Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Kansas Focused Program Integrity Review

Medicaid Managed Care Oversight

October 2024

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Kansas's Medicaid managed care program to assess the state's program integrity oversight efforts for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. *No recommendations were identified for this review period.*

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **six** observations related to Kansas's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages Kansas to add staff to its Program Integrity Unit (PIU) to conduct on-site reviews of MCOs to verify compliance with its fraud, waste, and abuse contract requirements.

Observation #2: CMS encourages Kansas to ensure the MCO SIUs or other program integrity-focused units have sufficient resources and staffing commensurate with the size of

their Medicaid managed care programs. In particular, Kansas could consider including MCO contract language addressing the organizational structure and minimum staffing ratios for the MCO's SIU. In addition, Kansas should consider the inclusion of MCO contract language for unannounced provider site visits.

MCO Contract Compliance

Observation #3: CMS encourages Kansas to develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans to ensure the required elements are covered.

Interagency and MCO Program Integrity Coordination

Observation #4: CMS encourages Kansas to reevaluate the fraud referral process to ensure the MFCU has adequate staff and/or assistance from KDHE to investigate and provide timely closure of MCO case referrals. This could include the vetting of referrals by KDHE prior to being sent to the MFCU to exclude those referrals that do not rise to the level of credible allegation of fraud. CMS encourages Kansas to work with the MFCU to resolve pending investigations and/or cases suspended due to a credible allegation of fraud.

Observation #5: CMS encourages Kansas, in conjunction with the MFCU when possible, to develop and provide program integrity training to MCO staff on a routine basis to enhance case referrals from, and oversight practices of, the MCOs. This includes ensuring that MCO staff, primarily the SIU and/or compliance officer, receive adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

Encounter Data

Observation #6: CMS encourages Kansas to conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, and to conduct investigations based on the results.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Kansas Managed Care Program and the Focused Program Integrity Review

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF) is the division responsible for the administration of the Kansas Medicaid managed care program, KanCare. Within KDHE/DHCF, the Compliance and Contracting, Program Integrity and Compliance unit is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Kansas contracted with three MCOs to provide health services to the Medicaid population. As part of this review, all three of these MCOs were interviewed: Aetna Better Health of Kansas (Aetna), United HealthCare (UHC), and Sunflower Health Plan (Sunflower). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In May 2023, CMS conducted a virtual focused program integrity review of Kansas's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as reviewed other primary data. CMS also evaluated the status of Kansas's previous corrective action plan that was developed in response to a focused program integrity review of Kansas's managed care program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified six observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be

submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Kansas, these oversight and monitoring requirements are met through contracted audits, recurring reports, and other efforts to monitor program integrity performance of the MCOs. Any concerns with MCO performance are addressed with KDHE-DHCF leadership and strategies are built to resolve the issues within the terms of the contract.

However, CMS noted the KDHE Compliance and Contracting, Program Integrity and Compliance unit, the state's PIU, does not directly employ investigators or conduct investigations. There were only two PIU staff and one vacant position during the review period. Investigations of enrolled managed care providers have been delegated by KDHE to the SIU of each MCO. CMS noted the state did not conduct any on-site reviews of MCOs to verify compliance with its fraud, waste, and abuse contract requirements during the review period.

CMS also noted the MCO general contract only requires the MCO to hire and maintain a Program Integrity Manager to be staffed in Kansas, whose duties are composed of at least 90 percent dedication to oversight and management of the program integrity efforts required under the contract. CMS found the contract to be lacking specific requirements regarding other program integrity staff, as well as staffing ratios. There was also a lack of site visits by the MCOs, both announced and unannounced, which can be important oversight tools. These efforts would increase the functionality and oversight potential of the PIU, while additional staff would allow the PIU to take on additional program integrity responsibilities and improve the program.

Observation #1: CMS encourages Kansas to add staff to its PIU to conduct on-site reviews of MCOs to verify compliance with its fraud, waste, and abuse contract requirements.

Observation #2: CMS encourages Kansas to ensure the MCO SIUs or other program integrity-focused units have sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. In particular, Kansas could consider including MCO contract language addressing the organizational structure and minimum staffing ratios for the MCO's SIU. In addition, Kansas should consider the inclusion of MCO contract language for unannounced provider site visits.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, KanCare MCO contract(s) were evaluated and found to be in compliance with 42 CFR ***438.602(g)(1).***

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

Section 5.12.1 of Kansas's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans found that each contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). Initial MCO compliance plans are reviewed during the readiness review period at the start of a new contract period. Any ongoing modifications or updates to the compliance plan are reviewed and approved by KDHE. Compliance plans are submitted annually as part of the annual audit of the MCOs. Ongoing compliance activities (i.e., committee meetings, discussion topics, compliance training/education efforts, internal disciplinary measures/sanctions) are reported to the state on a quarterly basis by each MCO. As per MCO general contract section 5.12.1.B.5., the MCO is to provide KDHE-DHCF an annual program integrity work plan that outlines the MCO's program integrity and fraud, waste, and abuse focus for the coming year. In addition, in accordance with MCO general contract section 5.12.1.K., MCOs are required to conduct an annual risk assessment listing the top five vulnerable areas and outline action to mitigate risks in each area. The assessment must be provided to the KDHE within thirty days of its completion each year. However, KDHE does not use a monitoring tool to conduct the review of the MCO compliance plans, which could help ensure consistency in MCO compliance plans and adherence to CMS requirements.

