

MAC Binder Section 2 – Letters to CMS

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Located online at <http://chfs.ky.gov/dms/mac.htm>

1 – CMS- Ltr to JG from SM re_ HIT IAPDU_072916:

DMS is requesting continued funding for the Kentucky Health Information Implementation Advanced Planning Document Updates #5 (IAPDU) for the continued support of the Kentucky Medicaid Electronic Health Records Incentive Programs.

2 – CMS- Ltr to MW from SM re _State Audit SFY2015_082616:

DMS is responding to the July 28, 2016 letter from CMS accepting the recommendations and corrective action plans taken/planned. DMS updated some responses/corrective action plans.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Stephen P. Miller
Commissioner

July 29, 2016

DHHS/CMS
Attn: Jackie Garner, Consortium Administrator
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

RE: Health Information Technology Implementation Advance Planning Document Update #5

Dear Ms. Garner,

The Kentucky Cabinet for Health and Family Services (CHFS) is requesting funding through the attached Kentucky Health Information Implementation Advance Planning Document Update #5 (IAPDU) for continued support of the Kentucky Medicaid Electronic Health Records Incentive Program. The requested funding is for incentive payments during FFY 2017 and FFY 2018, costs related to Kentucky's Health Information Exchange, and the associated administration.

Please contact Stacy Fish at (502) 564-0105, ext. 2925, if you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Stephen P. Miller".

Stephen P. Miller
Commissioner
Kentucky Department for Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Wm. Robert Long, Jr.
Director

Division of Program Integrity
275 E Main St, 6 E-A
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Vickie Yates Brown Glisson
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August 26, 2016

Ms. Michelle White
Acting Financial Management Branch Manager
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsythe Street, SW, Room 4T20
Atlanta, Georgia 30303-8909

CERTIFIED – Return Receipt Requested

Re: A-04-16-30057, Kentucky Single State Audit SFY 2015

Dear Ms. White:

The Department for Medicaid Services (DMS) received your Management Decision letter dated July 28, 2016, on August 2, 2016. We appreciate CMS's acceptance of all recommendations and corrective action plans taken/planned. Below please find the audit findings and CMS decisions reprinted along with DMS's updated response/corrective actions highlighted in yellow.

1. **Recommendation Code:** 299-901-10. 2015-003 The Cabinet for Health and Family Services Did Not Record Medicaid Expenditures to the Correct Contracts.

Recommendation Description: We recommend procedures be implemented to ensure all expenditures are properly charged to the correct contracts.

Response/Corrective Actions: The State agreed with the recommendation. In September 2014, CHFS developed and implemented new procedures to ensure all MCO payments are charged against the correct master agreement contracts. The Department of Medicaid Services sorts and approves the monthly MCO payments by master agreement contract and the Division of Accounting and Procurement Services pays accordingly. **This process is currently still in place and is working successfully.**

2. **Recommendation Code:** 211-922-10. 2015-007. The Cabinet for Health and Family Services Did Not Ensure Encounter Data Submitted to the Kentucky Medicaid Management Information System is Accurate and Complete.

Recommendation Description: We recommend procedures be implemented to ensure encounter data submitted is complete and accurate.

Response/Corrective Actions: The State agreed with the recommendation. Per the recommendation, beginning July 1, 2015 the new contract language (for State Fiscal Year 2016) accurately reflects the penalties being assessed for late or inaccurate encounter data. The Department of Medicaid Services began penalizing the MCOs effective July 1, 2015. The MCOs are notified via SharePoint of these penalties on or before the third Thursday of the month.

To date all MCOs have been penalized a total of \$8,724,320.00 for encounter related penalties. (Aetna - \$1,986,175.00, Anthem - \$1,584,850.00, Humana - \$1,033,275.00, Passport - \$1,055,920.00, WellCare – \$3,064,100.00)

3. **Recommendation Code:** 211-901-10. 2015-008. The Cabinet for Health and Family Services Did Not Ensure All System Audits and Edits Were Accurately Configured for the Kentucky Medicaid Management Information System and Were Kept up to Date Within System Documentation.

Recommendation Description: We recommend procedures be implemented to ensure validity of the system controls.

Response/Corrective Actions: The State agreed with the recommendation. The Department agrees that the MMIS audit and Edit manuals were not updated with the above referenced details since this finding only related to documentation no claims processing errors occurred. The Division of Medicaid Systems Created a task and requested the vendor to update the edit and audit manual. This corrective action was completed on September 16, 2015 by the HP Business Analyst. The updated data has been verified by the Systems Monitoring Branch Manager in the Division of Medicaid Systems and an updated copy has been posted for internal users. The edits that were updated are listed within a spreadsheet that was provided to the auditors along with this response.

Current versions of the Audit, Edit, and GMIS manuals are available on the Project Workbook (PWB) in real-time. These can be accessed at <https://home.KMMIS.com/>. After logging on, the user should click DDI Workbook, then Reso Manuals. It should be noted a user must have access to the DDI workbook within KYHealth Choices to access this link. If you are unable to access the manuals through this link, DMS can burn the updated manuals to discs and provide to CMS upon request.

4. **Recommendation Code:** 306-905-10-2. 2015-053, 2014-057, 13-CHFS-51, 13-CHFS-59. Eligibility.

Recommendation Description: This is a repeat finding. We recommend procedures be strengthened to ensure documentation supporting eligibility is properly maintained.

Response/Corrective Actions: Effective February 29, 2016, a new integrated eligibility system was implemented. This system fully integrates all programs currently remaining on the KAMES legacy system and all health insurance programs onto a new platform using the kynect platform. With this integration, there will only be one case for all programs, as to multiple cases on multiple systems. This one case will be associated with one electronic case file, streamlining workload management and documents received for processing. In addition, various other state and federal interfaces were built into the system. Many of these interfaces are real time and will assist with verifying

required information such as social security number, citizenship, etc. If verification cannot be verified through an available interface, the system will automatically pend the case and generate a request for information. If the required information is not received, the system will automatically take action to either deny the application or discontinue benefits depending on the status of the case.

