2021

Office of the Medicaid Inspector General

Calendar Year 2021 Annual Report
January 1 – December 31, 2021

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KANSAS
ATTORNEY GENERAL

DEREK SCHMIDT

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Letter from the Inspector General

February 7, 2022

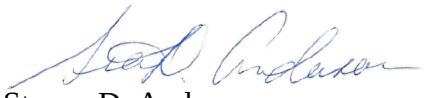
Dear Fellow Kansans:

It is our pleasure to submit the annual report of the Medicaid Inspector General within the Office of Attorney General Derek Schmidt for calendar year 2021. This report is issued in accordance with K.S.A. 75-7427(i) and is respectfully submitted to:

- The Citizens of the State of Kansas
- Governor Laura Kelly
- Members of the Kansas Senate Committee on Ways and Means
- Members of the Kansas House of Representatives Committee on Appropriations
- Kansas Department of Health and Environment Acting Secretary Janet Stanek
- Kansas Department for Aging and Disability Services Secretary Laura Howard
- Legislative Post Auditor Chris Clarke
- Kansas Attorney General Derek Schmidt

This report provides an overview of the Kansas Medicaid Inspector General's Office and describes the office's activities during calendar year 2021. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Medicaid Inspector General

Introduction

The Office of Medicaid Inspector General (OMIG) is charged with overseeing the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP). K.S.A. 75-7427(b)(1) states that the purpose of the OMIG is: "to establish a full-time program of audit, investigation and performance review to provide increased accountability, integrity and oversight . . . and to assist in improving agency and program operations and in deterring and identifying fraud, waste, abuse and illegal acts." The same statute requires the Medicaid inspector general to be "independent and free from political influence" in performing the duties of the position.

The OMIG is an independent division of the Kansas Attorney General's Office. The Medicaid inspector general reports directly to the attorney general. In accordance with K.S.A. 75-7427(b)(1), all budgeting, purchasing, related management functions and personnel are administered under the direction and supervision of the attorney general. In accordance with K.S.A. 75-7427(l), the scope, timing, and completion of all audits and investigations conducted by the OMIG shall be within the discretion of the Medicaid inspector general.

OMIG History

In 2007, Senate Bill 11 created the Office of Inspector General within the Kansas Health Policy Authority (KHPA). The original statutory provisions contained in that bill remain virtually unchanged today.

In 2011, Executive Reorganization Order No. 38 abolished the KHPA and transferred all powers, duties, and functions of the KHPA to the Division of Health Care Finance within the Kansas Department of Health and Environment (KDHE). The OMIG was transferred to KDHE as part of that Executive Reorganization Order.

In January 2014, the last Senate confirmed inspector general under KDHE left their position and the last OMIG staff member left in November 2014. This began a period of the OMIG being vacant until October 2018.

In 2017, Senate Bill 149 transferred the OMIG from KDHE to the attorney general's office effective June 1, 2017. On October 9, 2018, the Senate Confirmation Oversight Committee voted to authorize Sarah Fertig, the attorney general's first nominee for the Medicaid inspector general position, to exercise the powers of the office pending confirmation by the full Senate. Fertig was confirmed by the full Senate in January 2019.

Following Fertig's resignation from the position in July 2020, Attorney General Derek Schmidt nominated Steven Anderson to be the next Medicaid inspector general on January 21, 2021. On April 6, 2021, Anderson was confirmed as the new Medicaid inspector general by the Senate.

OMIG Staffing

Between January and June 2019, the OMIG had one staff member, the Medicaid inspector general. The OMIG hired an assistant Medicaid inspector general in June 2019 and a data analyst in February 2020.

The OMIG began the process of recruiting a new Medicaid inspector general in July 2020 due to the resignation of the former inspector general. In the interim, Attorney General Derek Schmidt appointed Jay Scott Emler (Deputy Attorney General/Chief Information Security Officer) to serve as the administrator for OMIG.

Steven Anderson was appointed on January 21, 2021, and confirmed on April 6, 2021.

A part time secretary was hired and started work on August 23, 2021. Approval for additional full time staff has been requested to enable the office to conduct a greater number of audits, reviews, and investigations.

