

2022

Office of the Medicaid Inspector General

Calendar Year 2022 Annual Report

January 1 - December 31, 2022

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KANSAS
ATTORNEY GENERAL
KRIS W. KOBACH

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Letter from the Inspector General

March 23, 2023

Dear Fellow Kansans:

It is our pleasure to submit the annual report of the Medicaid Inspector General within the Office of Attorney General Kris W. Kobach for calendar year 2022. 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 Secretary Janet Stanek
- Kansas Department for Aging and Disability Services Secretary Laura Howard
- Legislative Post Auditor Chris Clarke
- Kansas Attorney General Kris W. Kobach

This report provides an overview of the Kansas Medicaid Inspector General's Office and describes the office's activities during calendar year 2022. 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. 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(1), the scope, timing, and completion of all audits and investigations conducted by the OMIG shall be within the discretion of the Medicaid inspector general.*

Mission Statement: Conduct audits, investigations, and performance reviews to increase accountability, integrity, and oversight of Medicaid, MediKan, and the State Children’s Health Insurance Program (SCHIP); assist in improving agency and program operations; and in deterring and identifying fraud, waste, abuse, and illegal acts.

Vision: Pursue positive changes in Kansas Medicaid related programs to better serve the citizens of Kansas.

Goals:

- Prevent, detect, and deter fraud, waste, abuse, and illegal acts
- Identify funds for recovery or recoupment
- Provide suggestions for improving efficiency, effectiveness, and integrity
- Identify and refer criminal/civil matters for prosecution
- Foster sound financial practices and reduction of improper payments

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, former 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. Anderson continues to serve as Medicaid inspector general.

OMIG Staffing

Between January and June 2019, the OMIG had one staff member, the Medicaid inspector general. The OMIG hired an auditor 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, former Attorney General Derek Schmidt appointed Jay Scott Emler (former 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, by the full Senate.

A part-time secretary was hired and started work on August 23, 2021.

The current authorized staffing for the OMIG is six full time equivalents (FTE). That consists of the IG, three auditors, an analyst, and a part-time secretary. Two auditors were added at the end of FY 2022 and employment began on June 13, 2022. They were a critical addition to the OMIG's ability to fulfill part of its core missions of auditing and performance reviews.

A request has been made for two full-time special agents and an analyst to conduct investigations of Medicaid eligibility fraud.

Summary of OMIG Activities

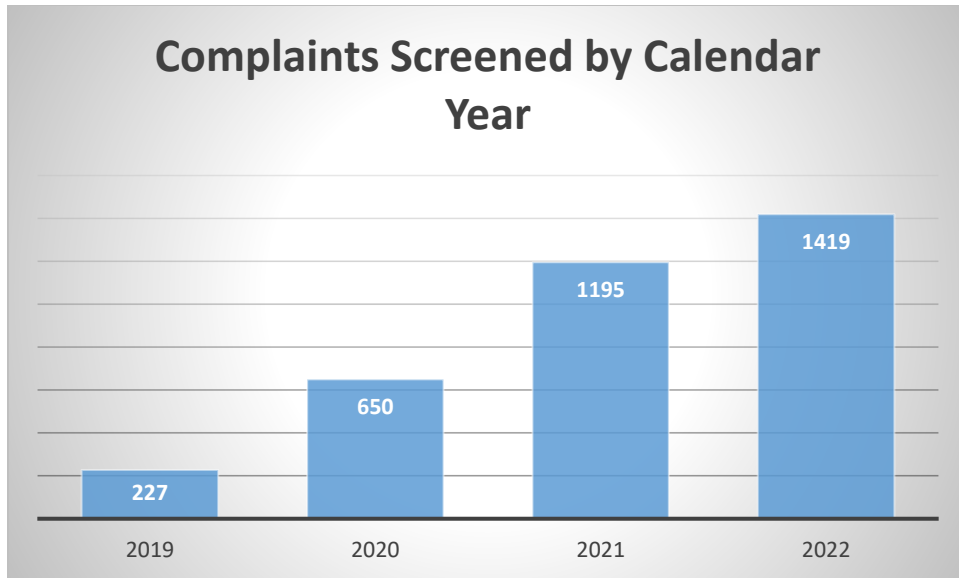
Detecting and Preventing Fraud, Waste, Abuse, and Illegal Acts

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.