Observation #3: CMS encourages Kansas to develop an effective monitoring tool for the

annual submission, review, and approval of MCO compliance plans to ensure the required elements are covered.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Kansas, this requirement is met in the MCO general contract, Section 5.12.1.M., which requires the MCOs to have in place a method to verify, on a regular basis, whether services reimbursed by the MCOs were furnished to beneficiaries as billed by the providers. Each of the three MCOs had a beneficiary verification method in place.

CMS did not identify any findings or observations related to this requirement.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. A review of the state's policy and MCO general contract Section 5.12.1.R.5. found that MCOs are required to establish written policies that provide detailed information about the federal laws identified in Section 1902(a)(68) of the Act, including information regarding employees' right to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act, or otherwise makes a good faith report alleging fraud, waste, or abuse. The contract requires the MCOs to provide a copy of its written policies to all of its employees, contractors, and agents.
CMS did not identify any findings or observations related to this requirement.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Kansas Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO general contract Section 5.12.1.N. requires the MCO to suspend all payments to a provider after KDHE determines there is a credible allegation of fraud for which

an investigation is pending under the Medicaid program against an individual or entity unless KDHE has identified in writing a good cause exception for not suspending payment or to suspend payments only in part.

CMS did not identify any findings or observations related to this requirement.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d). According to MCO general contract Section 5.12.1.L., the MCOs are entitled to only retain overpayment recoveries, including overpayments due to fraud, waste, or abuse that were first identified by the MCO. The MCO is not entitled to recover overpayments identified by KDHE. The MCO must immediately provide the amount recovered to KDHE or KDHE will withhold the amount recovered from future payment to the MCO. In the event the overpayment is not recoverable, the MCO must promptly notify KDHE and provide an explanation as to the reason the overpayment is not collectible. The MCO must require providers to report overpayments and specify the reason for the overpayment in writing. The overpayment must be returned to the MCO within 60 calendar days after the date on which the payment was identified. The MCO must provide an annual report of recoveries and any information or documentation related to recoveries retained by the MCO.

According to MCO general contract Section 5.12.1.R.6., the MCO must submit a quarterly payment integrity report to KDHE detailing, for the reporting period, the dollar amounts cost avoided through front end edits and other cost avoidance efforts, and the dollar amounts identified and recovered through fraud, waste, or abuse detection efforts.

CMS did not identify any findings or observations related to this requirement.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Kansas has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). **However, CMS noted that the MOU in place during the review period had not been updated since 2012, indicating noncompliance with § 455.21(c)(3)(v), which requires the MOU be updated no less frequently than every five years to ensure the agreement reflects current law and practice.** As reported by KDHE and the MFCU, after the review period, an updated MOU was signed and implemented on October 18, 2022. Kansas should continue to update the MOU at least every 5 years so that the state is in compliance with § 455.21(c)(3)(v) in the future.

Additionally, the state meets with the MFCU monthly to discuss case referrals. The MFCU conducts investigations of all enrolled Medicaid providers, including fee-for-service. The MCOs refer cases directly to the MFCU with a copy simultaneously going to KDHE. The MFCU informs both the MCO and KDHE by email whether MFCU will open an investigation into the matter. The MFCU and the MCO SIUs communicate by email to coordinate investigations and share information. The MFCU coordinates with the KDHE Program Integrity and Compliance unit when a law enforcement exception is requested. In addition, the MFCU coordinates with the KDHE Program and Integrity Compliance unit when a payment suspension notification delay is requested. The MFCU reported they are currently understaffed by three prosecutors and two special agents. The staffing shortage, coupled with a historic high in open cases, has resulted in long delays in closing cases. The average life span of an MCO referred case is approximately 975 days. There was no fraud, waste, and abuse training of MCOs conducted during the review period by either KDHE or the MFCU.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs and the MFCU to discuss program integrity issues, such as case referrals, leads, recoupment actions taken against providers, and administrative actions.

Observation #4: CMS encourages Kansas to reevaluate the fraud referral process to ensure the MFCU has adequate staff and/or assistance from KDHE to investigate and provide timely closure of MCO case referrals. This could include the vetting of referrals by KDHE prior to being sent to the MFCU to exclude those referrals that do not rise to the level of credible allegation of fraud. CMS encourages Kansas to work with the MFCU to resolve pending investigations and/or cases suspended due to a credible allegation of fraud.

