extent possible, DMS should measure outcomes and return on investment for each agency and vendor activity, benefit plan change, and innovation.

The Department for Medicaid Services should implement a comprehensive program to evaluate the performance and outcomes of Medicaid as a whole and of each vendor and each benefit program. To the extent possible, the program should attempt to measure the outcomes and calculate a return on investment for each agency and vendor activity and each benefit plan change and innovation.

Federal Requirement for Drug Use Review Board

Federal law and regulations require each state to create a Drug Use Review (DUR) Board. The board was included in the Social Security Act and is codified in 42 USC 1396r-8(g)(3) and 42 CFR 456.716. However, no cabinet officials that staff interviewed were familiar with such a board.

Federal law and regulations require each state to have a Drug Use Review Board. Kentucky created a statutory board that meets the federal requirement, but the board no longer exists.

According to KRS 205.5634-5639, the General Assembly intends the Drug Management Review Advisory Board to meet the federal DUR Board requirements. The advisory board continues to be referenced in regulation at 907 KAR 1:019, which describes meeting and appeals procedures. The PBA master agreement mentions the Drug Management Review Advisory Board and states that the PBA shall provide support for the DUR Board and perform certain functions according to criteria the board sets.

The Drug Management Review Advisory Board was established in 1998 and last met in August 2004. Staff interviewed several cabinet officials and none was aware of the reasons that the board ceased to function. Some cabinet officials suggested that the Pharmacy and Therapeutics Committee (P&T) serves as Kentucky's DUR Board, but a CMS pharmacy benefit official stated that the committee could not perform that function.

Some cabinet officials suggested that the Pharmacy and Therapeutics Committee serves as Kentucky's Drug Use Review Board. The committee fails to meet several federal requirements and would require statutory changes in order to operate in that capacity.

CMS has attempted to give states flexibility in implementing DUR, but the Pharmacy and Therapeutics Committee appears not to meet the federal requirements in at least five ways.

- The committee does not meet federal requirements for DUR Board membership. According to 42 CFR 456.716(b),

  Board composition. At least one-third but not more than 51 percent of the DUR Board members must be physicians, and at least one-third of the Board members must be pharmacists. These physicians and pharmacists must be actively practicing and licensed.

A CMS official stated that the board's composition was not flexible and the DUR Board must meet the regulatory requirements. According to KRS 205.564(2), P&T consists of 13 voting members, 10 of whom are physicians and 3 of whom are pharmacists. Well over 51 percent are physicians and fewer than one-third are pharmacists. Whether or not nonvoting members are included, the committee still fails both federal criteria.

- The committee does not carry out activities related to prospective drug use review as described in 42 CFR 456.716(d)(1) and (d)(2)(ii). A review of KRS 205.564 shows that P&T responsibilities are limited to the formulary (preferred drug list) and prior authorization procedures.
- The committee does not carry out activities related to retrospective drug use review. According to 42 CFR 456.716(d)(3):

  > *Retrospective DUR: Board's activities*. The DUR Board should perform the following activities:
  >
  > (i) Review and make recommendations on predetermined standards submitted to it by the Medicaid agency or the agency's contractor.
  >
  > (ii) Make recommendations to the Medicaid agency or the agency's contractor concerning modification or elimination of existing predetermined standards or the addition of new ones. [10]

  KRS 205.564 does not authorize P&T to carry out these activities.
- The committee does not carry out activities related to provider education as described in 42 CFR 456.716(d)(5). KRS 205.564 does not authorize P&T to carry out these activities.
- The committee does not produce an annual DUR report. According to 42 CFR 456.712(a),

  > *DUR Board report*. The State must require the DUR Board to prepare and submit an annual DUR report to the Medicaid agency that contains information specified by the State.

  A review of KRS 205.564 shows no mention of an annual report, and the responsibilities of P&T do not include DUR.

There is evidence that P&T never was intended to serve as Kentucky's DUR Board. The request for proposals for the

[10] "Standards" in this context includes those defined for retrospective DUR at 42 CFR 456.709(a), including pattern analysis of claims to detect "fraud, abuse, gross overuse, or inappropriate or medically unnecessary care." The description of how the standards are used at 42 CFR 456.716(4) also mentions fraud and abuse.

pharmacy benefits administrator mentioned a Kentucky DUR Board. The document described different responsibilities for the board and P&T. It referred to them both in the same paragraph (RFP §30.049.h).

In addition, some cabinet officials suggested that First Health ran regional retroDUR committee meetings and that these might have served as Kentucky's DUR Board. Such committees would not meet the federal requirements. First Health appears never to have billed for meetings of regional committees, the DUR Board, or the Drug Management Review Advisory Board, even though those services are billable under the PBA contract.

The cabinet should follow the Kentucky statute and federal regulation and reconstitute Kentucky's Drug Use Review Board.

Kentucky law gives the secretary of the Cabinet for Health and Family Services responsibility for appointing Drug Management Review Advisory Board members. The statute remains in effect, so it would appear that the cabinet remains responsible to operate the board. The Secretary of State's office was unable to find any executive orders that would have relieved the cabinet of that responsibility.

Recommendation 1.8

Recommendation 1.8 is that the cabinet should ensure that the Drug Management Review Advisory Board exists and fulfills its duties. The cabinet might propose combining the board with the Pharmacy and Therapeutics Committee in a way that is consistent with federal law.

The Cabinet for Health and Family Services should reconstitute the Drug Management Review Advisory Board and ensure that it fulfills its duties under federal and Kentucky law. If the cabinet believes that the board's duties and those of the Pharmacy and Therapeutics Committee could be combined, it should propose to the General Assembly legislation that is consistent with federal law.

Federal Requirement for Drug Use Review Reporting

Another responsibility of the DUR Board is to produce an annual report for the cabinet. Federal regulations require the cabinet to send a drug use review report annually to the secretary of the U.S. Department for Health and Human Services incorporating the DUR Board's report (42 CFR 456.712).

It appears that DMS has not provided federally required drug use review reports. DMS should ensure that such reports are completed and provided.

Despite repeated requests from staff, cabinet officials were unable to provide copies of any such DUR reports. The PBA contract gives First Health responsibility for compiling the annual DUR report to the federal government. Despite repeated requests from staff, First Health officials did not provide copies of any such DUR reports. It is possible that Kentucky has failed to produce the federally required DUR reports.

Recommendation 1.9

Recommendation 1.9 is that DMS should ensure the annual drug use review report is prepared and sent to the federal government. DMS should provide copies of the last five such annual reports and all future reports to relevant legislative committees.

The Department for Medicaid Services should ensure that the annual drug use review report is prepared and sent to the federal government. In addition, the department should provide copies of the last five such annual reports and all future reports to the Interim Joint Committee on Health and Welfare and the Medicaid Oversight and Advisory Committee of the Legislative Research Commission.

The Office of Inspector General Has Requested Additional Statutory Tools

OIG has requested additional statutory tools to fight fraud and abuse, such as administrative subpoena power, creation of civil penalties, mandatory reporting of fraud and abuse, and record-keeping requirements for providers.

A 2006 Program Review report noted that OIG has requested additional statutory tools to assist in fighting fraud and abuse. The report recommended that the General Assembly consider the request (Commonwealth. Legislative. Program. *Information* 90). The request consisted of administrative subpoena power; creation of civil penalties; mandatory reporting of fraud, abuse, and waste; and record-keeping requirements for providers. Senate Bill 223 in the 2005 Regular Session of the General Assembly would have enacted the requested tools, but the bill did not pass.

OIG reiterated its request in the 2006 joint report prepared by the Attorney General and OIG. Staff recommend that the General Assembly again consider the request.

Recommendation 1.10

Recommendation 1.10 is that the General Assembly may wish to consider the changes requested by the Office of Inspector General to combat Medicaid fraud and abuse.

If it is the intent of the General Assembly to more fully empower the Office of Inspector General to combat Medicaid fraud and abuse, then the General Assembly may wish to consider the changes requested by that office as embodied in Senate Bill 223 of the 2005 Regular Session.

Chapter 2

Eligibility Fraud and Abuse

Determination of Medicaid eligibility is complex; a detailed discussion is beyond the scope of this report. A person can become eligible for Medicaid by falling into one of the covered groups and meeting income and other requirements. There are 34 distinct categories of Medicaid recipients in Kentucky. Coverage for some groups is required under federal law; for others, it is optional.

There are several ways an applicant can become eligible for Medicaid.

Ways that a person can become eligible for Medicaid include

- receiving Social Security disability payments;
- becoming eligible for the Kentucky Transitional Assistance Program (KTAP);[1]
- being a foster child or a child in Kinship Care; or
- being a Medicare recipient, usually in long-term care and meeting other requirements.

Disability Determination

Disability is one of the qualifying criteria. Disability is jointly determined by the Social Security Administration and the Kentucky Department for Disability Determination Services (DDS).

Persons may qualify for Medicaid by receiving Social Security disability, typically Supplemental Security Income (SSI). The first step in the application process is handled by local Social Security offices that determine financial eligibility. Kentucky has no control over this federal process, but the second step in obtaining SSI is under state control. After the applicant is determined to be financially eligible, he or she must present medical documentation of disability. The Kentucky Department for Disability Determination Services (DDS) reviews the medical documentation and decides whether the applicant has a qualifying disability. DDS is funded and monitored by the Social Security Administration and functions independently of the federal and state Medicaid programs.

Fraud and abuse may occur in several ways in the disability determination process. DDS takes measures to ensure accuracy.

There are several opportunities for fraud in the disability determination process. A patient may report fake symptoms to a physician. The patient might give the physician fake medical images and records to support those symptoms. Out of sympathy or because of pressure from the patient, a physician could document the symptoms as being more severe than they really are.

[1] KTAP is Kentucky's implementation of the federal Temporary Assistance for Needy Families program.

A physician could fabricate medical documentation in exchange for cash or other compensation.

DDS's trained nonmedical staff assesses disability applications. Staff receive annual training on ways to identify fraud and abuse. The most experienced staff are designated as case consultants and handle cases considered to be at high risk for fraud or abuse. Medical consultants are available at the request of the case review staff. Mental health disability cases require a medical consultation. When DDS staff find documentation questionable or insufficient, they can request additional medical examinations or tests.

Supervisors at DDS review all the cases handled by new staff for their first year. Each month thereafter, supervisors review some claims each month for each staff member.

The department has a quality assurance unit that selects a random sample of cases and ensures that the decision was made properly with the available documentation. The unit does not look specifically for fraud or abuse and does not seek any additional documentation. Similarly, the Social Security Administration reviews half of all approved cases and 10 percent of denied cases. These reviews, like the DDS internal reviews, consider only the documentation available in the case file.

Despite consistently good reviews and a high rate of disability denials, Kentucky remains second in the nation in disabled citizens per capita. Speculation persists that fraud is a contributing factor, but further study is needed.

DDS officials stated that federal reviews have consistently supported the majority of Kentucky's disability decisions. They also provided documents showing that DDS denies more than 66 percent of applicants, more than the national average of 63 percent, to rank 14th among 52 programs nationally.[2]

Despite the rate of denied disability cases, Kentucky has a high percentage of disabled citizens. In 2006, according to the Kaiser State Health Facts database, 4 percent of Kentuckians were receiving SSI for disability. The only state with a higher rate was West Virginia at 4.1 percent. The national average was 2 percent (Henry. "Supplemental"). This disparity has led to speculation about fraud as one cause of Kentucky's disability rate. If disability fraud occurs very often, it could have a sizeable impact on the Medicaid program. Because it was not in the scope of this study, staff suggest that a review of disability determination and the causes of Kentucky's large disabled population be studied further.

[2] The programs are the 50 states, District of Columbia, and Puerto Rico.

Eligibility Determination by the Department for Community Based Services

The Department for Community Based Services (DCBS) handles all Medicaid applications, including those for disabled persons. There are two general categories of applications: family related and adult Medicaid.

The Department for Community Based Services handles all Medicaid applications, including those for disabled persons. Fraud can occur if the applicant or representative knowingly misrepresents income, resources, or expenses. Abuse can occur if the applicant or representative unintentionally fails to provide accurate and complete information about income, resources, or expenses. There are two general categories of applications: family-related and adult Medicaid.

Family-related Medicaid

Family-related Medicaid involves Kentucky Transitional Assistance Program (KTAP) or child protection case. Income, resources, and expenses are considered. Income, or lack thereof, is difficult or impossible to confirm. DCBS uses several methods to attempt to identify sources of income.

Medicaid that is received along with KTAP or by a foster or Kinship Care child is called family-related Medicaid. The application process for KTAP looks at a family's income, resources, and expenses to determine whether it qualifies for benefits. The caseworker conducts a face-to-face interview and ensures that the applicant understands all the information that is required. The caseworker also will cross-check information for consistency and will ask for clarification. One item that came up in Program Review staff's interviews with caseworkers is that sometimes the income and resources listed do not cover the expenses. Caseworkers explained that often when asked, the applicant will disclose some kind of support that was not listed on the application—often caused by lack of understanding.

The application process requires signed forms verifying income and resources, including signatures of employers, former employers, and other persons. The applicant must provide a list of all household members. Some groups of applicants must have someone else sign a form verifying the household composition. Statements are required for any bank accounts that the applicant may have. DCBS officials stated that the caseworker routinely sends out an inquiry to two local banks to see if there are unreported accounts.

Adult Medicaid

Adult Medicaid applicants are not asked about expenses, even though comparing expenses with income can show discrepancies leading to discovery of additional income and resources.

The application process for adult Medicaid differs from family-related Medicaid in a few details. Perhaps the most important is that the adult Medicaid questions do not include information about expenses. Expenses are not a factor in determining adult Medicaid eligibility. However, caseworkers suggested that having the information would allow them to find inconsistencies with the

reported income that could point to further income that was not listed on the application.

While adult Medicaid caseworkers are not prohibited from asking about expenses or challenging inconsistencies, they are not required to do so. The data entry screens discourage such questions because the caseworker tends to follow the prompts on the screen. The prompts do not include questions about expenses.

Persons claiming a disability may apply for adult Medicaid, even if that person has not yet received or has been denied SSI. In such cases, Medicaid requires a medical disability review. Further study of this process is suggested.

Persons claiming a disability may apply for adult Medicaid, even if that person has not yet received or has been denied SSI. In such cases, Medicaid requires a medical disability review conducted by a DDS team. This process raises the same questions as SSI disability determination.

Identifying Eligibility Fraud and Abuse

Verifying Applicant Information

It appears that many caseworkers accept the applicant's statement for much of the information. DCBS should consider whether it would be beneficial for caseworkers to ask questions and compare reported income, resources, and expenses.

A cabinet official, not with DCBS, expressed the opinion that many caseworkers have mistakenly concluded that they must accept the applicant's statement for much of the information in an application. This is similar to the impression Program Review staff formed from interviews with caseworkers. DCBS officials stated that caseworkers should verify income and resources in all cases and have been trained to do so.

Recommendation 2.1

Recommendation 2.1 is that DMS and DCBS should ensure that all caseworkers follow correct procedures for verifying an applicant's statements. DMS should consider whether to reconcile income, resources, and expenses for adult Medicaid applicants.

The Department for Medicaid Services should review Medicaid eligibility procedures, and the Department for Community Based Services should ensure that all caseworkers understand and follow the procedures for verifying an applicant's statements. The Department for Medicaid Services should consider whether it is desirable that caseworkers ask adult Medicaid applicants for information about expenses and attempt to balance income, resources, and expenses. If so, the departments together should develop such a procedure and incorporate it into caseworker training.

Quality Control Procedures

DCBS requires case reviews for new caseworkers and for a sample of cases for all other caseworkers. The sample review does not apply to adult Medicaid cases.

Case Reviews. Case reviews are a routine method of quality control used by DCBS. When a new caseworker is hired, a supervisor reviews all that person's cases for good decision

making. This continues until the caseworker has been granted case decision authority. A supervisor also reviews a random selection of 30 KTAP cases each month from among those handled by caseworkers with case decision authority.

Program Review staff noted that supervisors do not routinely review any adult Medicaid cases handled by caseworkers with case decision authority. DCBS officials indicated that it probably would be beneficial to review a selection of adult Medicaid cases if the supervisor has time.

Medicaid Eligibility Quality Control. CMS mandates that all states conduct quality control reviews of Medicaid eligibility. The Medicaid Eligibility Quality Control program offers states two options.

Federal rules require a Medicaid eligibility quality review. Kentucky has chosen an option to focus on a certain group or policy area each year. This protects Kentucky from penalties for high error rates but means the overall error rate is unknown.

The conventional option is to review a random sample of cases. If the eligibility error rate under this option exceeds 3 percent, the state must repay the federal share of the amount of benefits attributable to the percentage of ineligible members beyond 3 percent.

Kentucky and most other states use the second option. CMS allows states to conduct so-called pilot reviews targeting a specific group of recipients. While conducting these reviews, the state is not subject to any penalties based on eligibility errors. Before a state can take this option, the state must obtain a conventional eligibility error rate below 3 percent. At that point, the error rate is considered frozen. This policy encourages states to focus on eligibility issues that are more problematic without being penalized. However, it means the overall error rate is unknown (U.S. Dept. of Health. Health).

The current quality control focus is on adult Medicaid recipients in long-term care. The 2006 error rate was more than 20 percent, including possible fraud, abuse, and agency error.

In Kentucky, the review is conducted by the cabinet's Office of the Ombudsman, Quality Control Branch, under a memorandum of agreement with DMS. Most recently, the focus was on adult Medicaid recipients in long-term care. According to the 2006 Medicaid Eligibility Quality Control report, the error rate for these cases was more than 20 percent. These included cases in which the recipient was not eligible as well as cases in which the recipient was eligible but the calculated level of benefit was incorrect. The error rate included possible fraud, abuse, and errors on the part of DCBS.

Data Matching

DCBS uses automated systems to compare Medicaid application information to data in other systems to confirm identity, income, and resources.

In addition to the quality control procedures, DCBS uses the Kentucky Automated Management and Eligibility System (KAMES) to record and track public assistance applications and case information. KAMES performs a number of automatic data matches on new applications. In addition to locating previous applications and cases in which the applicant might have been involved, KAMES verifies the applicant's identity with a Social Security database. Additional matches available to the caseworker or KAMES include

- vital statistics (births and deaths),
- child support,
- SSI,
- wage information from the Department of Workforce Investment,
- federal taxes,
- Social Security, and
- property ownership.

KAMES continues to check current recipients against many of these databases on a regular basis. If a match is found that suggests an issue with eligibility, KAMES sends a message to the caseworker to follow up. Program Review staff commend DCBS for its efforts to enhance data matching to identify potential fraud and abuse.

Eligibility Investigations

Some information cannot be verified in the office or via data matching. Unreported income and misreported household composition are two frequent problems that require outside confirmation.

Despite all the data matches, some application information cannot be verified using automated systems. According to the caseworkers and others interviewed, much of the potential fraud and abuse arises from two sources: unreported income and misreported household composition, particularly an absent parent or an unreported marriage.

Without actually observing an applicant's home or interviewing acquaintances, the caseworker has no way to verify income and household composition. This was the reasoning in favor of an eligibility investigation unit. From 1997 to 2002, the cabinet's Office of Inspector General operated a program called the Cooperative Review of Eligibility. Because the program saw a positive return on investment, a 2004 Program Review report recommended that the program be reconsidered (Commonwealth. Legislative. Program. *Uncollected* 24).

In March 2005, the Office of Inspector General (OIG) initiated Determining Eligibility Through Extensive Review (DETER) to conduct field investigations of public assistance eligibility. DETER responds to caseworker suspicions in time to prevent benefits from being paid when the suspicions are justified.

Special Eligibility Investigations Unit. In March 2005, OIG initiated a similar program called Determining Eligibility Through Extensive Review (DETER). The objective of the program is to investigate public assistance applicants whenever a caseworker has suspicions about the accuracy of the information provided. DETER conducts a field investigation and attempts to report its findings to DCBS within 15 days so that benefits will not be provided to ineligible applicants. While DETER's primary goal is to conduct pre-eligibility and recertification investigations, it often receives referrals of active cases from DCBS caseworkers whenever questions about eligibility arise. If the allegation is that someone received benefits but was not eligible, DETER refers the case to another OIG branch for investigation.

Once an investigation is completed, DETER sends a report to the caseworker for action. In many pre-eligibility instances, because of federal regulations on the application time frame, case approval occurs prior to the issuance of DETER report. However, the case can be discontinued quickly if warranted and few if any benefits are paid.

Currently, DETER operates in 16 counties: Bath, Boone, Campbell, Christian, Daviess, Gallatin, Henderson, Hopkins, Jefferson, Kenton, McLean, Montgomery, Rowan, Trigg, Todd, and Warren. Expansion to Logan County is pending.

First implemented in Louisville, DETER later expanded to more counties. It is operated by the OIG's Division of Special Investigations, Fraud Compliance and Investigations Branch. As of November 2007, the program included the branch manager, one supervisor, and seven investigators who cover 16 counties: Bath, Boone, Campbell, Christian, Daviess, Gallatin, Henderson, Hopkins, Jefferson, Kenton, McLean, Montgomery, Rowan, Trigg, Todd, and Warren. A request for expanding the program to Logan County was pending.

The development of the DETER program in the wake of the former investigative program deserves praise. OIG has not, however, developed its own cost-benefit analysis. Staff suggest that OIG should routinely maintain a cost-benefit analysis of its initiatives, as recommended in the 2006 Program Review report on health care fraud and abuse (Commonwealth. Legislative. Program. *Information* 91).

Through April 2007, DETER had received 1,668 referrals including KTAP, Medicaid, food stamps, and other programs. DETER computes cost avoidance by assuming a year's worth of benefits were avoided when eligibility was denied.

Staff obtained financial information on DETER and developed a rough cost-benefit analysis, presented in Table 2.1. From inception through April 2007, DETER reported 1,668 referrals, of which nearly 38 percent were for Medicaid.[3] Some of the Medicaid cases

[3] DETER counts a referral once for each public assistance program involved. If a recipient received Medicaid, KTAP, and food stamps, it would count as three referrals.

also involved KTAP or food stamps. DETER calculates cost avoidance based on the assumption that the applicant would have received a year of benefits if the unit had not intervened. Medicaid savings are projected based on the average annual benefit received by recipients in general. Medicaid savings account for 58 percent of the estimated DETER cost avoidance among all the public assistance programs.

Program Review staff developed a cost-benefit analysis for DETER overall. The return on investment since inception has been $2.60 for each dollar spent.

Because some Medicaid cases also involve KTAP and food stamps, it was not possible to isolate DETER expenses related to Medicaid. Staff calculated the overall return on investment. Since the program started and as of April 2007, each dollar spent created $2.60 in cost avoidance. In 2006, the only full calendar year of DETER implementation, the return rate was $2.80 for each dollar. Because DETER has been expanding, the return probably will increase. For example, three new investigators were hired in October 2006, which probably lowered the 2006 and early 2007 savings. The return is likely to increase as the new staff become more productive.

Table 2.1
Determining Eligibility Through Extensive Review
Costs and Recoveries

	Time Period			
	March-Dec. 2005	**2006**	**Jan.-April 2007**	**Since Inception**
Medicaid Savings	$197,079	$510,037	$136,767	$843,883
Medicaid Percent of Total	58%	58%	56%	58%
Total Savings	$339,536	$882,420	$244,602	$1,466,558
DETER Costs	$107,275	$318,944	$142,444	$568,663
Savings Per Dollar Spent	**$3.20**	**$2.80**	**$1.70**	**$2.60**

Note: Savings are estimated cost avoidance assuming the applicant would have received a year of benefits.
Source: Compiled by Program Review staff from information provided by the Office of Inspector General, Division of Special Investigations.

Funding for DETER comes from several sources. Federal funds flow from Medicaid and DCBS and require a state match by OIG. There have been some accounting difficulties, and there may be differences of opinion between OIG and DCBS.

DCBS and OIG officials explained that DETER is funded partly by federal funds through memoranda of agreement with DMS and DCBS. Time and expenses are allocated to ensure the DMS funds pay for the Medicaid investigations and the DCBS funds pay for other assistance program investigations. The remainder of the funding comes from the OIG's state general fund that is required in order to match the Medicaid funds and some of the DCBS funds.

OIG officials acknowledged there was a period during which Medicaid was overcharged and some of the funds may have to be repaid to Medicaid. In addition, it appears that there has been some disagreement between OIG and DCBS officials about the desirability and funding of DETER.

Expansion of DETER depends on local DCBS office requests; office space; and funding from Medicaid, DCBS, and OIG's general fund.

OIG officials stated that DETER expansion is based on requests from local DCBS offices. They indicated that sometimes space for the investigators is an issue. DCBS officials acknowledged that there is a space shortage in many local offices. Program Review staff inferred that DETER's expansion depends on acceptance from DCBS officials, requests from local DCBS offices, available space, and adequate funding from DCBS and the Department of Medicaid Services as well as from the OIG's general fund dollars.

DCBS has claims workers who assist caseworkers in handling suspicions of eligibility fraud. They also assist OIG in gathering information for other recipient fraud and abuse allegations.

Claims Workers. Each DCBS service region has at least two staff members, known as claims workers, who handle suspicions of eligibility fraud. In counties without DETER, caseworkers send suspicions of eligibility fraud to the regional claims workers. A claims worker reviews the available case information and may request additional information from the applicant or recipient. If the suspicion of fraud appears to be justified, the claims worker forwards the information to OIG. In all counties, regardless of DETER's presence, claims workers assist OIG by summarizing case information and determining the months, if any, in which a recipient was eligible for Medicaid.

The cabinet should expand DETER and include claims workers in the overall plan.

Staff recommend that the cabinet expand DETER and include claims workers in the overall plan.

Recommendation 2.2

Recommendation 2.2 is that DMS, OIG, and DCBS should develop a plan to expand DETER to additional local offices. The plan should address local office acceptance, office space, funding, and the role of claims workers.

The Department for Medicaid Services, the Office of Inspector General, and the Department for Community Based Services should develop a plan to expand the Determining Eligibility Through Extensive Review program to additional local offices. The plan should address local office acceptance of the program, office space, funding, and the role of claims workers.

Applicant and Agency Error

No effort is made to recover Medicaid overpayments caused by agency and applicant error. Because the KTAP and food stamps programs do recover for these errors, staff suggest the cabinet consider the ethical and practical issues related to recovering these overpayments.

Section MS1668 of the DCBS Family Support Manual implies that when eligibility or overpayment was caused by agency error or by abuse as a result of erroneous information but not fraud, the case is corrected but no action is taken to recover any overpayments. This is supported by section MS3610 of the manual, which states that

the agency cannot require a long-term-care patient to pay a greater share of expenses retroactively.

Staff noted that the KTAP and food stamp programs do pursue recovery of benefits paid resulting from applicant and agency errors. A CMS official stated that there was no prohibition against seeking recovery of Medicaid payments caused by such errors. OIG officials indicated reluctance to do so for Medicaid. Staff suggest that DMS and OIG, in consultation with DCBS, consider whether it is ethically and practically desirable to pursue recovery of Medicaid payments made because of inadvertent applicant error and agency error.

Adult Medicaid Cases Not Processed

In 2006, 3.6 percent of adult Medicaid long-term care cases would not have been eligible if the correct information had been provided on the application.

The Quality Control Branch reported for the federal fiscal year ending September 2006 that 21.9 percent of the adult Medicaid cases reviewed had some kind of error. Of this percentage, 12.9 percent of the cases had agency errors and 9 percent had an error related to information provided in the application process. Looking at the 9 percent with nonagency errors, in about 3.6 percent of the cases, the recipient would have been ineligible if the correct information had been provided. In the other nonagency error cases, the recipient's care provider was being overpaid or underpaid, with overpayments predominating (Commonwealth. Cabinet. Office).

Despite the high applicant error rate, few if any adult Medicaid fraud cases have been reported to OIG. It is possible that DCBS caseworkers are not aware of the proper procedure for referring these cases to OIG.

OIG officials have indicated that there have been few if any adult Medicaid fraud cases referred. Staff interviews with DCBS caseworkers and claims workers suggest that many of them may be unaware of the procedure for referring those cases. Section MS1760 of the DCBS Family Support Manual states that Medicaid fraud cases that do not involve other benefit programs should be referred directly to OIG. Adult Medicaid cases typically fall into this category.

The quality control report did not indicate whether any of the case errors were attributable to fraud. It seems likely, however, that some of the errors were attributable to fraud. The assertion that OIG has received few or no such referrals for a recipient group with a high error rate is cause for concern.

Recommendation 2.3

Recommendation 2.3 is that DCBS should ensure that referrals for suspected fraud in adult Medicaid cases are made correctly to OIG. DCBS should reduce the error rate in adult Medicaid cases.

The Department for Community Based Services should ensure that referrals for suspected fraud in adult Medicaid cases are being made correctly to the Office of Inspector General. The department should implement procedures to reduce the error rate in adult Medicaid cases.

Some Eligibility Caseworkers Are Overwhelmed

Eligibility work involves multiple assistance programs and complex rules. It takes about 2 years for a new caseworker to become proficient. Some caseworkers report having difficulty completing tasks that could prevent overpayments.

Eligibility determination is a complex and difficult task. Benefit programs such as KTAP, food stamps, child care assistance, and Medicaid have distinct rules that the caseworker must learn. Within each program, there can be many complex eligibility criteria. Medicaid alone has 34 eligibility categories. DCBS staff and officials generally agreed that it takes about 2 years for a new caseworker to become proficient.

Interviews with DCBS staff indicated that in some parts of the state, caseworkers do not have time to complete all their tasks in a timely manner. This can mean some applicants become eligible who should not be. Later, caseworkers receive reports from the information system or someone may call indicating a change of status, such as increased income or death, that could end eligibility. DCBS staff explained that harried caseworkers may not be able to give full attention to the reports and status changes. As a result, they said, a recipient may continue to receive benefits for months after benefits should have stopped. Conversely, it is possible that increased benefits could be delayed.

DCBS reported caseloads in excess of a reasonable standard in many counties. Staff recommend that DCBS create a staffing and retention plan and request adequate funding.

The DCBS report of family support staffing levels dated August 2007 showed a statewide average weighted caseload of 789 and some counties with caseloads over 1,000. Different kinds of cases carry different weights, and the weighting system is an effort to measure overall caseload. Based on interviews with caseworkers, supervisors, and DCBS officials, it appears that 789 is higher than an optimal average caseload.

Recommendation 2.4

Recommendation 2.4 is that DCSB should develop an adequate staffing plan and a staff retention plan. DCBS should include any necessary additional positions or funding in its budget requests.

The Department for Community Based Services should determine a staffing level adequate to ensure quality results in the Division of Family Support. The department should develop a staff retention plan to reduce turnover. To the extent that either an adequate staffing level or a retention plan requires additional positions or funding, the department should include the needed resources in its budget requests.

Fraud by Eligibility Staff

Occasionally, DCBS caseworkers or supervisors commit fraud. DCBS has some safeguards in place to prevent such fraud, and it appears to be a rare occurrence.

An additional source of occasional fraud is the DCBS staff member who knowingly enters false, incomplete, or misleading information in order to obtain benefits for himself or herself or for an applicant who otherwise would not qualify.

DCBS officials described several procedures that combat staff fraud in addition to the supervisory case review process.

- The eligibility tracking system, KAMES, requires an "agency contact" entry be made when the client physically enters the office. This entry is made by the receptionist. If there is a caseworker entry and no agency contact entry, the system flags the case for supervisory review.
- DCBS policy is that a caseworker is not to take an application or be assigned a case involving a relative or close acquaintance.
- KAMES performs a match of applicants with the state personnel file. If a DCBS staff member appears to be an applicant, a review is initiated.
- Supervisors should look for signs of behavior change in a caseworker and monitor the caseworker's cases more closely.

The cabinet's Office of Human Resource Management processes cases of alleged fraud by eligibility staff. The office provided a list of personnel actions for 2004, 2005, and 2006. Table 2.2 shows that the number of alleged perpetrators has been small and is declining. The number of personnel actions may not reflect the actual occurrence of fraud by DCBS staff, but it does appear that most eligibility staff perform their work honestly.

Table 2.2
Personnel Actions Related to Eligibility Fraud, 2004 to 2006

	Year			
	2004	**2005**	**2006**	**Total**
Caseworkers	4	3	1	8
Supervisors	0	1	1	2
Total individuals	4	4	2	10
Total incidents	3	2	1	6

Source: Program Review staff compilation of information provided by the Office for Human Resource Management.

Chapter 3

Fraud and Abuse in the Use and Billing of Benefits

The first part of this chapter explains a recipient benefit fraud and abuse initiative that the General Assembly passed in 1994 but has never been implemented because of federal limitations. This rest of the chapter is divided into three sections. The first section focuses on benefit misuse by recipients that involves sharing or extending the benefit to others, overusing the benefit, or stealing the benefit. The second section takes a closer look at drug diversion. The third section discusses prescription drug billing fraud and abuse.

Recipient Utilization Review Committee

The Recipient Utilization Review Committee was to review Medicaid use by recipients who might be abusing or defrauding the program. The statute established a lock-in program and proposed to temporarily disqualify recipients who defraud the program. Disqualification would require a waiver of federal Medicaid rules.

In 1994, the General Assembly authorized the creation of a Recipient Utilization Review Committee. KRS 205.8455 describes the authority and responsibilities of the committee. Its primary objective is to review Medicaid use by recipients who might be abusing or defrauding the program. The statute specifies a lock-in program for benefit abuse that restricts recipients to a single doctor or pharmacist. It also stipulates that recipients found to have defrauded Medicaid should be prevented from receiving Medicaid services for up to 1 year. Recognizing that this last item and others would not be permitted under federal Medicaid rules, the statute specifies that the cabinet should seek waivers of the federal rules and that those sections of the statute would not be in force until a waiver was granted. The committee also is mentioned in KRS 205.8459(2).

According to a cabinet official, no request for a waiver was made until 2004. When KyHealth Choices was proposed to CMS, the waiver request included a disqualification provision.

> The state is seeking to disqualify for one year, *KyHealth Choices* members who have been convicted under state law of fraud against the Kentucky Medicaid program or convicted of the illegal sale of prescription drugs. In the event the member is incarcerated for such a conviction, the state seeks the discretion to apply this disqualification for a period of one year after the completion of the sentence (Commonwealth. Cabinet. Department. *Kentucky's* 50).

The KyHealth Choices waiver was withdrawn because the Deficit Reduction Act of 2005 made it unnecessary. However, the cabinet

official reported that CMS indicated it would have rejected the disqualification provision.

The Kentucky Recipient Utilization Review Committee probably never has been functional. The recipient disqualification concept in its statute remains unacceptable to the Centers for Medicare and Medicaid Services.

Currently, there is no Recipient Utilization Review Committee, and staff found no evidence that one ever operated. The Secretary of State's office found no executive orders related to the committee. Senate Bill 223 of the 2005 Regular Session of the General Assembly included amendments to KRS 205.8455 that would have removed the statutory definition of the committee and given its authority to DMS. It would have retained the disqualification provision, again dependent on a change in or waiver of federal law. The bill did not pass.

It might be beneficial to keep some elements of the statute while removing the requirement for a committee.

Some of the provisions of the statute might be advisable to keep. For instance, the statute establishes the authority of DMS to recover benefits received as a result of fraud and abuse and to operate a lock-in program. However, staff did not find a need for a committee to review recipient use, so long as DMS maintains recipient program integrity and lock-in operations.

Recommendation 3.1

Recommendation 3.1 is that the General Assembly may wish to consider removing references to the Recipient Utilization Review Committee and making other changes. If the statute is not so modified, DMS should operate the committee as defined in the law.

Recognizing that the Recipient Utilization Review Committee does not exist, the General Assembly may wish to consider amending KRS 205.8455 and KRS 205.8459(2) to remove references to the committee and make other changes it deems desirable. If the statute is not so modified, the Department for Medicaid Services should operate the committee as defined in the law.

Benefit Misuse

Sharing the Medicaid benefit with others and stealing Medicaid cards are two forms of benefit misuse.

Once a person becomes a Medicaid recipient, there are possibilities for fraud and abuse of the Medicaid benefit. Two examples are benefit sharing and benefit theft. Benefit sharing occurs when a recipient obtains prescriptions for someone else or shares a Medicaid card with someone else. Benefit theft occurs when someone steals a Medicaid card or identifying information and uses it to obtain prescriptions.

Agencies Involved in Medicaid Benefit Use

The following sections describe the agencies involved in this aspect of program integrity.

The pharmacy benefit administrator, Pharmacy and Therapeutics Committee, and DMS are responsible for setting the rules and managing benefit use.

Benefit Fraud and Abuse Administration. Several agencies are involved in preventing payment in cases of benefit fraud and abuse. First Health Services Corporation, which is Kentucky's pharmacy benefit administrator, ensures that all prescription claims meet the standards for claims payment and that the recipient is eligible at the time. The Pharmacy and Therapeutics Committee considers changes to the preferred drug list that include rules to discourage benefit fraud and abuse. DMS management oversees the prescription drug benefit, including the operation of the PBA and the Pharmacy and Therapeutics Committee.

DMS has a key role in determining the emphasis that is placed on prevention, detection, and recovery of losses resulting from benefit fraud and abuse. The PBA provides reporting that can assist in detecting and managing fraud and abuse.