To reinforce the importance of maintaining proper case files, central office management will address this issue in the regularly scheduled monthly meeting with regional management. Additionally, the Division of Family Support (DFS) will issue announcements on a quarterly basis reminding staff of the importance of following policy and procedures in the maintenance of case files beginning with April 2016.

Announcements regarding policy and procedures were initiated in Worker Portal in April 2016 – a screenshot has been included on the enclosed disc to evidence where the announcements post for staff access.

5. **Recommendation Code:** 339-935-10. 2015-054, 2014-058. Activities Allowed or Unallowed and Allowable Costs/Cost Principles – Drug Rebates.

Recommendation Description: This is a repeat finding. We recommend procedures be strengthened to ensure 1) drug rebate balances are collected in a timely manner and 2) adequate oversight over the drug rebate program.

Response/Corrective Actions: DMS implemented the following corrective actions beginning September 2015:

- (1) DMS explored options through the PBM to increase collection attempts on behalf of the Commonwealth; including:
 - (a) sending additional late payment notices to manufacturers (although additional penalties cannot be included);
 - (b) Increase the frequency of submitting notice to CMS regarding manufacturers that do not submit payment timely (quarterly):
- (2) DMS reviewed the supplemental agreement contract entered into with manufacturers through the National Medicaid Pooling Initiative (NMPI) to explore the addition of penalties and sanctions against untimely payments from manufacturers for the next contract renewal period. There is some provision for additional interest accrual on unpaid balances. DMS has considered the implication of this provision and uses its discretion to prefer or non-prefer products from manufacturers with a poor payment track record when doing so would not disadvantage recipients or the State.
- (3) In August 2015, DMS explored initiating requests for state hearings as allowed in the National Rebate Agreement. However, DMS must approach hearing proceedings with great caution to avoid causing unwanted complications.
- (4) DMS also instructed the PBM to compile a list of balances for manufacturers that continue to have returned mail due to them being terminated. This report will allow for balances to adjust down to zero in the rebate system since they are not collectable. This project began operation during spring 2016.

DMS, through its PBM, continues to execute the collection activities outlined as a result of the audit finding.

The below documents have been burned onto the enclosed disc to provide supporting evidence that those process changes were complied with:

1. Kentucky Delinquent Labelers folders (4 files) – These contain the evidence of the process described in “Increase of Communication with CMS”, related to the rebate invoices;
2. Dunning Letter PDF file - These contain the evidence of the process described in “Increase of Communication with Manufacturers”, related to the rebate invoices.

6. **Recommendation Code:** 099-901-10. 2015-055. Allowable Costs/Costs Principles.

Recommendation Description: We recommend procedures be implemented to ensure services provided to participants are properly monitored and are in accordance with State regulations.

Response/Corrective Actions: The State agreed with the recommendation in part. DMS disagrees that the program was not monitored correctly, rather with a different interpretation of the regulation at that time, due largely in part to the previous leadership within the Division of Community Alternatives. It wasn't until a new Director was named that the correct interpretation (the one which is outlined in this document) was allowed to be enforced.

In early 2015, DMS notified Michelle P. Waiver CDO providers/support broker agencies that effective April 1, 2015, any first time budget requests for the MPW that exceeded 40 hours per week would be denied, and the applicant would receive a right to a fair hearing. The notification included that any consumers currently receiving in excess of 40 hours per week would be required to adjust their plan of care to comply with the regulatory maximums starting April 1, 2016. This will require the consumer to submit a voluntarily reduced support spending plan/plan of care, or the consumer will have his or her budget denied, due to exceeding regulatory limits, and consumer will receive a right to a fair hearing. This transition period gave each consumer/representative a one year notice to prepare for any reduction in benefits. In addition, DMS notified the providers that any requests for budget exceptions that were presented in excess of 40 hours per week would also be denied with appeal rights.

DMS has also written multiple change orders for the MMIS system, which when fully implemented, will prohibit any MPW providers from billing for services which, when combined, would exceed the 40 hour limit; anything in excess of this limit would be scrutinized and require a manual override by DMS.

Starting April 1, 2016, DMS began denying Michelle P Waiver plans of care submitted with a level of care dated April 1, 2016 or later that exceeded the 40 hour limit. When the non-compliant plan of care is submitted, the member will have his or her budget denied, due to exceeding regulatory limits, and the member receives a right to a fair hearing in accordance with 42 CFR §431.211 and 907 KAR 1:563. If the member requests a hearing timely, the requested (non-compliant) plan of care is continued until a final order

is received from the Secretary of the Cabinet for Health and Family Services in accordance with 907 KAR 1:563 Section 5. To become compliant with the regulation and waiver, most of the non-compliant plans of care are being reduced by the member or representative prior to submission to DMS.

DMS will continue to work with members who receive adverse action notices regarding their waiver plans of care to ensure members are taking advantage of similar services offered through the Kentucky State Medicaid Plan. Please note there are several cases currently pending before the Administrative Hearings Branch where the member has appealed the 40 hour limit.

If you have questions, please feel free to contact Robert Long with the Division of Program Integrity at (502)564-5472, ext. 2181.

Sincerely,

A handwritten signature in blue ink that reads "Stephen P. Miller". The signature is written in a cursive style with a large initial 'S' and 'M'.

Stephen P. Miller
Commissioner, Department for Medicaid Service
Cabinet for Health and Family Services

Enclosure

CC: Lynda Bennett