Observation #5: CMS encourages Kansas, in conjunction with the MFCU when possible, to develop and provide program integrity training to MCO staff on a routine basis to enhance case referrals from, and oversight practices of, the MCOs. This includes ensuring that MCO staff, primarily the SIU and/or compliance officer, receive adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Kansas has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Kansas requires MCOs to report within two days to the KDHE-DHCF and the MFCU any evidence indicating the possibility of fraud, waste, or abuse by any participating or non-participating provider. If the MCO fails to report any suspected fraud, waste, or abuse, KDHE may invoke any penalties allowed under the contract including, but not limited to, suspension of payments or termination of the contract.

When a fraud investigation is completed by the MCO the state will review the referral to determine if a credible allegation of fraud exists, and take the appropriate action for payment suspension, good cause exceptions, provider education, claim recoupment, or provider termination, if needed. Additionally, the MFCU will review the referral and determine if they will investigate further for criminal or civil prosecution. The state will seek input from the MFCU when determining if the referral is credible, and if a law enforcement exception is needed prior to the state conducting further reviews for appropriate administrative action. Referrals from the MCOs generally consist of a completed MFCU referral form, investigative summaries from the SIU investigator, and supporting documentation. The status and the outcome of the referrals are then communicated back to the MCOs along with further direction, if needed.

CMS did not identify any findings or observations related to this requirement.

MCO Oversight of Network Providers

CMS verified whether each Kansas MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

All three MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through data analysis, tips and referrals, beneficiary verifications, and pre-payment/post-payment data analytics. Cases that are determined to be credible are documented and reported to the KDHE and MFCU simultaneously.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to Kansas by each MCO. As illustrated, CMS notes a limited number of provider investigations being conducted by the MCOs.

Figure 1. Number of Investigations Referred to Kansas by each MCO

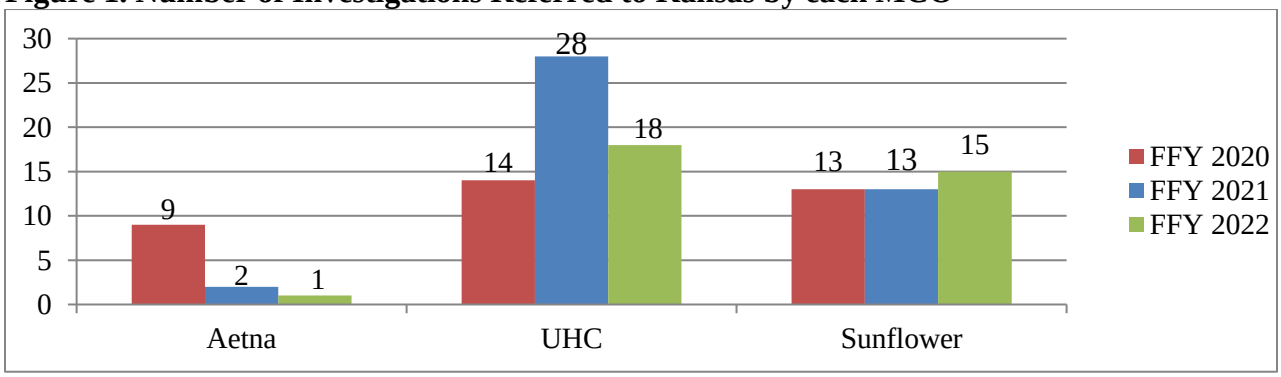

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Aetna's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	77	37	$120,119	$0
2021	51	26	$43,317	$61,782
2022	38	11	$12,215	$67,108

UHC's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	172	72	$4,143,377	$3,796,381
2021	230	158	$4,637,499	$4,512,260
2022	213	140	$5,515,629	$4,437,899

Sunflower's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	4	20	$232,179	$25,210
2021	25	27	$333,881	$547,384
2022	26	20	$326,817	$648,726

CMS did not identify any findings or observations related to this requirement.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. Through a review of the Kansas MCO general contract and interviews with each of the MCOs, CMS determined that Kansas was in compliance with § 438.242. Specifically, the contract language in Attachment J states each MCO must maintain a system that collects, analyzes, integrates, and reports data. It further states the system must provide information on areas including, but not limited to utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. Attachment K of the MCO general contract states that encounter data must be submitted weekly, and within five working days of the end of each weekly period and within 30 days of claim payment. It further states that all encounters must be submitted, both paid and denied claims, and that paid claims must include the MCO paid amount.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Kansas was in compliance with § 438.602(e). Specifically, KDHE contracted with

KFMC Health Improvement Partners to perform these duties on an annual basis.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Kansas has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, KDHE contracts with Gainwell Technologies to conduct data mining and report queries to identify abnormalities in claims data. Issues identified in relation to MCO providers are sent to KDHE for review and referral as needed. However, the KDHE PIU does not use encounter data to conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, nor did they conduct any MCO investigations during the review period.