The OIG's Division of Fraud, Waste and Abuse/Identification and Prevention looks for claims patterns showing misuse of the benefit. OIG's Division of Special Investigations investigates these cases as well as cases from its fraud hotline. This division coordinates criminal cases. The Division of Fraud, Waste and Abuse/Identification and Prevention attempts to recover the rest administratively.

Benefit Fraud and Abuse Enforcement. The Office of Inspector General's Division of Fraud, Waste and Abuse/Identification and Prevention (DFWAIP) operates on contract with DMS to comb through Medicaid claims data and identify suspicious patterns that might indicate improper use of the benefit. The division may refer some recipients to DMS to consider for the lock-in program. Other cases may be referred to the OIG's Division of Special Investigations (DSI).

DSI also operates a fraud hotline and will investigate when it receives information that a recipient is misusing Medicaid. If the suspected misuse is illegal, the case can be referred to law enforcement and outside prosecutors. If the misuse can be handled internally, DSI can refer the case to DFWAIP for further action. By statute, DSI also must refer all hotline calls to the Office of the Attorney General.

Electronic Data Systems provides software tools and reviews lock-in recipients. A future vendor will assist with program integrity.

Benefit Fraud and Abuse Support. Electronic Data Systems, the Medicaid fiscal agent, provides software tools so that DFWAIP can identify fraud and abuse. The agent also reviews lock-in recipients annually to assess the intervention's effectiveness in each case. Another vendor, yet to be determined, will provide expertise and additional tools for identifying fraud, abuse, and other overpayments.

Lock-in Program for Benefit Misuse

The Medicaid lock-in program restricts a recipient to a single physician or a single pharmacy or both. Such restrictions make it harder for the recipient to misuse the benefit.

The Medicaid lock-in program can restrict a recipient to obtaining services from a single medical provider, filling prescriptions from a single pharmacy, or both. It can be used to manage the benefits for a recipient who appears to be overusing medical care, particularly emergency room visits, or for misuse of the prescription drug benefit. When the prescription drug benefit is an issue, the drugs in question usually are controlled substances. This use of the lock-in program is covered in the section on drug diversion below.

Detection of Recipient Benefit Misuse Has Been Overlooked

Outside of drug overuse and diversion, OIG has not focused on benefit misuse and theft. The information system reports are not suited to identifying these issues. New reports will be available when the new system is fully operational.

OIG has not focused on recipient benefit misuse outside of drug overuse and diversion. The surveillance and utilization review reports mentioned by DFWAIP focus on overuse of drugs and are not designed to identify benefit sharing and theft. The reports also stopped being available at the end of May 2007 when the new Medicaid Management Information System began operation. New reports will be available when the new information system is fully operational.

DMS and OIG have not made recipient benefit misuse a focus for their vendors. The new program integrity request for proposals does include recipient fraud and abuse. DMS should make recipient benefit misuse part of its program integrity plan.

DMS and OIG have not requested their overpayment vendors to consider benefit sharing or theft. However, the request for proposals for a new program integrity and surveillance and utilization review vendor does include recipient fraud and abuse. Staff commend DMS and OIG for their plans to expand program integrity in this way.

DMS is the responsible state agency providing direction to OIG and all program integrity operations. Recipient benefit sharing and theft should be part of the overall program integrity plan recommended in Chapter 1.

Actions To Stop and Recover Losses Caused by Benefit Misuse

Fraudulent Misuse. When fraudulent misuse is discovered, either as a result of eligibility fraud or other kinds of misuse, OIG's Division of Special Investigations will seek prosecution. If the recipient is found guilty, often the court will order restitution, although the amount ordered may be less than the full cost of the fraud.

Abusive Misuse. DFWAIP operates a voluntary recovery program. In addition to sending out educational letters to inform recipients of more cost-effective ways to use Medicaid benefits, the division also requests voluntary repayment of misused benefits. According to an OIG official, recipients frequently do repay some of the benefit cost.

Diversion of Prescription Drugs

Pharmaceutical manufacturers sell prescription drugs to wholesalers who then sell them to pharmacies. The prescription drugs physically reside in the pharmacy awaiting customers to purchase them. A patient with symptoms visits a physician, is physically examined, and is appropriately diagnosed. The physician writes a prescription based on the diagnosis. The patient presents a pharmacy with the prescription and purchases the drug prescribed by the physician. Prescription drug diversion alters this chain of events in one or more ways.

Prescription Drug Diversion Process

Prescription drug diversion channels legitimate prescription drugs toward illegal markets and illegal use.

Prescription drug diversion channels legitimate prescription drugs toward illegal markets and illegal use. For example, a patient could

- pick up a prescription pad from a doctor's office and tear off five forms;
- forge prescriptions for a painkiller such as hydrocodone or another drug of abuse;
- have the prescriptions filled at the pharmacy;
- pay using a Medicaid card, which may or may not be their own; and
- use the drug or sell the individual pills for $20 each.

Prescription drug diversion can involve multiple parties. One form of collusion involves physicians writing fraudulent prescriptions in exchange for cash under the table, a share of the drugs, sex, and other services.

Prescription drug diversion can involve multiple parties. Health care providers, health care recipients, and pharmacies can work together on prescription drug diversion. One form of collusion involves physicians writing fraudulent prescriptions in exchange for cash under the table, a share of the drugs, sex, and other services from recipients.

Medicaid Drug Diversion Agencies

This section describes the agencies involved in preventing, detecting, and combating drug diversion.

Drug Diversion Administration. The agencies involved in drug diversion prevention and management for Medicaid are the same as those that prevent and manage benefit fraud and abuse generally. These include

- Department for Medicaid Services,
- Drug use review board,
- Pharmacy and Therapeutics Committee, and
- First Health Services Corporation as the pharmacy benefit administrator.

Drug Diversion Enforcement. There are several drug diversion enforcement agencies in addition to those described for benefit fraud and abuse.

A separate entity within DFWAIP is the Drug Enforcement and Professional Practices Branch. This branch operates the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system to track all prescriptions for controlled substances filled in Kentucky. The DFWAIP Medicaid staff obtain information from KASPER to assist them in identifying recipient drug diversion. KASPER also assists other agencies in combating drug diversion.

Most law enforcement agencies around the state, including the Kentucky Bureau of Investigation, Kentucky State Police, and local law enforcement, actively fight drug trafficking. These agencies often discover prescription drug diversion schemes; sometimes the schemes include billing Medicaid for the drugs. Law enforcement agencies usually inform OIG of these suspects.

Also involved in provider oversight are the respective licensing boards that regulate all professionals who prescribe or dispense medications. These boards also combat drug diversion by educating their licensees and investigating allegations that licensees might have participated in drug diversion. Table 3.1 shows the licensing boards and the professionals they oversee.

Table 3.1
Licensing Boards for Professionals
Who Dispense or Prescribe Medications in Kentucky

Board	Professions	KRS Chapter
Pharmacy	Pharmacists (dispensers), pharmaceutical distributors, pharmaceutical manufacturers	315 217 218A
Medical Licensure	Medical and osteopathic physicians, physician's assistants (prescribers)	311
Nursing	Advanced registered nurse practitioners (prescribers)	314
Dentistry	Dentists (prescribers)	313
Podiatry	Podiatrists (prescribers)	311
Optometric Examiners	Optometrists (prescribers)	320

Source: Compiled by Program Review staff.

DMS operates the lock-in program that restricts certain Medicaid recipients to a single prescriber or a single pharmacy or both.

Drug Diversion Support. The support agencies for drug diversion are the same as those for benefit use.

Effect of Drug Diversion on Medicaid

The problem of prescription drug diversion has grown steadily worse over the past 15 years.

Within Medicaid, the potential for prescription drug diversion is quite large. Fifteen years ago, Medicaid prescription drug diversion was characterized as "widespread" nationally (U.S. Government 7). The problem of prescription drug diversion has grown steadily worse.

Most Kentucky program integrity and law enforcement officials expressed the opinion that Medicaid does not pay for much prescription drug diversion.

However, it seems likely that prescription claims systems have become more sophisticated and do not allow drug duplication, early refills, and unusually high dosages. Thus, these systems may protect Medicaid and other insurers from paying for many of the traditional diversion schemes. Some Medicaid policies also make Medicaid less attractive as a way to pay for diverted drugs. In particular, drug diverters prefer brand-name drugs, but Medicaid requires prior authorization for brand-name controlled substances and limits recipients to three brand-name prescriptions per month. Several program integrity and law enforcement officials speculated that few diverted prescriptions actually are billed to Medicaid.

Diverters can employ countermeasures, such as using multiple Medicaid cards or exaggerating symptoms to obtain larger-than-necessary prescriptions and selling the unneeded portion.

Others pointed out that diverters, like other perpetrators of fraud, can be creative in finding ways through the claims process. There is some evidence that Medicaid recipients who receive narcotics prescriptions for pain are more likely than other patients to divert the prescribed drugs. Recipients use multiple Medicaid cards or exaggerate symptoms to obtain larger-than-necessary prescriptions and sell the unneeded portion. Also, the claims system is designed to allow terminally ill patients to receive high dosages of pain medications. Staff were told that occasionally these patients use their status—or others use their status—to divert prescription drugs, including narcotics or expensive HIV and cancer medications.

Indirect Medicaid costs resulting from prescription drug diversion include additional medical office, urgent care, and emergency room visits. Kentucky employers incur indirect costs such as loss of job productivity and absenteeism.

There are indirect costs to Medicaid and other state resources stemming from prescription drug diversion, such as additional medical office, urgent care, and emergency room visits by drug diverters and the individuals that purchase diverted drugs from them. Loss of job productivity and absenteeism are other potential indirect costs as well.

Prescription Drug Use

Between 1992 and 2002, the number of prescriptions written for controlled drugs increased 154.3 percent—12 times faster than the population and almost 3 times faster than prescriptions for noncontrolled drugs.

The availability of and access to prescription drugs has never been greater. According to a prominent national study by The National Center on Addiction and Substance Abuse at Columbia University,

> Between 1992 and 2002, the U.S. population increased by 13 percent and prescriptions written for noncontrolled drugs rose 56.6 percent, but the number of prescriptions written for controlled drugs increased 154.3 percent—12 times faster than the population and almost three times faster than prescriptions for noncontrolled drugs (3).

Prescription Drug Use in Kentucky

Kentuckians appear to be high users of prescription drugs. According to a variety of reports, Kentucky ranks among the top five states on this measure.

Kentuckians appear to be high users of prescription drugs. According to a variety of reports, Kentucky ranks among the top five states on this measure. A 2006 report ranked Kentucky third in the nation in the number of annual prescriptions per capita, at 15.7. The national average is 11.3 (Novartis 30). Another report suggested that Kentucky ranked fifth in the nation in prescription drugs filled annually at retail pharmacies per capita in 2006, at 15.4. The national per-capita figure was 11.1. (Henry. “Retail”).

Prescription Drug Abuse and Addiction

Prescription drug abuse and addiction has become a significant growing national problem, particularly among teenagers.

Prescription drug abuse and addiction has become a significant growing national problem, particularly among teenagers (National Center 4). Many of the prescription drugs taken by average Americans have high abuse and addiction potential associated with them, particularly medications employed to reduce and manage pain, such as Oxycontin and hydrocodone.

The number of people who admit abusing controlled prescription drugs increased from 7.8 million in 1992 to 15.1 million in 2003—up 93.8 percent—seven times faster than the increase in the U.S. population. Prescription drug abuse has increased twice as fast as marijuana abuse and five times faster than cocaine abuse.

> The number of people who admit abusing controlled prescription drugs (i.e., opioids, central nervous system depressants, and stimulants) increased from 7.8 million in 1992 to 15.1 million in 2003—up 93.8 percent—seven times faster than the increase in the U.S. population. Approximately six percent of the U.S. population (15.1 million people) admitted abusing controlled prescription drugs in 2003, 23 percent more than the combined number using cocaine (5.9 million), hallucinogens (4.0 million), inhalants (2.1 million) and heroin (328,000) (National Center 3).

Prescription drug abuse has greatly outpaced the growth of other kinds of abuse in the United States over the past decade or so, "twice that of marijuana abuse," and "five times greater than cocaine abuse" (National Center 4).

The major categories of abused prescription drugs are narcotic pain relievers, depressants, and stimulants.

The major categories of abused prescription drugs are narcotic pain relievers, depressants, and stimulants. Table 3.2 provides a brief description and examples of the major categories of abused prescription drugs.

Table 3.2
Major Categories of Abused Prescription Drugs

Drug Categories	Examples	Drug Purpose
Narcotic Pain Relievers	Oxycodone (Oxycontin) Hydrocodone Methadone	These prescription narcotics provide pain relief for moderate to severe pain in the case of oxycodone and for mild to moderate pain in the case of hydrocodone.
Depressants (tranquilizers and sedatives)	Tranquilizers (benzodiazepines): Valium Xanax Sedatives (barbiturates): Nembutal Mebaral	These prescription depressants are used to relieve anxiety, nervousness, and tension associated with anxiety disorders.
Stimulants	Adderall Ritalin	These prescription drugs act as central nervous system stimulants. Adderall and Ritalin are used to treat attention deficit and hyperactivity disorders.

Source: Program Review staff compilation of information from Partnership. "Prescription Pain," "Prescription Sedatives," "Prescription Stimulants"; U.S. Dept. of Justice. National Drug Intelligence Center.

Prescription Drug Abuse in Kentucky

Over the 2002-2004 period, Kentucky led the nation in the nonmedical use of prescription psychotherapeutic drugs including narcotic pain relievers, depressants, and stimulants.

Over the 2002-2004 period, Kentucky led the nation in the nonmedical use of prescription psychotherapeutic drugs, including narcotic pain relievers, depressants, and stimulants, as can be seen in Table 3.3. Nationally, 6.2 percent of individuals aged 12 or older said they had used a prescription psychotherapeutic drug nonmedically in the 12 months prior to the National Survey on Drug Use and Health (U.S. Department of Health. Substance. Office. *State*).

Table 3.3
States With the Highest Nonmedical Use of Prescription Psychotherapeutic Drugs (2002 to 2004)

State	Percent	National Ranking
Kentucky	8.5	1
Nevada	8.1	2
Colorado	7.8	3
Utah	7.8	3
New Mexico	7.7	4
Oregon	7.7	4
Rhode Island	7.7	4
United States	**6.2**	—

Source: U.S. Dept. of Health. Substance. Office. *State* Table 7.1B.

Most Kentuckians who acknowledge abusing prescription drugs said they abused narcotic pain relievers. Kentucky also led the nation in this category of drug abuse.

Most Kentuckians who acknowledged abusing prescription drugs used narcotic pain relievers. Kentucky led the nation in the nonmedical use of narcotic pain relievers, with 7 percent of respondents; the national percentage was 4.8 (U.S. Dept. of Health. Substance. Office. *State* Table 7.2B).

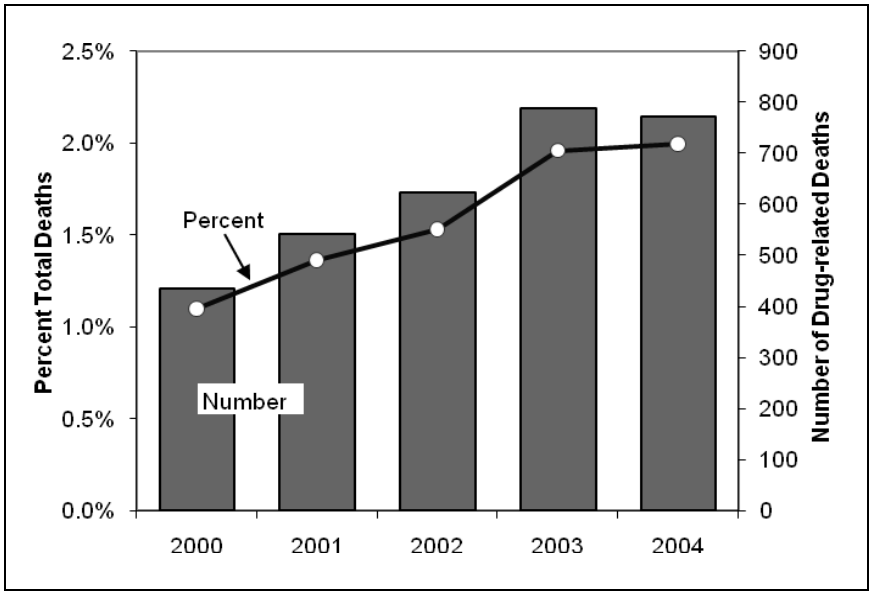
Drug-related Deaths in Kentucky Are Increasing

Taking too little or too much of a medication can sometimes mean the difference between life and death. More often, though, taking too much medication can be fatal. Program Review staff requested that the Kentucky Injury Prevention and Research Center analyze 2000-2004 National Center for Health Statistics data in order to determine the rate of drug-related deaths.

In 2000, there were 434 drug-related deaths in Kentucky. In 2004, there were 771 deaths. As a percent of total deaths, drug-related deaths almost doubled from 1.1 percent to 2 percent.

As shown in Figure 3.A, the number of deaths related to legal and illicit drugs in Kentucky increased between 2000 and 2004. In 2000, there were 434 drug-related deaths. In 2004, there were 771 deaths. As a percentage of total deaths, drug-related deaths almost doubled, from 1.1 percent to 2 percent.

Figure 3.A
Number and Percent of Drug-related Deaths in Kentucky
2000 to 2004



Source: Program Review staff figure showing Kentucky Injury Prevention and Research Center's analysis of data from the National Center for Health Statistics.

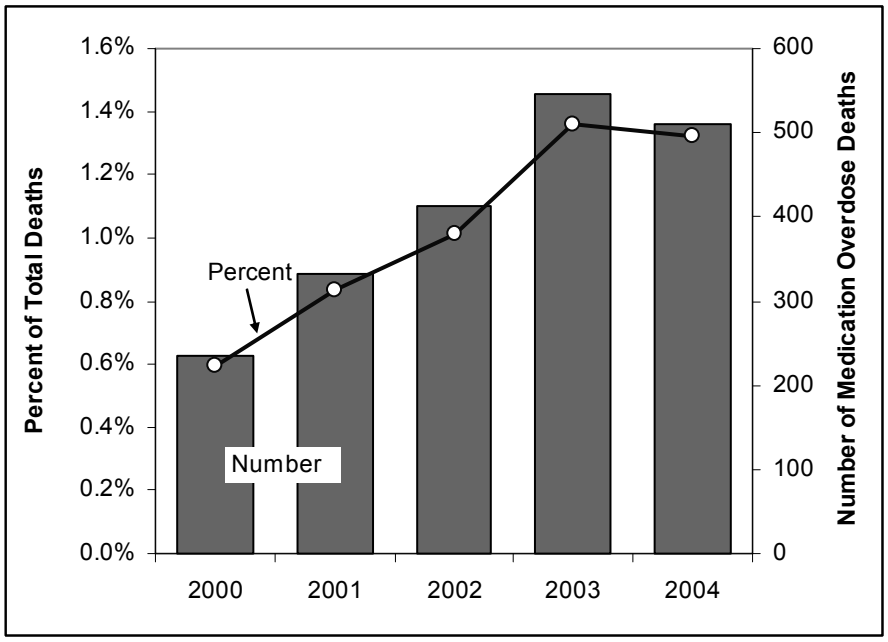
Not all the deaths measured in Figure 3.A were the direct result of drugs. Drug overdose itself was the most likely cause of death

when drugs were involved (65 percent in 2000 and 75 percent in 2004). Other causes included injury exacerbated by drug use. Similarly, not all the drugs involved were medications. Prescription medications were the drugs implicated in 60 percent to 75 percent of drug-related deaths between 2000 and 2004.

The number and percent of medication overdose deaths in Kentucky more than doubled between 2000 and 2004.

Figure 3.B indicates that the number and percent of medication overdose deaths more than doubled between 2000 and 2004. In 2000, 235 deaths were attributed to medication overdose. This represented 0.6 percent of all Kentucky deaths. By 2004, medication overdose deaths rose to 511 and 1.3 percent of all deaths.

Figure 3.B
Number and Percent of Medication Overdose Deaths in Kentucky
2000 to 2004



Source: Program Review staff figure showing Kentucky Injury Prevention and Research Center's analysis of data from the National Center for Health Statistics.

Prescription Drug Diversion in Kentucky

Kentucky faces significant drug threats from marijuana, cocaine, and methamphetamine and also from diverted prescription drugs.

According to the U.S. Drug Enforcement Administration, Kentucky faces significant drug threats from marijuana, cocaine, and methamphetamine and also from diverted prescription drugs. "Aside from marijuana cultivation and trafficking, the trafficking and illicit use of prescription drugs in the area is the most significant drug threat facing the residents of rural eastern Kentucky" (U.S. Dept. of Justice. Drug. *Kentucky*).

The hydrocodone and oxycodone products Lortab, Lorcet, Vicodin, and Oxycontin are particularly prone to diversion in Kentucky.

The hydrocodone and oxycodone products Lortab, Lorcet, Vicodin, and Oxycontin are particularly prone to diversion in Kentucky (U.S. Dept. of Justice. Drug. *Kentucky*). The principal diversion methodologies employed include pharmacy theft, "doctor shopping," prescription fraud, and procurement of large amounts of prescription drugs from illegal Internet pharmacies.

Doctor shopping consists of an individual visiting multiple physicians to get multiple prescriptions for the same drug and perhaps visiting multiple pharmacies to fill those prescriptions.

Doctor shopping consists of an individual visiting multiple physicians to get multiple prescriptions for the same drug and may also involve the individual visiting multiple pharmacies to fill those prescriptions. Prescription fraud includes activities such as stealing and forging prescriptions, posing as a physician or medical office worker and calling in fraudulent prescriptions to the pharmacy, or altering prescriptions in terms of quantity, dosage, or number of refills.

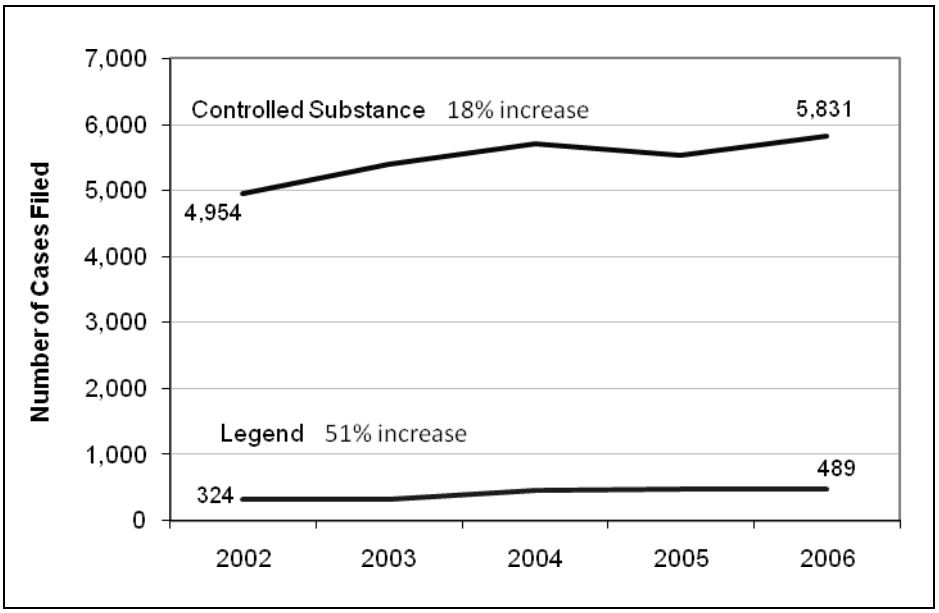
Based on interviews with state and local law enforcement agencies, it seems that law enforcement in Kentucky, as well as in the country as a whole, has been slow to recognize the severity of the problem of prescription drug abuse and the fraudulent activity associated with it. According to several interviewees, emphasis on combating the abuse and trafficking of illicit street drugs like cocaine and heroin has taken priority over investigating prescription drug diversion among many law enforcement personnel. This may be changing somewhat, particularly with the proliferation of illegal Internet pharmacies; the injection of counterfeit drugs into the marketplace; and the rise in prescription drug use, abuse, and diversion.

The Administrative Office of the Courts provided data on cases involving diversion of controlled substances and diversion of legend drugs—noncontrolled prescription drugs—for the years 2002 to 2006. It was not possible to determine how many of the cases involved Medicaid payments.

From 2002 to 2006, the number of prescription drug diversion cases for controlled substances increased by 18 percent, and the number for legend drugs rose by 51 percent in Kentucky.

Figure 3.C shows the number of diversion cases filed from 2002 to 2006. Most of the diversion cases were controlled-substance cases, which increased 18 percent, from 4,954 to 5,831 over the 3-year period. The number of legend drug cases increased 51 percent, from 324 to 489.

Figure 3.C
Prescription Drug Diversion Court Cases Per Year, 2002 to 2006



Source: Program Review staff analysis of data provided by the Administrative Office of the Courts.

Research on Prevalence of Drug Diversion

A recent study of 400 patients at a pain management facility in Paducah suggested that prescription drug abuse resulted in greater Medicare and Medicaid fraud in Kentucky.

A 2005 research article by staff of the Pain Management Center of Paducah suggested that "prescription drug abuse in Kentucky has led to an increase in Medicare and Medicaid fraud," based on a study of 400 patients at the center (Manchikanti. "Prevalence" 55). The researchers divided their patient sample into four groups: patients covered by third-party insurance; patients on Medicare, with or without third-party insurance; patients on Medicare and Medicaid; and patients on Medicaid only. All patients were receiving stable doses of an opioid: hydrocodone, oxycodone, methadone, or morphine. Their urine was tested for these and other potential drugs of abuse. It should be noted that the study had limitations. For example, the researchers knew the insurance coverage of the patients before performing the drug tests and there was no control group.

That study also suggested that the Medicaid-only group may have been significantly more likely to divert prescription drugs than other insured populations.

The Medicaid-only group had the highest rate of illicit drug use at 39 percent, compared to the Medicare and Medicaid group at 24 percent, the third-party insurance group at 17 percent, and the Medicare group at 10 percent. The Medicaid-only patients were the least likely to be using the opioids they were prescribed. Urine tests indicated that only 44 percent of the Medicaid-only group was using the prescribed drugs, compared to 64 percent of the Medicare and Medicaid group, 74 percent of the third-party

insurance group, and 76 percent of the Medicare group. This suggests that the Medicaid-only group may have been significantly more likely to divert prescription drugs than other insured populations (Manchikanti. "Prevalence" 57-59).

Staff encourage other researchers to conduct similar studies. To the extent funds are available, it might be productive to make such research part of the program outcome measurement plan recommended in Chapter 1.

Prescription Drug Diversion Schemes

Prescription drug diverters are becoming more sophisticated in the schemes they employ, particularly with the availability of the Internet, image scanners, cell phones, and other technological devices.

There are many ways individuals can defeat existing fraud and abuse prevention and detection systems in the prescription drug arena. Several common prescription drug diversion schemes were brought to Program Review staff's attention by state government agency officials; local, state, and federal law enforcement officials; and health care professionals around the state. In all of the interviews with relevant agencies and organizations, the view was expressed that prescription drug diverters are becoming more sophisticated in the schemes they employ, particularly with the availability of the Internet, image scanners, cell phones, and other technological devices.

Examples of prescription drug diversion schemes that may impact the Medicaid prescription drug program include fraudulent prescriptions, visiting multiple physicians to get prescriptions for the same drug, and physicians trading prescriptions for cash or services.

Appendix B has a list of recipient and provider prescription drug diversion schemes that potentially impact the Kentucky Medicaid prescription drug program. The schemes include

- recipients, medical office staff, and physicians writing fraudulent prescriptions on stolen prescription pads;
- recipients and medical office staff posing as physicians or nurses to call in fraudulent prescriptions to pharmacies;
- recipients scanning security prescription pads into a computer and producing high-quality fraudulent prescriptions;
- recipients altering prescriptions, including quantity, dosage, or number of refills;
- doctor shopping by recipients;
- doctor "pill mills" in which physicians trade prescriptions for cash, services, or a share of the drugs without examining the patient;
- individuals using someone else's Medicaid card to procure prescription drugs and then selling them for a profit; and
- recipients using fake imaging scans or medical records or faking symptoms as a way to procure prescriptions for various medical conditions that they do not have.

Recipient Prescription Drug Fraud or Abuse Activities

Program Review staff conducted Web-based surveys of Kentucky physicians and pharmacists on the subject of Medicaid prescription drug fraud and abuse. Appendices C and D have the detailed results of the surveys. Appendix E describes how the surveys were done. One area of inquiry was common prescription drug fraud or abuse activities engaged in by Medicaid recipients. Table 3.4 shows the most frequent prescription drug fraud activities engaged in by Medicaid recipients in the opinion of the respondents.

Table 3.4
Recipient Prescription Drug Fraud Activities
as Reported in Surveys of Physicians and Pharmacists

	Reported by	
Activity	**Physicians**	**Pharmacists**
Doctor shopping	85%	89%
Faking symptoms	79%	75%
Altering prescriptions	41%	36%

Note: Numbers of Respondents are 140 physicians and 594 pharmacists.
Source: Program Review staff analysis of surveys of Kentucky physicians and pharmacists.

According to Program Review staff's surveys of physicians and pharmacists, the top three recipient prescription drug fraud activities are doctor shopping; faking symptoms; and altering prescriptions in terms of the quantity, the dosage, or the number of refills.

Physicians' and pharmacists' survey responses indicated that the top three fraud activities engaged in by Medicaid recipients are doctor shopping; faking symptoms; and altering prescriptions in terms of the quantity, dosage, or number of refills. Program Review staff's interviews with seven individuals convicted of prescription drug fraud corroborated this survey opinion.[1] Physicians and pharmacists also agreed that doctor shopping and faking symptoms are far more prevalent than altering prescriptions.

The interviews with individuals convicted of prescription drug fraud also revealed that some physicians do not keep controlled substance prescription pads secure in their medical offices. The convicts asserted that it was easy to obtain prescription blanks and then to forge controlled substance prescriptions.

Some pharmacies do not adequately verify call-in prescriptions with the provider who purportedly wrote them.

In the Program Review staff survey, 23 percent of pharmacists and 14 percent of physicians responded that pretending to be a physician and calling in fake prescriptions was a common practice. Many law enforcement officers also mentioned this as a common scheme. Fraud convicts described fake phone-in prescriptions as

[1] It should be noted that almost all of the prescriptions the convicts fraudulently obtained were paid for by cash, not by a Medicaid card.

well. The convicts asserted that some pharmacies do not adequately verify call-in prescriptions with the provider who purportedly wrote them.

Recommendation 3.2

Recommendation 3.2 is that DMS and OIG should work with licensing boards for prescribers and pharmacists and their professional associations to determine whether limitations could be placed on filling phone-in prescriptions.

The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine whether fair and reasonable limitations could be placed on filling phone-in prescriptions.

Reasons Some Medicaid Recipients Commit Prescription Drug Fraud

Drug addiction is the most common reason that some Medicaid recipients commit prescription drug fraud, according to the survey responses of Kentucky physicians and pharmacists.

Respondents to the surveys of physicians and pharmacists indicated common reasons why some Medicaid recipients commit prescription drug fraud. Approximately 90 percent of respondents indicated that drug addiction is the most common reason that some Medicaid recipients commit prescription drug fraud. Table 3.5 shows the results.

Table 3.5
Reasons for Recipient Prescription Drug Fraud
as Reported in Surveys of Physicians and Pharmacists

Reason	Reported by	
	Physicians	Pharmacists
Drug addiction	88%	91%
Greed	49%	61%
Pseudo-addiction	36%	31%
Pain alleviation	34%	32%
Friend or family member has no insurance	32%	28%

Note: Numbers of respondents are 140 physicians and 594 pharmacists. Pseudo-addiction occurs when a patient who has legitimate pain does not receive enough pain medication and seeks more in order to relieve the pain.
Source: Program Review staff analysis of surveys of Kentucky physicians and pharmacists.

Commonly Diverted Prescription Drugs in Kentucky

Oxycodone, hydrocodone, Xanax, and Valium are among some of the most diverted prescription drugs in Kentucky.

Staff compiled information on diverted drugs from the Kentucky Office of Drug Control Policy, interviews with law enforcement, and surveys of pharmacists and physicians. Because diverters are said to prefer brand-name drugs, some brand names are shown in

parentheses. In alphabetical order, the most commonly diverted drugs in Kentucky appear to be

- alprazolam (Xanax),
- amphetamines (Adderall, Ritalin),
- carisoprodol (Soma),
- clonazepam (Klonopin),
- diazepam (Valium),
- hydrocodone (Lortab, Lorcet, Vicodin),
- hydromorphone (Dilaudid),
- methadone,
- oxycodone (Oxycontin, Percocet), and
- tramadol (Ultram).

The street value of prescription drugs can be many times what they would sell for if sold legally in a pharmacy.

Program Review staff learned anecdotally from interviews with Kentucky law enforcement personnel and from interviews with prescription drug fraud convicts that Oxycontin can sell on the street for up to $160 for one 80 milligram pill in certain areas of Kentucky, especially in eastern Kentucky. The street value of some prescription drugs can be many times what they would sell for if sold legally in a pharmacy. For example, according to the Cabinet for Health and Family Services Office of the Inspector General, 4-milligram Dilaudid legally sells for $88.24 per 100 tablets, but can command $10,000 on the street (Commonwealth. Cabinet. *Kentucky*).

Federal Drug Scheduling

Some drugs are regulated and controlled; others are not. Over-the-counter drugs can be purchased in pharmacies and grocery stores without a prescription. Prescription drugs by definition require authorization from a physician in the form of a written prescription.

Controlled substances are drugs with more restrictions than most prescribed drugs. There are five schedules, or classes, of controlled substances, known as Schedules I through V. The schedules are based on a drug's potential for abuse, accepted medical use, and accepted safety under medical supervision.

The Controlled Substances Act of 1970 (21 USC 812) is the federal law that regulates and controls the distribution and safekeeping of certain kinds of drugs. There are five established schedules or classes of controlled substances: Schedules I through V. The schedules are based on a drug's potential for abuse, accepted medical use, and accepted safety under medical supervision. Table 3.6 shows the five schedules, scheduling criteria, and examples.

Table 3.6
Federal Drug Schedules

Schedule	Criteria	Drug Examples
I	High abuse potential; no currently accepted medical use, lack of accepted safety for use under medical supervision	Heroin, PCP, LSD, and marijuana
II	High abuse potential; currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; abuse may lead to severe psychological or physical dependence	Ritalin, Oxycontin, methadone, and hydrocodone
III	Potential for abuse less than the drugs in Schedules I and II; currently accepted medical use in treatment in the United States; abuse may lead to moderate or low physical dependence or high psychological dependence	Lortab, Vicodin, and anabolic steroids
IV	Low potential for abuse relative to the drugs in Schedule III; currently accepted medical use in treatment in the United States; abuse may lead to limited physical dependence or psychological dependence relative to the drugs in Schedule III	Xanax, Valium, Klonopin, and Soma*
V	Low potential for abuse relative to the drugs in Schedule IV; currently accepted medical use in treatment in the United States; abuse may lead to limited physical dependence or psychological dependence relative to the drugs in Schedule IV	Robitussin A-C, Motofen, Lomotil, and Kapectolin PG

Note: *Soma is a Schedule IV drug in Kentucky, but it is not on the federal schedule.
Source: U.S. Dept. of Justice. Drug. "Drug."

Controlled Substance Schedules in Kentucky

States may place restrictions on controlled substances that differ from the federal schedule. Kentucky law codifies a schedule that generally corresponds to the federal one. The Cabinet for Health and Family Services can change the schedule by issuing administrative regulations.

The federal schedule of controlled substances determines what may be prescribed and how the prescriptions must be managed under federal law. The higher the schedule, the more restrictions there are on prescribing. States are free to place different restrictions on prescribing, but generally states do not choose to be less restrictive. Less restrictive state regulation would leave prescribers and pharmacists open to prosecution under federal law for acts that would be legal under state law.

KRS 218A.030-130 codifies lists of controlled substances that generally correspond with the federal schedule. In addition, KRS 218A.020 gives the Cabinet for Health and Family Services the authority to issue regulations to change the classification of any drug that is not available over the counter.

The authority granted to the cabinet permits a rapid response to changes in the federal schedule. It also allows the cabinet to exercise professional judgment to increase restrictions on drugs that are especially problematic in Kentucky.

One reason for having this kind of flexibility is to allow Kentucky to adjust the state schedule to match changes in the federal schedule without having to wait for legislative action. Another reason is to allow the cabinet to exercise professional judgment to increase restrictions on certain drugs that are problematic in Kentucky. The cabinet has made a few changes that are more restrictive than the federal schedule or state statute. The cabinet placed Soma, a federally unscheduled drug, on Schedule IV.

Kentucky's statutory schedule becomes more outdated with each change made by administrative regulation. Granting authority to the cabinet to alter a statutory schedule may raise concerns about the delegation of law-making power to this executive branch agency.

Staff are concerned that Kentucky's controlled substance statute may need to be clarified. Because the General Assembly wrote the specific drug schedule into statute, the statute becomes more outdated with each change in the drug schedule made by the cabinet through administrative regulation. Granting administrative authority to the cabinet to alter a statutory schedule may raise concerns about the delegation of law-making power to this executive branch agency.

If the cabinet chose to schedule a drug less restrictively than the federal government, then following state regulations might violate federal law.