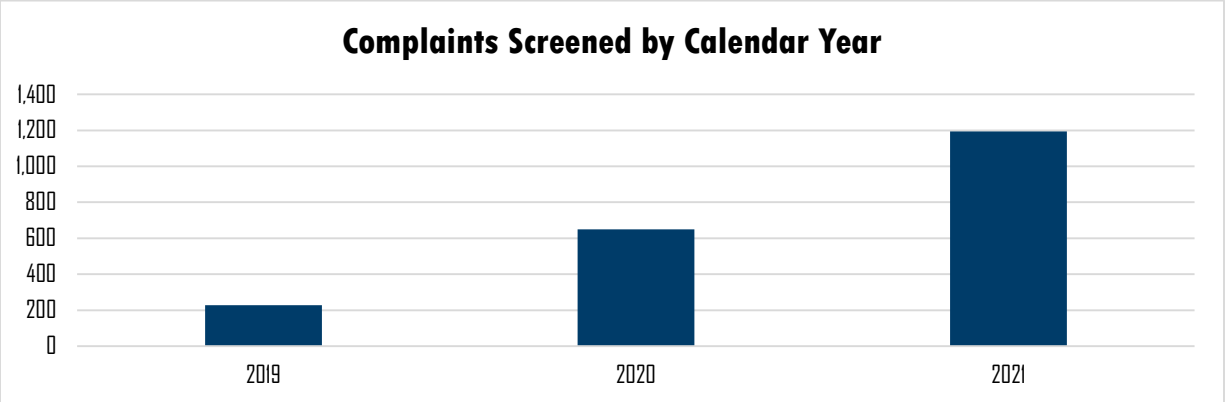
Summary of OMIG Activities

Detecting and Preventing Fraud, Waste, Abuse, and Illegal Acts

K.S.A. 75-7427(k)(1) requires the Medicaid inspector general to "make provision to solicit and receive reports of fraud, waste, abuse, and illegal acts." To that end, the attorney general's office created a dedicated email address, MedicaidIG@ag.ks.gov, that concerned citizens may use to submit such reports. The attorney general's office also offers an online form which can be used to report suspected fraud, waste, abuse, and illegal acts related to the programs within the OMIG's jurisdiction.

As noted in the previous 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. 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. The OMIG staff have received updated training on the case management system. Small tweaks to the system are still being planned; however, the overall system is up and running.

The OMIG continues to oversee an increasing number of 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). The majority of complaints received are submitted by the Kansas Department for Children and Families (DCF) and primarily allege beneficiary eligibility fraud. OMIG staff currently screens each complaint received for substance and jurisdiction. If staff determine there is a need for eligibility clarification, the complaint is forwarded to the KanCare Clearinghouse for review and possible follow-up. In CY 2019, the OMIG screened 227 complaints, which were primarily submitted by DCF. In CY 2020, the OMIG screened 650 complaints with 629 (97%) being submitted by DCF. In CY 2021, the OMIG screened 1,195 complaints, with 1,080 (90.4%) being submitted by DCF, nearly double the number of complaints handled in CY 2020.



The OMIG has also referred 33 cases to the attorney general's Medicaid Fraud and Abuse Division (MFAD), 33 cases to KDHE for Personal Care Attendant fraud, four referrals to

Managed Care Organizations to review for potential overpayment, and one case to the Financial Abuse and Litigation Division (FALD) for Medicaid Eligibility Fraud.

CY 2021 Oversight Activities

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is a standing committee of the Kansas State Legislature. The OMIG has ongoing interaction with the committee to ensure that policy makers are aware of the strengths and vulnerabilities in the Medicaid, MediKan, and SCHIP programs.

In CY 2021, the OMIG attended a total of four committee meetings. During each meeting, the OMIG presented reports from completed work and updates of the OMIG's current activities to the committee. Listed below are the dates of each meeting along with a short description of each activity that was presented to members of the committee.

ID	Date of Meeting	Subject	Type	Formal Report Issued	Report No.
1	02/19/21	MediKan being discontinued after 12-month lifetime limit	Review	No	N/A
2	04/22/21	MediKan review update	Review	No	N/A
3	09/22/21	Reporting fraud to the Clearing house	Review	Yes	22-01
		MediKan program overpayments	Review	Yes	22-02
		Capitation payments for deceased Medicaid recipients	Review	Yes	22-03
4	12/13/21	Update on HCBS audit	Audit	No	N/A

The OMIG released three reports in calendar year 2021. These reports, summarized below, can be accessed at https://ag.ks.gov/fraud-abuse/medicaid-inspector-general.