> **Observation #6:** CMS encourages Kansas to conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, and to conduct investigations based on the results.

IV. Conclusion

CMS supports Kansas's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified six observations. The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Kansas to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Kansas's last CMS program integrity review was in June 2018, and the report for that review was issued in January 2019. The report contained seven recommendations for improvement. During the virtual review in May 2023, the CMS review team conducted a thorough review of the corrective actions taken by Kansas to address all recommendations reported in calendar year 2019. The findings from the 2019 Kansas focused PI review report have not all been satisfied by the state.

Findings

1. ***The state should consider adding additional FTEs to the KDHE Medicaid Program Integrity Unit to increase the functionality and oversight potential of the department. Additional employee positions would allow the unit to take on additional PI responsibilities and improve the program.***
   Status at time of the review: Not Corrected

2. ***The state should consider establishing a minimal staffing requirement for all contracted MCOs. The requirement should also specify the minimal levels for the number of investigative staff members who are fully dedicated to Kansas' Medicaid program. In addition, the state should define the frequency and level of contact it expects the local MCO staff to have with those MCO investigative staff members assigned to the program integrity activities for the state plan.***
   Status at time of the review: Not Corrected

3. ***The state should consider adding specific language to their contract that requires reporting of all identified and/or recouped overpayments from the MCOs for the purposes of rate setting. This language should include specifications on terminology for identified and recouped overpayments to maintain continuity for purposes of comparison.***
   Status at time of the review: Corrected

   Kansas added contract language to address reporting all identified and/or recouped overpayments for the purposes of rate setting.

4. ***The state should obtain evidence from its MCOs in support of any statements attributing a decline in the overpayments as the direct result of cost avoidance activities or proactive measures in place.***
   Status at time of the review: Corrected

   Kansas added an element to the quarterly fraud, waste, and abuse report for the MCOs to prove a decline in overpayments identified is the direct result of cost avoidance/pre-pay

measures.

5. ***The state should consider developing guidance that outlines an acceptable timeframe for FWA cases being investigated by MCO SIU units. This timeframe should include checkpoints to assess case progression and the inclusion of metrics on existing reporting to assess the general performance within these guidelines.***
   Status at time of the review: Corrected

   The MCOs explain why cases are open beyond 90 days on the current fraud, waste, and abuse quarterly report template.

6. ***The state should consider implementing a verification mechanism to ensure that TIBCO providers are not being included in provider networks. This could potentially be an attestation that distributed TIBCO files are being cross checked against the provider network or could be a state level control mechanism.***
   Status at time of the review: Unable to determine if this finding was corrected as it is outside the scope of the current review.

   All MCO providers will be within the KMAP Provider Management system. Program Integrity staff will continue to send the DEX Adverse Action report on a monthly basis to the fiscal agent. The fiscal agent will run the DEX Adverse Action report against all providers in the KMAP Provider Management system. They are required to respond back to Program Integrity staff with results, either no matches found or a list of matches.

7. ***The state should conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, in addition to the data mining contractually required and conducted by the MCOs. The state should require the MCOs to provide regular updates on performance improvement plans for changing algorithms and data mining updates.***
   Status at time of the review: Not Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Kansas MCOs

Kansas MCO Data	Aetna	UHC	Sunflower
Beneficiary enrollment total	133,630	170,788	216,711
Provider enrollment total	102,711	26,905	43,341
Year originally contracted	2019	2013	2013
Size and composition of SIU	175*	70+**	212***
National/local plan	Local	Local	Local

* Aetna has one dedicated Program Integrity Manager and one dedicated Investigator. Aetna's SIU team receives support from the national Aetna Medicaid organization's SIU team.
** UHC does not have any SIU staff solely dedicated to Kansas. The only SIU staff residing in Kansas is the Program Integrity Manager and the Compliance Officer. UHC is supported by United Health Group's corporate SIU.
*** Sunflower is supported by Centene's SIU, which includes a Program Integrity Manager and a dedicated Investigator, along with support staff.

Table C-2. Medicaid Expenditure Data for Kansas MCOs

MCOs	FY 2020	FY 2021	FY 2022
Aetna	$739,723,429.41	$799,004,800.66	$916,183,487.42
UHC	$1,097,388,954.71	$1,142,348,798.85	$1,253,871,594.39
Sunflower	$1,178,078,107.35	$1,145,817,091.75	$1,287,332,670.42
Total MCO Expenditures	$3,015,190,491.47	$3,087,170,691.26	$3,457,387,752.23

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)