Another issue to consider is that KRS 218A.020(3) allows the cabinet to choose whether to reschedule a substance when the federal schedule changes. This raises the possibility that the state schedule could be less restrictive than the federal schedule; therefore, following state regulations might violate federal law.

There are several options to streamline the controlled substance schedule process and remedy the potential constitutional problem:

- The list of controlled substances could be kept in statute, and the authority could be given to the cabinet to schedule drugs that are not mentioned in statute. This option does not allow the Commonwealth to adjust easily to changes in the federal schedule.
- The list of controlled substances could be removed from the statute, and the authority to schedule drugs could be given to the cabinet.
- The cabinet could be required to maintain a schedule no less restrictive than the federal schedule.
- The cabinet could be given discretion to be more or less restrictive than the federal schedule. This option opens the possibility that following state regulations would violate federal law.

Recommendation 3.3

Recommendation 3.3 is that the General Assembly may wish to consider options to remove potential conflicts among Kentucky statutes, administrative regulations, and the federal controlled substance schedule.

The General Assembly may wish to consider options to remove potential conflicts among KRS 218A.020-130, related administrative regulations, and the federal controlled substance schedule.

Medication Rescheduling

Seventy-nine percent of the Kentucky pharmacists surveyed indicated they believe tramadol, a pain reliever that is currently a nonscheduled drug, should be a scheduled drug in Kentucky.

Physicians and pharmacists were asked to list noncontrolled substances that should be scheduled and controlled substances that should be rescheduled. Their responses revealed two drugs of concern. Tramadol (brand name Ultram), a pain reliever used to treat moderate to severe pain, is currently a nonscheduled drug. Seventy-nine percent of the pharmacists indicated they believe tramadol should be a scheduled drug in Kentucky. A far smaller number—8 percent—responded that Lortab, a Schedule III drug consisting of hydrocodone and acetaminophen, should be restricted further to Schedule II. Program Review staff interviews with Kentucky law enforcement officials and with individuals convicted of prescription drug fraud also suggested that Lortab is prone to fraud and abuse and in need of rescheduling.

Recommendation 3.4

Recommendation 3.4 is that the cabinet should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling.

The Cabinet for Health and Family Services should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling.

Impressions of Drug Diverters Based on Staff Interviews

Many drug diverters outwardly have typical lives.

Program Review staff interviews with law enforcement personnel and drug diverters showed that many drug diverters hold jobs and outwardly have typical lives. Altogether, Program Review staff interviewed seven individuals who were drug addicts incarcerated for prescription drug fraud offenses. A few general impressions emerged from the interviews.

Drug addicts reported that
- addiction frequently is the main reason for prescription drug fraud,
- treatment and incarceration are important, and
- it seemed easy for drug diverters to obtain prescribers' Drug Enforcement Administration numbers.

- Prescription drug addiction, sometimes coupled with alcohol addiction, was the primary reason for committing prescription drug fraud in most cases. A secondary reason, in some cases, was to sell some of the medication to recoup its cost or to make a profit.
- The interviewees frequently expressed the opinion that drug treatment in concert with incarceration is needed to reduce the recidivism rate relative to prescription drug fraud offenses.

- It appears to be easy for prescription drug diverters to obtain prescribers' Drug Enforcement Administration numbers. This was supported by interviews with Kentucky law enforcement officers and with PBA officials as well.

Medicaid Lock-in Program

Lock-in programs require Medicaid recipients to go to one physician to procure prescriptions and to fill their prescriptions at one pharmacy.

Medicaid uses a "lock-in" program to help control prescription drug diversion. Lock-in programs require selected Medicaid recipients to go to one physician to procure prescriptions and to fill their prescriptions at one pharmacy in order to receive the Medicaid benefit (907 KAR 1:677). Other reasons for placing a Medicaid recipient in the lock-in program include reducing emergency room and physician overutilization. OIG identifies candidates for lock-in by reviewing prescription claims and hotline reports. Others, such as physicians, can suggest the program. The DMS medical director makes the final lock-in decision.

Table 3.7 shows the number of Medicaid recipients assigned to the lock-in program for the period 2002 to 2006:

Table 3.7
Kentucky Medicaid Recipients in Lock-in Program, 2002 to 2006

Year	Additions	Total in Program
2002	106	912
2003	252	1,154
2004	163	1,228
2005	104	1,105
2006	63	1,062

Source: Information provided by Electronic Data Systems.

Problems With the Lock-in Program

There has been an interface issue between the Medicaid Management Information System and the PBA. The physician lock-in information from Electronic Data Systems has not been transmitting properly, so the PBA cannot enforce lock in to a specific prescriber. The PBA is able to enforce lock in to a specific pharmacy

DMS officials informed Program Review staff that there has been an interface issue between the Medicaid Management Information System and the PBA system since December 2004. The physician lock-in information from the MMIS has not been transmitting properly to the PBA. When the PBA processes a pharmacy claim from a locked-in Medicaid recipient, the system is unable to prevent payment of prescriptions written by other physicians (Ramsey). This has diminished the effectiveness of the lock-in program. Further, any recent lock-in analysis will be skewed if Medicaid paid claims for a prescription written by a physician who was not the lock-in (or referring) physician. The issue has not,

however, affected the PBA's ability to enforce lock in to a specific pharmacy.

DMS does not have any overall analysis of the efficacy of the lock-in program, although a DMS vendor is supposed to conduct annual reviews of each lock-in recipient's claims.

The larger issue is that the Department for Medicaid Services does not have any overall analysis of the efficacy of the lock-in program, although Electronic Data Systems is supposed to conduct annual reviews of each lock-in recipient's claims. Staff suggest that DMS consider asking Electronic Data Systems to compile an annual assessment of the lock-in program based on the individual reviews. This process could be part of the program outcome measurement plan recommended in Chapter 1.

Prescription Drug Diversion by Physicians

There are some physicians who commit prescription drug diversion, sometimes acting alone and sometimes acting in collusion with patients, pharmacists, medical office staff, lab technicians, or others.

The vast majority of physicians abide by stringent medical and ethical standards, but a few do not. Whether driven by greed, personal substance abuse addiction, power, empathy for patients, or even naïveté, there are some physicians who commit prescription drug diversion, sometimes acting alone and sometimes acting in collusion with patients, pharmacists, medical office staff, lab technicians, and others in the health care system.

A few physicians provide unlawful access to powerful drugs to drug addicts and to drug profiteers, even to the point of contributing to the death of patients under their care.

Physicians wishing to defraud or abuse the system have used several common prescription drug diversion methods. Program Review staff learned of many of these fraud and abuse schemes during the course of interviews with state agency officials and with state and local law enforcement agency personnel. A few physicians provide unlawful access to powerful drugs for drug addicts and for drug profiteers, even to the point of contributing to the death of patients under their care.

For example, a physician in St. Louis, Missouri, egregiously overprescribed the pain killer Oxycontin to his patients. Eight of his patients died in 2005 and 2006 from prescription drug overdose or intoxication. An audit of prescribing patterns revealed that this physician wrote two-thirds of the prescriptions for Oxycontin in a regional Medicaid plan (Patrick). In a case in Spokane, Washington, a physician and his physician assistant regularly prescribed oxycodone and methadone to known drug addicts who sold these drugs on the street. Two of the drug addicts died after procuring prescriptions from this physician (Morlin).

A "pill mill" involves recipients paying physicians for a written prescription for a drug that they are abusing or selling on the street. Often, there are no physical examinations or reviews of medical records.

One of the prescription drug diversion schemes is commonly called a "pill mill." A frequent pill mill scheme involves recipients paying physicians for a written prescription for a drug that they are abusing or selling on the street. Often, there are no physical

examinations or reviews of medical records. Law enforcement often mentioned $150 as the going price for such prescriptions. Sometimes physicians receive kickbacks of pills or even sexual favors from the recipients.

Program Review staff interviews with three Kentucky physicians convicted of prescription drug fraud and disciplined by the Kentucky Board of Medical Licensure revealed that writing fraudulent prescriptions for themselves, relatives, or for some other third party was their primary fraud method. It should be noted that those three interviewees were drug addicts and are not representative of all physicians who commit prescription drug fraud and abuse.

Prescription Drug Fraud or Abuse Activities by Physicians

The Program Review surveys of physicians and pharmacists asked about common prescription drug fraud or abuse activities engaged in by physicians. Table 3.8 shows the most prevalent activities in the opinion of the respondents.

Table 3.8
Physician Prescription Drug Fraud Activities
as Reported in Surveys of Physicians and Pharmacists

Activity	Percent Reported by	
	Physicians	Pharmacists
Inappropriate prescribing	77%	87%
Writing "dispense as written" at a patient's request when not medically necessary	24%	58%
Practicing as a pain management specialist without adequate training or credentialing	39%	37%

Note: "Dispense as written" means the pharmacist must dispense a brand-name drug to the patient rather than substituting a generic equivalent.
Numbers of respondents are 140 physicians and 594 pharmacists.
Source: Program Review staff analysis of surveys of Kentucky physicians and pharmacists.

Kentucky physicians and pharmacists responding to staff surveys indicated that inappropriate prescribing is the main physician prescription drug fraud activity. Inappropriate prescribing can involve under- or overprescribing medication, prescribing medically unnecessary drugs, or prescribing without an adequate diagnosis.

More than three-quarters of the physicians and more than 85 percent of the pharmacists said inappropriate prescribing is the main physician prescription drug fraud activity. This activity can involve under- or overprescribing medications, prescribing medically unnecessary drugs, or prescribing without an adequate diagnosis.

When a physician writes "dispense as written" on a prescription, the pharmacist must dispense a brand-name drug to the patient rather than substituting and dispensing a lower-cost generic drug.

Physicians were less inclined to agree with pharmacists that this is a common prescription drug fraud activity engaged in by physicians.

Nearly 40 percent of both physicians and pharmacists responding to the survey indicated that practicing as a pain management specialist without adequate training or credentialing is a common activity of physicians.

Inappropriate Prescribing of Controlled Substances

Inappropriate prescribing is considered a significant issue among Kentucky physicians and pharmacists. Prescribers such as physicians, dentists, and nurse practitioners represent the main access point for individuals to obtain drugs.

Program Review staff interviews and focus groups with physicians and pharmacists corroborated the opinions expressed in the survey that inappropriate prescribing is a significant issue. Prescribers such as physicians, dentists, and nurse practitioners represent the main access point for individuals to obtain drugs. However, prescribers' knowledge, experience, and attention vary widely, leading to inconsistent application of prescribing guidelines.

Guidance for prescribing controlled substances in Kentucky exists. KRS 218A.170 states: "A practitioner may...prescribe a controlled substance only for a legitimate medical purpose and in the course of professional practice." More specifically, the Kentucky Board of Medical Licensure has adopted guidelines for prescribing controlled substances that meet the criteria of the Federation of State Medical Boards of the United States.

Inappropriate prescribing of controlled substances likely contributes to the cost of drugs in the Medicaid prescription drug benefit.

The board's guidelines provide direction regarding diagnoses, management plans, monitoring progress, control of supply, and the recognition of drug-seeking behavior, among others. Inappropriate prescribing of controlled substances likely increases the cost of drugs in the Medicaid prescription drug benefit.

Reasons Physicians Abuse Their Prescribing Authority

Patient deception is the most common reason that physicians abuse their prescribing authority, according to statewide surveys of Kentucky physicians and pharmacists.

Physicians abuse their prescribing authority for several reasons. Table 3.9 shows the four most common reasons why physicians abuse their prescribing authority based on the surveys of physicians and pharmacists. Patient deception was the most common reason cited. Inexperience, lack of knowledge, and inability to recognize drug-seeking behavior were other reasons given.

Table 3.9
Reasons Physicians Abuse Their Prescribing Authority
as Reported in Surveys of Physicians and Pharmacists

Reason	Percent Reported by	
	Physicians	Pharmacists
Patient deception	62%	68%
Physician's inexperience in dealing with manipulative and/or demanding patients	48%	51%
Physician's inadequate knowledge of the patient's medical and/or drug history	46%	46%
Physician's inability to recognize patient's drug-seeking behavior on the part of the patient	44%	47%

Note: Number of respondents are 140 physicians and 594 pharmacists.
Source: Program Review staff analysis of surveys of Kentucky physicians and pharmacists.

Physician Education To Reduce Inappropriate Prescribing Practices

Physicians and pharmacists surveyed believed that physician education would be helpful.

The surveys of physicians and pharmacists asked whether physician education would be helpful in reducing inappropriate prescribing practices. Sixty-five percent of the physicians and 81 percent of the pharmacists indicated that physician education would be helpful in reducing inappropriate prescribing. Of the physicians who believe that education would be helpful, 42 percent indicated that continuing medical education would be a useful method.

Reasons Some Physicians Commit Medicaid Prescription Drug Fraud

Sixty-six percent of the physicians indicated on a staff survey that conflict avoidance with patients is the main reason that some physicians commit Medicaid prescription drug fraud.

The Program Review staff survey of physicians asked them to indicate common reasons some physicians commit prescription drug fraud. Table 3.10 shows the most prevalent reasons in the opinion of physicians. Conflict avoidance with patients was cited as the main reason. Other reasons included empathy for patients, greed, and the physician's own drug or alcohol dependence.

Table 3.10
Reasons Some Physicians Commit Medicaid Prescription Drug Fraud as Reported in Survey of Physicians

Reason	% Reported by Physicians
Conflict avoidance with patients	66%
Empathy for patients and their families	46%
Greed	30%
Physician's drug or alcohol dependence	25%

Note: The number of respondents is 140 physicians.
Source: Program Review staff analysis of survey of Kentucky physicians.

Severity of Medicaid Prescription Drug Fraud and Abuse Among Various Groups

Medicaid prescription drug fraud and abuse among recipients was regarded by surveyed physicians and pharmacists as a more serious problem than among other groups. Physician fraud and abuse was the second most seriously perceived fraud problem in the opinion of those surveyed. Pharmacists were perceived by surveyed physicians and pharmacists as less likely to commit Medicaid prescription drug fraud and abuse.

The surveys of physicians and pharmacists asked them to rate the seriousness of Medicaid prescription drug fraud and abuse among various groups. The results in Table 3.11 suggest that physicians and pharmacists responding to the survey regarded Medicaid prescription drug fraud and abuse among recipients as a more serious problem than among other groups. Fraud and abuse among physicians is the second most seriously perceived fraud problem in the opinion of those surveyed. Surveyed pharmacists appear to have some concern about prescription drug fraud committed by pharmaceutical manufacturers, pharmacy benefit administrators, and nurse practitioners. Surveyed pharmacists expressed significantly more concern about these groups than did physicians. Pharmacists are perceived by both physicians and pharmacists who responded as less likely to commit Medicaid prescription drug fraud and abuse.

Table 3.11
Seriousness of Medicaid Prescription Drug Fraud and Abuse Among Various Groups as Reported in Surveys of Physicians and Pharmacists

Group	Percent Reported by	
	Physicians	Pharmacists
Recipients	3.68	3.89
Pharmacists	1.62	1.40
Pharmacy Techs	1.63	1.50
Physicians	2.02	2.54*
Nurse Practitioners	1.94	2.30*
Other Prescribers	2.01	2.22
Medical Office Workers	1.80	2.14
Lab Techs	1.17	1.09
Pharmaceutical Manufacturers	1.83	2.37*
Pharmacy Benefit Administrators	1.63	2.34*

Note: Seriousness is rated on a scale from 0, not a problem at all, to 5, a very serious problem. The number of physician responses for each group ranged from 82 to 128. The number of pharmacist responses for each group ranged from 388 to 564.
*Significantly different from physicians' ratings (less than 1 percent chance that difference is random).
Source: Program Review staff analysis of physician and pharmacist surveys.

Controlled Substance Registry

The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system has garnered widespread praise.

The Kentucky All Schedule Prescription Electronic Reporting system began operation in 1999. KASPER is operated by the Drug Enforcement and Professional Practices Branch, which is in the Cabinet for Health and Family Services' Office of Inspector General; Division of Fraud, Waste and Abuse/Identification and Prevention.

In interviews with law enforcement and Medicaid officials, KASPER has received praise as a powerful tool for fighting drug diversion. With its Web-based interface, more prescribers and pharmacists have been using KASPER to detect doctor shoppers and other drug diverters. Congress created grants to help other states develop similar systems, and other states look to Kentucky as a leader in this area. Staff commend the cabinet on its success in developing and promoting KASPER.

Medicaid-eKASPER Interface. Part of the new Medicaid Management Information System is an interface with KASPER,

called the Medicaid-eKASPER interface.[2] The system has been tested and will become operational when the new MMIS is fully running. Although there have been several MMIS delays, the most recent target is the end of January 2008.

DMS has designed an interface between Medicaid and KASPER that will greatly assist in identifying recipient drug diversion.

The interface will allow Medicaid to receive information from KASPER about large numbers of Medicaid recipients that Medicaid has identified as having unusual usage of controlled substances. The information will assist DMS in determining whether or not a recipient should be placed in the lock-in program or investigated for fraud. In addition, the interface is designed to allow Medicaid to ask for KASPER information about a list of prescribers or pharmacists. When compiling provider information, the interface will remove information about prescriptions for non-Medicaid recipients.

The interface is expected to greatly increase the efficiency of the recipient utilization review process. Staff commend the cabinet on its initiative in developing the system.

A vendor is in place to begin capturing controlled substance prescription data electronically on a daily basis. The system should be operational by the end of 2007.

Improving KASPER's Effectiveness. Several prior assessments have recommended that KASPER obtain controlled substance prescription data as soon as possible after the prescription is filled. Staff heard similar recommendations from several physicians and pharmacists in interviews and survey responses. In order to improve the timeliness of KASPER data, the cabinet has awarded a contract to NDCHealth to design and build a system that will capture pharmacy information on a daily basis.[3]

Most pharmacies today use computerized systems to fill prescriptions and to file insurance claims. The pharmacy's computers are connected with a network of "switching companies" that receive prescription billing information from pharmacies and transmit the information to the correct insurer. NDCHealth is a switching company. It has proposed to identify controlled substance prescription records as they come through and send a copy to KASPER each evening.

The missing piece in such a process is that prescriptions paid with cash do not need to be sent to an insurer. Cash transactions are a

[2] eKASPER refers to enhanced KASPER that was implemented in 2005. The term KASPER today refers to the enhanced system.
[3] NDCHealth became part of Per-Sé Technologies because of a merger completed in January 2006. Per-Sé was acquired by McKesson in January 2007 and has become part of the McKesson RelayHealth business. This report will refer to NDCHealth as named in the contract.

large part of prescription drug diversion schemes. Recognizing this, NDCHealth has proposed to create a process that will allow pharmacies to send a record about such cash payments to the switching company. If this proposal proves workable, pharmacy computers will be programmed to send information about cash prescription payments automatically to NDCHealth, which will send a copy to KASPER each evening.

Pharmacies that do not send electronic prescription information via switching companies, or that do not send their cash transactions, would have to continue to send their controlled substance prescription information to KASPER every 8 days as they do now. NDCHealth will collect all the transactions from all the sources and remove any duplicates.

KASPER's target is that 80 percent of all controlled substance prescriptions will be in KASPER within 24 hours. The remaining prescriptions will be obtained through an improved version of the existing process. The new system should be implemented by the end of 2007.

Staff commend the cabinet on its efforts to improve the timeliness of KASPER data by capturing electronic prescription information.

Electronic prescribing should further reduce opportunities for drug diversion.

Electronic Prescribing. Most experts agree that the major remaining gap in the prevention of drug diversion is the way prescriptions are sent to the pharmacy. Written prescriptions can be altered or forged, and phone-in prescriptions can be faked. One solution is electronic prescribing, a component of the national electronic health records initiative. Unfortunately, at this time, the federal Drug Enforcement Administration does not allow electronic prescribing of controlled substances.

The Kentucky eHealth Network Board is coordinating the electronic health records rollout as the Kentucky Health Information Partnership. Cabinet officials stated that KASPER has been identified as a key component of the project. Early in 2007, Kentucky received a $4.9 million federal Medicaid Transformation Grant to promote electronic access to Medicaid and other medical records as well as electronic prescribing in Kentucky.

Staff commend the board and the cabinet for leveraging Medicaid funds to further electronic health records and electronic prescribing. Kentucky should be well placed to take advantage of electronic prescribing of controlled substances when federal rules permit it.

The KASPER statutes appear to contain some ambiguities that deserve further consideration.

KASPER Statutes. The Kentucky law that controls KASPER appears to contain some ambiguities that deserve further consideration.

KRS 218A.202 lists persons and entities that may have access to KASPER information and the conditions of that access. In most cases, access to KASPER information about a specific individual requires that the person obtaining the information be in the process of a prior bona fide investigative, practitioner-patient, or criminal oversight relationship with that individual. There are some exceptions, including the Medicaid program.

KRS 218A.202(6)(c) appears to grant any state's Medicaid program access to KASPER. Technically, the statute appears to provide a Medicaid agency access to information about all recipients and providers, not just those participating in Medicaid. In practice, Kentucky's Medicaid-eKASPER interface has been designed to remove non-Medicaid recipient information from provider reports, and Medicaid has taken steps to ensure that only Medicaid recipient information is requested.

No one who receives information about an individual from KASPER may provide the information to a third party, with a few exceptions. Among these exceptions, KRS 218A.202(8)(b) states that Medicaid may share KASPER data regarding Medicaid recipients with law enforcement and with licensing boards. However, it is not clear whether the law enforcement officer or licensing board must already be involved in an investigation of those recipients. Furthermore, the paragraph does not mention sharing information about providers.

Presumably, KRS 218A.202(8)(c) was intended to allow KASPER data as evidence in Medicaid administrative hearings regarding Medicaid recipients and providers. The statute does not say that the information must be about a Medicaid recipient or provider. The statute also does not clearly indicate that the administrative hearing must be related to Medicaid.

In addition, KRS 218A.202(12) defines the penalties for violating the rules on obtaining and disclosing information from KASPER. The subsection states that it is a felony for anyone to obtain "information under this section not relating to a bona fide specific investigation." It does not provide an exception for Medicaid programs and other entities authorized in KRS 218A.202(6) to obtain KASPER data for other purposes.

KRS 218A.240(7)(a) requires designated cabinet staff to use KASPER data in a number of ways, including "investigations, research," and others. It is not clear whether this paragraph authorizes searching KASPER data to identify possible criminal activity without there being a prior investigation of an individual suspect as outlined in KRS 218A.202(6).

Table 3.12 summarizes the questions raised above.

Table 3.12
Questions About KASPER Statutes

Section of KRS 218A	Question
202(6)(c)	Does this paragraph authorize the Medicaid program to access KASPER information about non-Medicaid recipients?
202(6)(c)	Does this paragraph authorize Medicaid programs in other states to have access to KASPER data? If so, should that access be limited in any way?
202(8)(b)	In conjunction with KRS 218A.202(6)(a) and (b), does this paragraph technically limit Medicaid to sharing KASPER information with law enforcement or a licensing board only when that entity is already engaged in an investigation of the persons being reported? Should such a restriction exist?
202(8)(b)	Should this paragraph mention Medicaid providers as a group whose KASPER information Medicaid may share?
202(8)(c)	Should this paragraph explicitly state that Medicaid may use KASPER information only about Medicaid recipients or providers in Medicaid administrative hearings?
202(12)	Should this subsection explicitly reference exceptions for obtaining KASPER data by Medicaid and other entities under KRS 218A.202(6) for purposes other than "a bona fide specific investigation"?
240(7)(a)	Does this paragraph give designated cabinet officials the authority to look for patterns in KASPER data in order to identify and investigate possible criminal activity without prior suspicion of specific persons?

Source: Program Review staff analysis of KRS 218A.202 and KRS 218A.240.

Recommendation 3.5

Recommendation 3.5 is that the General Assembly consider amending the KASPER statutes to remove possible ambiguities and inconsistencies.

If it is the intent of the General Assembly to clarify the permitted and prohibited uses of data in the Kentucky All Schedule Prescription Electronic Reporting system, then the General Assembly may wish to consider amending KRS 218A.202 and KRS 218A.240 to remove possible ambiguities and inconsistencies.

Fraud and Abuse in Pharmacy Billing

The only source of prescription drug claims is pharmacists. Interviews and surveys suggest that pharmacist billing fraud and abuse might be relatively minor in Kentucky but seems to be significant in other states. Even so, actual recoveries in 2003 for pharmacy overpayments—not fraud—exceeded $4 million.

For the Medicaid prescription drug benefit, only licensed pharmacists can dispense medications. The impression that Program Review staff received from interviews with pharmacists, a focus group with pharmacists, and surveys of physicians and pharmacists is that, overall, prescription drug billing fraud and abuse committed by pharmacists is a relatively minor problem. Nevertheless, pharmacy overpayments—not fraud—found by Kentucky Medicaid in 2003 exceeded $4 million.

In other parts of the country, pharmacy billing fraud seems to be relatively active. Staff found frequent examples of pharmacy fraud in New Jersey and New York as well as other examples from Pennsylvania, Tennessee, and the state of Washington.

Pharmacists in Kentucky occasionally commit billing fraud. One 2007 case in Louisville illustrates this point. A pharmacist with an independent pharmacy sold, purchased, and traded prescription drug samples to the public by purchasing the drug samples from others, including a local physician and a pharmaceutical company sales representative. After obtaining the drug samples, the pharmacist repackaged and sold the drug samples to the public through his pharmacy. The pharmacist billed Medicare and Medicaid for the drug samples. The pharmacist also admitted that he had billed insurance companies and Medicaid for prescriptions that were never filled. According to the plea agreement, the federal government intends to seek nearly $6 million in restitution for losses caused by the pharmacist's inappropriate sale of sample drugs. Of this amount, the federal government has estimated that approximately $4 million would be payable to the Centers for Medicare and Medicaid Services and $1.7 million would be payable to Kentucky (U.S. Dept. of Justice. United).

Appendix B lists many possible ways pharmacies can defraud Medicaid and other insurers. Most of the methods were found in descriptions of actual fraud convictions and fraud reports. Although modern prescription claims processing systems make some aspects of fraud more difficult, those few pharmacists seeking to defraud the system still find ways to do so. For example, billing fake prescriptions to various recipients' Medicaid accounts might appear to be doctor shopping or misuse by the recipients. Unless the program integrity unit specifically compared the pharmacy provider on the different recipients' claims, this pattern could go undetected for some time.

The Kentucky Medicaid Fraud Control Unit has only prosecuted one pharmacist for billing fraud in the past few years. However, the lack of prosecutions may result in part from the limited efforts that DMS and OIG have made to identify such fraud.

Prescription Drug Fraud or Abuse Activities by Pharmacists

Minorities of surveyed providers identified pharmacist fraud activities as prebilling for refills, not reversing unclaimed refills, and filing false claims.

Surveys of physicians and pharmacists around the state revealed that no majorities of either group of respondents believe any fraudulent or abusive prescription drug activities are commonly engaged in by pharmacists. Even so, there are a few prescription drug fraud and abuse activities in which minorities of physicians and pharmacists believe some pharmacists engage. All these activities involve billing fraud, as shown in Table 3.13. The activities are billing for refills before the patient requests them; reusing the medication in unclaimed refills without reversing the claim; and filing false claims, such as billing two different payers or billing for drugs not actually dispensed.

Table 3.13
Pharmacist Prescription Drug Fraud Activities as Reported in Surveys of Physicians and Pharmacists

Activity	Percent Reported by	
	Physicians	Pharmacists
Preparing and billing a prescription refill prior to a patient request	Not asked	32%
Reusing unclaimed refills without reversing submitted claims	Not asked	31%
Filing false claims (double billing or billing for prescription drugs not dispensed)	26%	Not asked

Note: Numbers of respondents are 140 physicians and 594 pharmacists.
Source: Program Review staff analysis of surveys of Kentucky physicians and pharmacists.

A majority of pharmacists surveyed suggested that education would help reduce inappropriate dispensing.

In the opinion of 69 percent of the responding pharmacists, pharmacist education would be helpful in reducing inappropriate dispensing practices.

Reasons Some Pharmacists Commit Medicaid Prescription Drug Fraud

Greed and conflict avoidance were reported as reasons some pharmacists might commit fraud. Inadequate Medicaid reimbursement was mentioned by a minority of survey respondents.

The survey of pharmacists asked them to indicate common reasons some pharmacists commit Medicaid prescription drug fraud. Table 3.14 shows the most prevalent reasons in the opinion of pharmacists who responded to the survey.

In the opinions of surveyed Kentucky pharmacists, greed and conflict avoidance are the most likely reasons for committing Medicaid prescription drug fraud. Three of the top four reasons are the same as were said to motivate some physicians. Inadequate reimbursement from Medicaid was cited by 37 percent of the pharmacists as a reason pharmacists might commit prescription drug fraud.

Table 3.14
Reasons Some Pharmacists Commit Medicaid Prescription Drug Fraud as Reported in Survey of Pharmacists

Reason	Percent
Greed	59%
Conflict avoidance with pharmacy customers	55%
Inadequate reimbursement from Medicaid	37%
Empathy for patients and their families	36%

Note: Number of respondents is 594 pharmacists.
Source: Program Review staff analysis of survey of Kentucky pharmacists.

Medicaid Pharmacy Billing Fraud Agencies

Agencies involved in prevention of billing fraud are
- PBA,
- Pharmacy and Therapeutics Committee, and
- DMS.

Billing Fraud and Abuse Prevention. The PBA ensures that all prescription claims meet the standards for claims payment. The Pharmacy and Therapeutics Committee considers changes to the preferred drug list that include rules to discourage benefit fraud and abuse. DMS management oversees the prescription drug benefit, including the operation of the PBA and the Pharmacy and Therapeutics Committee.

Billing Fraud and Abuse Administration. The agencies involved in prevention and management of billing fraud and abuse for Medicaid are the same as those that prevent and manage benefit fraud and abuse generally. These include
- Department for Medicaid Services,
- Drug use review board,
- Pharmacy and Therapeutics Committee, and
- First Health Services Corporation as the pharmacy benefit administrator.

OIG has two divisions that handle pharmacy billing fraud and abuse. The Division of Fraud, Waste and Abuse/Identification and Prevention has the task of identifying suspicious claims patterns and referring them to the Division of Special Investigations. At the direction of DMS, it has not done so for several years.

Billing Fraud and Abuse Enforcement. The Office of Inspector General's Division of Fraud, Waste and Abuse/Identification and Prevention has been given the task of identifying suspicious claims patterns and providing information support for investigations. At the direction of DMS, the division has not looked for suspicious prescription claims patterns for several years. If it had, suspect cases would be referred to the OIG's Division of Special

Investigations to prepare a case. If suspicions are borne out, the cases would be referred to the Office of the Attorney General's Medicaid Fraud and Abuse Control Division.

The Division of Special Investigations operates the fraud hotline and refers calls to the attorney general's Medicaid fraud control unit (MFCU).

In addition, the Division of Special Investigations operates the Medicaid fraud and abuse hotline under KRS 205.8483(2). By statute, the division must refer all hotline calls, whether related to recipients or providers, to the attorney general's office.

The attorney general's Medicaid Fraud and Abuse Control Division is Kentucky's Medicaid fraud control unit (MFCU). Each state chooses whether to have such a unit. Currently, 50 of the 51 Medicaid programs have one (U.S. Dept. of Health. Office. "Medicaid Fraud"). Most are run by the attorney general of the state. MFCU is responsible for investigation and criminal prosecution of provider billing fraud against the Medicaid program and for investigation and prosecution of patient abuse and neglect in health care facilities that receive Medicaid payments. It receives its funding under a contract with the U.S. Department of Health and Human Services' Office of Inspector General.

The Board of Pharmacy also plays a role in regulating the activities of pharmacists and assisting in investigations.

Electronic Data Systems and First Health Services Corporation provide services in support of pharmacy claims program integrity.

Billing Fraud and Abuse Support. Electronic Data Systems provides the same kinds of supporting tools for billing fraud and abuse as it does for benefit use and drug diversion. In the area of billing fraud and abuse, First Health Services Corporation, as the Kentucky Medicaid administrative agent, enrolls Medicaid providers and verifies that they are properly credentialed.

Identifying Pharmacy Billing Fraud and Abuse

DMS and OIG directed their overpayment vendors to seek abusive claims and paid them on a contingency basis. The vendors also shifted their focus from one type of provider to another. Pharmacies have not been a focus since 2003.

Over the past several years, the DMS program integrity unit and later OIG engaged the services of overpayment recovery vendors to identify and recover overpayments. These vendors have been paid on a contingency basis, which encourages a focus on easily identified overpayments rather than on fraud. Under the direction of DMS and OIG, these vendors have focused primarily on billing errors and other kinds of abuse. In addition, the vendors have focused from time to time on different specific types of providers, such as hospitals, dentists, long-term care facilities, and various types of medical practices. Pharmacies have not been a focus since 2003.

When a provider is identified for review, claims from as long ago as 5 years might be examined and identified as overpayments.

When a provider is identified for review, claims from as long ago as 5 years might be examined and identified as overpayments. Although there is no statutory limit to the review period, a cabinet official explained that providers are allowed to discard records after 5 years. DMS determined that it might be impractical to seek recovery for overpayments after the supporting records have been discarded.

In the following sections, staff used accounts receivable information provided by OIG. Staff made some assumptions about how to attribute the amounts to time periods, so the totals for each period presented here may differ slightly from OIG's totals. This report does not attempt to present the total amount identified for recovery. OIG indicated that millions of dollars worth of possible overpayments had to be dropped because they were mistakenly identified as abuse but were legitimate payments.

During these periods, OIG used the Medicaid Management Information System to identify some overpayments. Other overpayments were identified from other sources. Most such overpayments were the result of Medicaid claims processing errors, payment owed by other health insurers, and other sources.

It is possible that some of these recoveries from other sources included criminal restitution from fraud cases handled by local or federal prosecutors. The Office of the Attorney General, as discussed later, reported one criminal prosecution of a pharmacist during this period. The OIG information did not distinguish these cases from others. For the purposes of this report, staff included all recoveries from other sources in the "other factors" category.

Program Integrity Activities, 2001 to 2003

At only one point since 2001 has the focus turned to pharmacies. Roughly in the period from 2001 to 2003, DMS was making significant changes to the prescription drug benefit. Some of the changes that impacted pharmacies were implementing the Pharmacy and Therapeutics Committee, reducing prescription reimbursement rates, reducing dispensing fees, and setting new upper payment limits.

From 2001 to 2003, DMS made significant prescription benefit changes, including a reduction in reimbursement and dispensing fees. DMS decided to delay review of pharmacy claims until 2003. The review undertaken then found over $4 million in overpayments.

At the time, HealthWatch Technologies (now HWT) was the overpayment recovery vendor. Although HWT planned to address pharmacy abuse, DMS delayed the project because it would be an additional burden on pharmacies in conjunction with the prescription program changes. Shortly before the HWT contract

expired, DMS permitted the vendor to proceed with the pharmacy review. The review eventually recovered more than $4 million going back 5 years.

Staff review of the computer procedures showed that they were designed to identify abuse in the form of common billing errors, but not fraud. The results of such procedures might include cases of fraud. An OIG official pointed out that there are no conventional fraud-specific procedures. Staff urge DMS and OIG to explore unconventional procedures that are more likely to identify fraud.[4]

In response to the HWT review, pharmacy representatives requested a meeting with DMS. DMS explained the process of moving the focus from one provider type to another so that pharmacies would have some respite from review.

For the same time period, DMS recovered about $108,000 in pharmacy overpayments attributable to agency error, additional health coverage, and other factors.

Program Integrity Activities, 2003 to 2006

In 2003-2006, DMS directed the overpayment vendor to focus on other provider types. During the period, OIG recovered $2.4 million in pharmacy abuse overpayments identified by other means and $3.1 million attributable to agency error, additional health coverage, and other factors.

After the HWT review of pharmacy overpayments, DMS instructed the new overpayment vendor, Myers and Stauffer, to focus on other types of providers. This process continued after the program integrity unit moved to OIG in 2004. OIG officials stated that another pharmacy review was planned, but the overpayment contract was not renewed when it ended in June 2006. During this time, DMS and OIG recovered approximately $2.4 million in overpayments from abuse identified through other means. OIG indicated these were identified by DFWAIP, but the codes for most of the cases indicate they were caused by claims processing errors.

For the same time period, DMS recovered more than $3.1 million in pharmacy overpayments attributable to agency error, additional health coverage, and other factors.

Program Integrity Activities, 2006 to 2007

Since July 2006, DMS has not had an overpayment vendor. No abuse overpayment collections were identified. Agency error and other overpayments accounted for $257,000 collected.

By the time the Myers and Stauffer contract ended, OIG staff were heavily involved in designing and testing a new MMIS. Lack of an overpayment vendor and limited staff time probably account for the small amount of prescription drug overpayments recovered in

[4] Staff observed a demonstration of a pattern-recognition system that can more reliably detect fraud than traditional systems. Also, procedures designed to detect specific fraud methods could be developed.

this period. Through May 2007, OIG reported a negative total for abuse overpayments. This may mean that some recoveries from earlier periods were refunded.

For the same time period, DMS recovered almost $257,000 in pharmacy overpayments attributable to agency error, additional health coverage, and other factors.

Program Integrity Overhaul Planned

The pattern of prescription drug benefit overpayment recoveries from 2001-2007 has depended on the attention DMS and OIG paid to prescription claims and on the occurrence of claims processing errors. There has been little attention to prescription claims since the middle of 2003, and the bulk of recoveries since then appears to result from agency errors and other sources.

