TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Behavioral Health
Technical Advisory Committee Meeting
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Kentucky Medicaid Audits

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Medicaid Program Integrity

- Social Security Act, Section 1936 establishes the Program Integrity program
- Requires the program to review the actions of individuals or entities furnishing items or services for which payment may is made under a State plan (or any waiver plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds which is not intended under the provisions of the program.
- Identification of overpayments to individuals or entities.

Targeted Case Management (TCM) Audit

- The Single State Audit (SSA) for SFY 2019 found that DMS "failed to timely perform and monitor managed care organizations' compliance with targeted case management assessments" consistent with federal and state case management services regulations. The SSA noted that providers did not have documentation or evidence that services were performed and the state did not monitor to ensure compliance.
- Centers for Medicare and Medicaid Services (CMS) require states to develop a Corrective Action Plan (CAP) to address SSA findings.
- DMS submitted a Targeted Case Management Audit Plan which was approved by CMS.
- The Single State Audit for SFY 2020 had a similar finding as the CAP had not yet been put into place due to COVID.

Targeted Case Management Audit Process

- On the 15th of each month, a report is generated of FFS and MCO TCM claims billed the prior month.
- Using a random number generator, DMS selects three TCM single claim audits per month, per MCO, for a total of 18 single claim audits.
- Audit letters are mailed to providers requesting documentation.
- Providers are given 30 days to submit the requested records.
- If documentation is not received, a second notice is sent giving an additional 30 days.

Targeted Case Management Audit Process

- If no records are received, the claim is deemed an overpayment and a demand letter is issued for recoupment. Due process rights apply.
- Received records are reviewed. Records must validate the assessment, plan of care, monthly contact, and BHDID credentialing, in addition to verifying the billed claims.
- If no overpayment is identified, a letter is issued back to the provider letting them know the results of the review.
- If an overpayment is identified, a demand letter is issued for recoupment. Due process rights apply.

Targeted Case Management Audit Process

- If the DMS TCM review results in a finding of deficiency, a notification letter is mailed to the MCO instructing them to conduct a one-year look-back of TCM claims submitted by the provider. (This timeframe was reduced in 2022 from a two-year lookback period.)
- MCOs have 180 days to complete their review. Extensions may be requested prior to their due date.
- MCOs are responsible for any identified overpayments and due process rights for provider.

Prepayment Reviews

- Effective January 1, 2024, MCOs must submit prepayment policies and procedures to DMS for review and approval before implementation.
- When there is a sustained or high level of payment error, or data analysis identifies a problem, an MCO may request approval from DMS to implement a prepayment review.
- Prepayment review requests to DMS must include the following:
    - Case Number, Provider Name, Provider ID, NPI
    - Summary of the concern
    - Draft of the provider notice
    - Start date of the review

Prepayment Review Process

- DMS must respond to the MCO prepayment request within 5 business days.
- DMS may approve/deny the request or request additional information.
- If a prepayment request is approved:
  - MCOs must issue notice to the provider in writing two (2) business days in advance of the prepayment review start date through multiple means of communication (i.e. certified letter, email).
  - The written notice shall, at a minimum, include:
    - Reason for the review, description of documentation required;
    - Method of submission;
    - Timeframe for returning the documentation and result of the review;
    - Length of time of the prepay review;
    - Contact information for questions; and
    - Information on how to request prepay removal.

Prepayment Review Process Continued

- A provider shall be given 45 days to submit documentation.
- Claims on or after day 46 may be denied if documentation has not been provided.
- The appeals process should be followed per the contract, internal policies, and procedures.
- The contract may extend the prepayment review period if determined necessary.
- If the provider has sustained a 90% error-free claim submission for 45 days, the MCO must request permission from DMS to continue prepayment review.
- The MCO must notify DMS once a provider is removed from prepayment review.
- MCOs must submit to DMS an annual report of all providers placed on prepayment during a calendar year.

Post-Payment Reviews

- The Division of Program Integrity (DPI) conducts post-payment reviews to identify if services billed are in accordance with policy and regulation.

- Post-Payment reviews are completed on **all** provider types, including, but not limited to, pharmacy, home health, medical equipment and supplies, ambulatory services, physicians, hospitals, surgical centers, laboratories, radiology, audiology, optometry, podiatry, and dental.

