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

Medicaid Inspector General Update
October 11, 2023

Chair Gossage 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.

The OMIG has completed a performance audit of eligibility determinations for Medicaid beneficiaries on the Transitional Medical Assistance Program (TransMed). The objective of the audit was to answer the following questions:

1. **Does the Kansas Department of Health and Environment (KDHE) have an effective system for processing and tracking determinations of Medicaid beneficiaries on the TransMed program?** No. The number and types of findings identified during the audit indicate control weakness placing Medicaid monies at risk. We identified significant compliance and control gaps within the TransMed program. A lack of oversight has led to staff misunderstanding, which has contributed to a 45% error rate within the TransMed program. We also identified a lack in targeted reviews aimed towards resolving eligibility issues related to the TransMed program. We identified numerous households that went without a review for several years prior to the declaration of the Public Health Emergency (PHE). Out of the 53 review errors identified in our sample, over 50% of the affected beneficiaries have gone without a review since the 2015-2019 timeframe.

2. **Has KDHE adopted a single TransMed period of 12 months in lieu of two, six-month periods?** Yes.

3. **Are there Medicaid beneficiaries on the TransMed program who have been in the program for longer than allowed by governing regulations?** Yes. We identified 9,322

beneficiaries who were enrolled in TransMed during our audit period of January 1, 2019 through December 31, 2021, and had 13 months or more of continuous TransMed coverage. Beneficiaries are limited to only 12 months of continuous coverage. We considered the COVID-19 Federal PHE that was declared on March 2020 and narrowed our review sample to only include the 2,322 beneficiaries who had unallowed coverage prior to the PHE.

Our review identified $16,326,364.59 in estimated capitation payment overages as being wasted on ineligible persons as of June 2022. We interviewed KDHE program staff who identified that KDHE tracks overpayments on an overpayment Excel spreadsheet tracker but takes no action to recoup overpayments from the MCOs or beneficiaries. Our analysis on recoupments made on TransMed members with 13 months or more of continuous coverage supported staff's claims on KDHE not collecting overpayments. A follow-up review found that 14 of the 57, or 25% of the beneficiaries identified, are still active TransMed members as of June 2023, with a monthly capitation cost of $6,335.84, or $452.56 per beneficiary.

The OMIG also completed a performance audit of Medicaid beneficiaries with multiple identification numbers. The objectives of this audit were to determine the following:

1. **Does KDHE have an effective system of tracking beneficiaries with multiple Medicaid identifications numbers?** The current system has noted deficiencies that could easily be corrected by updating policies and procedures.

2. **Does KDHE identify capitation overpayments and are they following contracts that are in effect?** It does not appear that KDHE recoups capitation overpayments in the majority of instances.

KDHE has procedures in place for recoupments that are not followed. There is also a rule in place to limit the 'look back' period to 22 months. This appears to be an arbitrary restriction that has no basis in federal or state law or regulation.

The audit found that only 3 instances out of 53 (6%) cases reviewed with multiple beneficiary IDs had been recouped in a timely manner during the designated audit period. After accounting for the 8 (15%) who had fee for service, 42 (79%) were left with no capitation recoupments totaling $95,145.21 from the MCOs. There were also 57 instances of one SSN connected to multiple bene IDs. Of those, one beneficiary (adoption situation) had duplicate capitation payments of $18,475.11 to Sunflower, which were not recouped.

KDHE's correction efforts following the start of our audit resulted in 13 beneficiaries whose capitation payments were recouped or stopped. We determined that the savings for a one-year period totaled $105,255.72.

OMIG has initiated three additional performance audits. The first involves Medicaid reimbursements to public schools; the second involves the prior authorization process for Medicaid providers and managed care organizations (MCOs); and the third involves the process for facilities to be designated as continuous care retirement centers.

OMIG conducted a review of COVID-19 test kit claims to determine if Kansas Medicaid received fraudulent claims for at-home COVID-19 test kits and if Kansas Medicaid paid any fraudulent claims. We reviewed claims from all providers that billed for at-home test kits from April 1, 2022, through May 31, 2023. There were 548 providers who billed for 247,190 kits totaling $4,119,421.44. Medicaid paid $0 on the claims. We identified that 11 of the 548 providers billed for 32% of the kits. These 11 only billed under code K1034 and did not bill for any other service or supply. While Medicaid did not pay any of the claims, records indicated that Medicare paid $899,811.84. None of the providers are located in Kansas and 9 of the 11 registered for their National Provider Identifier (NPI) numbers after March 2020. The information developed from this review was forwarded to the Health and Human Services Office of Inspector General (HHS/OIG).

In cooperation with KDHE, the OMIG developed fraud, waste, and abuse awareness training that was provided to KDHE and contract employees. Last calendar year, we completed six training sessions and provided the training to 196 employees. So far this year, we have conducted 17 training sessions and provided the training to 710 people. The training will be offered on an annual basis to KDHE employees and contract employees. Some sessions are open to the public. The purpose of the training is to ensure employees are better prepared to identify fraud, waste, and abuse and how to report it.

An example of a referral that was opened for further investigation was an allegation that a Medicaid beneficiary had committed Medicaid fraud by clocking in a Personal Care Attendant (PCA) when they were not actually working. The Medicaid beneficiary's daughter was informed she had been receiving outside income while allegedly working as a PCA for her mother. Approximately $10,000 was billed to Medicaid for services that were not rendered, and the funds were illegally obtained for personal use by the Medicaid beneficiary.

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