A federal review of Kentucky's program integrity process in 2005 found several commendable practices, including a unit independent of the Medicaid agency, KASPER, and educational letters to providers.

In August 2005, a CMS fraud and abuse team conducted a review of Kentucky Medicaid's program integrity procedures. The report is reproduced in Appendix F. It noted several commendable practices, including

- having the program integrity unit under an independent inspector general,
- having the controlled substance registry (KASPER) in the same unit, and
- using letters to alert providers about recipients who may be abusing Medicaid services (U.S. Dept. of Health. Centers. Medicaid 4).

The federal review found that Kentucky did not have a systematic surveillance and utilization review process, lacked staff, did not have an audit system, and lacked in-house medical expertise.

The report found some potential fraud and abuse vulnerabilities, including the following.

- While Kentucky did perform some activities consistent with a Surveillance and Utilization Review Subsystem (SURS), it had not had a systematic SURS process for several years.
- Critical program integrity functions, such as its SURS-like activities and its enrollment processes, seemed to be understaffed.
- While state contractors did some provider audits, Kentucky did not have a system of conducting audits across all provider types in a methodical manner.[5]

[5] Program Review staff were unable to find evidence of any provider audits conducted other than investigations of specific allegations. In particular, the CMS report indicated that the PBA contract called for random pharmacy audits. Staff were unable to identify such a requirement, and the PBA has neither billed for nor acknowledged conducting any such audits.

- The OIG did not have any in-house clinical expertise available to it (U.S. Dept. of Health. Centers. Medicaid 3).

DMS responded by issuing a request for proposals for a program integrity vendor. The new Medicaid Management Information System has been delayed. The request for program integrity proposals was canceled, but a new one is expected by early December 2007.

In response to the CMS review, DMS initiated a request for proposals (RFP) for a program integrity and surveillance and utilization review vendor. The request was issued in October 2006, after the termination of the Myers and Stauffer contract. A DMS official explained that the original plan was to have the new vendor in place to coincide with the implementation of the new Medicaid Management Information System, scheduled for November 2006.

The new MMIS was delayed, and the full implementation that includes the SURS capability is not expected to be completed until late January 2008. The program integrity proposal evaluation process was extended, and eventually the request for proposals was canceled in October 2007. A DMS official stated that it was canceled primarily in order to develop an improved request based on new information from CMS about its Comprehensive Medicaid Integrity Plan. The official reported that the new request for proposals would be issued in early December 2007.

Staff found that the program integrity request for proposals addressed the shortcomings identified in the review and was consistent with previous Legislative Research Commission recommendations. Some of the features were particularly commendable.

Staff found that the procurement addressed the shortcomings identified by the CMS review and was consistent with recommendations from previous LRC reports. In particular, staff found the following features to be commendable.

- Fraud and abuse explicitly were made part of the vendor's responsibility. Recipient and provider fraud were included.
- The vendor would train OIG staff to perform program integrity and surveillance and utilization review activities.
- The vendor would identify advanced technological tools and algorithms to identify potential overpayments, including fraud.
- The vendor would provide medical expertise to OIG.
- There would be a prepayment review of claims for targeted providers.[6]
- Desk and field audits of selected providers would be conducted.
- Payment to the vendor was not based on a contingency fee. Contingency fee payments in the past appear to have discouraged vendors from addressing fraudulent billings because abuse overpayments are much easier to identify and collect.

[6] This concept is discussed as concurrent fraud and abuse detection in Chapter 1. The PBA system currently is not designed to permit prepayment review of prescription claims.

Program Integrity Plan, 2008 and Onward

Staff found that the program integrity plans developed by DMS and OIG were commendable. Unfortunately, delays in the full implementation of the new MMIS and procurement of a program integrity and surveillance and utilization review vendor prevented firsthand assessment of these activities.

With the delay, the window for reviewing pharmacy claims is closing. If DMS does not include claims older than 5 years, the next review must be conducted by June 2008 in order to cover claims submitted since the previous review.

Closing of the Review Window. One consequence of the delay is that the 5-year window for reviewing prescription claims is closing. Because the last pharmacy review was conducted in June 2003, any reviews conducted after June 2008 will lose access to some claims that might have overpayments. The same situation exists for to certain kinds of nursing facility reviews that last were conducted in December 2003.

It appears that the greatest challenge to OIG will be bringing together a new vendor, a new information system, and adequate staff in time to conduct a comprehensive review of all claims from 2003 forward. Having such a broad and immediate review is important to limit future losses, to recover overpayments before they age, and to establish the perception among providers that their claims will be reviewed.

Recommendation 3.6

Recommendation 3.6 is that DMS should reissue a program integrity request for proposals substantially similar to the one canceled in October 2007 and award a contract as soon as prudent. A review should be implemented as soon as possible of all Medicaid claims, especially prescription claims submitted since June 2003.

As part of its overall program integrity plan, the Department for Medicaid Services should reissue a program integrity request for proposals substantially similar to the one canceled in October 2007 and award a contract as soon as it is prudent to do so. The new vendor and program integrity staff should implement as soon as possible a review of all Medicaid claims, with special priority on prescription claims submitted since June 2003.

Passport Health Plan

Passport Health Plan, the Medicaid managed care organization, appears not to be addressing fraud and abuse aggressively.

As part of the contract between DMS and University Health Care, Inc., Passport Health Plan performs its own provider program integrity function for the Kentucky Medicaid managed care region, which consists of Jefferson and surrounding counties. Staff did not assess Passport's program integrity operation. The CMS program integrity review report reproduced in Appendix F stated that Passport conducted routine reviews of unusual utilization patterns but did not focus on fraud and abuse. The report also stated that

Passport acknowledged a need to improve fraud and abuse detection (U.S. Dept. of Health. Centers. Medicaid 11).

All Medicaid managed care organizations must receive an annual review by an external review vendor. The 2007 annual review of Passport operations found Passport in compliance on program integrity. Staff saw no indication, however, that the review addressed Passport's methods of identifying fraud and abuse through claims analysis. Passport officials did describe a pharmacy audit program. A review of Passport's program integrity function from the standpoint of proactively identifying potential fraud and abuse probably would be worthwhile.

Additional Fraud and Abuse Detection Measures

Explanation of benefits is used by commercial health insurers to verify claims with the recipients. DMS satisfies the federal minimum requirement but does not have a full explanation of benefits program. It is not clear whether such a program would be cost effective for Medicaid.

Explanation of Benefits. Many commercial health insurers, including Medicare Advantage plans, issue explanation of benefits letters to their members. Members are asked to contact the insurer if any of the claims shown on the letter are incorrect.

Federal Medicaid rules require each state to send explanations of benefits to a sample of recipients. DMS meets the federal requirement by selecting a sample of 500 claims, including medical and prescription claims, and sending a letter to the recipients asking for verification.

When bidding on the PBA procurement, First Health proposed to send a detailed "verification of benefits" for prescription claims, possibly including an image of the medication for easier identification. When a recipient reported not receiving the medication described, First Health proposed that its staff would follow up with the prescriber and member. Whether this is a cost-effective procedure for Medicaid recipients is a question that deserves further study.

Pharmacy audits are considered a standard part of program integrity. It appears that the Medicaid program generally conducts few if any audits. An audit program is recommended.

Pharmacy Audits. The PBA request for proposals did not include an explicit statement requiring pharmacy audits. However, there were four lines related to audits in the cost proposal table. In response to vendor questions, DMS stated, "Auditing of performance is an integral part of this process and is a usual and customary business practice for a" pharmacy benefit manager (Commonwealth. Finance. Questions 39 and 46). Audits are considered a means of discouraging fraud and abuse, identifying overpayments, and improving pharmacy compliance with benefit rules.

Staff interviews suggest that Kentucky and several other state Medicaid programs conduct few if any pharmacy audits. First Health has not billed for any audits, and it appears that DMS has not requested any for several years. However, it is a usual and customary business practice for a commercial PBA to conduct regular pharmacy audits. In fact, officials of Passport Health Plan told staff that it conducts desk audits of 20 percent to 25 percent of its member pharmacies each year plus field audits of targeted pharmacies.

In the request for proposals for program integrity and surveillance and utilization review, DMS and OIG included a general requirement for audits. There was no mention made of including or excluding pharmacy audits. In the program integrity plan recommended in Chapter 1, DMS should consider whether OIG or the PBA or both will conduct pharmacy audits. Staff further recommend that DMS institute a pharmacy audit program similar to that of Passport and commercial insurers.

Recommendation 3.7

Recommendation 3.7 is that DMS should conduct both regular and targeted pharmacy desk and field audits, measure the costs and benefits of the program, and modify it over time to optimize costs and benefits.

As part of its overall program integrity plan, the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and develop an ongoing cost-benefit analysis of the program. The department should modify the program over time to optimize costs and benefits.

Criminal Investigations and Prosecutions

The Division of Special Investigations (DSI) refers likely criminal cases to MFCU, which is responsible for investigating and prosecuting criminal fraud.

OIG's Division of Special Investigations operates the Medicaid fraud hotline specified in KRS 205.8483. It also is positioned to receive referrals from DFWAIP for initial investigation. When a case appears to involve criminal fraud, DSI refers it to the Office of the Attorney General's Medicaid fraud control unit.

MFCU is responsible for investigating and pursuing criminal fraud by Medicaid providers. In addition to referrals from OIG, it receives referrals from other sources including the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, the U.S. Attorney's Office, private insurance companies, and the unit's own fraud hotline. While it is possible that local prosecutors or U.S. Attorneys could pursue a case involving Medicaid fraud without informing MFCU, it appears that the unit is consulted in most such cases.

Staff commend DMS for providing MFCU with direct access to Medicaid claims data. DMS should ensure that MFCU staff remain fully informed of Medicaid program rules for interpreting the claims.

Kentucky's MFCU investigators have direct access to information from the Medicaid Management Information System. They do not have to send requests to OIG or DMS and wait for a response. Conversely, MFCU must ensure that its staff thoroughly understand Kentucky Medicaid program rules in order to determine whether or not fraud is indicated in the claims record. On balance, staff commend DMS for providing MFCU access. However, as part of the overall program integrity plan recommended in Chapter 1, DMS and MFCU should agree on a means to ensure that MFCU staff are up to date on all Medicaid claims processing rules.

MFCU may decide not to prosecute a case and will send it to DSI. DSI may decide the criminal case has merit and try to find a prosecutor. If not, DSI can refer the case to Division of Fraud, Waste and Abuse/Identification and Prevention for administrative recovery.

Whatever the source, MFCU investigates the case and determines whether it has potential for prosecution. If so, MFCU prepares and files criminal charges. If not, MFCU refers the case to DSI, regardless of its source.

When a case is referred from MFCU to DSI, DSI may send it to DFWAIP for administrative recovery or may attempt to have criminal charges filed by a county or Commonwealth's attorney.

Kentucky's fraud hotline statute and a federal regulation place DSI in a bind. Kentucky requires all cases be referred immediately to MFCU, while the regulation requires DSI to conduct a preliminary investigation. The General Assembly may wish to amend the statute to be consistent with the federal regulation.

OIG and MFCU have pointed out a conflict between KRS 205.8483 and federal regulation 42 CFR 455.14. The federal regulation states that the Medicaid agency—in this case OIG under its contract with DMS—"must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation." However, the state statute requires OIG to send a referral to MFCU "immediately." OIG and MFCU in their joint reports in 2002 and 2003 recommended that the statute be changed to allow OIG to conduct a preliminary investigation as required by the federal rule before referring the cases to MFCU. The General Assembly may wish to consider this change.

OIG and MFCU did not mention the recommendation in the 2004 joint report. It reappeared in the 2005 and 2006 reports not as a joint recommendation but as a recommendation from OIG alone. Staff noted a difference in the perspective of OIG and MFCU on the role of DSI in preparing cases prior to referring them to MFCU. MFCU officials stated that they would support a recommendation allowing DSI to conduct a preliminary investigation first, provided there is a time limit on that investigation.

MFCU and DSI appear to disagree on the scope of preliminary versus full investigations. DMS should mediate this disagreement and develop a protocol.

The primary issue between the two agencies appears to be the definition of "preliminary investigation." The federal regulation does not indicate what constitutes a sufficient basis to warrant a full investigation. It simply indicates that once that determination has been made, cases having a sufficient basis should be referred to MFCU for full investigation (42 CFR 455.15). The issue of division of labor also can arise when DSI receives information indicating fraud from sources other than the hotline. Staff recommend that DMS, as the single Medicaid agency, work with OIG and MFCU to develop a protocol for preliminary and full investigations of all potential provider fraud cases.

Recommendation 3.8

Recommendation 3.8 is that the General Assembly may wish to consider making Kentucky law consistent with federal regulations regarding a preliminary fraud investigation prior to referral to the Office of the Attorney General for a full investigation.

If it is the intent of the General Assembly that the Kentucky Medicaid fraud hotline statute be consistent with federal regulation 42 CFR 455.14, then the General Assembly may wish to consider amending KRS 205.8483(2) to allow the Office of Inspector General to conduct a preliminary investigation to determine if a sufficient basis exists for a full investigation, prior to referring the case to the Office of the Attorney General.

Recommendation 3.9

Recommendation 3.9 is that DMS, OIG, and the Office of the Attorney General establish protocols for preliminary and full investigations of potential provider fraud cases, consistent with federal regulations.

As part of its overall program integrity plan, the Department for Medicaid Services should work with the Office of Inspector General and Office of the Attorney General to establish protocols for preliminary investigation of all potential provider fraud cases by the Office of Inspector General and for timely referral to the Office of the Attorney General for full investigation, consistent with federal regulations.

Medicaid Fraud Control Unit's Workload and Funding

MFCU has prosecuted only one pharmacy-related case in the past 5 years, so the information presented represents all Medicaid cases.

Kentucky's MFCU has investigated some prescription drug benefit provider fraud allegations but only reported one prosecution and conviction in the past 5 years. Partly, this appears to be caused by a lack of referrals from OIG. It might also indicate that pharmacies in Kentucky do not commit as much Medicaid fraud as pharmacies in other states. In the following discussion, therefore, case counts, budget figures, and other measures reflect all MFCU cases, not just those related to the prescription drug benefit.

The MFCU workload has increased significantly. The number of complaints received has increased more than fourfold. The unit also handles patient abuse in Medicaid-paid facilities. That has accounted for much of the workload increase. The number of cases pending at year-end has more than doubled.

Kentucky's MFCU has experienced an increase in workload. Because an MFCU is responsible for handling allegations of patient abuse and neglect in health care facilities, a couple of extensive cases of patient abuse in the past couple of years have stretched Kentucky's MFCU staff. The number of patient abuse referrals rose from almost 1,500 in 2005 to more than 2,400 in 2006. Table 3.15 shows that MFCU received a much greater number of complaints in 2006 than in 2002, and cases pending at year end increased significantly. The unit has been opening only slightly more cases, but this could be a result of limited resources.

Table 3.15
Kentucky Medicaid Fraud Control Unit Case Statistics
Fiscal Year 2002 and Fiscal Year 2006

Case Status	Fiscal Year 2002	Fiscal Year 2006	% Change 2002-2006
Complaints Received	572	3,239	466.3%
Cases Opened	90	102	13.3%
Cases Closed	72	69	-4.2%
Cases Pending (Year End)	103	238	131.1%

Note: Case counts include patient abuse and provider fraud. In 2006, patient abuse accounted for 75 percent of complaints received.
Source: Program Review staff compilation of information provided by the Office of the Attorney General.

MFCU has created a triage unit to assess referrals. The objective is to increase overall staff efficiency.

In June 2007, MFCU created a triage unit, the Fraud Investigation Support Team. The team quickly does a preliminary assessment of each referral and determines how to route it for investigation. According to MFCU officials, this team has made the entire unit more efficient and effective.

Upcoming changes related to federal and Kentucky Medicaid initiatives could dramatically increase the MFCU provider investigation workload.

Staffing issues could become highly significant in 2008 and beyond as several changes noted in Chapter 1 take place. The federal Medicaid Integrity Plan audits and Payment Error Rate Measurement project have the potential to generate some fraud referrals. Perhaps more significantly, if DMS carries out its plan to hire a program integrity vendor and implement a modern and comprehensive program integrity function, MFCU might receive a large increase in referrals.

MFCU is funded by a match of federal and state dollars. Each dollar of state money receives a $3 federal match within a cap.

The federal funding formula sets aside funds for MFCU units equal to 0.25 percent of each state's total Medicaid expenditures, but no less than $125,000 for each quarter, to total $500,000 per year. The state must allocate $1 for each $3 of federal funds received. It is up to the state to determine how much of the federal funds to match.

For example, if a state's Medicaid budget annually was $3 billion, MFCU would be eligible to receive $7.5 million in federal matching funds. To receive this amount, the state would have to budget $2.5 million of state funds.

MFCU's budget increased more slowly than the workload. Unclaimed federal funds remain available.

From 2002 to 2006, Kentucky's MFCU saw its budget increase 83 percent, from $1.6 million to nearly $3 million, of which about $750,000 was state money. This rate of growth is slower than the growth of referrals and pending cases. Kentucky still is not accessing the full portion of federal dollars available. Table 3.16 shows total MFCU and Medicaid expenditures, as well as the amount of federal funding not accessed. In state fiscal year 2006, Kentucky left approximately 80 percent of available federal dollars unclaimed.

Table 3.16
Kentucky Medicaid Fraud Control Unit Expenditures
Fiscal Year 2002 to Fiscal Year 2006

State Fiscal Year	Federal Money Available	Federal Money Received	Percent of Federal Funds Remaining	State Expenditure	State Increase Needed to Access All Federal Funds
2002	$9,472,238	$1,221,150	87.2%	$329,050	$2,828,363
2003	$9,759,906	$1,218,150	87.6%	$368,050	$2,885,252
2004	$10,530,878	$1,279,050	88.0%	$426,350	$3,083,943
2005	$10,842,960	$1,590,675	85.2%	$530,225	$3,084,095
2006	$11,474,857	$2,241,225	80.4%	$747,075	$3,077,877

Source: Program Review staff compilation and analysis of OAG-MFCU data and Kentucky budget data.

In fiscal year 2006, Kentucky could have allocated up to an additional $3 million of state funds to fully access almost $11.5 million in federal funds. Given the role of MFCU in investigating and prosecuting Medicaid fraud and abuse cases, additional state funding might be considered to access more federal matching dollars. With the likely increase in referrals in 2008 and beyond, such an increase might be even more important.

In recent years, MFCU has returned more than its budget in Medicaid recoveries, but some cases cost more to prosecute than they recover. The state must decide whether or not to fund criminal prosecutions in those cases.

MFCU officials pointed out that in its role of prosecuting Medicaid criminal fraud cases, return on investment is not always a consideration. There may be cases in which prosecution costs more than the amount recovered through restitution. Since 2002, the Kentucky MFCU has brought in recoveries that exceed the state share of funding. There is no guarantee that such a return on investment will continue. The policy question is whether the state should fund prosecutions of criminal activity even if the restitution does not cover the cost of prosecution.

A Program Review report in 2006 recommended that the Office of the Attorney General prepare a comprehensive plan and request additional state funding, if justified, to access additional federal matching funds. The report also recommended that the General Assembly consider allocating funds for that purpose (Commonwealth. Legislative. Program. *Information* 75). Staff make a similar recommendation now.

Recommendation 3.10

Recommendation 3.10 is that the Office of the Attorney General should request state funding to cover the costs of investigating and prosecuting all anticipated criminal Medicaid fraud cases and performing other MFCU duties. The attorney general should provide a justification and a range of estimated recoveries.

The Office of the Attorney General should develop a budget request for state funding necessary to cover the costs of investigating and prosecuting all the anticipated criminal Medicaid fraud cases referred as well as performing the other duties of the Medicaid fraud control unit. The attorney general should provide a justification for the funding request and a range of estimated recoveries.

Opportunities for Pharmacy Benefit Manager Fraud and Abuse

Staff found no evidence that the state's PBA has committed fraud or abuse. There have been cases of fraud and abuse by other PBAs, however. DMS should properly oversee the PBA contract to ensure exemplary behavior continues.

Program Review staff found no evidence that First Health Services Corporation has committed any fraudulent or abusive acts. This section of the report points out ways that PBAs for other states and for commercial health plans have been accused of defrauding or abusing their clients. Because PBA fraud and abuse can be costly, it is important that DMS properly oversee the PBA contract. Staff point to contract oversight mechanisms that can help ensure continued exemplary behavior by First Health.

First Health handles hundreds of millions of dollars representing Kentucky and federal funds. The PBA is involved in receiving and adjudicating prescription claims and paying the pharmacies for those claims. As the administrator of the National Medicaid Pooling Initiative, First Health negotiates supplemental rebates with the drug manufacturers. First Health also serves as Kentucky's collection agent to invoice drug manufacturers and to collect their payments for both federal and supplemental rebates. Each of these roles presents potential for fraud and abuse.

Vulnerabilities exist in the claims settlement and payment cycle. DMS should take all reasonable steps to manage these vulnerabilities.

Claims Settlement and Payment. When a PBA settles a claim, the pharmacist receives a message indicating the amount of reimbursement. The PBA then transfers the claim to the Medicaid Management Information System and requests a transfer of funds from the Medicaid program so the PBA can pay the pharmacy. At the end of the year, the PBA sends federal tax form 1099 to each

pharmacy. There are a few ways that this process is vulnerable to fraud or abuse.

- Fraud could occur if the PBA submitted a claim to Medicaid for a higher amount than the settlement amount shown to the pharmacy. The PBA would keep the difference.
- Fraud could occur if the PBA created fake claims and submitted them to Medicaid for payment.
- Abuse could occur if the PBA incorrectly calculated the payment to the pharmacy based on erroneous pricing information or programming error.
- Abuse could occur if the PBA incorrectly paid a claim that should have been denied.

To manage these possibilities, DMS should, as part of its overall program integrity plan,

- balance the amounts requested by First Health for claims payment with the claims submitted to the MMIS,
- spot-check that the amounts listed on prescription claims match the amounts shown on remittance advice documents received by the pharmacies,
- consider taking over the issuance of federal tax form 1099 to pharmacies,
- consider whether it is feasible for the MMIS to double-check the payment calculation on prescription claims,
- consider what other checks the MMIS can make to determine whether the decision to pay the claim was correct, and
- implement any other appropriate oversight methods.

In addition to federal rebates, states may seek supplemental rebates. A state may negotiate directly with a manufacturer or join a multistate pool. Kentucky joined the National Medicaid Pooling Initiative. Manufacturers are invoiced for rebates based on the quantity paid for by Medicaid.

Drug Rebate Amounts. The federal Medicaid program negotiates rebates with pharmaceutical manufacturers as a condition of participating in Medicaid. In addition, most state Medicaid programs engage a vendor to negotiate supplemental rebates with pharmaceutical manufacturers. Kentucky and many other states have joined the National Medicaid Pooling Initiative or another rebate pool. The manufacturers pay the federal and state rebates when the vendor prepares an invoice showing the quantity of each drug that Medicaid paid for in each quarter. Often there are disputes over the correctness of the claims on which the invoices are based. The vendor is responsible for settling these disputes and collecting the amounts owed.

A state will choose preferred drugs based on cost among clinically equivalent drugs. The PBA advises Kentucky regarding the cost, but under the National Medicaid Pooling Initiative, the actual amount of the rebate is not revealed to the state.

Rebates come into play when the state chooses preferred drugs. The preferred drug list is the state's way of encouraging the use of the lowest-cost drug among those that are considered clinically equivalent. Kentucky makes its decision based on advice from the PBA, including advice about the relative cost of drugs after rebate.

While the amounts of the federal rebates are known to the states, the amounts of rebates available via pools are not. The pool itself negotiates confidentially with the manufacturers, and the rebate amounts are considered a trade secret. Staff of the National Medicaid Pooling Initiative indicated that state auditors could view the contracts between the pool and the manufacturers but would not be allowed to make copies or record any information from them.

Fraud and abuse could occur in the rebate and preferred drug list process. DMS should consider steps to prevent such fraud and abuse.

The rebate process presents several vulnerabilities.

- Abuse could occur if the vendor was not diligent in attempting to recover all the disputed rebate amounts.
- Fraud could occur if the rebate pool accepted kickbacks in exchange for influencing states to prefer certain drugs regardless of the bottom-line cost to the states.
- Fraud could occur if the rebate pool, without consent of the states, retained some of the negotiated rebates for itself.
- Fraud could occur if the PBA advised the state to prefer drugs that benefited interests of the PBA (such as pharmacies linked to the PBA) rather than those of the state.

As part of its overall program integrity plan, DMS should consider

- reviewing the collections of federal and supplemental rebates,
- sending auditors to review rebate pool contracts,
- working with other states and the rebate pool to make the supplemental rebate amounts available to the states, and
- taking any other appropriate action to address vulnerabilities in the rebate process.

Chapter 4

Medicaid Prescription Drug Cost Management

Cost management probably has the potential to save more than Medicaid program integrity alone.

Regardless of the amount of potential savings through program integrity, the amount that can be saved through good program management probably is greater. The Medicaid prescription drug benefit's overall cost dropped during federal fiscal year 2005 by more than $55 million. If costs had continued to rise at the national average rate, the net savings might be as much as $94 million.[1] Much of this drop appears to be the result of cost management measures. This chapter takes a closer look at that drop and discusses additional opportunities for savings.

In order to understand some of the issues around managing costs and measuring success, it is first necessary to understand the effect of Medicare Part D on the Medicaid prescription drug benefit.

Effect of Medicare Part D

Medicare Part D is partially funded by a reimbursement of funds from the state Medicaid prescription drug programs. The reimbursement is called the Medicare clawback.

When Congress created Medicare Part D, it decided that some of the funding should come from savings in the Medicaid program. Prior to 2006, Medicare recipients who met certain eligibility requirements could receive Medicaid to pay for prescriptions and some other medical expenses. These were called "dual-eligible" recipients. Congress enacted a formula to estimate how much state Medicaid programs would pay for dual eligibles if Medicare Part D did not exist. States have to remit to the Centers for Medicare and Medicaid Services the amount calculated by the formula. The amount begins at 90 percent of the estimate and declines in stages, remaining at 75 percent from 2015 forward. The states and the media have named this reimbursement the Medicare clawback.

[1] The calendar year 2004 prescription rise was 8.3 percent and in 2005 it was 5.4 percent. For federal fiscal year 2005, the weighted rate was 6.13 percent. The expenditures in fiscal 2004 were $633 million. At 6.13 percent, the increase would be almost $39 million.

Questions About Fairness of Medicare Part D Clawback

The Medicare clawback may be unfair to states that, like Kentucky, instituted cost saving measures after 2003 and to those that experience a prescription drug inflation rate lower than the nation as a whole.

Medicaid programs no longer have to pay for prescription drugs for dual eligibles and so experience potential savings of many millions of dollars.[2] The Medicare clawback was intended to capture that savings and transfer it to the Medicare Part D budget. Because the formula is based on the Medicaid payments to dual eligibles in 2003, the clawback can be unbalanced in two ways.

- States that put cost-containment measures in place after 2003 will not see the benefit of those cost reductions.
- States that experience a prescription drug inflation rate lower than the nation as a whole will have to pay more in clawback than their true inflation rate would indicate.

In a 2006 survey of states, 15 states estimated they pay more in clawback than their Medicaid program saves.

In a 2006 survey of states, 30 states indicated that clawback does not balance Medicaid savings. Fifteen states estimated they pay more in clawback than their Medicaid program saves, while 15 others reported they save more than they pay out (Kaiser 49).

The U.S. Supreme Court refused to hear a lawsuit challenging the constitutionality of the clawback.

In 2005, Kentucky was the first state to file a lawsuit challenging the clawback. Later, Kentucky joined Maine, Missouri, and New Jersey in a 2006 lawsuit initiated by Texas in the U.S. Supreme Court challenging the constitutionality of the clawback provision. Ten other states' attorneys general filed *amicus* briefs. The Supreme Court refused to hear the case, leaving clawback intact (New).

One estimate of Kentucky's clawback overpayment is $18.5 million over 5 years. Staff did not obtain a current estimate and recommend that DMS provide one.

The Attorney General estimated that the Commonwealth stood to lose $18.5 million over 5 years (Commonwealth. Office). DMS indicated that it did not have a current estimate of the potential clawback overpayment. With such an estimate, the General Assembly and DMS would be better placed to ask Congress for a change in the clawback formula.

[2] There is a minor exception. Congress decided that Medicare Part D will not cover benzodiazepines, barbiturates, and certain over-the-counter drugs. State Medicaid programs must continue to cover those drugs for dual eligibles if the program covers the drugs for other Medicaid recipients.

Recommendation 4.1

Recommendation 4.1 is that DMS should estimate and report on the amount by which Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual eligibles if they had remained in the Medicaid prescription drug program.

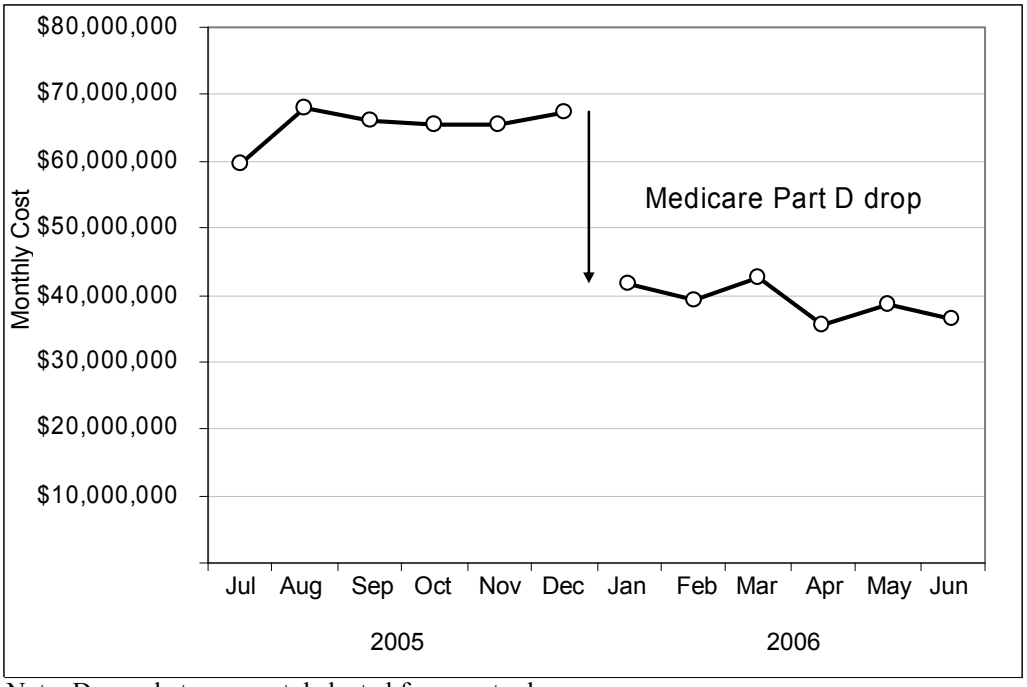
The Department for Medicaid Services should estimate the amount by which the Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual-eligible recipients if they had remained in the Medicaid prescription drug benefit. The department should report its estimate to the Program Review and Investigations Committee by September 2008.

Medicare Part D and Prescription Program Costs

Medicare Part D and the clawback created an accounting dilemma for state Medicaid prescription drug benefit programs. Traditional measures such as overall cost, average cost per recipient, and average cost per user are affected.

The Medicare Part D benefit and the clawback have created an accounting dilemma. It is difficult to compare costs before and after January 1, 2006. Three of the traditional measures of performance are the overall cost of the program, the average cost per recipient, and the average cost per user (a recipient who actually receives a prescription in a given month). Performance is measured by comparing these numbers over time and looking at their rate of growth. Figure 4.A shows the drop that occurred in the gross cost of the Kentucky Medicaid prescription drug benefit.

Figure 4.A
Medicare Part D Causes Apparent Drop in Gross Medicaid Prescription Cost



Note: Drug rebates are not deducted from costs shown.
Source: Program Review staff analysis of data from the Department for Medicaid Services.

Medicare Part D has the following effects on comparison of costs before and after its inception.

- The absence of Medicare dual eligibles starting in 2006 creates an apparently precipitous drop in the Medicaid prescription program cost.
- Medicare dual eligibles typically have greater prescription drug use per person, and the rate of increase in their costs appears to have been higher than that of other groups. The absence of dual eligibles in 2006 makes it invalid to compare the cost per recipient, cost per user, and overall program cost growth between 2005 and 2006.
- Medicare Part D does not cover benzodiazepines, barbiturates, and certain over-the-counter medications. Congress mandated that Medicaid programs continue to cover those drugs for dual eligibles if they are covered for other recipients. Some dual eligibles, therefore, are included among the prescription drug benefit users in 2006 and onward. Their inclusion only for a limited group of drugs artificially reduces the apparent per-user cost of the Medicaid benefit.
- When calculating the actual cost of the program after 2005, it is necessary to remember to include the clawback payments.
- The clawback affects both the Medicaid prescription drug benefit operated by DMS and Passport Health Plan's benefit. Because Passport's costs are not included in the overall cost of the DMS prescription drug program, the portion of the clawback that is based on Passport must be excluded.

Medicare Part D also makes it difficult to compare Medicaid program performance with that of commercial prescription plans that are not affected by issues such as the partial coverage of dual eligibles by both programs.

Staff recommend that DMS take Medicare Part D and clawback into account when measuring performance and presenting information about the prescription drug benefit.

Staff do not propose a solution to these difficulties. Instead, staff recommend that DMS consider the effects of Medicare Part D and the clawback whenever it attempts to evaluate the performance of the prescription drug benefit and that DMS point out these effects whenever it presents performance measures.

Recommendation 4.2

Recommendation 4.2 is that DMS and all vendors should consider the effects of Medicare Part D and the clawback when measuring the performance of the prescription drug program. DMS should explain these effects when reporting on performance.

When measuring the performance of the Medicaid prescription drug program, the Department for Medicaid Services and all its vendors should consider the effects of Medicare Part D and the clawback. When presenting any performance information to the public, and particularly to the General Assembly, the department should explain these effects.

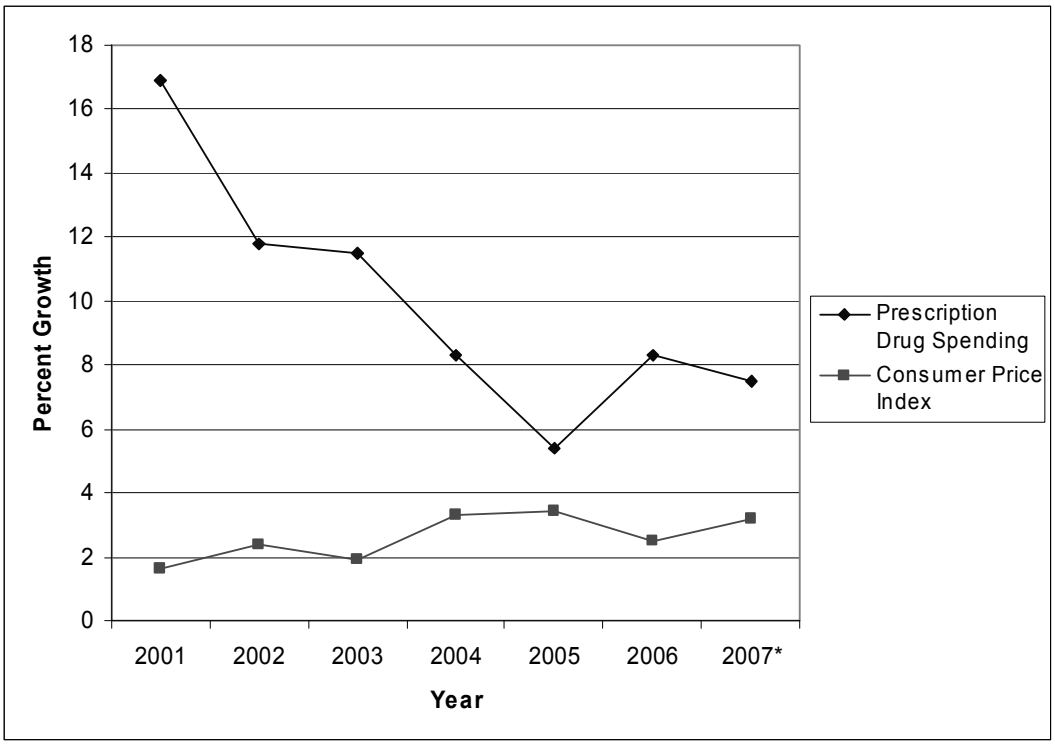
Long-term Prescription Drug Cost Trends

Drug market growth has exceeded the consumer price inflation rate since 2001.

The long-term trend in the economy for goods and services overall for many years has been upward. For health care and prescription drugs, the trend has exceeded the consumer price inflation rate.

Figure 4.B shows the drug market growth in the United States since 2001 compared with the Consumer Price Index. According to industry reports, the declining growth rate has been a result of more aggressive negotiations by commercial and government buyers and a larger number of drugs coming off patent (IMS. "IMS Reports U.S."). Even at its lowest point, however, the drug market growth in 2005 was 5.4 percent, significantly above the consumer price inflation rate of 3.4 percent.

