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Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

Medicaid Inspector General Update
September 22, 2021

Chairman Hilderbrand and Members of the Committee:

Thank you for the opportunity to appear today and discuss the Office of the Medicaid Inspector General (OMIG) with you this morning. My name is Steve Anderson and I am pleased to present this update regarding the OMIG.

OMIG Staffing

I completed the required training and obtained the certification as a certified inspector general from the Association of Inspectors General on August 27, 2021. The OMIG recently added a secretary, which brought our staffing to three full time employees and one part-time employee. We hope to eventually recruit more staff members as appropriations allow.

Since my confirmation in April 2021, the OMIG has issued three reports that identified $1,665,815.43 in improper payments, $1,252,520.00 in potential savings, $1,534,043.17 in lost interest, and nine recommendations for improvement. These reports are summarized below and can be accessed at https://ag.ks.gov/fraud-abuse/medicaid-inspector-general.

The OMIG has also referred 29 cases to the attorney general's Medicaid Fraud and Abuse Division (MFAD) and 33 cases to KDHE for Personal Care Attendant fraud, plus four referrals to Managed Care Organizations to review for potential overpayment. I am confident the OMIG will continue to produce results like these and with additional resources would be able to audit, review, and investigate a greater range of issues that need our attention timelier.

Updates

The OMIG continues to oversee complaints of fraud, waste, abuse, and illegal acts concerning the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP). In CY 2019, the OMIG screened a total of 227 fraud reports which were primarily submitted by the Kansas Department for Children and Families (DCF). In CY 2020, the OMIG screened a total of 650 fraud reports with 629 (97%) being submitted by DCF. That was an increase of more than 186% in one year. So far in CY 2021, the OMIG has screened 833 cases, with 736 (88%) being submitted by DCF. That is far ahead of CY 2020's pace. Since the last meeting of this committee, the OMIG has received 489 complaints, the majority of which alleged Medicaid eligibility fraud and 419 (86%) were received from DCF.

The OMIG is currently conducting an audit of the HCBS program and with the intention of answering the following questions:

1. Does KDHE have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program?
2. Are there Medicaid beneficiaries on the HCBS program that have not used it for more than a year?
3. What are the requirements and responsibilities of the Managed Care Organizations to ensure Medicaid beneficiaries are properly enrolled in the HCBS program?

The OMIG is also conducting a review of Medicaid beneficiaries reporting financial windfalls; particularly windfalls from lottery and casino winnings. The review is looking at beneficiaries that win more than $10,000.00, but do not report the winnings as required.

As noted in the annual report, the OMIG was working on a process improvement plan to allow for more insight to policymakers about the types, amounts, and outcomes of the fraud reports received. After being confirmed as IG, a significant overhaul of the case management system was undertaken. The system was updated to ensure cases were opened and closed with an appropriate level of oversight and quality control. The coding and tracking of different case types was enhanced and updated. The ability to track and record referrals and outcomes was added. OMIG staff have received updated training on the case management system. We are still making small tweaks to the system; however, the overall system is up and running.

Reporting Fraud to the Clearinghouse, Report 22-01

A review of the process for the public to report cases of suspected Medicaid eligibility fraud was conducted. The KanCare Clearinghouse does not have an option in its call tree to allow a concerned citizen to report fraud. Callers are given several options, however, none of them include an option to report fraud. Based on ruse calls made to the Clearinghouse, it was confirmed that no fraud reporting option existed. Efforts made to speak with Clearinghouse staff to report fraud were met with mixed results. Typically, the staff member did not know what to do or who was the point of contact. Often after lengthy waits on hold, we were directed to call the attorney general's Medicaid Fraud and Abuse Division, which does not handle Medicaid eligibility fraud. Less than 50% of the time we were directed to the Kansas Public Assistance Fraud line 800-432-3913. They will accept callers wanting to report Medicaid eligibility fraud.

The KanCare website was also very difficult to navigate. There is no obvious link to a website or telephone number to report Medicaid eligibility fraud. We recommended the following:

1. The KanCare Clearinghouse telephone tree should include an option to report fraud. The caller should be given the choice to report eligibility or provider fraud and then be provided the telephone number to either MFAD for provider fraud or the Kansas Public Assistance Hotline for eligibility fraud.