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. 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 the Medicaid Fraud and Abuse Division 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

A review of the MediKan program was conducted to determine if KDHE paid any medical claims on behalf of beneficiaries who have exceeded the 12-month lifetime maximum limit. The review identified 912 MediKan beneficiaries that had 13 or more months of eligibility during the 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 the review, KDHE staff began the process of removing 556 individuals that were identified as no longer eligible for MediKan for an estimated savings of $1,252,520 to the MediKan program.

We made the following recommendations:

1. KDHE management should work with the Kansas Eligibility Enforcement System (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 Kansas administrative regulations.

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

A review was conducted to determine if the 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 loaned the MCOs $1,534,043.17 at no interest. KDHE should review the matter and determine if it is feasible to recover these funds.

K.S.A. 75-7427(i) requires the inspector general to include the following information in this annual report:

Aggregate provider billing and payment information. The OMIG has obtained the following FY 2021 aggregate provider billing and payment information from KDHE. The amounts for Medicaid and SCHIP are rounded to the nearest dollar and include payments made to providers under both the fee-for-service and KanCare models.

Medicaid:

- Total Medicaid provider payments: $3,086,903,886.01

- Number of Medicaid provider claims: 12,395,602

MediKan:

- Total MediKan provider payments: $5,720,801.10
- Number of MediKan provider claims: 36,875

SCHIP:

- Total SCHIP provider payments: $92,919,202.84
- Number of SCHIP provider claims: 632,202

KanCare Capitation Payments:

- Total Medicaid managed care capitation payments: $3,928,940,931.00
- Total SCHIP managed care capitation payments: $125,783,758.00

The number of audits of Medicaid, MediKan, and SCHIP and the dollar savings, if any, resulting from those audits. No audits were completed in CY 2021; however, three reviews were completed and the OMIG released reports for each review, which are summarized in detail above. In the review of MediKan, Report 22-02, it is reported that an estimated savings of $1,252,520 resulted from removing 556 individuals that were no longer eligible for MediKan.

Health care provider sanctions, in the aggregate, including terminations and suspensions. No providers were sanctioned as a result of OMIG activities in CY 2021. In CY 2021, the OMIG referred 33 providers to the attorney general's Medicaid Fraud and Abuse division for possible prosecution. Criminal investigations were opened for each of those providers. The attorney general's Medicaid Fraud and Abuse Division informs us that those investigations are ongoing and have not yet resulted in sanctions. An additional group of 33 HCBS providers were referred to KDHE for potential overpayments totaling $23,460.69 for billing for services that were not provided. In CY 2021, $11,419.12 was collected from these providers by Sunflower. Overpayment collection is pending on the remaining $12,041.57 by Aetna and United Healthcare.

A detailed summary of the investigations undertaken in the previous fiscal year. During FY 2021, the OMIG focused the majority of its attention on audits and reviews. The OMIG also does not currently have a position authorized for an investigator to conduct investigations. However, the OMIG opened seven investigations in FY 2021, each of which concerned potential Medicaid eligibility fraud.

IG-21-000274: Allegation received that Medicaid beneficiary was not reporting the income of a household member and father of four children living in the household. Preliminary investigation confirmed that the Medicaid beneficiary provided false income information on eligibility application. The case was referred to the attorney general's Fraud and Abuse Litigation Division for further criminal investigation. Charges are currently pending with the Crawford County Attorney.

IG-21-000318: Allegation received that Medicaid beneficiary under reported income and would not be eligible for Medicaid. A review of documents provided with allegation indicated that Medicaid beneficiary had an income over $116,000. Investigation is ongoing.

IG-21-000454: Allegation received that Medicaid beneficiary owns several rental houses and has not reported this income. Investigation is ongoing.

IG-21-000458: Allegation received that Medicaid beneficiary lives with someone that makes more than $60,000 per year and does not report this income to KanCare as required. Investigation is ongoing.

IG-21-000531: Allegation received that Medicaid beneficiary provided false information concerning household income and composition. The Medicaid beneficiary was reportedly questioned about these details by Medicaid eligibility staff. During a recent hearing, Medicaid beneficiary testified that information previously provided concerning household composition and income were false. Investigation is ongoing.

IG-21-000558: Allegation received that someone had applied for Medicaid benefits for the reporting party without their consent. Our preliminary investigation determined that no application for Medicaid had been filed. Investigation is closed.

IG-21-000568: Allegation received that Medicaid beneficiary had filed for Medicaid benefits for a child that was not in their custody. Our preliminary investigation determined that the allegations were not supported and no Medicaid benefits had been requested for the child. Investigation is closed.

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