Figure 4.B
Percentage Growth in U.S. Pharmaceutical Market, 2001 to 2007



Note: The pharmaceutical market growth rate for 2007 was projected by IMS Health to be from 6 percent to 9 percent. The value shown is the middle of the range (7.5 percent). The Consumer Price Index growth rate for 2007 was projected by the Federal Reserve.
Source: Program Review staff compilation of information from IMS Health, U.S. Dept. of Labor, and U.S. Federal Reserve.

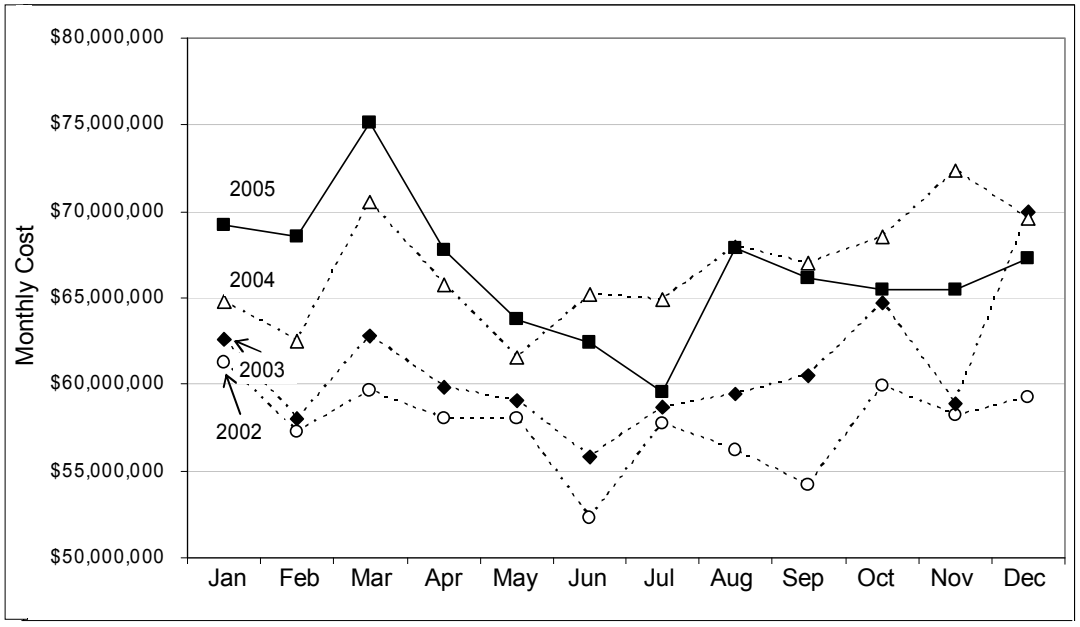
Targets for the Medicaid prescription drug program should take external factors like the prescription inflation rate into account.

When measuring the cost trend of the Medicaid prescription drug program, it is important to keep the prescription drug inflation rate and other economic factors in mind. Because Medicaid cannot control those factors, it might be more meaningful to measure the success of the Medicaid program at keeping costs below some inflation-adjusted benchmark. The overall prescription inflation rate may not be the best benchmark because the drug use of Medicaid recipients is different from that of the general population.

Medicaid prescription drug cost management measures in 2005 appear to have resulted in savings even without including rebates.

For this report, staff did not attempt to adjust the Medicaid prescription cost growth for inflation. Figure 4.C shows the years 2002 to 2005 simply for illustration. Each year from after 2002, the cost for every month was higher than it had been the year before, until 2005. In December 2004, First Health Services Corporation, the pharmacy benefit administrator, took over the prescription drug benefit in Kentucky. In 2005, many program changes were put in place that appear to have reduced the cost of the program. By the second half of the year, the total cost went below the cost in 2004 and stayed there. Rebates are not shown in the figure but reduced the 2005 cost even further.

Figure 4.C
Kentucky Medicaid Prescription Drug Benefit Cost Without Rebates
2002 to 2005

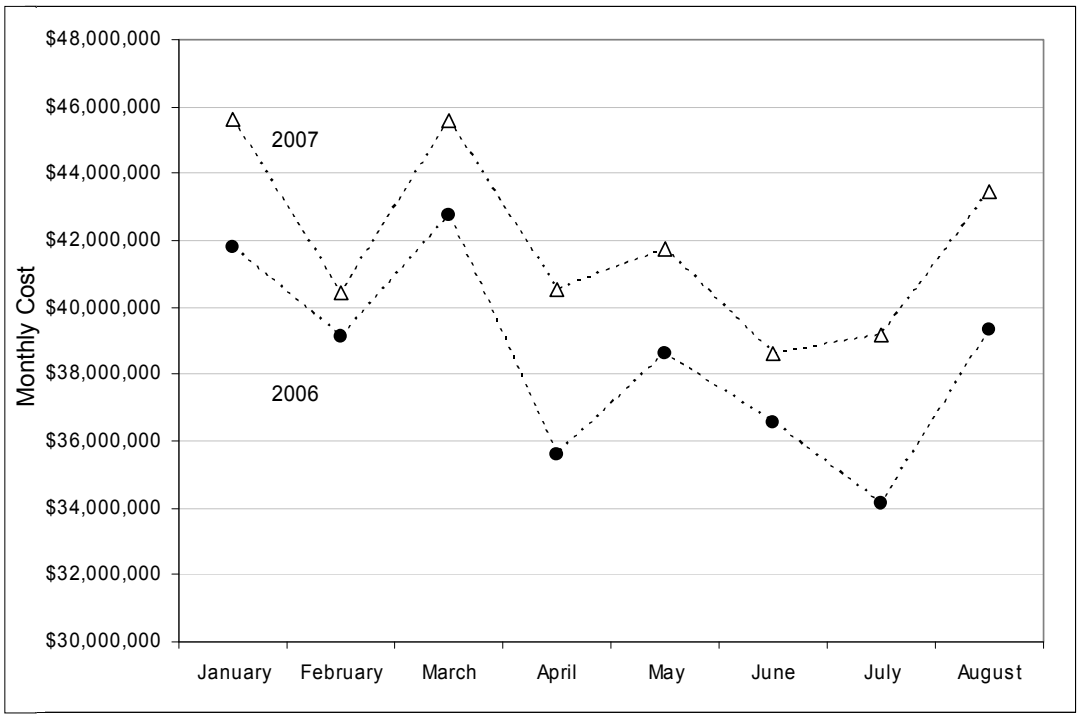


Note: Drug rebates are not deducted from costs shown. The costs for 2005 would be significantly lower if rebates were deducted.
Source: Program Review staff analysis of data provided by Department for Medicaid Services and First Health Services Corporation.

After the decline in 2005, costs have begun to increase again.

Because of the dramatic shift in costs with Medicare Part D in January 2006, it is not meaningful to compare 2005 with 2006. However, staff did compare 2006 with 2007 for the available months. Figure 4.D shows that costs in 2007 have gone up consistently over the corresponding months in 2006. The increase in the first 8 months of 2007 was about 9 percent. One projection of national drug market growth in 2007 was from 6 percent to 9 percent, so that is within the expected range (IMS. "IMS Reports U.S.").

Figure 4.D
Kentucky Medicaid Prescription Drug Benefit Cost Without Rebates
2006 to 2007



Note: Drug rebates are not deducted from costs shown. Rebates for the 2 years are comparable and so the difference would not be significant.
Source: Program Review staff analysis of data provided by Department for Medicaid Services and First Health Services Corporation.

Although it is unrealistic to expect Medicaid prescription drug costs to drop or to increase much more slowly than prescription inflation, Medicaid can take steps to remove unnecessary spending through improved program integrity and cost management while maintaining quality care. Cost savings will not be visible but can continue indefinitely. Changes made so far are commendable.

It is unrealistic to expect prescription costs in Medicaid to drop steadily or even to increase much more slowly than overall prescription drug inflation rates statewide or nationally. If Medicaid did a better job of program integrity and cost management than other insurers, it might be possible to achieve a slightly lower rate of growth.

However, the primary finding is that Medicaid can remove unnecessary spending through improved program integrity and

cost management while maintaining quality care. Cost management programs, if properly run, will continue to result in cost savings indefinitely, even though they are not visible in the growth rate. Staff commend DMS and First Health for implementing measures that have resulted in ongoing savings. The next sections describe specific cost factors and interventions.

Factors Affecting Medicaid Program Costs

Some factors affect the overall program cost, and other factors affect the cost of individual members' care.

When looking at Medicaid program costs from year to year, there are many factors to keep in mind beyond Medicare Part D. The factors can be divided into two groups: those that impact the program as a whole and those that affect costs member by member.

Cost Factors Affecting the Overall Program

From month to month, the program cost is affected by several factors. Some of these are under the control of the program and some are not.

- The number of members may go up or down.
  - When the economy declines, the number of eligible citizens tends to go up and vice versa.
  - Program rules regarding optional eligibility may change.
- Drug use patterns of the Medicaid population might differ from the general population. For example, Medicaid recipients tend to use more behavioral health medications.
- Need for drugs varies seasonally and with the presence or absence of epidemics and natural disasters.
- The costs of drugs may change.
  - New drugs that come on the market are more expensive.
  - Old drugs that come off patent become less expensive, and their generic versions are even less expensive.
  - Economic inflation may increase the costs of drugs.
  - Laws regarding drug rebates may change.
  - Drug rebate amounts, especially supplemental state rebates, may change.

Factors Affecting Individual Member Costs

Some factors affect the costs of drugs for a given member. There are some cost management measures that can affect these.

- The member's health and medical condition will change, affecting the number of prescriptions and quantity of medications needed.
- Prescribing habits of the prescriber can determine whether more or less expensive drugs are used.

Medicaid Prescription Drug Cost Management Interventions

Table 4.1 lists some ways to affect prescription drug program costs.

There are hundreds of possible ways to manage prescription drug benefit costs more effectively. Staff have collected some methods in Table 4.1.

Table 4.1
Selected Cost-Management Methods

Cost Containment
Reducing dispensing fee to pharmacists
Reducing reimbursement to pharmacists
Tightening coverage, such as • limiting the number of simultaneous prescriptions • limiting the number of brand-name prescriptions • limiting the types (classes) of drugs covered • limiting coverage for optional groups (classes of individuals whom the state does not have to cover by federal law)
Using the more cost-effective choice: a PBA vendor or in-house benefit administration
Managing coverage of over-the-counter medications (both for first-line use instead of prescription drugs and to exclude some over-the-counter drugs)
Contracting for prescription drugs for residents of nursing homes and other congregate care facilities (Example: North Carolina)
Using the more cost-effective choice: traditional fee for service or managed care
Use of electronic prescribing (Example: Florida)*
Reducing the period to accept retroactive claims*
Cost-effective Care
Case, care, and disease management programs
Medication management programs
Retrospective drug utilization review that includes provider education
Counter-detailing (presenting prescribers with unbiased scientific prescribing literature)
Preferred drug list*
Prior authorization to manage deviations from prescribing rules*

Instituting practices that reduce individual prescription costs, such as • multiple months' supply • generic substitution • lowest-cost form (tablet vs. capsule vs. liquid) • pill-splitting • combining doses (once-daily vs. more frequent) • using a mail-order pharmacy
Requiring the diagnosis be specified on the prescription form (Example: Oregon)*
Detecting and managing early refill and re-use of medications*
Tighter oversight of hospitals' and nursing homes' dispensing of medications*
Lock-in program*
Cost-sharing (increasing copays and premium participation) to the extent allowable by federal law, particularly for optional groups*
Eligibility
Ensuring that recipient eligibility records are kept up to date:* • Recipients who become ineligible are removed immediately from the eligibility list • Recipients who die are removed immediately from the eligibility list
Other Sources of Payment
Identifying and billing third-party payers • Medicare • Private insurance • Casualty insurance • Child support
Rebates
Complying with Deficit Reduction Act of 2005 provisions to collect supplemental rebates for physician-administered drugs
Negotiation of supplemental rebates and other discounts with pharmaceutical manufacturers • Consideration of multistate pools or compacts • Consideration of value-added or in-kind programs from pharmaceutical companies in lieu of monetary rebates • Gain economy of scale by combining Medicaid program administration with the state employee insurance program and possibly others

Note: *These items might be ways of managing fraud and abuse as well as waste.
Source: Program Review staff compilation of information from interviews and literature.

Staff commend DMS and First Health for implementing many high-impact cost management interventions.

Staff commend DMS and First Health for implementing many high-impact cost management interventions since December 2004. The remainder of this section reviews some additional measures that might be helpful.

Pharmaceutical Manufacturer Rebates

The federal Medicaid program negotiates rebates. States also are allowed to negotiate rebates individually or in a pool of states.

Prescription drug rebates are a large potential source of savings. Commercial health plans negotiate rebates with pharmaceutical manufacturers, and federal law requires all pharmaceutical manufacturers to negotiate rebates with Medicaid in order to participate in the program. The U.S. Department of Health and Human Services negotiates the federal Medicaid rebates. States collect these rebates on a quarterly basis by invoicing the manufacturers for the quantity of their drugs that Medicaid paid for during the quarter. The states send the federal match percentage to the federal treasury and keep the remainder.

Federal law also allows states to enter into agreements with pharmaceutical manufacturers for supplemental rebates. A state may negotiate directly with the manufacturers or may join a multistate rebate pool.

According to DMS and the PBA, Kentucky first began to receive supplemental rebates in October 2004. These rebates were negotiated for Kentucky alone and amounted to an annual rate of $18.5 million.

Supplemental Rebates Negotiated for Kentucky. According to information from First Health Services Corporation, in October 2004, Kentucky began to receive supplemental rebates negotiated by Provider Synergies, a rebate vendor. The rebates continued until August 2005, when Kentucky joined a national rebate pool. Through July 2005, Kentucky received $15.5 million, which amounts to a yearly rebate rate of $18.5 million.

Beginning in August 2005, Kentucky joined the National Medicaid Pooling Initiative (NMPI).

Supplemental Rebates Through Multistate Pool. Effective August 2005, DMS chose to join the multistate rebate pool run by First Health. This pool is the National Medicaid Pooling Initiative (NMPI) and currently has 14 participating states. Table 4.2 shows the supplemental and federal rebates collected by First Health during calendar year 2006.

Table 4.2
Kentucky Prescription Drug Rebate Receipts, 2006

Quarter	Supplemental	Federal	Total
Jan.-March	$3,919,923	$31,880,868	$35,800,791
April-June	$4,237,525	$29,108,405	$33,345,930
July-Sept.	$6,009,898	$31,643,162	$37,653,060
Oct.-Dec.	$5,582,495	$27,974,710	$33,557,205
Total	$19,749,841	$120,607,145	$140,356,986

Note: Supplemental rebates are through National Medicaid Pooling Initiative
Source: Staff compilation of First Health Services Corporation's collections report dated November 6, 2007.

NMPI negotiates a rebate schedule with each manufacturer. A state receives rebates based on how many similar drugs it places on its preferred drug list and how many recipients it has. The pooling schedule combines the recipients in states that have the same number of preferred drugs in a drug class or type.

NMPI negotiates a rebate schedule for each drug. The rebate that a state receives depends on how many similar drugs it has on its preferred drug list and on how many Medicaid recipients are covered. The rebate formula combines recipients from states that have the same number of similar drugs on their preferred drug lists. Table 4.3 illustrates this concept. The number of dollar symbols shows the relative size of the rebate for each formula category.

Table 4.3
National Medicaid Pooling Initiative Supplemental Rebate Grid
(More $ = Higher Rebates)

Number of Recipients	Preferred in Drug Class			
	1 of 3+	1 of 3	1 of 2	1 of 1
0-3 million	$	$$$	$$$$$	$$$$$$$
3-6 million	$$	$$$$	$$$$$$	$$$$$$$$
6-9 million	$$$	$$$$$	$$$$$$$	$$$$$$$$$
9 million or more	$$$$	$$$$$$	$$$$$$$$	$$$$$$$$$$

Note: The number of recipients is the combined number of states that have the same number of preferred drugs from the drug class. The $ symbols are arranged to show that greater savings usually are generated by preferring fewer drugs than by having more recipients. Not all manufacturers offer increases at all tiers.
Source: Program Review compilation of information provided by First Health Services Corporation.

For example, if Kentucky chose Drug X and another drug as the two preferred blood pressure drugs, Kentucky's recipients would be pooled with those of other states that selected Drug X and one other drug (the column "1 of 2"). If Virginia also chose Drug X and one other blood pressure drug, Kentucky's and Virginia's combined number of recipients would place Kentucky in the first row (0-3 million). The relative rebate in the illustration would be five "$."

In order to receive a larger rebate, Kentucky might consider adopting the policy of a larger state or group of states or could choose Drug X as its only preferred blood pressure drug. Because manufacturers value market share, they usually offer larger rebates when their drug is the only drug or one of a small number of drugs on the preferred drug list. The number of recipients is not so important in determining the rebate.

So if New York preferred Drug X with two other blood pressure drugs, Kentucky could do the same. Even with New York's 5 million recipients, Kentucky's rebate would decrease. Kentucky would move down to the "1 of 3" column and up to the second row for a relative rebate of four "$." However, if Kentucky chose to prefer only Drug X, even if no other state did so, Kentucky would move up to the "1 of 1" column in the first row and increase its relative rebate to from five to seven "$."

Information about drug rebates negotiated by NMPI is considered a trade secret and is not made available to the state Medicaid program. DMS instead receives advice from First Health about the relative benefit of different preferred drug list options.

NMPI and First Health would not disclose the exact amount of supplemental rebates for specific drugs. This information is considered a trade secret and may be protected by federal law. However, First Health staff explained that they give DMS officials adequate information in terms of the relative cost of different preferred drug list options to make trade-off decisions on different drugs.

NMPI locks in rebates for up to 3 years but allows manufacturers to offer better rebates in any year. A state-run program could renegotiate rebates as often as quarterly.

NMPI renegotiates rebates with manufacturers every 3 years on a rolling basis. Each year, some of the rebates are due for renegotiation. When drug costs are increasing, this time frame has advantages by locking in a lower rate for 3 years. When drug costs are decreasing or significant downward pressures occur in the market, a shorter time frame is advantageous. NMPI does allow manufacturers to improve their rebates each year during its annual rebid period. A state-run rebate program could renegotiate rebates as often as quarterly if it seemed prudent.

Some drug manufacturers have refused to negotiate supplemental rebates with NMPI and most states. Texas and Florida have laws that require all manufacturers to negotiate.

Some pharmaceutical manufacturers have refused to negotiate supplemental rebates generally. NMPI and most states do not receive any rebates on drugs from those manufacturers. However, at least two states—Florida and Texas—require all manufacturers to negotiate rebates.

The Florida Medicaid prescription drug rebate program is said to maximize competition among drug manufacturers and result in significant rebates even from those manufacturers that refuse to negotiate with other states and rebate pools.

For example, Florida legislative staff reported that Florida Medicaid will not pay for a drug if the manufacturer has not provided at least a minimum rebate. Florida staff stated that their program has been successful in reducing the cost of its Medicaid prescription drug benefit. Florida staff asserted that better rebates can be achieved when all the drugs in a drug class can be on the preferred drug list rather than one or two. If all can be on the list, all the manufacturers are competing for the best price. A specific example given was the atypical antipsychotics, a group of drugs whose manufacturers have been highly resistant to rebates.

NMPI has increased Kentucky's supplemental rebates beyond the level of its previous state-only rebates. What is not known is how much Kentucky could achieve with an aggressive rebate negotiation process. This topic merits further study.

Kentucky received annualized supplemental rebates of about $18.5 million between October 2004 and July 2005. Comparison with the $19.5 million received via NMPI in 2006 is difficult because Medicare Part D took over prescription coverage for many Medicaid recipients in 2006. It is likely that the amount of the Provider Synergies rebates would have declined in that year. It is clear that NMPI has increased the amount of supplemental rebates, but it is not known how much Kentucky could have obtained on its own with an aggressive rebate negotiation process. Staff did not attempt to evaluate NMPI rebates. Information about rebates in other states and other pools is difficult to obtain.

In-kind Services

CMS must approve in-kind services before a state may accept them.

Some of the pharmaceutical manufacturers that do not offer supplemental rebates do offer in-kind services. CMS must approve these services before a state may accept them.

DMS plans to enter into an agreement by which Eli Lilly will pay another company to review behavioral health drug use in Kentucky, in lieu of supplemental rebates on Zyprexa.

Review of Behavioral Health Drug Use. DMS plans to enter into an agreement with Eli Lilly to perform behavioral drug use review for 2 years. The objective of the program is to identify prescribers who may not be following best practice in the use of behavioral health drugs and to educate them. The service is paid by Eli Lilly in lieu of any supplemental rebate for Zyprexa and is provided by Comprehensive NeuroScience.

Similar agreements elsewhere have raised conflict of interest concerns. Costs and benefits of these programs are difficult to measure. Florida reported that its law no longer allows in-kind programs.

Such agreements in other states have raised questions of conflict of interest. Eli Lilly has an interest in marketing Zyprexa, an atypical antipsychotic medication. In addition, costs and benefits are difficult to measure. Florida legislative staff reported that state law was changed to prohibit in-kind services in lieu of rebates. It was difficult to determine the actual value of the services received.

The agreement in Kentucky appears to require DMS to keep Zyprexa on the preferred drug list and to treat Zyprexa at least as favorably as any other antipsychotic drug. The letter to CMS requesting approval of the agreement states, "… Kentucky Medicaid agrees it will not restrict or actively discourage or disadvantage the use of Zyprexa in any way within the package label…" (Jennings). Currently, DMS requires prior authorization for all atypical antipsychotics to ensure they meet certain clinical criteria. Staff believe the wording could limit flexibility in prior authorization for Zyprexa. If the current clinical criteria are any more restrictive than the package label, the criteria probably would have to be relaxed. DMS probably would not be able to require step therapy for Zyprexa, meaning alternative drugs would not have to be tried first. Finally, DMS probably would not be able to place Zyprexa on a more expensive tier of the preferred drug list.

The Eli Lilly program limits the ability of DMS to manage costs and care through the preferred drug list and may result in lower rebates on some other antipsychotic drugs.

The behavioral health drug use review agreement limits the ability of DMS to manage costs and care through the preferred drug list. Because about half of the manufacturers of drugs in this class offer supplemental rebates, the agreement also might result in lower supplemental rebates on similar drugs.

Recommendation 4.3

Recommendation 4.3 is that DMS should conduct a complete cost-benefit analysis of the behavioral health drug use review program and should ensure a tracking system is in place to monitor the results and compare them with expectations. DMS should report on the cost-benefit analysis and the results of the program.

The Department for Medicaid Services should conduct a complete cost-benefit analysis of the behavioral health drug use review program, including historical trend data by drug class and the effect of the agreement on the preferred drug list and supplemental rebates. The department should ensure that a tracking system is in place to monitor the results of the program and should compare actual with expected results. The department should report to the Program Review and Investigations Committee

- **the cost-benefit analysis by September 2008 and**
- **the results after the 2-year program.**

Improving Prescribing and Dispensing Practices

Prescribers are the main access point for obtaining prescription drugs and may represent one of the best opportunities to reduce costs. Prescribers' knowledge may be outdated or incomplete, possibly leading to additional prescription costs.

Management of prescribing practices might be one of the best opportunities to reduce costs. Prescribers such as physicians, dentists, and nurse practitioners represent the main access point for individuals to obtain prescription drugs. However, prescribers' knowledge and experience vary widely leading to inconsistent application of prescribing guidelines. Outdated or incomplete knowledge of pharmaceutical trends and prescribing guidelines was noted as a major reason for inappropriate or inefficient prescribing (Murphy). This problem likely contributes significantly to the cost of the Medicaid prescription drug benefit. Measures should be taken to appropriately influence the practices and behaviors of prescribers.

Pharmacists may benefit from education to help recognize problems with prescriptions, recipients, and prescribers and improve dispensing practices. Surveyed practitioners supported education to improve prescribing and dispensing practices.

Pharmacists, too, may benefit from education to help them recognize problems with prescriptions, recipients, and prescribers. They might find refreshers on dispensing practices helpful.

Physicians and pharmacists who responded to the Program Review survey supported additional education to promote better prescribing and pharmacy dispensing practices.

Recommendation 4.4

Recommendation 4.4 is that DMS and OIG should work with licensing boards and professional associations to determine effective and acceptable education regarding best practices for prescribing and dispensing.

The Department for Medicaid Services and Office of Inspector General should work with the licensing boards and professional associations of prescribers and pharmacists to determine effective and acceptable education regarding best practices for prescribing and dispensing.

Counter-detailing

Counter-detailing is a way of providing unbiased scientific information to medical providers independently of the drug manufacturer representatives, called "detailers." It has been used by Medicaid in other states and was proposed by Kentucky's PBA. DMS officials recently expressed interest in the concept.

According to the, chair of the National Legislative Association on Prescription Drug Prices,

> Academic detailing is a way to provide better information to medical providers and consumers about which drugs are the most effective and have the least adverse effects, as well as information on the costs of these drugs. Rather than rely on pharmaceutical salespersons to provide this information, "academic" or "counter" detailing programs are independent from the drug companies and provide unbiased, balanced, evidence-based information to physicians and other medical providers. These programs use physicians, pharmacists, nurses and other clinical professionals to present scientific evidence to medical providers (Treat 2).

Counter-detailing, also called academic detailing or clinical detailing, has been used by Medicaid programs in other states including Michigan, Pennsylvania, and Vermont. First Health offered to provide this service when it bid on the PBA procurement. Kentucky Medicaid chose not to include counter-detailing in the PBA contract. However, DMS officials recently expressed support for the concept.

In the Program Review staff survey of physicians, 41 percent reported drug manufacturers promoting the use of a prescription drug without adequate research and medical literature. Counter-detailing is a means of providing such research and literature. It also serves to offset some of the inappropriate incentives and improper influence of drug company detailers as reported by 32 percent of the physicians and 39 percent of the pharmacists in the survey.

Pharmacist Medication Management

Medicare requires Medication Therapy Management by a pharmacist. Although Medicaid is not required to provide the service, it has potential to improve care and reduce costs.

The Medicare Modernization Act of 2003 required Medicare prescription drug benefit programs to include Medication Therapy Management, a process by which pharmacists are paid to meet with patients and do a comprehensive review of all their prescribed medications. Medicaid programs are not required to provide this service, although it has the potential to improve care and reduce costs (Felt-Lisk; University). DMS officials recently expressed support for this approach.

Recommendation 4.5

Recommendation 4.5 is that DMS should consider whether to implement counter-detailing and Medication Therapy Management. If either program appears cost-effective and feasible, DMS should request enabling legislation and should implement the program.

The Department for Medicaid Services should consider whether to implement counter-detailing to provide unbiased prescribing information to physicians and other prescribers. The department also should consider Medication Therapy Management by pharmacists as a means of improving care and reducing costs. If either program appears to be effective and feasible, the department should request any necessary enabling legislation and should implement the program.

Retrospective Drug Utilization Review

RetroDUR is an extensive drug utilization review of prescribing patterns that can improve prescribing and help manage recipient medication usage. This program is part of the PBA's responsibility but has been suspended for technical and legal reasons. DMS should use retroDUR to the fullest extent possible.

Kentucky Medicaid's PBA contract calls for an extensive program of drug utilization review after claims have been received and paid, known as retroDUR. In retroDUR, the PBA provides a series of reports showing unusual prescribing patterns, unusual prescription dispensing patterns, and unusual recipient usage patterns. The PBA also identifies the prescribers, pharmacists, and recipients who exhibit the unusual patterns and provides profiles of their claims history. In conjunction with DMS, the PBA determines whether some kind of intervention is appropriate. For prescribers and pharmacists, the intervention often is educational. For recipients, it consists of a letter to the prescriber describing the recipient's usage pattern.

First Health has not conducted retroDUR since discovering that the letter describing a recipient's prescription history might go to the wrong provider in violation of federal privacy laws. RetroDUR does have the potential to increase greatly the cost effectiveness of the prescription drug benefit. DMS should use the retroDUR capability of the PBA to the fullest extent possible given the technical and legal issues.

Third-party Payments

When Medicaid is aware of additional health coverage, that coverage pays first. Recipients inform Medicaid of their coverage, and other insurers provide information.

Medicaid recipients may also have coverage from other insurance. For instance, a child may have insurance coverage through a child support agreement. Kentucky Medicaid operates a third-party insurance process that ensures Medicaid pays what is left after all other coverage is used. However, the system works only for coverage of which Medicaid is aware.

Recipients are obligated to inform Medicaid when they have other insurance coverage. Medicaid also has information exchanges with other insurers.

Casualty insurance awards also should pay for any related medical expenses. The law could be strengthened in this area. The topic deserves further study.

Casualty insurance awards and settlements represent an area in which recipients might be reimbursed for medical expenses that were billed to Medicaid. Although there is a requirement that the recipient's attorney notify the cabinet, there does not appear to be an enforcement mechanism or a requirement for insurers to inform the cabinet.

KRS 205.623 requires insurance companies to provide coverage and claims information about Medicaid recipients. A 2004 Program Review report noted that the statute could be strengthened by adding penalties for noncompliance (Commonwealth. Legislative. Program. *Uncollected* 31). Staff reiterate the recommendation and add that it might be helpful to explicitly address casualty insurance information exchange and penalties for failing to provide information about such actions in that statute and in KRS 205.629.

Reducing Reimbursement to Pharmacies

Kentucky uses the average wholesale price to calculate reimbursement for many drugs. It has been shown to be an unreliable indicator, often much higher than a pharmacy's acquisition cost.

To calculate the price paid to pharmacies for many drugs, Kentucky relies on the reported average wholesale price that manufacturers submit to commercial publications. In fact, pharmacies' costs are often much lower than published prices. Since Kentucky sets its rate using these prices, pharmacies may be reimbursed more than they should relative to their costs. The average wholesale price has been the subject of many lawsuits. Drug manufacturers have inflated the average wholesale price and then marketed the drugs to pharmacies at discounted prices knowing that Medicaid will reimburse at a higher rate.

States now have access to the average manufacturer price, which may be a more reliable indicator of actual pharmacy cost. Pharmacists claim that reimbursement based on this price might force them out of business. DMS should consider using this price with input from pharmacists.

The average wholesale price is not defined by federal statute and does not necessarily reflect actual sales transactions. In contrast, the average manufacturer price that is reported quarterly to the federal government is defined in statute and reflects actual sales of drugs by manufacturers to wholesalers. A 2005 study by the Inspector General of the U.S. Department of Health and Human Services found the manufacturer price more than 50 percent lower than the average wholesale price (U.S. Dept. of Health. Office. *Medicaid Drug* 9). Kentucky might realize significant savings from using the average manufacturer price to calculate reimbursement instead of the average wholesale price. Changes in federal rules pursuant to the Deficit Reduction Act of 2005 have made this price available to the states to calculate payment rates.

Staff note that pharmacists, particularly independent pharmacists, claim that reduced reimbursement based on average manufacturer

price might force them out of business. DMS should consider using this price, but any move to reduce reimbursement should be made carefully and with input from the pharmacists' associations.

Measuring the Success of the Prescription Drug Benefit

Measurement of program success is essential. DMS appears to have inadequate measurement and oversight of the PBA.

It is essential that DMS have good measures of success and some targets for the prescription drug benefit. At this time, it appears that DMS depends on First Health's self-assessment and that DMS is not providing adequate management oversight. Partly this is a result of turnover of the prescription drug benefit director and the First Health Kentucky account manager. However, staff urge DMS to take a more active role in overseeing the PBA.

This section describes some specific issues of measurement, primarily as examples to illustrate the larger evaluation issue.

Incorrect Member Count in First Health Statistics

It appears that First Health has miscalculated the per-member-per-month cost of the prescription drug benefit by including Passport members. First Health should correct the calculation or explain why Passport members should be included.

First Health provided Program Review staff with self-assessment data covering the period from October 2004 to February 2007. One of the key statistics for measuring a health benefit's costs is the per-member-per-month cost showing how much the program costs on average per recipient. Calculation of this cost requires two pieces of information: the total cost of the program for a month and the total number of recipients. The program cost shown in the First Health data does not include the Passport prescription drug benefit. However, First Health has consistently included Passport recipients and so overcounted the number of recipients by about 140,000. This mismatch has led First Health to understate the per-member-per-month cost by 18 percent. First Health should correct this measurement or explain why Passport members should be included.

Measuring the Effectiveness of Point-of-sale Edits

The Medicaid pharmacy point-of-sale system warns pharmacists of potential problems with claims. Pharmacists may override these messages if they determine there are no problems.

The Medicaid pharmacy point-of-sale (POS) system checks each claim against a set of rules called edits. Many of the edits check to make sure the information entered is meaningful, for instance, by rejecting a date of service in the future. Many other edits check for clinical issues, such a whether the recipient already has filled a prescription for the same or a similar drug or whether the recipient has a prescription for a drug that might interact with the new prescription. When the POS recognizes such an issue, it sends a message to the pharmacist. The pharmacist often has to take some

action and respond to the message before the claim can go through. If the pharmacist verifies that there is a problem, the claim will be denied, and the pharmacist will not fill the prescription. If the pharmacist determines there is no problem, he or she can override the edit and proceed.

Point-of-sale messages may be less effective than they could be. DMS and the PBA should review their performance routinely.

In the Program Review survey of pharmacists, some respondents expressed the opinion that the First Health POS has too many messages and that some of them can be overridden too easily.

The First Health information system includes reports that summarize the POS edits, how many messages were issued, and how many were overridden. These reports represent a measurement of the issue raised by the survey respondents. Review of the effectiveness of the POS edits should be a routine part of DMS and PBA cost management. Based on an understanding of the clinical issues, there should be benchmarks for how often each message should be overridden. When an edit falls outside the target range, someone should evaluate whether a change is needed.

Measuring the Effectiveness of Prior Authorization

Prior authorizations should not be denied too often or too seldom. DMS and the PBA should review the performance of this process routinely.

Prior authorization is required for certain medications or for prescriptions in certain situations. The process requires the prescriber to fax a request to First Health. At least some of the time the prior authorization will be denied. Management of the process should look for indications that a prior authorization is almost always approved. Such a prior authorization should be reviewed to determine whether it is being enforced properly, is unnecessary, or should be modified.

Some pharmacists in the Program Review survey expressed the opinion that prior authorizations are rarely denied and that too many are granted for narcotic pain medications.

As with POS edits, the First Health information system includes reports that summarize prior authorization approvals and denials. Review of the effectiveness of prior authorization should be a routine part of DMS cost management. Based on an understanding of the clinical issues, there should be benchmarks for how often each prior authorization should be approved or denied. When an authorization falls outside the target range, someone should evaluate whether a change is needed.

Measuring Outcomes

Beyond looking at how a point-of-sale message or prior authorization is performing, it is important to measure its effect on health care and cost. This is more difficult.

It is more difficult to measure how a POS edit, prior authorization, or any other specific program rule affects health care and program costs. Attempting to evaluate the impact of benefit program rules, however, is important, and an effort should be made to devise ways to measure outcomes. Staff heard some examples of possible outcome questions during interviews and focus groups.

Looking at the shift in market share of drugs in response to changes in the preferred drug list is a measurement tool.

Effectiveness of the Preferred Drug List. An objective of the preferred drug list is to increase generic usage and shift prescribing toward brand-name drugs that are less expensive to Medicaid. Cost reports should be available and broken down by individual drug with rebates taken into account. Because DMS does not have access to the rebate amounts on individual drugs, a complete assessment is not possible. However, a market shift report showing the quantity of each drug covered over time would help.

It is important to measure the effectiveness of prescription limit policies.

Effectiveness of Prescription Limits. DMS adopted limits of four prescriptions and three brand-name drug prescriptions per month per recipient. These limits can be overridden by the pharmacist. Like the general issue of POS edits and prior authorization, it would be good to know how often these limits are being exceeded, what their overall impact is, and whether they should be modified. One approach is to review the care of recipients who fall outside the limits and the prescribing patterns of their prescribers. It also could be helpful to review the care of some recipients whose use falls at or just below the limit.

It is important to ensure that cost sharing with recipients works as planned and is cost effective.

Effect of Cost Sharing. The use of copays and coinsurance for Medicaid is controversial. DMS instituted them on the assumption that cost sharing will make recipients more aware of the costs of their medications but will not prevent recipients from obtaining needed medications. It is important with innovations like this to measure their effect on health as well as on costs.

It is possible for cost-saving measures in the prescription drug benefit to increase costs in the medical benefit. Such interactions should be considered when evaluating the program.

Interaction Between Prescription and Medical Benefits. It is possible that cost savings in the Medicaid prescription drug benefit could increase costs in the medical benefit. Hypothetically, a step therapy rule that requires a patient to try a series of medications before Medicaid will pay for a more expensive drug might cause the patient to become more ill or have side effects that require medical treatment. Prescription limits might result in some recipients not receiving all the medication they need and subsequently requiring medical care. The same might happen as a result of cost sharing.

Staff urge DMS to make these and similar assessments part of the performance and outcome evaluation program recommended in Chapter 1.

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Appendix A

Related Issues Deserving Further Study

Each section below presents a topic deserving further study. For some topics, Program Review staff developed a series of questions. For others, there is a description of the issues and areas needing review.

Passport Health Plan

A 2005 review found that Passport Health Plan needed to improve its program integrity procedures. Although a 2007 review by a different agency and from a different perspective found Passport in compliance, a full review of Passport's program integrity function might be beneficial. Are there any program integrity best practices from other insurance plans or from other states that might enhance Passport's program integrity function?