2. The option to report fraud should be clearly indicated on the KanCare home page and not require clicking on several links that are confusing.

3. Add the numbers for the Kansas Public Assistance Hotline and OMIG to the KanCare Phone Contact List.

Review of MediKan, Report 22-02

The OMIG conducted a review of the MediKan program to determine if KDHE paid any medical claims on behalf of beneficiaries who have exceeded the 12-month lifetime maximum limit. According to Kansas Administrative Regulations (K.A.R.), MediKan is a totally state-funded program covering all or part of the cost of medical care for disabled individuals who do not qualify for Medicaid. In addition, assistance under this K.A.R. shall be limited to 12-months in a lifetime.

Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System (KMMS), we identified 912 MediKan beneficiaries that had 13 or more months of eligibility during our review period of January 1, 2018, to April 30, 2021. The failure to

timely discontinue MediKan eligibility after the 12-month lifetime limit ended, resulted in state funds being used to pay medical claims for ineligible persons in the amount of $1,665,815.43.

As a result of our review, KDHE staff began the process of removing 556 individuals that were identified as no longer eligible for MediKan. An estimated savings of $1,252,520.00 to the MediKan program was based on the amount of claims for these individuals for the past one-year period and extended out for six months.

We made the following recommendations:

1. KDHE management should work with the KEES team to have a report automatically generated on a monthly basis that indicates the current amount of eligibility remaining for each beneficiary.

2. Review existing policy and procedures to ensure there are no conflicts with K.A.R.s.

3. Ensure that changes to policies, procedures, and directives are published and transmitted to all staff members. This should receive a special emphasis when new systems are implemented or when substantial changes occur.

4. Review quality control measures and staff training protocols to ensure they are sufficient to confirm staff members know how to properly document case files and are actually completing the task.

Review of Capitation Payments, Report 22-03 (Amended)

Capitation Payments Made After Beneficiaries' Deaths – The objective of the review was to determine if the Kansas Department of Health and Environment (KDHE) made capitation payments to Managed Care Organizations (MCOs) for deceased beneficiaries. It was determined that $1,313,175.55 in monthly capitation payments were made for the 25 beneficiaries whose dates of death preceded the payment dates and recoupment had not occurred.

We also performed a two-year look back from July 2019 to July 2021 of capitation payments made on behalf of deceased beneficiaries. Any beneficiary with a capitation payment description of "recoupment" and recorded as deceased was captured. From this list of beneficiaries, we kept beneficiaries where the MCOs received three or more months of capitation payments after the month of death. We found 632 cases where

MCOs continued to receive capitation payments. The capitation payments totaling $19,202,562.21 were eventually recouped by KDHE via an offset with each MCO. There were 56 cases within this group where capitation payments continued for five or more years after the beneficiaries' month of death.

We looked at the length of time these overpaid funds were in the possession of the MCOs and conducted a cost of money analysis. We determined the total cost of money to the State of Kansas to be $1,534,043.17.

We made the following recommendations:

1. Review quality control measures and staff training protocols to ensure they are sufficient to confirm staff members know how to effectively and efficiently identify and process cases involving death of a beneficiaries.

2. The failure of KanCare staff to timely and efficiently process cases where Medicaid beneficiaries had died caused a substantial overpayment to the MCOs of $19,202,562.21. Due to this delay the State of Kansas effectively gave the MCOs a cash loan of $1,534,043.17. KDHE should review the matter and determine if it is feasible to recover these funds.

COVID-19 Monitoring

The COVID-19 pandemic has created new opportunities for fraud. Our analyst continues to run data queries based on his training and experience. To date, he has not found evidence of billings for improper COVID-19 testing. However, we are regularly reviewing encounter data related to COVID-19 to identify any improper activity. The OMIG is constantly reviewing data to look for irregularities, trends, or errors related to COVID-19. Any instances of provider fraud that are identified will be forwarded to the MFAD for review.

Thank you for your time this morning. As always, we welcome any suggestions from the Committee on audit, review, or investigation topics.