Post-Payment Review Process

- A complaint/allegation of fraud, waste, or abuse is received.

- Staff review and determine if the provider is currently under investigation by law enforcement (OIG, OAG, or UASO).
  - If yes, staff contact the relevant agency and inquire on whether to proceed or continue.
  - If no, the complaint is reviewed; a timeframe for the review is established and data is obtained.

- After reviewing the data, a sample size is determined, and members are selected for review using a randomizer.

Post-Payment Review Process Continued

- A records request letter is sent to the provider.
  - Letter outlines the requested documentation, submission instructions, and due date - 30 calendar days.

- If records are not received by the due date, a second request letter is sent to the provider.
  - The letter allows an additional 30 calendar days for submission.

- Upon receipt of records, the desk review is conducted.
  - If no records are received, those claims are considered an overpayment and DMS will issue a demand letter to the provider.

Post-Payment Review Process Continued

- Upon completion of the desk audit, an explanation of findings letter is issued to the provider.
  - Letter outlines the review, reports any findings, and, if appropriate, identifies any overpayment.

- If an overpayment is identified, an accounts receivable will be set up to monitor overpayment recovery.

Behavioral TAC Questions & DMS Responses

What are the different types of audits that MCOs conduct on their providers and the purpose of each type? Which audit types must be pre-approved by DMS, if any?

- There are two types of audits: Prepayment and Postpayment.
- Prepay audits are mostly due to a provider having a post-pay audit that has not resulted in a change of billing practice by the provider, they have been identified as an outlier, or the provider is being investigated by a law enforcement partner. All Prepayment audits must be pre-approved by DMS.
- Postpay audits include, but are not limited to, data mining, outliers for billing, complaints received via multiple sources, requests from DMS, or other. Postpay audits do not have to be approved by DMS unless the provider is currently under investigation.

What is the history and purpose of Prepayment Audits by MCOs in Kentucky?

- MCOs have historically been allowed to conduct prepay audits since contract inception. However, due to an increase in activity, DMS recently began requiring prepay audits be approved in advance.
- Prepay audits general occur when a provider had a postpay audit, education was provided, and further review of the provider's billing shows nothing has changed with the provider's billing behavior.
- MCOs may see patterns or inconsistencies via data analysis and can request a prepay audit to assess billing until the error rate is lowered.
- Prepay audits are meant to be used as an educational platform for engagement between the provider and MCO to correct the behavior or coding to align with MCO contract, regulations, coding guidelines, or other federal or state requirements.

Are MCOs required to get permission from DMS to perform certain types of audits? If so, which ones? Are MCOs required to get permission from DMS to perform certain types of audits on certain providers? Why is this and what are the criteria that DMS uses to give permission or to withhold it? Does the permission come with some parameters given, such as the service(s) being audited; the number of records to be requested; the timeframe in which the provider is required to reply?

- MCOs must obtain approval from DMS before a prepay audit. This change was made due to provider concerns regarding the number of audits being conducted.
- MCOs must obtain approval from Program Integrity to conduct any audit of a provider who is being investigated by a law enforcement agency. This is to ensure law enforcement agencies are given notice and there is no overlap with an investigation.
- There are times DMS will provide conditions or parameters regarding approval. These are usually the result of requests made by a law enforcement partner conducting an investigation. An example: The audit must exclude a specific rendering provider's claims.

Does DMS direct MCOs to conduct certain types of audits? Does DMS direct MCOs to conduct certain types of audits of specific providers? What are the criteria that DMS uses to make such a request of an MCO or multiple MCOs? Are there specific questions that DMS wants to be answered by the audit? Is the provider notified that the audit is being done at the request of DMS?

- DMS directs MCOs to conduct certain TCM audits and Quality Review audits and these could be general or for a specific provider. For TCM and Quality Review audits, DMS requests a one-year lookback.
- DMS may receive referrals from a law enforcement partner that may result in direction from DMS to request the MCOs to conduct an audit. If directed by DMS, providers are not notified the request was made by DMS. The audit may come with specific instructions for the MCO to follow in their audit.