Medicaid Worker Fraud and Abuse

There have been six known cases of worker fraud and abuse involving 10 individuals in the past 3 years. The actual number of cases is unknown, but it seems reasonable to assume that the vast majority of workers are honest and do not participate in fraud or abuse. The cabinet depends on tips and case reviews to discover this kind of fraud or abuse. It might be possible for the cabinet to be more proactive. What additional prevention and detection measures might be effective in curbing this kind of fraud and abuse?

Medicaid Disability Eligibility Fraud

Kentucky ranks second in the nation for its percentage of disabled persons, and the Social Security Administration has found that the Kentucky Department for Disability Determination's findings have been accurate. However, the Social Security Administration reviews are based exclusively on review of documents available to the department and do not address the possibility of deception on the part of applicants and their medical providers. Are so many Kentuckians actually disabled? Could the process, including medical review teams that conduct Medicaid disability reviews, be improved?

Tamper-resistant Prescription Pads

One national effort to combat prescription drug diversion is a Centers for Medicare and Medicaid Services requirement to use tamper-resistant pads for all Medicaid prescriptions. This requirement was originally supposed to go into effect on October 1, 2007, but has been delayed until April 1, 2008. Program Review staff interviews with prescription drug fraud convicts revealed that several of them had stolen prescription pads from medical offices and some had also altered drug quantities on legitimate prescriptions. What will this requirement cost? How effective will it be after it is implemented? What are possible undesirable consequences?

Recipient Medical Benefit Fraud

Recipients might not report casualty insurance settlements or awards, damage awards not involving insurance, and other third-party sources that should cover medical expenses. A study could examine the question of how often this happens and what could be done to recover the funds for Medicaid.

Safeguarding the Kentucky All Schedule Prescription Electronic Reporting System From Prescription Drug Diverters

The Drug Enforcement and Professional Practices Branch must ensure that only legitimate users access data from the Kentucky All Schedule Prescription Electronic Reporting system that is the controlled substance registry. Drug diverters find KASPER reports useful, and the reports are said to command $50 on the street. However, the KASPER login account application procedures have been challenged by some users as intrusive. How can KASPER best ensure that the person requesting a KASPER report is a legitimate requestor?

Paying for Prescription Drug Diversion

Most law enforcement and Medicaid officials expressed the opinion that Medicaid does not pay for much drug diversion. This appears to be based on anecdotal evidence and reasoning that the claims adjudication system does not allow drug duplication, early refills, and unusually high dosages. However, it does not take into account possible countermeasures on the part of recipients, such as using multiple Medicaid cards or exaggerating symptoms to obtain larger-than-necessary prescriptions and selling the unneeded portion. Also, the system is designed to allow terminal patients to receive high dosages of pain medications. Staff were told that sometimes these patients use their status—or others use their status—to divert drugs.

Sharing Provider Fraud Information Between Medicaid and Commercial Insurers

Commercial insurers hold meetings among their special investigation groups to share information about possibly fraudulent providers. Would Medicaid benefit from participating? Commercial insurers hesitate to share actual claims and eligibility data. Might it be worth considering ways to share data for program integrity purposes among commercial insurers and Medicaid, perhaps by providing their data to a trusted third party?

Electronic Health Record Systems and Fraud

Electronic health record systems might actually make it easier for providers to commit fraud by copying and pasting to create false medical notes to support false claims. In what ways can electronic health record systems increase opportunities for fraud?

Medicaid Prescription Drug Explanation of Benefits

What is the cost effectiveness of sending an explanation of benefits routinely to Medicaid recipients regarding their prescription claims? How might this Medicaid strategy help reduce prescription drug fraud and abuse?

Medicaid Generic Drug Reimbursement Rule

A new CMS rule, mandated by the Deficit Reduction Act of 2005, is scheduled to take effect on December 30, 2007. It will reduce reimbursements to pharmacies for generic drugs in order to save the federal government and the states approximately $8.4 billion over the next 5 years. CMS expects Medicaid to procure prescription drug discounts similar to those obtained by private insurers. Independent pharmacists assert they will only be reimbursed for 64 percent of the cost of generic drugs they dispense. What will be the impact of this rule on Kentucky pharmacies, particularly independent pharmacies?

Pharmaceutical Supplemental Rebates

Some states, like Kentucky, have joined multistate purchasing pools. Other states, like Florida, strongly support their independent negotiations. It is difficult to compare these options because the amounts negotiated are protected trade secrets and may be protected by federal law. What options do states have for evaluating their choices? What are the relative merits of pooling versus independent negotiations? What are the effects of different laws and policies regarding manufacturer participation in rebate negotiations?

Management of Off-label Prescribing

Federal Medicaid regulations do not require a state to reimburse off-label prescriptions. Department for Medicaid Services officials indicated there was a policy regarding off-label prescribing but were unable to provide a copy. What are reasonable options for management of off-label prescribing and when should it be reimbursed?

Durable Medical Equipment Cost Management

It may be possible for a state to manage the cost of some durable medical equipment supplies by paying for them through the pharmacy benefit and obtaining supplemental rebates via the preferred drug list. What are the legal and practical issues? How cost effective might such a program be?

Making Kentucky Medicaid Statutes Consistent With Medicaid Modernization

Some Kentucky statutes related to Medicaid, particularly related to the information systems, do not take into account the new Medicaid structure. For example, KRS 205.8453(2), KRS 205.6318(5), KRS 205.5606(8), and KRS 216.267(2) refer to the Medicaid Management Information System or the fiscal agent. The new Kentucky Medicaid has additional systems that fall under the previous concept of information systems and additional vendors that perform tasks

traditionally thought of as the fiscal agent's tasks. In the statutes generally, what language needs to be updated to reflect changes in Medicaid?

Medicaid Provider Enrollment and Credentialing Process

It is important that the Medicaid provider enrollment and credentialing process detects and prevents persons from becoming providers when they are not qualified. For example, the process should carefully look for applicants who are not licensed, have had prior licensing problems in other states, have a criminal history, or are on the federal Medicaid and Medicare exclusion list.

Pain Management Physician and Pain Management Clinic Regulation

Nearly 40 percent of both physicians and pharmacists responding to the Program Review staff surveys said that practicing as a pain management specialist without adequate training or credentialing occurs commonly. Other providers interviewed told staff that the quality and reputation of some pain management clinics are questionable. What regulations are there for providing pain management services? Should physicians who claim to provide pain management services be subject to more stringent regulation?

Overutilization of Emergency Room Services by Medicaid Recipients

How often do Medicaid recipients use emergency room services? Several physicians and pharmacists responding to the Program Review staff surveys mentioned overuse of emergency rooms by Medicaid recipients. Other providers interviewed by staff indicated that drug diverters often use emergency rooms to obtain controlled substance prescriptions.

Nurse Practitioner Prescribing

Prescribing by nurse practitioners, particularly of controlled substances, began relatively recently. Some physicians and a nurse practitioner interviewed by staff claim that nurse practitioners often prescribe inappropriately, particularly for controlled substances. Are nurse practitioners' prescribing decisions significantly different from physicians' decisions? Should there be any change in the prescribing authority or training and education for nurse practitioners?

Appendix B

Methods of Committing Prescription Drug Fraud and Abuse

The following table contains a list of possible methods for committing fraud and abuse against a prescription drug benefit. There may be methods not listed here. Staff did not find actual examples of all the methods, but all the methods listed are possible. There may be some debate about whether a particular method is fraud or abuse.

Shaded rows indicate that the items do not represent a direct cost to the prescription drug benefit.

Methods of Committing Prescription Drug Fraud and Abuse

Fraud or Abuse	Description
Pharmaceutical manufacturer	
	• Price agreements—federal and state Medicaid programs
Fraud	• Hiding discounts from federal and state Medicaid officials in order to inflate the average wholesale price
Fraud	• Hiding best price from federal government, particularly using nominal pricing
Fraud	• Hiding true average wholesale price from states
Fraud	• Labeling deeply discounted drugs with the drug code of a different entity (such as an HMO) instead of the actual manufacturer
Fraud	• Kickbacks to state officials or PBA vendors for favorable treatment in the prescription drug program
Fraud	• Inappropriately promoting off-label use of a medication
Fraud	• Manufacturing fraud, such as putting less than the labeled dose in the medication, using an unapproved process, or distributing a counterfeit medication
Fraud	• Manipulating clinical trials or data from clinical trials to obtain or maintain approval from the FDA
Fraud	• Kickbacks or other illegal incentives to physicians to prescribe
Abuse	• Providing gifts, meals, and other incentives to prescribers
Abuse	• Using detailers (sales representatives) who aggressively promote medications, especially using information about their prescribing habits
Fraud	• Sales representatives providing samples to a pharmacy for repackaging and sale

Fraud or Abuse	Description
Pharmaceutical wholesaler	
Fraud	• Distributing counterfeit drugs
Fraud	• Distributing veterinary drugs
Fraud	• Distributing stolen or other black-market drugs, including diverted drugs
Fraud	• Cornering the market through illegally obtained drugs and then reselling at a premium price
Pharmacy Benefit Administrator (PBA)	
Fraud	• Skimming some of supplemental rebates rather than remitting entire amount to the state
Fraud	• Paying the pharmacy less than the state program reimbursement and pocketing the difference (not possible if the state reconciles payments with claims)
Fraud	• Bribes or kickbacks to state officials in order to obtain PBA contract
Fraud	• Submitting fake claims and keeping the payments
Abuse	• Recommending preferred drugs that have a large rebate instead of other drugs that would have a lower bottom-line cost (Because First Health Services Corporation does not receive a percentage of rebates, Kentucky is protected against this.)
Fraud	• Recommending preferred drugs based on kickbacks or other hidden incentives from pharmaceutical manufacturers
Fraud	• Recommending preferred drugs in order to direct business to interests owned by the PBA or otherwise to enhance the PBA's profits at the expense of the state
Abuse*	• Ineffective prospective drug use review (intended to prevent fraudulent and abusive claims from being paid)
Abuse*	• Ineffective retrospective drug use review (intended to detect and recover overpayments resulting from fraudulent and abusive claims)
Abuse*	• Ineffective case/care management (may be provided in part by other vendors)
Medical provider not involved in prescribing	
Fraud	• Knowingly documenting false symptoms of disability
Abuse	• Failing to exercise vigilance in verifying symptoms of disability
Fraud	• Providing false medical records, including images and lab results

Fraud or Abuse	Description
Prescriber and prescriber's staff	
	• Prescribing unneeded medications (These schemes affect the pharmacy benefit if the patient uses Medicaid to fill the prescription.)
Abuse	• Outdated or ill-informed prescribing habits
Abuse	• Acquiescing to patient's demands for brand-name or other medications that may not be necessary but are not harmful
	• Traditional pill mill, providing unnecessary prescriptions for cash or services
Fraud	• No further involvement
Fraud	• In collaboration with a pharmacist who shares the profits
	• In collaboration with a recipient, who
Fraud	• returns some of the medication for the prescriber's use or resale
Fraud	• provides sexual or other favors to the prescriber
	• In collaboration with a recipient, who diverts the drugs and
Fraud	• sells them and shares the profits
Fraud	• sells them back to the prescriber (or whom the prescriber pays to get the prescription filled) for the prescriber's own use or for resale to other drug abusers or drug users (e.g., HIV patients)
Fraud	• Writing prescriptions in the name of Medicaid recipients who were never seen and filling the prescriptions for personal use or resale, with or without the knowledge of the pharmacist
Fraud	• Writing a prescription in someone else's name in order to get it covered (when the patient does not have insurance)
Fraud	• Office staff calling in prescriptions without the knowledge of the prescriber
Fraud	• Falsifying diagnosis in order to get the prescription covered
	• Physician-dispensed medications (not billed through the pharmacy benefit.)
Fraud	• Billing for medications not dispensed
Fraud	• Billing under a different family member if one member's benefit will not cover the medication dispensed
	• Double billing for dispensed medications
Fraud	• Billing Medicaid and a private insurer or Medicare for the same service
Fraud	• Billing Medicaid twice for the same service (maybe by submitting claims from two different doctors)
Fraud	• Dispensing and buying back medications after insurance has paid for them
Fraud	• Dispensing generic but billing for brand-name medication

Fraud or Abuse	Description
Prescriber and prescriber's staff (continued)	
	• Physician-dispensed medications (continued)
Fraud	• Billing for a more expensive form of medication than was dispensed (e.g., intravenous liquid instead of oral)
Fraud	• Falsifying diagnosis in order to get the dispensed medication covered
Fraud	• False or altered claims submitted by prescriber's staff (even clerical staff) without the knowledge of the prescriber
	• Coercive tie-ins, such as agreeing to write a controlled substance prescription only if the patient agrees to expensive procedures, such as spinal injections, which may not even be performed properly
Fraud	• Controlled substance prescription is medically necessary
Fraud	• Controlled substance prescription is not medically necessary
Fraud	• Referring patients to a specific pharmacy and receiving kickbacks for the referrals
Fraud	• Referring patients to a specific pharmacy in which the prescriber or a family member has a financial interest
Fraud	• Prescribing by a provider who has been barred from Medicaid
Fraud	• Prescribing of controlled substances by a provider who is not licensed to do so
Fraud	• Providing samples to a pharmacy for repackaging and sale
Pharmacist	
Fraud	• Billing for medications not prescribed
	• Billing for medications prescribed but not dispensed
Fraud	• Buying legitimate prescriptions from patients to bill but not to fill
Fraud	• Employing so-called runners, assistants who obtain prescriptions by deception
Fraud	• Failing to reverse claims for prescriptions not picked up
Fraud	• Repackaging samples and dispensing as regular inventory
Fraud	• Dispensing stolen drugs
Fraud	• Dispensing counterfeit drugs
Fraud	• Dispensing drugs obtained by fraudulent means or purchased at an inappropriate discount (including kickbacks) from a legitimate source

Fraud or Abuse	Description
Pharmacist (continued)	
	• Double billing
Fraud	• Billing Medicaid and a private insurer for the same prescription
Fraud	• Billing Medicaid and Medicare for the same prescription (less likely to happen as data sharing between Medicaid and Medicare improves)
Fraud	• Billing Medicaid twice for the same prescription (maybe by submitting claims from two different pharmacies)
Fraud	• Knowingly billing for medications for deceased recipients, whether or not prescribed or dispensed
	• Billing Medicaid knowing there is another policy that would cover some or all of the cost
Fraud	• In an effort to hide the additional coverage for the benefit of the recipient
Abuse	• In an effort to file the claim quickly without having to identify the additional coverage
Fraud	• Billing under a different family member if one member's benefit will not cover the prescription
	• Dispensing and buying back medications
Fraud	• For use in further prescriptions
Fraud	• For the pharmacist's own use
Fraud	• For resale to drug abusers
Fraud	• Receiving a share of dispensed prescribed medication (typically a controlled substance)
Fraud	• Dispensing generic but billing for brand-name medication
Fraud	• Dispensing a less expensive form of medication (e.g., substituting tablets for capsules)
	• Prefilling and billing for refills even when the patient has not requested it
Abuse	• Dispensing the refill when the patient comes in
	• Recycling the medication when the patient does not come in after a certain period (perhaps waiting until the next subsequent refill period)
Abuse	• Reversing and repaying the claim
Fraud	• Keeping the payment
Fraud	• Mail-order or Internet pharmacy persisting in sending and billing refills even when the recipient has not asked for them
Fraud	• Dispensing a compounded medication when the prescription does not require compounding

Fraud or Abuse	Description
Pharmacist (continued)	
Fraud	• Dispensing less medication than prescribed and billed (short-fill)
Fraud	• Dispensing a placebo, counterfeit, or inexpensive (e.g., over-the-counter) medication instead of the prescribed medication
Fraud	• Knowingly filling a prescription based on a false diagnosis by a physician in order to get the prescription covered
Abuse	• Accidentally dispensing the wrong medication or wrong amount
Abuse	• Accidentally billing for the wrong medication or wrong amount
Fraud	• False or altered claims submitted by pharmacy staff (even clerical staff) without the knowledge of the pharmacist
Abuse	• Failing to maintain adequate documentation of legitimate prescriptions filled
Fraud	• Billing by a pharmacist who has been barred from Medicaid
Fraud	• Paying kickbacks to prescribers to direct their patients to the pharmacy to have prescriptions filled
Fraud	• Paying recipients to use the specific pharmacy to have prescriptions filled
Nursing home, hospital, other congregate care provider**	
	• Related to in-house pharmacies
Fraud	• Billing for medications dispensed but not consumed and therefore returned to the in-house pharmacy for reuse
Fraud	• Facility's steering the prescriber to a therapeutic equivalent in order to obtain a greater profit margin, even though the insurer will pay for both
Pseudo-provider (someone who does not operate a pharmacy but finds a way to submit claims)	
Fraud	• Fraudulently obtaining a provider license and recipient billing information and submitting false claims
Fraud	• Fraudulently obtaining provider and recipient billing information and submitting false claims
Recipient	
	• Using incorrect information when applying or reapplying for Medicaid so that an ineligible person becomes or remains a recipient (includes dependents)
Fraud	• Falsifying information
Abuse	• Accidentally failing to disclose information

Fraud or Abuse	Description
Recipient (continued)	
	• Using incorrect information when applying or reapplying for SSI so that an ineligible person becomes or remains a Medicaid recipient (includes dependents)
Fraud	• Falsifying information
Abuse	• Accidentally failing to disclose information
	• Failing to inform Medicaid in a timely manner when eligibility factors change and continuing to use the benefit
Fraud	• Intentionally
Abuse	• Unintentionally
	• Failing to inform Medicaid about available third-party payers
Fraud	• Intentionally (most likely involving casualty insurance)
Abuse	• Unintentionally (most likely involving dependents in divorce or foster care cases)
	• Sharing Medicaid benefit with others in order to obtain payment for their medications
Fraud	• Traditional card-sharing—nonrecipient pretends to be the recipient and uses the Medicaid card
Fraud	• Benefit-sharing—recipient fakes or exaggerates symptoms in order to obtain medications and then gives them to someone else who medically needs them
	• Doctor shopping to obtain additional drugs
Fraud	• For personal use
Fraud	• For resale
Fraud	• Selling some of the medicine from a legitimate prescription while using the rest
Fraud	• Forging prescriptions on stolen or scanned prescription pads
Fraud	• Posing as a prescriber and phoning in prescriptions
Fraud	• Altering legitimate prescriptions, for example, to increase the quantity or dose
Fraud	• Faking or exaggerating symptoms in order to obtain medications
Fraud	• Buying or using falsified medical records or medical records belonging to someone else to use to convince a prescriber that drugs are needed
Abuse	• Insisting on medication or on specific brand-name drugs when not medically necessary
Fraud	• Pressuring doctors into documenting disabling conditions in order to obtain SSI or other disability benefits

Fraud or Abuse	Description
Pseudo-recipient (someone who impersonates a recipient to obtain prescription drugs)	
Fraud	• Nonrecipient who obtains Medicaid cards or numbers and uses them to obtain prescriptions, whether legitimate or fraudulent
Medicaid employee or vendor	
Fraud	• Fraudulently obtaining benefits for self or others, including selling eligibility
Fraud	• Providing information that others can use to defraud or abuse the system (e.g., provider identifiers, recipient identifiers, edits and audits)
Fraud	• Intercepting or shepherding improper claims in order to ensure they are paid
Abuse*	• Ineffective case/care management (may be provided in part by the PBA)
Abuse*	• Ineffective overpayment recovery methods

Note: *These might be considered a form of waste or mismanagement rather than abuse.
**These methods are in addition to many of the other types of fraud and abuse.
Source: Program Review staff compilation of information from news and academic literature, interviews, and descriptions of claims payment systems.

Appendix C

Results of the Survey of Kentucky Pharmacists

This appendix consists of tabulated responses to the closed-ended questions from the survey of Kentucky pharmacists. There were 594 respondents to the survey. For questions for which respondents could give more than one answer, percentage totals will exceed 100. For questions with one answer, percentage totals may not equal 100 because of rounding.

Instructions From the Questionnaire

This survey focuses on prescription drug fraud and abuse, especially as it relates to the Medicaid prescription drug program in Kentucky. For the purpose of this survey, fraud and abuse will be defined as in the Code of Federal Regulations (42 KAR 455.2). "Fraud" means an "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." "Abuse" means "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program." Abuse does not refer to behavior associated with drug addiction.

Experience with Medicaid and Medicaid recipients varies widely among physicians. Please answer the survey questions as best as you can based on your medical practice experience, including what you hear about this topic from patients, medical colleagues, and medical office staff.

The survey is anonymous. You will not be personally identified by your responses. The survey should only take approximately 10-15 minutes to complete. Please complete the survey only once. If for any reason you wish to start the survey again, please click on the browser's refresh button. After completing the survey, please click the submit button at the end.

1. In your opinion, what are the three most common fraud and/or abuse activities engaged in by Medicaid Recipients or Impersonators? Check up to three.

Activity	Responses	Percent
Doctor shopping	528	89
Faking symptoms to procure prescription drugs	446	75
Stealing and forging prescriptions	76	13
Scanning prescription forms into a computer to forge prescriptions	2	< 1
Posing as a physician or medical office staff and calling in fraudulent prescriptions	139	23
Using someone else's Medicaid card	57	10
Altering prescriptions	214	36
Presenting forged/altered medical records to procure prescriptions	45	8
Other	62	10

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

In your opinion, what are the three most common fraud and/or abuse activities engaged in by Physicians and Other Prescribers? Check up to three.

Activity	Responses	Percent
Prescribing drugs for illegitimate use	166	28
Inappropriate prescribing	515	87
Using faked medical documentation to justify a prescription	26	4
Billing for office visits to write prescriptions without seeing patient	158	27
Practicing as pain management specialist without adequate training/credentialing	219	37
Writing "dispense as written" at a patient's request when not medically necessary	347	58
Collusion with others to illegally divert prescription drugs	31	5
Other	36	6

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

In your opinion, what are the five most common fraud and/or abuse activity engaged in by Pharmacists or Pharmacy Staff? Check up to five.

Activity	Responses	Percent
"Short counting" pills	130	22
Dispensing generic rather than brand name and billing for brand name	92	16
Buying prescriptions and billing, but not dispensing	47	8
Creating false prescriptions and pick-up records and billing for drugs never ordered	78	13
Preparing and billing a prescription refill prior to patient request	189	32
Billing twice or billing two different insurers for same prescription	66	11
Billing someone's Medicaid benefit for an uncovered family member or friend's prescription	95	16
Reusing unclaimed refills without reversing submitted claims	184	31
Repacking and Dispensing drug samples	87	15
Collusion with others to illegally divert prescription drugs	67	11
Other	96	16

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

In your opinion, what are the two most common fraud and/or abuse activities engaged in by Pharmaceutical Manufacturers? Check up to two.

Activity	Responses	Percent
Improper influence in Continuing Medical Education	85	14
Improper influence by drug representatives	300	51
Withholding true price information or hiding discounts to inflate average wholesale price	109	18
Marketing a drug for a medical purpose sans any supporting research	109	18
Inappropriate incentives to state officials or PBA vendors for favorable treatment	207	35
Inappropriate incentives to physicians to prescribe a drug	364	61
Other	28	5

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

2. What prescription drugs are most prone to fraud and/or abuse activities? Please list up to five drugs and indicate the reason for the drug's susceptibility to fraud and/or abuse. (Open-ended)

3. Please list any non-controlled or controlled substances that you think should be scheduled or rescheduled and what schedule you would recommend. (Open-ended)

4. What do you think are the most common reasons that some physicians abuse their prescribing authority with controlled and non-controlled substances? Please check up to three reasons.

Reason	Responses	Percent
Lack of pharmaceutical knowledge	102	17
Patient deception	406	68
Patient lacks health insurance	31	5
Inadequate diagnosis	58	10
Inadequate treatment plan	112	19
Inexperience with manipulative and/or demanding patients	305	51
Physician fraud/dishonesty	82	14
Inadequate knowledge of patient's medical and drug abuse history	274	46
Inability to recognize "drug seeking" behaviors	277	47
Physician impairment/addiction	36	6
Other	73	12

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

5a. Would physician education be helpful in reducing inappropriate prescribing practices?

	Responses	Percent
Yes	470	81
No	112	19
Total	582	100

5b. Would pharmacist education be helpful in reducing inappropriate dispensing practices?

	Responses	Percent
Yes	399	69
No	183	31
Total	582	100

6. What do you think are the three most common reasons that some Medicaid recipients commit prescription drug fraud? Please check up to three reasons.

Reason	Responses	Percent
Greed	364	61
Addiction	539	91
Pain alleviation	191	32
Pseudo-addiction	184	31
Friend or family member has no health insurance	167	28
Other	93	16

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

7. What do you think are the three most common reasons that physicians commit Medicaid prescription drug fraud? Please check up to three reasons:

Reason	Responses	Percent
Greed	349	59
Pharmacist's drug or alcohol dependence	119	20
Conflict avoidance with pharmacy customers	329	55
Pressure/manipulation from pharmaceutical companies	11	2
Pressure/manipulation from doctors	126	21
Inadequate reimbursement from Medicaid	221	37
Empathy for patients and/or their families	215	36
Other	36	6

Note: Percentages are based on the overall number of survey respondents: 594. The number of responses varies by item.

8. On a scale of 1 to 5, with 1 being an insignificant problem and 5 being a very serious problem, how serious a problem would you say Medicaid prescription drug fraud and abuse is among the following groups? If it is not a problem at all, please click on "zero."

Group, Number of Responses	No Problem	1	2	3	4	5	Unsure
Recipients, 578	1 (<1%)	13 (2%)	33 (6%)	130 (22%)	208 (36%)	179 (31%)	14 (2%)
Pharmacists, 581	77 (13%)	263 (45%)	138 (24%)	58 (10%)	8 (1%)	4 (1%)	33 (6%)
Pharmacy Techs, 580	98 (17%)	197 (34%)	152 (26%)	67 (12%)	24 (4%)	3 (1%)	39 (7%)
Physicians, 581	16 (3%)	92 (16%)	158 (27%)	172 (30%)	84 (15%)	27 (5%)	32 (6%)
Nurse Practitioners, 580	30 (5%)	118 (20%)	153 (26%)	134 (23%)	66 (11%)	23 (4%)	56 (10%)
Other Prescribers, 577	33 (6%)	105 (18%)	156 (27%)	133 (23%)	42 (7%)	21 (4%)	87 (15%)
Medical Office Workers, 575	51 (9%)	100 (17%)	134 (23%)	105 (18%)	54 (9%)	18 (3%)	113 (20%)
Lab Techs, 574	126 (22%)	145 (25%)	84 (15%)	26 (5%)	5 (1%)	2 (< 1%)	186 (32%)
Pharmaceutical Manufacturers, 576	52 (9%)	81 (14%)	102 (18%)	105 (18%)	46 (8%)	49 (9%)	141 (25%)
Pharmacy Benefit Administrators, 577	69 (10%)	87 (15%)	83 (14%)	75 (13%)	40 (7%)	64 (11%)	168 (29%)

9a. How effective is the First Health Medicaid POS [point of sale] system at preventing the following:

Item, Number of Responses	Not Effective at All	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Very Effective
Recipient Drug Diversion, 545	108 (20%)	106 (19%)	112 (21%)	189 (35%)	30 (6%)
Recipient Card Sharing, 544	85 (16%)	83 (15%)	152 (28%)	166 (31%)	58 (11%)
Errors in Claims Submission, 545	42 (8%)	80 (15%)	123 (23%)	240 (44%)	60 (11%)
Fraudulent/Abusive Claims Submission, 546	56 (10%)	92 (17%)	148 (27%)	216 (40%)	34 (6%)

9b. How effective is the First Health Medicaid prior authorization process at preventing the following?

Item, Number of Responses	Not Effective at All	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Very Effective
Recipient Drug Diversion, 548	126 (23%)	106 (19%)	123 (22%)	163 (30%)	30 (6%)
Recipient Card Sharing, 548	102 (19%)	79 (14%)	147 (27%)	156 (29%)	64 (12%)
Unnecessary Use of Brand or Non-Preferred Drugs, 553	70 (13%)	96 (17%)	81 (15%)	220 (40%)	86 (16%)

9c. If you have further comments on the effectiveness of First Health (including edits and overrides) at preventing Medicaid fraud and abuse (please provide them below. (Open-ended)

10. Please use the space below to comment on any aspect of prescription drug fraud and abuse you wish to. (Open-ended)

Demographics

Respondent works:

	Responses	Percent
In a Chain Pharmacy	279	48
In an Independent Pharmacy	188	32
Other	118	20
Total	585	100

Years of Pharmacy Practice

	Responses	Percent
1 year of less	9	2
2-5 years	93	16
6-10 years	90	15
11-15 years	73	12
16-20 years	75	13
21+ years	247	42
Total	587	100

Age

	Responses	Percent
25-30	94	16
31-40	156	27
41-50	128	22
51-60	133	23
61-70	52	9
70+	16	3
Total	579	100

Gender

	Responses	Percent
Female	278	48
Male	305	52
Total	583	100

Pharmacy fills mail order prescriptions?

	Responses	Percent
No	557	97
Yes	19	3
Total	576	100

Pharmacy fill prescriptions via the Internet?

	Responses	Percent
No	502	88
Yes	71	12
Total	573	100

Pharmacy serves Medicaid patients?

	Responses	Percent
No	17	3
Yes	552	96
Unsure	8	1
Total	577	100

Primary Medicaid Payer is:

	Responses	Percent
Kentucky Health Choices	368	67
Passport Health Plan	137	25
None	43	8
Total	548	100

Appendix D

Results of the Survey of Kentucky Physicians

This appendix consists of tabulated responses to the closed-ended questions from the survey of Kentucky physicians. There were 140 respondents to the survey. For questions for which respondents could give more than one answer, percentage totals will exceed 100. For questions with one answer, percentage totals may not equal 100 because of rounding.

Instructions From the Questionnaire

This survey focuses on prescription drug fraud and abuse, especially as it relates to the Medicaid prescription drug program in Kentucky. For the purpose of this survey, fraud and abuse will be defined as in the Code of Federal Regulations (42 CFR 455.2). "Fraud" means an "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." "Abuse" means "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program." Abuse does not refer to behavior associated with drug addiction.

Experience with Medicaid and Medicaid recipients varies widely among physicians. Please answer the survey questions as best as you can based on your medical practice experience, including what you hear about this topic from patients, medical colleagues, and medical office staff.

The survey is anonymous. You will not be personally identified by your responses. The survey should only take approximately 10-15 minutes to complete. Please complete the survey only once. If for any reason you wish to start the survey again, please click on the browser's refresh button. After completing the survey, please click the "submit" button at the end.

1. In your opinion, what are the three most common fraud and/or abuse activities engaged in by Medicaid Recipients or Impersonators? Check up to three.

Activity	Responses	Percent
Doctor shopping	119	85
Faking symptoms (to procure prescription drugs)	110	79
Stealing and forging prescriptions	23	16
Scanning prescription forms into a computer to forge prescriptions	0	0
Posing as a physician. or medical office staff and calling in fraudulent prescriptions	20	14
Using someone else's Medicaid card	21	15
Altering prescriptions	58	41
Presenting forged/altered medical records to procure prescriptions	7	5
Other	12	9

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

In your opinion, what are the three most common fraud and/or abuse activities engaged in by Physicians and other Prescribers? Check up to three.

Activity	Responses	Percent
Prescribing drugs for illegitimate use	30	21
Inappropriate prescribing	108	77
Using faked medical documentation to justify a prescription	8	6
Billing for office visits to write prescriptions without seeing patient	32	23
Practicing as pain management specialist without adequate training/credentialing	55	39
Writing “dispense as written” at a patient's request when not medically necessary	33	24
Collusion with others to illegally divert prescription drugs	10	7
Other	10	7

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

In your opinion, what is the most common fraud and/or abuse activity engaged in by Pharmacists or Pharmacy Staff? Check only one.

Activity	Responses	Percent
Repackaging and dispensing drug samples	21	15
Collusion with others to illegally divert prescription drugs	25	18
Filing false claims (double billing or billing for drugs not dispensed)	36	26
Other	23	16

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

In your opinion, what are the two most common fraud and/or abuse activities engaged in by Pharmaceutical Manufacturers? Check up to two.

Activity	Responses	Percent
Marketing to promote use of a drug for medical purpose without any supporting research	58	41
Inappropriate incentives to physicians to prescribe drugs	45	32
Improper influence in Continuing Medical Education	16	11
Improper influence by drug representatives	54	39
Other	15	11

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

2. What prescription drugs are most prone to fraud and/or abuse activities? Please list up to five drugs and indicate the reason for the drug's susceptibility to fraud and/or abuse. (Open-ended)

3. Please list any non-controlled or controlled substances that you think should be scheduled or rescheduled and what schedule you would recommend. (Open-ended)

4. What do you think are the most common reasons that some physicians abuse their prescribing authority with controlled and non-controlled substances? Please check up to three reasons.

Reason	Responses	Percent
Lack of pharmaceutical knowledge	14	10
Patient deception	87	62
Patient lacks health insurance	11	8
Inadequate diagnosis	14	10
Inadequate treatment plan	14	10
Inexperience with manipulative and/or demanding patients	67	48
Physician fraud/dishonesty	20	14
Inadequate knowledge of patient's medical and drug abuse history	65	46
Inability to recognize “drug seeking” behaviors	61	44
Physician impairment/addiction	12	9
Other	10	7

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

5a. Would physician education be helpful in reducing inappropriate prescribing practices?

	Responses	Percent
No	46	35
Yes	86	65
Total	132	100

5b. If yes, which of the following would be useful? Check all that apply.

Item	Responses	Percent
Counter-detailing by Medicaid	36	26
Continuing Medical Education	59	42
Reports from the Pharmacy and Therapeutics Committee	35	25
Letters to physicians from the Kentucky Dept. for Medicaid Services	34	25
Letters to physicians from the Kentucky Board of Medical Licensure	14	10
Letters to physicians from the Kentucky Medical Association	27	19
KBML Newsletter	18	13
KMA Newsletter	15	11
Other	10	7

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

6. What do you think are the three most common reasons that some Medicaid recipients commit prescription drug fraud? Please check up to three reasons.

Reason	Responses	Percent
Greed	69	49
Addiction	123	88
Pain alleviation	48	34
Pseudo-addiction	51	36
Friend or family member has no health insurance	45	32
Other	12	9

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

7. What do you think are the three most common reasons that physicians commit Medicaid prescription drug fraud? Please check up to three reasons.

Reason	Responses	Percent
Greed	42	30
Pressure/manipulation from pharmaceutical companies	15	11
Physician's drug or alcohol dependence	35	25
Conflict avoidance with patients	93	66
Inadequate reimbursement from Medicaid	27	19
Empathy for patients and/or their families	65	46
Other	13	9

Note: Percentages are based on the overall number of survey respondents: 140. The number of responses varies by item.

8. On a scale of 1 to 5, with 1 being an insignificant problem and 5 being a very serious problem, how serious a problem would you say Medicaid prescription drug fraud and abuse is among the following groups? If it is not a problem at all, please click on "zero."

Group, Number of Responses	No Problem	1	2	3	4	5	Unsure
Recipients, 133	0 (0%)	6 (5%)	19 (14%)	25 (19%)	33 (25%)	40 (30%)	10 (8%)
Pharmacists, 131	16 (12%)	35 (27%)	20 (15%)	14 (11%)	5 (4%)	3 (2%)	38 (29%)
Pharmacy techs, 130	14 11%)	29 (22%)	24 (18%)	8 (6%)	4 (3%)	4 (3%)	47 (36%)
Physicians, 130	11 (8%)	34 (26%)	32 (25%)	25 (19%)	7 (5%)	7 (5%)	14 (11%)
Nurse Practitioners, 131	12 (9%)	32 (24%)	26 (20%)	14 (11%)	6 (5%)	8 (6%)	33 (25%)
Other Prescribers, 131	7 (5%)	29 (22%)	22 (17%)	9 (7%)	7 (5%)	7 (5%)	50 (38%)
Medical Office Workers, 130	14 (11%)	32 (25%)	26 (20%)	16 (12%)	5 (4%)	5 (4%)	32 (25%)
Lab Techs, 128	26 (20%)	31 (24%)	12 (9%)	6 (5%)	2 (2%)	2 (2%)	49 (38%)
Pharmaceutical Manufacturers, 129	19 (15%)	29 (22%)	18 (14%)	16 (12%)	5 (4%)	8 (6%)	34 (26%)
Pharmacy Benefit Administrators, 129	24 (19%)	27 (21%)	12 (9%)	11 (9%)	5 (4%)	7 (5%)	43 (33%)

9. Please use the space below to comment on any aspect of prescription drug fraud and abuse you wish to. (Open-ended)

Demographics

Type of Practice

	Responses	Percent
Primary Care	73	54
Specialist	63	46
Pain Specialist	0	0
Total	136	100%

Years of medical practice

	Responses	Percent
1 year or less	1	<1
2-5 years	9	7
6-10 years	28	22
11-15 years	19	15
16-20 years	19	15
21+ years	53	41
Total	129	100%

Age

	Responses	Percent
25-30	1	1
31-40	34	26
41-50	30	23
51-60	37	29
61-70	20	16
70+	7	5
Total	129	100%

Gender

	Responses	Percent
Female	34	25
Male	100	75
Total	134	100%

Practice includes Medicaid patients

	Responses	Percent
No	3	2
Yes	133	98
Total	136	100%

Number of physicians in respondent's medical practice (Open-ended)

	Responses	Percent
1	48	37
2	16	12
3	17	13
4	6	5
5	11	8
6	5	4
7	7	5
8	4	3
9	3	2
10	3	2
11	2	2
12	3	2
13	1	<1
15	2	2
30	2	2
100	1	<1
Total	131	100%

Appendix E

Research Methods

Surveys of Kentucky Physicians and Pharmacists

The target population of Medicaid physician providers was those with e-mail addresses listed in the Medicaid Management Information System. The Department for Medicaid Services provided the e-mail addresses. The target population of pharmacists was those with e-mail addresses registered with the Kentucky Board of Pharmacy.

The Web-based surveys were distributed to 1,597 physicians by e-mail. The Kentucky Board of Pharmacy e-mailed Web-based surveys to 3,597 pharmacists. Surveyed physicians and pharmacists received a series of three e-mails inviting them to participate in the study. Each e-mail contained a link to the appropriate survey form. Respondents answered the questions anonymously.

There were 140 physicians (9 percent response rate) and 594 pharmacists (16.5 percent response rate) who responded to the surveys. Ninety-eight percent of the physicians served Medicaid populations. Ninety-six percent of the pharmacists served Medicaid populations.

Physicians who responded to the survey were almost evenly divided in terms of practice type: 54 percent primary care and 46 percent specialty. There were no pain specialists among the physician respondents. Among pharmacist respondents, 48 percent worked for chains; 32 percent worked for independent pharmacies; and 20 percent worked for "other" organizations, which includes hospitals, clinics, and managed care organizations. The pharmacist respondents' primary Medicaid payers were KyHealth Choices (67 percent) and Passport Health Plan (25 percent). More than 40 percent of each group of respondents reported having more than 20 years of experience (41 percent of physicians and 42 percent of pharmacists).

Analysis of Court Case Data

The Administrative Office of the Courts (AOC) provided data on court cases filed with charges related to prescription drug fraud. Staff provided AOC with a list of offenses, as shown in the table below, which lists categories of fraud and the related charges. In general, the categories were related to provider billing, eligibility, diverting controlled substances, and diverting noncontrolled prescription drugs. The table also identifies Uniform Offense Reporting codes and Kentucky statutes related to each category.

Medicaid Fraud and Abuse Offenses Examined

Fraud and Abuse Category	Uniform Offense Reporting Code	KRS
Offenses related to billing Medicaid, including illegal referrals	02040	205.846(1)
	02041	205.846(1)
	02042	205.846(3)
	02043	205.846(3)
	02044	205.8463(3)
	02045	205.8463(4)
Offenses related to determination of eligibility for medical assistance	21440	194A.505
	21441	194A.505
	21442	194A.505
	21443	194A.505
	21444	194A.505
	21445	194A.505
	21446	194A.505
Offenses related to diverting controlled substances (includes patients and providers)	01859	218.210
	25013	218A.282
	25014	218A.282
	25063	218A.284
	25064	218A.284
	35918	218A.140
	35925	218A.140
	41998	217.182(6)
	41999	217.182(6)
	42025	218A.1404(3)
	42026	218A.1404(3)
	42027	218A.180
	42028	218A.180
	42035	218A.140(1)(a)
	42036	218A.140(1)(a)
	42037	218A.140(1)(b)

Fraud and Abuse Category	Uniform Offense Reporting Code	KRS
	42038	218A.140(1)(b)
	42039	218A.140(1)(c)
	42040	218A.140(1)(c)
	42041	218A.140(1)(d)
	42042	218A.140(1)(d)
	42043	218A.140(1)(e)
	42044	218A.140(1)(e)
	42050	218A.286(2)
	42051	218A.286(2)
	42052	218A.286(1)
	42053	218A.286(1)
	42055	218A.210
	42056	218A.210
	42057	218A.286(3)
	42058	218A.286(3)
	42155	218A.1413(1)(b)
	42156	218A.1413(1)(b)
Offenses related to diverting noncontrolled prescription drugs (legend drugs) (includes patients and providers)	25015	217.208
	25016	217.208
	41992	217.209
	41993	217.209
	41994	217.182(5)
	41995	217.182
	41996	217.182(7)
	41997	217.182(7)
	42068	217.207(3)
	42069	217.207(3)
	42070	217.207(1)
	42071	217.207(1)

Source: Program Review staff request for data from the Administrative Office of the Courts.

Appendix F

Centers for Medicare and Medicaid Services' Review of Kentucky's Program Integrity Unit

In August 2005, a federal Centers for Medicare and Medicaid Services (CMS) fraud and abuse team reviewed the Kentucky program integrity process. This appendix reproduces the transmittal letter and the report produced by that team.

Program Review staff point out that the CMS team characterized the HealthWatch Technologies and Myers and Stauffer computer procedures as fraud related. The description appears on page 7 of the CMS report. Considering the definition of fraud used by Program Review—intentional (and therefore criminal) filing of false claims—it appears that most of these procedures were designed to identify and recover overpayments resulting from abuse. However, some fraud cases probably were found among the results.

Program Review staff substituted a clearer version of the table on page 14 of the CMS report because the original was difficult to read.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

February 16, 2006

Ms. Shannon Turner
Commissioner
Department of Medicaid Services
275 East Main Street
Frankfort, KY 40621-001

Dear Ms. Turner:

During the week of August 8, 2005 a Centers for Medicare and Medicaid Services (CMS) Medicaid fraud and abuse team conducted a review of the Kentucky program integrity procedures.

The general purpose of the review was to determine whether the program integrity policies and procedures of Kentucky's Department of Medicaid Services (DMS) and Office of Inspector General (OIG) comply with Federal statutory and regulatory requirements. The review team was also interested in learning how other components of Kentucky's DMS and OIG identified, received and used information about potential fraud and abuse involving providers participating in the Kentucky Medicaid program.

Enclosed please find the review team's final report on the results of the review. The report identifies one area of non-compliance with the Code of Federal Regulations and offers suggestions that the team believes may enhance Kentucky's program integrity efforts. It also notes several state practices the team believes qualify as "Benchmark Practices." The report incorporates the state's response to the findings and vulnerabilities noted in the draft report.

We would like to take this opportunity to thank you and your staff for the cooperation and assistance provided to the review team during the review. If you have any questions, please contact review team members Mary Linda Morgan by phone at (410) 786-2011 (marylinda.morgan@cms.hhs.gov) or Robb Miller at (312) 353-0923 (robb.miller1@cms.hhs.gov), or Mark Rogers of my staff at (404) 562-7321 (mark.rogers@cms.hhs.gov).

Sincerely,

Dale K. Kendrick
Associate Regional Administrator
Division of Financial Management

Enclosure

cc: Mr. Robert Benvenuti
Inspector General
Mr. Zachary Ramsey
Director, FWAIP
Ms. Pamela Murphy
MFCU Director

Department of Health and Human Services
Centers for Medicare & Medicaid Services

MEDICAID ALLIANCE FOR PROGRAM SAFEGUARDS

REVIEW OF STATE MEDICAID PROGRAM INTEGRITY PROCEDURES

STATE OF KENTUCKY

Centers for Medicare & Medicaid Services Reviewers:

Mary Linda Morgan, Lead Reviewer, Central Office, Baltimore
Robb Miller, Chicago Regional Office

February 2006

FINAL REPORT

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Executive Summary

The Centers for Medicare & Medicaid Services is committed to partnering with states and other stakeholders to fight fraud and abuse in the Medicaid program. To further that commitment and in an oversight role, a CMS Medicaid Alliance for Program Safeguards (the Alliance) review team conducted a management review of Kentucky's program integrity policies and procedures.

This review explored current program integrity procedures and those under development by components of the Cabinet for Health and Family Services (CHFS), including the Department of Medicaid Services (DMS) and the Office of Inspector General (OIG). In addition, the team met with representatives of the Medicaid Fraud Control Unit (MFCU) and other entities within CHFS.

The purpose of this review was to determine whether Kentucky's program integrity procedures satisfy the requirements of the Code of Federal Regulations (CFR) at Title 42, Parts 455 and 447.10 and applicable provisions of the Social Security Act (the Act). A related purpose of the review was to learn how the State Medicaid agency identifies, receives and uses information about potential fraud and abuse involving Medicaid providers.

Findings involve regulatory noncompliance. The team's review of Kentucky's program integrity policies and procedures found that the state is not in compliance in one area.

- 42 CFR 455.106 requires the Medicaid agency to report, within twenty days, any criminal history disclosure from a provider agreement. Kentucky has not been complying with this regulation. (See state's response on page 10.)

Potential Vulnerabilities include observations the team made related to areas the state should consider correcting as they might harm the Medicaid program if left unaddressed:

- While Kentucky does perform some Surveillance and Utilization Review Subsystem (SURS)-like activities, it has not had a systematic SURS process for several years.
- The OIG and the MFCU seem to be at odds. They neither meet regularly nor have much communication between the leaderships of the two entities.
- Critical program integrity functions, such as its SURS-like activities and its enrollment processes, seem to be understaffed.
- While state contractors do some provider audits, Kentucky does not have a system of conducting audits across all provider types in a methodical manner.
- The OIG does not have any in-house clinical expertise available to it.

The team observed several Benchmark Practices during its review:

- The recent re-organization of the Cabinet resulted in moving the former Division of Program Integrity out from under the Department of Medicaid Services. The new Division of Fraud, Waste and Abuse Identification and Prevention (FWAIP) reports directly to the CHFS Inspector General who reports directly to the Cabinet Secretary.

- Organizationally housing the management responsibility for Kentucky's electronic prescription monitoring system (KASPER) in FWAIP allows for improved fiscal integrity related to pharmaceutical behaviors in the Medicaid program.

- FWAIP's "correspondence campaign" alerts physicians to potentially abusive Medicaid client behaviors of which they may have previously been unaware. Doing so provides a sentinel effect on both physician and client behaviors.

- During provider enrollment, Kentucky also checks the General Service Administration's (GSA) Excluded Parties List System (EPLS) before issuing an enrollment number. Although not specifically required to do so by federal regulation, Kentucky will not issue a provider number to a person or entity on the EPLS.

The State' responses to CMS' comments are included in this final report.

I. BACKGROUND

In June 1997, CMS' Southern Consortium assumed leadership of the Alliance, formerly the National Medicaid Fraud and Abuse Initiative. The Alliance was established with the primary goal of preventing fraud and abuse by assisting states in their efforts to identify proactive strategies and by sharing information with other program integrity stakeholders. Through CMS' leadership, every effort is made to encourage participation and communication among state and federal entities working to fight fraud and abuse.

Designing and conducting the review were important steps toward fulfilling the Alliance's goals. Taking full advantage of CMS' regional presence, a national review team was formed using Medicaid fraud and abuse coordinators from CMS' ten Regional Offices as well as its Baltimore Central Office. Coordinators from the Chicago Regional Office and the Central Office conducted the Kentucky review.

II. INTRODUCTION

Program Administration
The Kentucky Medicaid program is administered by the Cabinet for Health and Family Services' (CHFS) Department for Medicaid Services. CHFS was created in 2004 by combining the former Cabinet for Health and the former Cabinet for Family Services. The program serves approximately 689,274 beneficiaries who represent about 16% of the state's population. Approximately 136,568 of those beneficiaries (20%) are enrolled in Medicaid managed care plans.

Medicaid Expenditures
Medicaid expenditures for state FY 2004 totaled approximately $2.037 billion, of which the federal government contributed 73% (FFY 04) as its share for medical expenditures. In FFY 05, FMAP went down to 69%.

Kentucky's Medicaid budget represents approximately 10% of the state's overall budget (SFY 05 $20.732 billion) and 33% (SFY 05 $6.231 billion) of CHFS' budget. The state processed approximately 59.8 million claims in SFY 05 from about 33,714 enrolled providers participating in the both fee for service and managed care components of the Medicaid program.

III. METHODOLOGY

Purpose
This review was conducted to assess whether the state is complying with applicable federal laws and regulations. The review team wanted to understand the program integrity operations within the Kentucky Medicaid operation and to learn how potential fraud and abuse information is identified, received and used.

The Alliance's Regional Office Review Protocol was the source of the review's direction and content. The protocol was designed to assist the reviewers and to add consistency to the process. The review team interviewed staff and evaluated state operations.

Scope of Review

The review was conducted at CHFS & MFCU offices located in Frankfort, Kentucky. The team limited its review to Kentucky's current procedures and projects in development for handling provider fraud and abuse issues. Although the review focused on program integrity efforts related to FFS providers, many of the oversight rules that guided the review team can also be effectively applied in a managed care environment. The Alliance's Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care were intended to help states implement effective standards for improving fraud and abuse prevention, detection and investigation in a managed care setting. It is available on the Internet at: http://www.cms.hhs.gov/states/fraud/reports.asp.

Report Terminology

Findings involve regulatory non-compliance. Kentucky had one finding of non-compliance. *Potential Vulnerabilities* involve situations that might harm the state's Medicaid program if unaddressed. *Benchmark Practices* are those State agency procedures the Alliance considers exemplary.

IV. FUNCTIONAL AREAS

A. OFFICE OF INSPECTOR GENERAL

CHFS' Office of Inspector General (OIG) is responsible for program integrity in the Kentucky Medicaid program. The OIG was created in early 2004. Prior to that time, the former Division of Program Integrity was the primary Medicaid fiscal watchdog and was housed in DMS. Upon its transfer to the newly-created OIG, it was renamed the Division of Fraud, Waste and Abuse/Identification & Prevention (FWAIP). FWAIP continues to have the bulk of the administrative responsibility for Medicaid program integrity. The OIG has executed Memoranda of Agreement between itself and DMS and itself and the MFCU. The functions of the Division of Special Investigations (DSI) and the Division of Audits and Detection are described later.

Benchmark Practices

In most single state agencies, the program integrity staff is subordinate to the Medicaid director. While this may facilitate cooperation between policy/program staff and the fraud and abuse staff, the goals of those groups can often be at odds. By placing FWAIP directly under the Inspector General, the organizational status of the program integrity functions has been elevated. In reporting to the Inspector General (IG), the director of FWAIP has the immediate and direct attention of the IG. Having the independence of the OIG also gives FWAIP the freedom to take unpleasant but necessary measures to protect the integrity of the Medicaid program.

Identifying Suspected Fraud Cases

The responsibility for the identification, investigation and referral of suspected fraud cases lies within the OIG. These duties are shared by FWAIP and DSI. Some of this would traditionally be conducted through a Surveillance and Utilization Review Subsystem (SURS). According to OIG staff, Kentucky has not conducted a traditional SURS program for more than 10 years. However, the review team is satisfied that the activities required to identify and investigate suspected fraud cases exist in the Kentucky Medicaid program. Further, CHFS' Department of Medicaid Services is designing a new MMIS which will include SURS.

FWAIP's Medicaid Provider and Third Party Compliance Branch has 10 dedicated positions, including 2 managers. At this time, there are five staff assigned full-time to provider fraud and abuse activities with an operating budget of $745,215. $481,162 represent staff and administrative costs. FWAIP also contracts with Myers and Stauffer (MS) to provide financial oversight at a cost of $264,053. M&S has 13 full time staff along with clinical expertise as needed. FWAIP also formerly worked with Health Watch Technology (HWT) on fraud-based algorithms. A small number of other FWAIP staff work on various issues as needed.

The following provide a few examples of some of the SURS-like functions the OIG maintains. HWT has provided FWAIP with more than 70 fraud algorithms that have been periodically conducted since 2000. M&S has also developed more than 50 such algorithms for FWAIP since 2003. [1]FWAIP staff monitors the Top 10 billers in various areas such as oxycontin prescribers. FWAIP chaired an agency committee which reviewed all MMIS edits and audits to ensure compliance with agency policies.

Although there is no data warehouse or data mart incorporated into the current MMIS, FWAIP staff does have access to BI-Query which allows for data mining efforts. Other SURS-like functions include monitoring the Top 10 billers by provider type. This process began in early 2005. To date, two dentists have been referred to DSI for further preliminary investigation.

During the last 3 state fiscal years, FWAIP has conducted or overseen 9,141 program integrity reviews, the bulk of which took place in SFY 2004. 7,906 of those reviews were conducted by Myers and Stauffer. During that same time, the OIG recovered $10,240,856 in provider overpayments.

	Recoveries
SFY 2005	$2,224,685
SFY 2004	$4,526,957
SFY 2003	$3,489,214

[1] M&S' algorithms have identified potentially improper billing practices on the part of more than 7,200 providers, some of whom may have been identified by more than one algorithm. No such information is available for HWT's data mining routines.

Potential Vulnerabilities

Staffing
There is no formula for calculating optimal staffing ratios for program integrity functions. However, the review team noted, and OIG leadership agreed, that staffing levels are disproportionately low given the size of Kentucky's Medicaid program.

Program Integrity Audits
While the state does contract with outside parties to conduct program integrity reviews and audits of providers, it does not have a systematic program integrity (PI) audit process. It does not have any procedures to ensure that its oversight is commensurate with the risks presented by various provider types. For example, although nursing home expenditures represent a significant portion of every state's Medicaid budget, Kentucky does not have a nursing home PI audit plan.

Clinical Expertise
Although its contractors have medical clinicians available, there is no clinical staffing within the OIG. This highlights the overall shortage of program integrity staff. Having no staff with medical expertise represents a failure to recognize the importance of medical quality expertise as part of an overall fraud and abuse strategy. Currently, the state's peer review organization looks at hospitals and nursing homes, not physician quality.

Kentucky All Schedule Prescription Electronic Reporting
The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system is a database of all controlled substance prescriptions filled in the State of Kentucky. It is intended to prevent or earlier detect the diversion of controlled substances. FWAIP inherited KASPER from the Department of Public Health along with its staff of pharmacists who are also sworn law enforcement agents. The database is maintained by CHFS OIG and is accessible to physicians, pharmacists, licensing boards, law enforcement officers and the Medicaid program. According to OIG staff, KASPER is the most comprehensive controlled substance tracking system in the nation.

Benchmark Practices
By housing this function in FWAIP, the OIG is better positioned to directly address fraud and abuse related to pharmacy claims. If it was not housed in the OIG, it is possible that the Medicaid program integrity staff might not have even have access to the data.

FWAIP has also addressed its outstanding accounts receivable in the last 3 years. In 2002, there were 2,509 open accounts with approximately $44.4 million outstanding for an average age of 2,208 days. After "re-engineering" internal processes and clearing out uncollectible accounts, there are now 673 open accounts with $19.3 million outstanding for an average age of 679 days.

OIG Administrative and Civil Enforcement (ACE) Team
A process that is new since the OIG reorganization involves the ACE team which monitors referrals made to the MFCU. In the past, no further administrative action took place while the referral was in the hands of the MFCU. Now, FWAIP staff monitors the status of the referral and makes decisions on potential administrative sanctions that may take place prior to the

completion of the MFCU's efforts. The OIG recognizes the importance of a state-based, pro-active provider exclusion program and intends to be more aggressive in this area in the future.

Benchmark Practice
FWAIP operates a program integrity education program called the "correspondence campaign." Letters are sent to recipients who appear to be overutilizing Medicaid services. Examples would include multiple emergency room visits and using multiple physicians or pharmacies. The letters are purposefully vague, alluding to these issues. Copies are also mailed to the recipient's physician, when known. Physicians have generally responded positively to these letters which also include guidance on how to access KASPER reports. Passport uses a variation of these letters for recipients overutilizing managed care benefits. In SFYs 2003, 2004 and 2005, the state sent out 24, 22 and 5 such letters, respectively.

Division of Special Investigations (DSI)
In the reorganization of the OIG, the DSI is responsible for coordinating all fraud-related complaints, including those against recipients, employees and providers. It currently has two full-time employees devoted to provider fraud with a third employee expected to be hired soon. Most of those complaints come to DSI through its hotline. State law requires all Medicaid fraud complaints to be referred to the MFCU.

The division also forwards cases it has partially developed, called "preliminary reviews." These reviews are conducted in accordance with 42 CFR 455.14. DSI investigators and KASPER agents work closely together on potential pharmacy fraud issues. DSI also contracts with Kentucky State Police officers in a secondary employment role to conduct pre-eligibility investigations.

The following table illustrates the referrals sent to the MFCU in the last 3 state fiscal years.

	Hotline Complaints	Preliminary Reviews
SFY 2005	480	2
SFY 2004	399	7
SFY 2003	390	6

Division of Audits & Detection
The Division of Audits and Detection serves as CHFS' internal auditor, identifying key areas of risk for the agency. Its primary mission is to protect the assets and integrity of the Cabinet overall. It has not had any involvement to date with provider audits but, based on its discussion with the review team, it may consider adding a provider component to its master work plan. It has no interaction with the Auditor of Public Accounts which is responsible for the annual single state agency audit.

B. DEPARTMENT OF MEDICAID SERVICES

The Department of Medicaid Services (DMS) described its three-part modernization plan for the review team. This includes upgrading MMIS (and creating a new SURS), developing a Kentucky Medicaid Administrative Agent and contracting with a pharmacy benefit manager. DMS is also responsible for provider enrollment, managed care and vaccines for children, all of which are discussed here in more detail.

Provider Enrollment
The Division of Hospitals & Provider Operations in the Department for Medicaid Services is responsible for provider enrollment (PE). It was formerly housed in the Division of Program Integrity before DPI became part of the OIG in the recent reorganization. Although it is organizationally separate, both OIG and PE staff agree there is a lot of interaction between the units. The PE staff has two employees which both entities agree is inadequate.

PE staff conducts manual checks on the OIG's List of Excluded Individuals/Entities (LEIE) for exclusion on all provider applicants. They check everyone listed on the provider enrollment form, not just the provider itself. All providers, including those participating only in Passport, are enrolled in Medicaid.

PE staff does not check for criminal (42 CFR 455.106) histories independently of what is reported on the enrollment application. FWAIP has historically not had access to computerized criminal history information as it is not a law enforcement agency. Provider applicants are denied enrollment if they have an open account receivable with CHFS. The state does not conduct any type of periodic re-enrollment process. It also de-activates provider numbers when there have been no billings for 24 months.

A new Kentucky state law requires that all health insurers, including Medicaid, use a uniform provider enrollment form. State staff does not expect the uniform enrollment form to comply with federal enrollment regulations so they plan on developing an addendum for Medicaid providers.

Finding
Kentucky is not in compliance the requirements of 42 CFR 455.106. It does not report criminal history disclosures it discovers through provider enrollment. This finding was not raised at the exit conference because of a miscommunication between the review team and the enrollment staff on this point. During the time of the onsite review, the team was under the mistaken impression that the state was in compliance on this regulation. FWAIP is working with Provider Enrollment to develop a mechanism to achieve compliance with this regulation.

State Response: During the review, state staff discovered and acknowledged to the review team that the agency was not automatically notifying the federal OIG of criminal history disclosures. They felt the federal OIG was already aware of many of the non-disclosures since they would involve criminal sanctions under Medicare and Medicaid imposed by the federal government through DHHS and DOJ. The remaining non-disclosures of criminal history would be those imposed by their state MFCU. Nevertheless, they are aware of the

non-compliance and agree strongly that it should be corrected. They are currently working with the Medicaid agency provider enrollment unit to establish a process to fully comply with 42 CFR 455.106(b).

Benchmark Practice
Besides checking HHS OIG's exclusion list before enrolling a provider, the unit also checks the General Service Administration's (GSA) Excluded Parties List System (EPLS) to see if owners or management of the provider are listed on that debarment site as well. According to FWAIP, Kentucky law gives the Medicaid agency final authority to determine who should be allowed to enroll as a provider. The agency has determined that it is in its best interest to deny enrollment to any potential provider associated with GSA's debarment list. The review team believes this measure affords the taxpayers additional protection beyond the OIG's exclusion list.

Managed Care
Kentucky contracts with a full-risk based HMO called Passport. Passport contracts with AmeriHealth Mercy to provide employees and management services and currently has employees in both Louisville, Kentucky and Philadelphia, Pennsylvania. Passport supplies Medicaid services to enrollees in 16 counties in Kentucky. Enrollment is mandatory for Medicaid recipients. Recipients are not subject to a term renewal process. They are enrolled with Passport for as long as they are eligible to receive Medicaid services. Some of the services not covered by Passport include long-term care services and behavioral health services.

Passport currently has contracts with approximately 3,000 providers to provide Medicaid services. The providers are enrolled through OIG's FWAIP Division. However, before a contract is accepted by Passport from a provider to do business, Passport staff does its own screening of providers. This includes checking credentials, licensing boards, background checks and some onsite visits.

Passport sends encounter data to Kentucky's MMIS. Claims are submitted to FWAIP and information is keyed into the MMIS. Ninety-five percent of Passport's encounter data is submitted and accepted.

Suspected fraud can be identified through computerized reports showing outliers or from member services complaints. Staff reviews quarterly reports for quality and utilization patterns, but not necessarily fraud and abuse (F&A). When an aberrant pattern occurs, Passport's Louisville staff will send the information to the Philadelphia staff for follow-up actions (medical review, data gathering, etc.). The staff in Philadelphia has backgrounds in clinical expertise, working for the Attorney General's office, information systems expertise and Medicaid fraud. If something is suspected of rising to the level of fraud, the case is sent back to Louisville and forwarded to the FWAIP group to follow their procedures for investigation, further case development, and referral to the MFCU if necessary.

Observation
Passport's staff readily admits they need to strengthen their F&A procedures. They have a good working relationship with FWAIP and they are working together now to develop stronger

procedures. Passport employees have read the "Guidelines for Addressing Medicaid Fraud and Abuse in Managed Care" and plan to use and reference this document when working on strengthening their F&A procedures.

Medicaid Management Information System
Effective December 1, 2005, EDS will take over responsibility for all MMIS and claims processing activities from Unisys. By November 2006, a new MMIS will be in place. Twenty key staff from throughout CHFS are working with EDS to design the new system as well as projects related to the Kentucky Medicaid Administrative Agent (see KMAA below). FWAIP staff is involved in the joint application design workgroup for the SURS component. The review team suggested that the MFCU be consulted in the development of the program integrity functions of the new MMIS. The system will include state of the art data mining tools as well as increased real time access to claims data.

Pharmacy Benefit Manager
DMS contracts with First Health to be its pharmacy benefit manager (PBM). First Health has been handling all pharmacy claims processing and formulary issues since December 2004. The contract calls for First Health to conduct audits of randomly selected pharmacy providers at a frequency of not more than twice a year. All audits findings will be presented to the OIG.

Since First Health took over as the PBM, pharmacy claims have not been available through the existing MMIS. This has been a source of some frustration for FWAIP staff. However, the new MMIS will include all pharmacy claims.

Kentucky Medicaid Administrative Agent
First Health is also the Kentucky Medicaid Administrative Agent (KMAA). KMAA's primary responsibilities are disease and case management and service utilization. KMAA will be responsible for all provider credentialing and education as well as handling all questions from providers. It will also conduct disease analysis, utilization management and develop future initiatives. Initially, it is working on a diabetes management pilot project which is currently being rolled out statewide. Staff expects the next project to involve pediatric asthma.

KMAA is also responsible for the state's client restriction program. At any given time, there are approximately 1,200 clients locked into a specific physician and/or pharmacy. Lock-in lasts 1 year and an additional year added if utilization does not improve. KMAA intends to turn the lock-in program into more a case management system to improve utilization and health outcomes. It is also expected that this monitoring will be incorporated into the department's new MMIS.

Observation
DMS has eight registered nurses and four nurse-managers assigned to oversee KMAA. Without making any judgment as to the propriety of that staffing level, it serves to illustrate the lack of staffing involved with the overall program integrity activities.

State Response to Vulnerabilities in Report: State staff addressed the vulnerabilities in this report by acknowledging that a traditional, systematic provider SURS function, and a related clinical auditing function, has not existed in Kentucky for many years and that traditional program integrity functions related to SURS have been understaffed. They are working to correct this by re-establishing a more traditional SURS function with a new CORE system soon to be in place through their new fiscal agent, EDS. Through additional funding or outsourcing, they are also hoping to bring more clinical expertise to the OIG which would be devoted exclusively to Medicaid fraud and abuse.

Vaccines for Children (VFC)

During our visit we did not ask specifically about the VFC program and the administration of it in Kentucky. However, in the documentation received from Kentucky, they did include a survey that was completed in 2003 regarding their VFC program and their interaction with the Department for Public Health (DPH) Immunization Program. The DPH is the agency responsible for administering the VFC program in Kentucky. The survey, and a subsequent telephone conversation with Kentucky staff, indicates there is a good working relationship between DPH and the Kentucky State agency with a good exchange of information between the two agencies.

Kentucky's Medicaid providers are not required to be enrolled in the VFC program. Currently, there are no identifiers in the MMIS to show that a provider is a participant. However, in a follow-up telephone conversation, Kentucky staff indicated they are working on a means to identify participating VFC providers in the MMIS. Kentucky has structured its payment system so that the Medicaid reimbursement is for the administration of the vaccine only, not the vaccine itself.

If a situation occurs that is identified as potentially fraudulent and involves a Medicaid provider, the State agency would refer the case to the OIG to undergo the standard process of a preliminary investigation and possible referral to the MFCU.

C. MEDICAID FRAUD CONTROL UNIT

The Kentucky Medicaid Fraud Control Unit (MFCU) is part of the Office of Attorney General, an independently elected statewide official. The unit has 27 staff altogether including 7 attorneys, including a director and 6 prosecutors, 15 sworn law enforcement investigators, 1 RN, 1 auditor, 1 Medicaid specialist and 2 support staff. Four of the attorneys focus on provider fraud while the other two are assigned to assist in the national investigation related to pharmaceutical Average Wholesale Price. The number of investigators dramatically increased recently when the CHFS OIG terminated its long-standing contract for 13 Attorney General investigators who exclusively worked client welfare fraud cases. Those investigators were approved to transfer to MFCU.

In the three most recent years available from HHS OIG, the MFCU has reported the following statistics.

	Grant	Staff	Convictions	Recoveries
FY 2003	$1.2 million	17	3	$1.7 million
FY 2002	$1.2 million	19	8	$3.5 million
FY 2001	$1.2 million	18	5	$2.8 million

Source: U.S. Dept. of Health. Centers. Medicaid.

Potential Vulnerability

During the review, it became apparent that there is significant tension between the MFCU and the Medicaid agency. There were a number of issues that came up during discussions with either the OIG or the MFCU. The review team did not feel it would be appropriate to attempt to referee what appeared to be major areas of disagreement between the units. The review team did, however, advise both units that neither would likely be as successful as they could be without finding a way to more together in more cooperative manner. [2]

State's Response: State staff agreed that maintaining a good working relationship with the MFCU is vital in the fight against Medicaid provider fraud and welcomed any insight the review team may have, such as best practices and model agreements from other states.

V. CONCLUSION

The State of Kentucky's program integrity procedures adequately protect the state's Medicaid program. However, the state does have one area of non-compliance which it is currently correcting. There are several other areas of potential vulnerabilities. The review team recommended that the state make every reasonable effort to address these to continue to ensure the fiscal integrity of the Kentucky Medicaid program.

Kentucky also deserves credit for establishing a number of benchmark practices which would well serve other Medicaid programs to consider. These benchmark practices demonstrate the state's commitment to program integrity.

[2] The team provided each with the TAG-sponsored report which was co-written by the New Jersey MFCU and Program Integrity staffs. This report lists a number of best practices for the criminal investigators and administrative staff to work well together.

Appendix G

Response From the Cabinet for Health and Family Services

The Cabinet for Health and Family Services, on behalf of the Department for Medicaid Services and Office of Inspector General, provided a written response to the report. The response is reproduced below. A brief reply from Program Review and Investigations Committee staff follows the response.

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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July 1, 2008

Mr. Van Knowles
Legislative Analyst
Program Review and Investigations Committee
Legislative Research Committee
Capitol Annex, Room 009
702 Capitol Avenue
Frankfort, KY 40601

Dear Mr. Knowles:

This is in response to the Program Review and Investigations Committee Report on Medicaid Prescription Drug Benefit Fraud, Abuse and Cost Management. Thank you for the opportunity to respond. You will find the Department for Medicaid Services' responses to each recommendation below.

Recommendations and Responses

1.1. If it is the intent of the General Assembly to provide the most effective tools for recovering losses due to Medicaid fraud, then after receiving input from the Office of Attorney General and other interested parties the general Assembly may wish to consider passage of a state false claims act that meets the requirements outlined in the deficit Reduction Act of 2005 to qualify for the federal incentive in combating Medicaid fraud.

Response: A state False Claims Act (FCA) bill, consistent with the federal Deficit Reduction Act of 2005 (DRA) provisions, was proposed by the Office of the Attorney General in both 2006 and 2007 Legislative Sessions. This bill was also introduced by Representative Lee in the 2008 Legislative Session and did not pass. The CHFS supports the passage of a state FCA that meets the approval of the federal HHS guidelines under the DRA.

1.2. The Department for Medicaid Services should develop a process that ensures the documentation of policies and procedures is comprehensive and kept up-to-date. The department should work with all vendors, both governmental and private, to ensure that they also maintain comprehensive and up-to-date documentation of their policies and procedures.

Response: DMS agrees with the recommendation to document internal policies and procedures related to the management of the pharmacy program. We are also working on enhancing our contract oversight of the current pharmacy benefit manager, which will include the monitoring of their policies and procedures on an on-going basis.

1.3. The Department for Medicaid Services should ensure that an adequate staffing resource plan is developed and maintained. To the extent possible, such planning also should be implemented by the department's vendors, both governmental and private. The Cabinet for Health and Family Services should present an adequate staffing plan in its budget proposals to the governor and the General Assembly.

Response: The DMS is reviewing all positions to determine area's of critical need. Due to current funding constraints of the enacted budget, the Department is identifying staffing needs that can be alleviated through efficiencies or staff reallocation. DMS has transferred some existing pharmacy responsibilities to the Pharmacy Benefit Administrator. DMS is also reviewing the Department's personnel cap to determine whether it is possible to hire additional staff for the pharmacy program.

1.4. The Department for Medicaid Services, in consultation with all involved agencies and vendors, should ensure that a comprehensive Medicaid program integrity plan is developed, maintained, and followed. The plan should delineate responsibility for all aspects of program integrity: prevention, detection, and recovery of fraud, abuse, and other overpayments related to recipients, providers, Medicaid contractors, state employees, and pharmaceutical and other medical supply manufacturers. The plan should include funding and staffing considerations. The plan should mandate an aggressive program integrity effort while ensuring quality health care for eligible recipients and fairness for providers.

Response: DMS agrees with the recommendation to develop a comprehensive, well-detailed Medicaid program integrity plan in consultation with all involved agencies. This plan will also clearly delineate the responsibilities of the various agencies and vendors, as well as the overall responsibility for management of the program and its resulting outcomes. The Department, the OIG and the Cabinet as a whole is currently engaged in the development of a more comprehensive program integrity plan, with special emphasis on bringing all organizational elements from Medicaid, the OIG and vendors into the plan. The new Program Integrity vendor referenced in Recommendation 3.6 was awarded the contract on April 1, 2008. The vendor, HealthCare Excel (HCE), will be largely responsible for assisting state staff in developing and implementing this plan. The plan will also be consistent with the current federal Comprehensive Medicaid Integrity Plan (CMIP), the most recent version released by CMS in August of 2007 (and subject to yearly updates in accordance with federal DRA requirements).

1.5. As part of its overall program integrity plan, the Department for Medicaid Services should explore ways to implement concurrent fraud, abuse, and overpayment detection within the pharmacy point of sale system as well as the medical claims processing system.

Response: DMS is currently working with First Health to identify additional opportunities to enhance the current reporting and activities related to detection of possible fraud and abuse within the current point of sale system. We expect to have the first edition of new reports within the next month. Such detection already exists

to a large degree within the normal editing and auditing of claims as they are processed and adjudicated for payment by the Pharmacy Benefit Administrator (PBA). The current Medicaid PBA vendor is First Health. Enhancements to this process will be aggressively explored with the next PBA vendor procurement and will also be fully addressed by the new Program Integrity vendor referenced in Recommendation 1.4 above.

1.6. If it is the intent of the General Assembly to assist the Kentucky Medicaid program in seeking more favorable federal laws on recovery of overpayments and on the impact of federal audit and review programs, the General Assembly may wish to consider a resolution asking congress to provide such relief.

Response: The 60 day repayment rule has been detrimental to more aggressive financial recovery operations within program integrity, and throughout Medicaid and all state Medicaid programs since its inception in the 1980s. The original goal was to incentivize state operations to be more aggressive in recovering state and federal dollars. The long term result has been much more of a disincentive because the states must repay the Federal share within the sixty day time frame but may not be able to actually recover the identified overpayment for a much longer time period. As this report points out, the new federal program integrity initiatives from the DRA will only enhance this problem. A more favorable option would be to require states to refund the federal share in the quarter in which the recovery is made. The National Association of Medicaid Program Integrity (NAMPI), working with the CMS Fraud and Abuse Technical Advisory Group (TAG) has year in and year out lobbied CMS and Congress to provide the states relief from this rule. The Cabinet fully supports any effort or assistance by the General Assembly in persuading Congress to provide relief.

1.7. The Department for Medicaid Services should implement a comprehensive program to evaluate the performance and outcomes of Medicaid as a whole and of each vendor and each benefit program. To the extent possible, the program should attempt to measure the outcomes and calculate a return on investment for each agency and vendor activity and each benefit plan change an innovation.