How is it determined how many records have to be provided and the timeframe of the audit period? Do these metrics vary depending upon the type of audit? Is there a number of records or timeframe that DMS would consider excessive? If so, would the complaint form be used to report these concerns to DMS?

- The minimum number of records for review is 20, unless the audit is for TCM, for which the minimum number of records is 50. If the MCOs do not have that many records in their universe, they inform DMS, and the number of records is adjusted accordingly.
- If the number of records appears to be excessive, the MCO Dispute Inquiry Form (a.k.a. provider complaint form) can be used to bring awareness to DMS. However, the provider should always take immediate action with the MCO that has made the request first. MCOs have the flexibility and capability to work with each provider to ensure a claim volume is met for compliance.

What is the relationship between a Prepayment Audit and withholding payment for a service? May the payment be withheld until the conclusion of the audit process?

- Prepay audits withhold payment until the review of the required documentation has been completed to ensure the provider is billing properly.
- There will be a payment or a denial upon the conclusion of the audit process.
- MCOs are not permitted to unnecessarily extend the review time. They must promptly review the documentation to determine whether the claim should be paid or denied.

Are MCO's allowed to extrapolate from a few case records to an entire group of records that have not been reviewed?

- MCOs are never allowed to extrapolate.

Are all behavioral health services subject to a Prepayment Audit?

- All Medicaid covered services are subject to a Prepayment Review.

Is there a way DMS can ensure that different audits conducted by the same MCO in the same time period on the same provider are coordinated? Providers express concerns that they have multiple audits going on at the same time by the same MCO, with little indication that there is any coordination between the different entities that are conducting the audits for the MCO. The different audit entities aren't talking to one another, and they are all requesting different records at the same time, which overwhelms the provider.

- DMS allows MCOs to manage their audits. DMS allows MCOs to combine audit lookback requests into one audit so that multiple audits do not need to be completed at the same time.
- We can take this concern back internally and discuss it further we recognize collaboration between MCO entities could decrease the burden on providers, while still capturing the issues/concerns for the audit. However, claims are proprietary to the MCO entity and provider.
- Providers should always begin by addressing the issue with the MCO. If that proves unsuccessful, providers should submit a complaint inquiry to DMS.

It has been recommended that a given provider submit the MCO Provider Complaint form to bring DMS's attention to concerns about MCO behavior with regard to audits or other issues. This was suggested with regard to the prepayment audits being conducted by MCOs. What information about audits needs to be included in the complaint form when it is filed with DMS? What would be the expected length of time for review by DMS and a response made back to the provider and the MCO ? It is not uncommon for a concern with specific information to be provided to DMS by a provider with no response received for months.

- A provider complaint may be submitted when there is a concern the MCO is excessive in the number of audits being performed, or if the requests are unreasonable such as not providing a sufficient amount of time for response. As much detail as possible should be provided to give a clear picture of the situation and concerns.
- At a minimum, DMS would need to see the audit letters providers are receiving, the timeframe in which the audit is requested, what is being audited, and the volume of claims the provider has submitted for the MCO to review. Information regarding the provider's contact with the MCO to express concerns and the level of responsiveness is also helpful information to include.
- The Contract Monitoring Branch is very responsive to inquiries, most taking 30 days or less. However, depending on the scope of the complaint, it make time several months to properly investigate. If months have passed with no response, please contact DMS to inquire about the review status.

In instances where an MCO doesn't follow their own appeals procedures as outlined in their contractual requirements with DMS, is it appropriate for the provider to bring this to the attention of DMS and to expect the MCO to be held accountable? What process should a provider use to notify DMS when an MCO does not follow their own appeals process? What are the possible consequences for the MCO in this situation? Would the action taken by the MCO against the provider be modified or negated if the appeals procedures were not followed?

- If a provider has concerns that an MCO is not following requirements, provider may submit a complaint form to the Contract Monitoring Branch.
- MCO contracts dictate the MCO appeals process and require the MCOs to follow it. If the MCO does not follow the process, then actions of non-compliance will be taken.
- DMS has an internal process following complaint reviews. Sometimes the issue is handled through that process. If not, DMS has a variety of other non-compliance options such as issuing a Letter of Concern, a Corrective Action Plan, or a variety of different penalties.
- The MCO would be required to correct the part of the process that was not completed properly.

Questions?

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