Response: DMS will commit to creating comprehensive program evaluations for the entire Medicaid program. We will also continue our efforts to enhance and/or create comprehensive evaluations of the performance of our various contractors. These evaluations will include an analysis of proposed versus actual savings of key program or benefit changes.

1.8. The Cabinet for Health and Family Services should reconstitute the Drug management Review Advisory Board and ensure that it fulfills its duties under federal and Kentucky law. If the cabinet believes that the board's duties and those of the Pharmacy and Therapeutics committee could be combined, it should propose to the General Assembly legislation that is consistent with federal law.

Response: DMS will pursue reinstating the Drug Management Review Advisory Board (DMRAB). The responsibilities of the P&T Committee, as outlined in KRS 205.564, are directed toward the development and administration of an outpatient drug formulary for the Medicaid Program. KRS 205.5638 requires the DMRAB to focus primarily on utilization management of the pharmacy program and educating providers as to the appropriate prescribing of pharmaceuticals. At this time, CHFS does not believe that the duties of DMRAB and the Pharmacy and Therapeutics

Committee should be combined to be included in an extended Pharmacy & Therapeutics Committee meeting.

1.9. The Department for Medicaid Services should ensure that the annual drug use review report is prepared and sent to the federal government. In addition, the department should provide copies of the last five such annual reports and all future reports to the Health and Welfare Committee and the Medicaid Oversight and Advisory Committee of the General Assembly.

Response: DMS has reviewed the report for FFY 2007, as prepared by First Health Services, and it has been sent to the federal government. We have also requested copies of prior years' reports from First Health, and will share copies with the committees, as suggested.

1.10. If it is the intent of the General Assembly to more fully empower the Office of Inspector General to combat Medicaid fraud and abuse, then the General Assembly may wish to consider the changes requested by that office as embodied in Senate Bill 223 of the 2005 Session.

Response: The Office of Inspector General (OIG) concurs with the report's recommendation that the General Assembly consider the changes to KRS Chapter 194A requested by OIG in Senate Bill 223 from the 2005 legislative session. Specifically, the OIG considers the proposed administrative subpoena authority to be the greatest priority of Senate Bill 223 with respect to combating fraud and abuse by recipients and providers in the Kentucky Medicaid Program, as well as fraud and abuse in the other benefit programs administered by the Cabinet for Health and Family Services.

Given that the regulatory and investigative responsibilities of OIG are centered around the examination of documentary evidence, the authority to issue administrative subpoenas to produce documentation relevant to an investigation is an essential requirement for fulfilling OIG's statutory obligations under KRS 194A.030 and under KRS 205.8453 as a designated agent of the Department for Medicaid Services.

The authority to issue administrative subpoenas, as originally proposed in Senate Bill 223, would ultimately strengthen the OIG's ability to identify overpayment amounts associated with fraud and abuse and improve the agency's ability to successfully initiate recovery proceedings. The OIG will work with the 2009 General Assembly on legislation that will incorporate the intent of Senate Bill 223.

2.1 The Department for Medicaid Services should review Medicaid eligibility procedures and the Department for Community Based Services should ensure that all caseworkers understand and follow the procedures for verifying an applicant's statements. The Department for Medicaid Services should consider whether it is desirable that caseworkers ask adult Medicaid applicants for information about expenses and attempt to balance income, resources, and expenses. If so, the departments together should develop such a procedure and incorporate it into caseworker training.

Response: Verification *is* required for income and resources for <u>all</u> Adult Medicaid cases. Client's statement for income and resources is not accepted. This is a two step process. First, the caseworker obtains information on the client's situation, and then the caseworkers verifies the information using available means, including on-

line verification of SSI, and computer system verification for RSDI, Unemployment Insurance, wages, lottery winnings, child support, etc. The client is required to provide proof of any other income and provide copies of bank statements, annuities, trusts, IRA's and any other type of resources the client may have. If this information is not provided the case is to be denied. Workers are required to do property checks and check for other bank accounts at two different banks in the client's county or residence. The Department for Community Based Services (DCBS) will work to expand training to assure caseworkers understand policy. DCBS will also create an interview tip sheet reminding staff of correct interviewing procedures.

Adult Medicaid members generally receive a fixed income from a retirement account and/or federal benefits such as SSI or RSDI, which is verifiable via system check with SOLQ and or Bendex. Typically, Adult Medicaid cases only consider the income of the applying member. The spousal income is only considered in calculating for a spousal deduction. Therefore, workers should concentrate on the exploration of potential resources of this population as this is generally the area that is subject to error. However, workers should continue to use prudent judgment when completing the eligibility determination and should certainly request verification in any area that appears to be out of line with reported income, expenses, and resources.

2.2 The Department for Medicaid Services, the Office of Inspector General, and the Department for Community Based Services should develop a plan to expand the Determining Eligibility through Extensive Review program to additional local offices. The plan should address local office acceptance of the program, office space, funding, and the role of claims workers.

Response: The Office of Inspector General (OIG) concurs with the LRC recommendation to expand the Determining Eligibility through Extensive Review (DETER) program to additional local offices. Expansion of the DETER program statewide would require additional funding as the program is funded 100 percent by a DCBS contract for which OIG provides the general fund match. At present, the DETER program is operational in 16 counties with staff consisting of a Branch Manager, one supervisor and seven investigators.

DCBS Claims Workers are not involved in the DETER process on a consistent basis. Potential fraud claims are referred to a Claims Worker by DCBS Eligibility Workers who have the responsibility of processing public assistance applications and verifying the information provided by the client. Generally, Claims Workers become involved only after the client has been receiving benefits for a period of time. If the client is determined to be ineligible for those benefits, an overpayment claim is established.

DETER investigations are conducted to prevent ineligible clients from receiving benefits to which they are not entitled. Two of the Service Regions have requested additional staff be copied on the distribution of DETER investigative reports to review and identify potential fraud claims and overpayments. The OIG will work with the DCBS to develop procedural instructions to formalize a similar policy for all DETER counties to assist with the identification and establishment of overpayments.

2.3 The Department for Community Based Services should ensure that referrals for suspected fraud in adult Medicaid cases are being made correctly to the Office of Inspector General. The department should implement procedures to reduce the error rate in adult Medicaid cases.

Response: DMS requires DCBS staff to refer only Medicaid Intentional Program violations to OIG. DCBS workers are referring an average of 31.75 Medicaid cases to OIG which equates to almost 380 per year. Procedures in the Operation Manual which outline Medicaid fraud and abuse, how to identify fraud and abuse, how to prevent fraud and abuse, and how to refer to OIG were updated and expanded in 2006. Procedures in the Operation Manual are clear and concise. DCBS is preparing correspondence to remind staff of this policy. This policy will also be reviewed by the Medical Support and Benefits Branch with staff at the next policy panel. DCBS will work with training staff to ensure this policy is covered in training.

The contract between DMS and DCBS includes the corrective action plan below to reduce Medicaid errors.
DCBS agrees to:

- Collaborate with other Cabinet staff to develop a common baseline for the Medicaid error rate;
- Based on the Quality Control Adult Medicaid Report, target 10 counties, including Jefferson and Fayette, for error reduction by providing training, procedures, tip sheets, best practices: Phase I – target counties with high error rate Phase II – target counties identified as having specific problem areas (example resources, unearned income, medical deductions);
- Create on-line 117 case review system, and utilize the online 117 system, Quality Control Reports, and the Clarifications Log to identify and monitor counties which need training and policy clarification (implementation June 2, 2008);
- Provide to the Department for Medicaid Services (DMS)a quarterly report tracking complaints and issues from (DMS);
- Provide annually, statewide Adult Medical Refresher Trainings for all adult Medicaid caseworkers, program specialists and supervisors;
- Create a best practice handbook utilizing tip sheets and other sources;
- Conduct Policy Panels annually for program specialists, Service Region Administrator Associates (including staff from DMS, and the Quality Control Branch, Training Branch, Division of Family Support) to respond to questions and improve understanding for field staff; and
- Complete case reviews at the central office level quarterly in a county with an identified problem and/or high error rate and provide assistance to address issues.

2.4 The Department for Community Based Services should determine a staffing level adequate to ensure quality results in the Division of Family Support. The department should develop a staff retention plan to reduce turnover. To the extent that either an adequate staffing level or retention additional positions or funding, the department should include the needed resources in its budget requests.

Response: The Department for Community Based Services has been reviewing turnover data with the intent to implement a staff retention plan. Due to current funding constraints of the enacted budget, the Department is developing non-monetary strategies, such as employee appreciation and recognition, opportunities for staff to have input into policy and procedures through the Continuous Quality Improvement system, fiscal office conditions, etc. Recent efforts to boost employee morale included new/fast computers, office security upgrades, ACE awards, new technology such as the on-line 117 case review system, etc.

Further, the Department is in the process of: (1) evaluating all positions and caseloads; and (2) identifying efficiencies that can be gained through policy/procedural simplification and technology. The Department will collaborate with the Department for Medicaid Services in this effort and identify staffing needs that cannot be alleviated through efficiencies or staff reallocations.

3.1 Recognize that the Recipient Utilization Review committee does not exist, the General Assembly may wish to consider amending KRS 205.8455 and 205.8489(2) to remove references to the committee and make other changes it deems desirable. If the statute is not so modified, the Department for Medicaid Services should operate the committee as defined in the law.

Response: The appropriate amendments to KRS 205.8455 were contained in SB 223, which this report addresses in Recommendation 1.10 above. These amendments address the problems with the Committee and other issues/problems regarding federal rules in conflict with state policy regarding recipient utilization review efforts. Operating the committee as currently defined in statute would possibly be in violation of federal rules concerning single state agency requirements by having individuals not employed by or under contract with the state agency making determinations regarding Medicaid eligible individuals. DMS will pursue the repeal of this law.

3.2 The Department for Medicaid Services and office of the Inspector General should work with the licensing boards for prescribers and pharmacists and their professional associations to determine whether fair and reasonable limitations could be placed on filling phone-in-prescriptions.

Response:

- The manager of the Drug Enforcement and Professional Practices Branch (DEPPB) in the Office of the Inspector General (OIG) has been involved in periodic discussions going back to 2006 with members of the Kentucky Board of Medical Licensure and the Kentucky Board of Pharmacy, regarding the problem with fraudulent phoned-in Schedule III – V controlled substance prescriptions. Current U.S. Drug Enforcement Administration (DEA) regulations do not allow Schedule II controlled substance prescriptions to be phoned-in.
- Members of the licensure boards as well as many health care providers have expressed concern that restricting phone-in controlled substance prescriptions would result in undue hardships for critically ill patients and patients with limited mobility to obtain needed medications. In addition, restricting phone-in controlled substance prescriptions may be viewed by pharmacy trade associations as having a negative impact on the level of customer service their members provide.
- The cabinet agrees that fraudulently phoned-in controlled substance prescriptions are a problem. The General Assembly may wish to consider establishing a task force or other investigative entity to engage the licensure boards and pharmacy trade associations to study the problem and take the lead in identifying and recommending a solution to address the problem.
- To help increase awareness of the problem by health care providers, during 2007 OIG staff incorporated actual examples of fraudulently phoned-in controlled substance prescriptions, along with preventive actions for prescribers and dispensers, into the KASPER training curriculum for health care providers and staff.

3.3 The General Assembly may wish to consider options to remove potential conflicts among KRS 218A.020-130, related administrative regulations, and the federal controlled substance schedule.

Response:

- The federal controlled substance schedule takes precedence if more restrictive than a state schedule. However, Kentucky can make its schedule more restrictive (e.g.; Kentucky classifies carisoprodol (Soma) as a Schedule IV controlled substance while it is not scheduled federally).
- Currently, the cabinet resolves conflicts between the federal and Kentucky controlled substance schedules by filing changes to the controlled substance regulations (902 KAR 55:020-035) to remain consistent with the federal controlled substance schedule (except where Kentucky is more restrictive as described above).
- The cabinet recommends that KRS 218A.070-130 be modified to incorporate the corresponding federal schedules in 21 CFR Part 1308 by reference. The cabinet would then only need to modify Kentucky regulations to specify additional Kentucky controlled substance restrictions.

3.4 The Cabinet for Health and Family Services should consider making tramadol (Ultram) a scheduled drug and should review other drugs for more restrictive scheduling.

Response: The OIG works closely with health care providers, the Kentucky Board of Medical Licensure and the Kentucky Board of Pharmacy to understand the potential for abuse of tramadol as well as certain other unscheduled drugs. Because of the concern regarding tramadol, the Cabinet has filed a regulation change with LRC that classifies tramadol as a schedule IV controlled substance.

3.5 If it is the intent of the General Assembly to clarify the permitted and prohibited uses of data in the Kentucky All-Schedule Electronic Reporting system, then the General Assembly may wish to consider amending KRS 218A.202 and 218A.240 to remove possible ambiguities and inconsistencies.

Response: The LRC report identifies seven questions regarding KRS 218A, each of which is discussed below. In 2004 a legislative Prescription Drug Abuse Task Force recommended changes to KRS 218A.202. One result of this task force was authorization for the Kentucky Medicaid program to access KASPER data. OIG and Department for Medicaid Services (Medicaid) personnel participated in meetings with the cabinet general counsel to discuss and recommend proposed changes that would define appropriate and allowable Medicaid use of KASPER data, and that were subsequently incorporated into KRS 218A.202.

OIG and the cabinet Office of Legal Services are comfortable with their understanding of the intent of the statute, and with the controls the cabinet has in place for Medicaid use of KASPER data, however the cabinet will be supportive of efforts to further clarify any aspects of the statute that the General Assembly believes may be necessary.

202(6)(c): Does this paragraph authorize the Medicaid program to access KASPER information about non-Medicaid recipients?

- No. The cabinet interprets 202(6)(c) to mean that the Medicaid program may only access KASPER data for Medicaid recipients and Medicaid providers.

202(6)(c): Does this paragraph authorize Medicaid programs in other states to have access to KASPER data? If so, should that access be limited in any way?

- Yes. The statute specifies in 202(6)(c) that a state Medicaid agency may have access to KASPER data.
- Should an official of another state Medicaid program request access to KASPER data, they would be required to complete the KASPER account application process that includes verification of identity and credentials. Another state Medicaid program would have the same limitations that are in place for Kentucky's Medicaid program under KRS 218A.202.

202(8)(b): In conjunction with KRS 218A.202(6)(a) and (b), does this paragraph technically limit Medicaid to sharing KASPER information with law enforcement or a licensing board only when that entity is already engaged in an investigation of the persons being reported? Should such a restriction exist?

- Yes. The statute does specify that Medicaid may share KASPER data or reports regarding overutilization by Medicaid recipients with a licensure board or law enforcement officer only when that entity is engaged in an investigation of the persons being reported. The General Assembly may wish to remove that restriction.
- Additionally, the cabinet has implemented strict controls for situations where Medicaid staff has reason to suspect potential controlled substance overutilization or diversion. In these situations, Medicaid staff does not provide KASPER reports/data but do refer the situation to the Drug Enforcement and Professional Practices Branch in OIG. DEPPB staff can open an investigation and access the KASPER data, or can refer the situation to the appropriate licensure board for review or to another law enforcement agency for investigation.

202(8)(b): Should this paragraph mention Medicaid providers as a group whose KASPER information Medicaid may share?

- It is not necessary to mention that Medicaid may share KASPER information with Medicaid providers because those providers can access KASPER and obtain their own reports as provided for under KRS 218A.202(6)(e). Medicaid staff can alert Medicaid providers to potential controlled substance overutilization (including potential abuse or addiction) by a recipient, but cannot give the provider a KASPER report.

202(8)(c): Should this paragraph explicitly state that Medicaid may use KASPER information only about Medicaid recipients or providers in Medicaid administrative hearings?

- The cabinet restricts Medicaid KASPER access to data on Medicaid providers and recipients only.

- The cabinet would not be opposed to modify the statute to specify that Medicaid may only provide data on Medicaid recipients and providers in Medicaid administrative hearings if the General Assembly believes that it would provide additional clarification.

202(12): Should this subsection explicitly reference exceptions for obtaining KASPER data by Medicaid and other entities under KRS 218A.202(6) for purposes other than a "bona fide specific investigation"?

- Medicaid access to KASPER data is enumerated in KRS 218A.202(6)-(8), and the exception for using KASPER data in a Medicaid administrative hearing is referenced in KRS 218A.202(10). While the Medicaid exception is referenced in paragraph 10, if the General Assembly believes it is needed, a reference to the exception in paragraph 10 could be added to KRS 218.202(12) to provide further clarification.

240(7)(a): Does this paragraph give designated cabinet officials the authority to look for patterns in KASPER data in order to identify and investigate possible criminal activity without prior suspicion of specific persons?

- This paragraph does give the cabinet authority to research the data compiled to identify trends that would help identify potential problem areas and identify when further investigation may be appropriate about inappropriate or unlawful prescribing or dispensing.
- The General Assembly may wish to modify this paragraph to clarify whether the cabinet has authorization to proactively research KASPER data for investigative purposes to identify specific controlled substance drug abusers or diverters.

3.6 As part of its overall program integrity plan, the Department for Medicaid Services should reissue a program integrity procurement substantially similar to the one cancelled in October 2007 and award a contract as soon as it is prudent to do so. The new vendor and program integrity staff should implement as soon as possible a review of all Medicaid claims with special priority on prescription claims submitted since 2003.

Response: As LRC staff may now be aware, and as addressed in Recommendation 1.4 above, the RFP for the new vendor was awarded on April 1, 2008 to Healthcare Excel. We fully expect to engage in comprehensive claim review, including pharmacy, with the new vendor as soon as possible.

3.7 As part of its overall program integrity plan, the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and develop an ongoing cost-benefit analysis of the program. The department should modify the program over time to optimize costs and benefits.

Response: DMS has already met with First Health and discussed implementation of desk and field audits. The current contract is somewhat unclear on these items, but we will work to address all concerns and get these programs implemented, as soon as we can secure the appropriate contract modifications. These will be included in the program integrity plan and will be part of the new program integrity vendor functionality.

3.8 If it is the intent of the General Assembly that the Kentucky Medicaid fraud hotline statute be consistent with federal regulation 42 CFR 455.14, then the General Assembly may wish to consider amending KRS 205.8483(2) to allow the Office of Inspector General to conduct a preliminary investigation to determine if a sufficient basis exists for a full investigation, prior to referring the case to the Office of Attorney General.

Response: The Office of Inspector General (OIG) concurs with the report's recommendation that the General Assembly clarify the respective roles of the OIG and the Office of the Attorney General (OAG), Medicaid Fraud Control Unit (MFCU), in regard to conducting Medicaid Preliminary Investigations of complaints received on the Medicaid fraud hotline.

The mandate of KRS 205.8483(2) that OIG make an immediate referral of complaints received on the fraud hotline to the OAG/MFCU conflicts with the federal requirements found at 42 CFR 455.14, which requires the Medicaid state agency to conduct a Medicaid Preliminary Investigation to determine if complaints warrant referral to the OAG/MFCU for a full investigation.

The General Assembly could resolve the conflict by amending KRS 205.8483(2) to mirror the relevant portions of 42 CFR 455.14 and 42 CFR 455.15.

Correcting the existing conflict between the state statute and federal regulation would enable both agencies to streamline their processes and promote greater efficiency in the handling of provider fraud and abuse in the Medicaid program. Given that many complaints will ultimately be handled administratively, and given that the OAG/MFCU is only obligated to review cases in which there appears to be criminal conduct by Medicaid providers, requiring the immediate reporting of all hotline complaints to the OAG/MFCU places an undo burden on both the OIG and OAG/MFCU.

The regular communication between OIG and OAG/MFCU regarding hotline complaints that is presently required by KRS 205.8483(2) can be maintained through existing processes after the statute is amended. For example, the Office of Inspector General has entered into a Memorandum of Agreement with the Department for Medicaid Services and the Office of the Attorney General, Medicaid Fraud Control Unit, for the sharing of information, including a joint review of all hotline complaints. It is the intent of the OIG to have the review process that is outlined in the MOA fully implemented in 2008.

3.9 As part of its overall program integrity plan, the Department for Medicaid Services should work with the Office of Inspector General and Office of Attorney General to establish a protocol for preliminary investigation of all potential provider fraud cases by the Office of Inspector General and for timely referral for full investigation to the Office of Attorney General, consistent with federal regulations.

Response: It is the position of the Office of Inspector General that the protocols endorsed by Recommendation 3.9 presently exist in a Memorandum of Agreement, and are adequate and in full compliance with the requirements of 42 CFR 455.13 (c), 42 CFR 455.14 and 42 CFR 455.21.

According to the current Memorandum of Agreement between the Department for Medicaid Services (DMS), the Office of Inspector General (OIG), and the Office of the Attorney General, Medicaid Fraud Control Unit (OAG/MFCU), "OIG is solely responsible for conducting preliminary investigations on Medicaid providers for

complaints received or practices identified by the Department or the OIG..." The MOA between the three parties also stipulates that the OIG is the "exclusive referral agency within the Cabinet to the MFCU."

The MOA between DMS, OIG, and OAG/MFCU outlines, in detail, the responsibilities and authority of the participating agencies, as well as the protocols for the handling of Medicaid Preliminary Investigations resulting from hotline complaints and 'other source referrals', referrals for full investigations, and the reporting of actions taken in response to referrals for full investigations.

4.1 The Department for Medicaid Services should estimate the amount by which the Medicare Part D clawback payments might exceed the cost of Medicare-Medicaid dual eligible recipients if they were still in the Medicaid prescription drug benefit. The department should report their estimate to the Program Review and Investigations Committee by September 2008.

Response: DMS will perform an analysis of Pharmacy Expenditures since the inception of the Medicare Part D program to determine if it has increased or decreased the state cost of providing Pharmacy Benefits to Medicare-Medicaid dual eligible recipients. The analysis will be completed after final figures are in for State Fiscal Year 2008 with a target date of September 30th 2008 for providing that information to LRC.

4.2 When measuring the performance of the Medicaid prescription drug program, the Department for Medicaid Services and all its vendors should consider the effects of Medicare part D and the clawback. When presenting any performance information to the public, and particularly to the General Assembly, the department should explain these effects.

Response: DMS will provide a footnote to reports issued to Medicaid stakeholders, including the General Assembly, regarding the impact of the Medicare Part D Pharmacy program. The footnote will explain that the removal of pharmacy payments for Medicare recipients from Medicaid expenditure reports should be considered when Medicaid performance and expenditure trends are analyzed, and that failure to adjust for this anomaly will result in erroneous conclusions.

4.3 The Department for Medicaid Services should conduct a complete a cost-benefit analysis of the behavioral health drug use review program, including historical trend data by drug class and the effect of the agreement on the preferred drug list and supplemental rebates. The department should ensure that a tracking system is in place to monitor the results of the Program Review and Investigations Committee.

- The cost-benefit analysis by September 2008 and
- The results after two-year program.

Response: DMS has negotiated and thoroughly explored entering into an agreement with Comprehensive Neurosciences (CNS) for Behavioral Health Drug Use Review (BDUR). The program and the State Plan Amendment allowing this action have been approved by CMS. DMS continues to meet and discuss the final agreement.

The descriptive text Chapter 4, page 130ff contains some possibly misleading information:

1. Eli Lilly does not participate in supplemental rebate programs and therefore the 'in-kind' program is not 'in lieu of'. If DMS failed to participate in this program there would be no supplemental financial contribution to KY DMS nor the Federal share.
2. Some have suggested a 'conflict of interest' and although this would be difficult to deny, if the educational program is successful one would reasonable anticipate a reduction in the utilization of Zyprexa as well as other atypical antipsychotics as has happened in other states.
3. The Agreement does require KY DMS to maintain a level playing field for this class of drugs. All drugs in this class require prior authorization (PA) before approval by the pharmacy benefits administrator (PBA). We can require step therapy for Zyprexa if similar step therapy is applied across the drug class. This is the typical manner step therapy is applied.
4. DMS moved all the atypical antipsychotics to tier one (1) in order to reduce the copay for the recipients requiring these drugs that are necessary for daily functioning. DMS has many brand name drugs that are placed on tier 1 for assorted reasons.
5. This behavioral drug use agreement could conceivably limit DMS in various ways but DMS has documented significant inappropriate use of these potent pharmaceuticals because there are not enough behavioral and mental health specialists to meet the need. Primary care physicians are forced to adapt to using these new drugs with little formal training. The CNS program was initially explored in order to address that pressing need. Much of the inappropriate use occurs in children. CNS should supply much needed education to the very physicians who demonstrate the need for additional assistance in caring for these vulnerable patients. The Cabinet asked for consideration of this program to address the serious medical situation we now experience. The Cabinet approached Lilly Co. first because of the success of similar programs in other states. Additionally there is an escape clause in the agreement that allows either party to step away with notice.

The Cabinet has no significant disagreement with any of the components of this recommendation. If cost-benefit analysis requires postponing the project the program may not be initiated.

4.4 The Department for Medicaid Services and Office of Inspector General should work with the licensing boards for prescribers and pharmacists and their professional associations to determine effective and acceptable education regarding best practices for prescribing and dispensing.

Response: The Kentucky Board of Medical Licensure (KBML) and Kentucky Board of Pharmacy (KBP) are responsible for implementation and training on best practices for prescribing and dispensing respectively. The Office of the Inspector General has worked jointly with the KBML to develop and implement a training program for prescribers covering KBML policies and guidelines regarding controlled substance prescribing, along with proper and effective use of the KASPER system. This training is now being scheduled and conducted for prescribers throughout the state. The Office of the Inspector General is hoping in the near future to begin development with the KBP of a similar training program for dispensers.

4.5 The Department for Medicaid Services should consider whether to implement counter-detailing to provide unbiased prescribing information to physicians and other prescribers. The department also should consider Medication Therapy Management by pharmacists as a means of improving care and reducing cost. If either program

appears to be effective and feasible, the department should request any necessary enabling legislation and should implement the program.

Response: DMS will evaluate the potential savings that might be achieved by the implementation of a counter-detailing program. We will initiate discussions with First Health Services regarding the potential benefits of a medication therapy management program.

If you have any questions or require additional information, please do not hesitate to contact the Department for Medicaid Services Commissioner Elizabeth Johnson at (502) 564-4321.

Sincerely,

Janie Miller
Secretary

Xc: Elizabeth Johnson, DMS
Reina Diaz-Dempsey, DMS
Carol Muldoon, DMS
Stephanie Hold, OIG
Mark Cornett, DCBS
Michael Lawrence, OIG
Dr. Thomas Badgett, DMS

JM/EAJ/vlp00481

Reply From Program Review and Investigations Committee Staff

Staff thank the cabinet for its response to the report. Regarding Recommendation 4.3, the cabinet indicated that the report might have some misleading statements in its discussion of Eli Lilly's Behavioral Pharmacy Management Program. Below is the staff's reply to the cabinet's items by number.

1. Eli Lilly participates in the Medicaid supplemental rebate program for Zyprexa in Florida. Staff did not have time to confirm any other states. It is true that Lilly strongly resists participating in supplemental rebate programs for Zyprexa. More to the point, Lilly does not participate in the National Medicaid Pooling Initiative to which Kentucky belongs. That is why staff did not recommend that Kentucky take a firm stand to obtain supplemental rebates for Zyprexa.
2. There is a potential conflict of interest because Eli Lilly is paying another company to educate prescribers about behavioral health drugs, including Lilly's. The conflict question is not whether the program will reduce the use of atypical antipsychotic drugs, but whether it will reduce the use of Zyprexa in a fair and unbiased manner relative to other such drugs. The question is important because Zyprexa typically costs a state's Medicaid program more than any other drug.
3. Staff have not had the opportunity to review the final text of the agreement. However, a letter to CMS describing the Eli Lilly agreement states,

   > Kentucky Medicaid shall ensure that Zyprexa… is included on a timely and unrestricted basis on any Preferred Drug List or other list or mechanism… during the term of this Agreement. Furthermore, Kentucky Medicaid agrees it will not restrict or disadvantage the use of Zyprexa in any way within the package label [FDA-approved uses] or treat it less favorably than any other product within its therapeutic category.

   The clause about treatment of Zyprexa relative to other products is irrelevant because the earlier clauses prevent Kentucky Medicaid from applying any restrictions to Zyprexa. Staff suggest that if the letter correctly represents the agreement, it could prohibit any prior authorization, step therapy, increased copay tier, or any other limitation on Zyprexa, even if those restrictions are applied to all the other drugs in its class.
4. Staff acknowledge that prior authorization, step therapy, and other restrictions may be placed on a medication at any cost tier. Staff have removed the related statements from the final version of the report.
5. Staff acknowledge the need to educate primary care physicians, particularly those who prescribe for children, on the best practices for use of antipsychotic drugs. The question is whether the Eli Lilly proposal is a cost-effective means to do so when all of its costs and benefits are considered.

Appendix H

Response From the Office of the Attorney General

The Office of the Attorney General provided a written response to the report. The response is reproduced below.

COMMONWEALTH OF KENTUCKY
OFFICE OF THE ATTORNEY GENERAL

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July 21, 2008

Gregory L. Hager, Ph.D.
Staff Administrator
Program Review and Investigations Committee
Legislative Research Commission
Capitol Annex, Room 009
Frankfort, KY 40601

Re: Draft Report: *Medicaid Prescription Drug Benefit Fraud, Abuse, and Cost Management*

Dear Mr. Hager:

Enclosed please find the response of the Attorney General's Office to the above-referenced draft report. We appreciate the opportunity to review and comment upon the report prior to its finalization. If you have any questions, please feel free to contact Pamela J. Murphy, Director, Medicaid Fraud and Abuse Control Division at (502) 696-5405. Thank you.

JACK CONWAY
ATTORNEY GENERAL

Tad Thomas
Assistant Deputy Attorney General
Office of the Attorney General
Capitol, Room 118
Frankfort, KY 40601

Enclosure: Response to Draft Report: *Medicaid Prescription Drug Benefit Fraud, Abuse, and Cost Management*

cc: Dana Mayton
Deputy Attorney General

Pamela J. Murphy, Assistant Attorney General
Medicaid Fraud and Abuse Control Division

Office of the Attorney General
Response to Draft Report of the Program Review and Investigations Committee
June 16, 2008

The following is a section by section response to the Draft Report of the Program Review and Investigations Committee. The Office of the Attorney General continues to be committed to the prosecution of persons engaged in Medicaid fraud as well as maximizing the recovery of misappropriated funds.

Page xi – Conclusion 6 states that "(i)t is arguable that as a crime fraud should be prosecuted even if there is a net loss to the state." The Attorney General agrees. The prosecution of Medicaid Fraud crimes may, in some cases, result in a net loss to the Commonwealth. While Medicaid Fraud prosecutions often include recovery of restitution, this recovery should not be the deciding factor in the decision to prosecution. As with vigilant prosecution of most crimes Medicaid fraud cases often serve to deter future crimes and reduce future losses to the Medicaid program.

Page xi – Conclusion 7 states that until passage of the Deficit Reduction Act of 2005, "many, if not most states placed little emphasis on fighting fraud and abuse." That conclusion is erroneous. Medicaid Fraud Control Units throughout the nation have been successfully fighting fraud and abuse for over 25 years. Kentucky's Medicaid Fraud and Abuse Control Unit (MFCU) has prosecuted these cases since 1982, recouping over $90 million in Kentucky state and federal funds. Kentucky has a fine reputation for fighting fraud and abuse of the Medicaid Program.

Page xii – Conclusion 8 states that Kentucky "Medicaid has not actively sought any provider fraud for many years." The Attorney General's MFCU has received a few referrals from that agency.

Page xiii – The first paragraph on this page states in part, "The Kentucky Attorney General operates the federally-required Medicaid fraud control unit." The Attorney General's MFCU is actually required by state and federal laws and is funded by both state and federal funds. The paragraph also states that "(t)he Attorney General's office is responsible for prosecuting fraudulent providers and any recipients who might be involved in assisting such providers." To clarify, the Attorney General does not prosecute cases of recipient fraud but may prosecute any individuals who assist Medicaid providers in schemes to defraud the program.

Page xiii – Recommendation 1.1 suggests consideration of passage of a state false claims act. False claims act legislation has been filed for the past three years (2006 HB 735; 2007 HB 477; 2008 HB 691). The Attorney General is currently considering the possibility of presenting a false claims act to the 2009 or 2010 Regular Session of the Kentucky General Assembly.

Page xiii – Recommendation 1.4 proposes creation of a comprehensive Medicaid program integrity plan. The Attorney General recommends specific inclusion of the

MFCU, by reference, in development and implementation of such a plan to ensure proper referrals to the MFCU and a commitment to prosecution of providers who unlawfully procure payment from the Medicaid program.

Page xiv – Recommendation 1.9 recommends that the Department for Medicaid Services prepare the annual drug use review report and provide copies to the Health and Welfare and the Medicaid Oversight and Advisory Committees of the General Assembly. The Attorney General should also be provided with copies of the referenced reports.

Page xv – Recommendation 3.5 concerns the Kentucky All-Schedule Electronic Reporting (KASPER) system. The report clearly sets forth problematic provisions in the current statutes governing KASPER, specifically KRS 218A.202 and 218A.240, which appear to preclude law enforcement's thorough use of this excellent tool. For instance, as the law currently stands it remains unclear whether attorneys and prosecutors within the same office are permitted to review KASPER reports obtained by investigators for the purpose of assisting in or directing investigations. The Attorney General recommends full consideration of these issues if statutory amendments to KASPER are proposed in coming legislative sessions.[1]

Page xv – Recommendation 3.7 states that "the Department for Medicaid Services should institute a program of both regular and targeted pharmacy desk and field audits and an ongoing cost-benefit analysis of the program." The Attorney General requests that this Recommendation include prompt referrals to the MFCU for prosecutions and recovery of funds.

Page xv – Recommendation 3.8 refers to the Department for Medicaid Services' Toll-free hotline and the handling of reports of fraud and abuse received by that route. The Attorney General strongly recommends that if this recommendation is adopted, the term "preliminary investigation" be defined and time-limited to ensure prompt referral of the case to the MFCU.

Page xvi – Recommendation 3.9 suggesting that the Department for Medicaid Services, the Office of Inspector General, and the Office of the Attorney General establish a protocol for preliminary and timely referrals of potential fraud cases is fully endorsed by the Attorney General, who also recommends that a definition of "preliminary investigation" be included to ensure prompt response by law enforcement and prosecutorial agents in the MFCU.

Page xvi – Recommendation 3.10 – The Attorney General agrees with Recommendation 3.10 and will timely develop an appropriate budget request and estimated range of recoveries. It is essential to note that due to the wide range of factors impacting

[1] Effective June 16, 2008, the Kentucky Bureau of Investigation (KBI) was replaced with the Department of Criminal Investigations (DCI). Investigators who previously reported to both KBI and the MFCU now report exclusively to the MFCU.

prosecution and settlement of these cases of multi-state litigation, no consistent, accurate annual recovery estimates can be forecast.

Page 8 – The last sentence of the paragraph entitled "Kentucky Medicaid Managed Care" advises that the report does not include facts pertaining to or a discussion of Passport, Kentucky's managed health care prescription benefit. The Attorney General agrees that a distinct study of managed care program integrity may be appropriate given that the program currently covers 16 counties, including population dense Jefferson County.

Page 22 – In the third full paragraph on this page, it may benefit the reader to know that the cases referred to, i.e., "Pharmaceutical Distribution, Pricing, and Marketing Fraud," are being actively pursued by the Attorney General. The office has instituted litigation against 38 pharmaceutical corporation defendants in Franklin Circuit Court for improperly reporting inflated average wholesale prices (AWP). This litigation has been ongoing for over five years and has included the exchange of millions of pages of discovery. The first trials in these cases are currently scheduled for the Spring of 2009.

Page 27 – The Attorney General strongly concurs with the last incomplete paragraph on this page. Federal law mandates operation of a program to identify provider fraud and refer cases to the Attorney General's Medicaid Fraud and Abuse Control Division.

Page 31 – It should be noted that the National Association of Medicaid Fraud Control Units (NAMFCU), referred to in the first paragraph on this page, is comprised of Unit staff from across the nation and its function is largely administrative work handled by an Executive Director and 2 support staff. States' staff, including staff from Kentucky, perform the bulk of the Association's work on behalf of Kentucky and its sister states. Kentucky has been a leading participant in this national coalition and is being honored by hosting the 2009 national meeting which will be held in Louisville, Kentucky in September.

Page 36 – The last paragraph on this page refers to the CMS Medicaid Integrity Program Advisory Committee's members. The Director of the Attorney General's MFCU represents NAMFCU on this committee.

Page 43 – Footnote 7 states that the Attorney General's MFCU is funded under a contract with the federal government. It should be noted that a 25% state match is required as well.

Page 97 – The note in the margin of page 97 discusses the apparent "relatively minor" billing fraud by pharmacists in Kentucky while that crime is significant in other states. The Attorney General recommends increasing DMS audits of pharmacy claims in addition to on-site pharmacy audits.

Page 131 – The last paragraph discusses the Average Whole Price (AWP) of pharmaceuticals, upon which reimbursements from DMS are calculated. AWP figures are now widely known as fictitious at best and intentionally fraudulent in many cases. The

Attorney General has filed civil complaints against many companies, making Kentucky one of the first states to recognize and pursue this type of fraud.