K.S.A. 75-7427(k)(1) also required that the inspector general shall not disclose or make public the identity of any person or persons who provide such reports pursuant to this subsection unless such person or persons consent in writing to the disclosure of such person's identity. Disclosure of the identity of any person who makes a report pursuant to this subsection shall not be ordered as part of any administrative or judicial proceeding.

In cooperation with KDHE, the OMIG developed fraud, waste, and abuse awareness training that was provided to KDHE and contract employees. We completed six training sessions to a total of 196 employees. It is anticipated that the training will be offered on an annual basis to current employees and to all new KDHE and contract employees. The purpose of the training is to ensure employees are better prepared to identify fraud, waste, and abuse and how to report it.

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. In CY 2020, the OMIG screened 650 complaints. In CY 2021, the OMIG screened 1,195 complaints, nearly double the number of complaints handled in CY 2020. In CY 2022, the OMIG screened 1419 complaints.



The OMIG referred three cases to the attorney general’s Consumer Protection Division, 44 cases to the Medicaid Fraud and Abuse Division, and one case to the Financial Abuse and Litigation Division. OMIG also referred nine cases to KDHE for administrative action. A case was forwarded to the Health and Human Services Office of Inspector General due to suspected Medicare fraud and another case to the Social Security Administration Office of Inspector General for suspected false claims of disability.

CY 2022 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 2022, 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	02/04/22	Update on HCBS Audit	Audit	No	N/A

2	04/20/22	Audit Report of findings involving the Home and Community Based Services program and recommendations	Audit	Yes	22-04
3	09/26/22	Update on Eligibility Audit	Audit	No	N/A
		Start of Transitional Medical program Audit	Audit	No	N/A
		Start of Multiple Identifications Audit	Audit	No	N/A
4	11/02/22	Update on Eligibility Audit	Audit	No	N/A
		Update on Transitional Medical program Audit	Audit	No	N/A
		Update on Multiple Identifications Audit	Audit	No	N/A

The OMIG released one audit report in calendar year 2022. This report, summarized below, can be accessed at <https://ag.ks.gov/fraud-abuse/medicaid-inspector-general>.

Home and Community Based Services (HCBS), Audit Report 22-04

The audit detailed seven findings and made 17 recommendations for improvement to the HCBS program. The audit period ran from January 1, 2018 to April 30, 2021. Our audit determined that 2,854 beneficiaries did not have any HCBS waiver services claims filed on their behalf for a total of 12 or more months during the audit period. The amount of capitation payments made to Managed Care Organizations (MCOs) for the 2,854 beneficiaries identified during the audit period was \$193,253,420.91.

It is understood that some waiver participants would qualify for regular Medicaid based upon their income level. A thorough review of each beneficiary's Medicaid case would need to be made to determine the portion of the \$193,253,420.91 in capitation payments that could have been saved and not wasted. This is noteworthy due to the requirement that individuals on the waiver programs must use the service at least once a month to remain eligible. The lack of use should have been identified by the HCBS program managers and MCOs, which would have triggered an effort to have the individuals removed from the waiver program.

There is an apparent financial incentive for people to be on HCBS waivers, but do not actually receive HCBS from anyone. It was explained by KDHE and KDADS HCBS staff that if a person qualifies for an HCBS waiver, their income is not included with household income for calculation of financial eligibility. This allows a person that would not otherwise qualify for

Medicaid due to household income, to receive full Medicaid services, which includes pharmacy coverage.

It was observed that procedure code S5161 (Emergency Response System Service Admin Fee) is being billed on a monthly basis. We identified 560 beneficiaries who had one or more months of S5161 billed without any additional Medicaid claims. It should be expected that other Medicaid services would be billed in addition to procedure code S5161. Waiver services are to help beneficiaries who would otherwise be institutionalized in a nursing facility, hospital, or intermediate care facility.

Rental, not the purchase, of this equipment is covered. Maintenance of equipment is included as a part of the rental agreement. This service must be billed at a monthly rate. The average paid amount for the system on a monthly basis was \$32.02. The total amount of capitation payments made for these beneficiaries was \$8,057,560.85. If the medical alert equipment was paid for directly by the state via fee for service and not through the MCO system, the total expenditure would have been \$55,769.69.

The Kansas Assessment Management Information System (KAMIS) is the repository for functional assessment information. Five of the seven waivers assessments are maintained in KAMIS, to which KDADS contracted assessors have access. It was found that KAMIS only sends out a single notification that annual assessments are due. The system does not automatically generate reports that the annual assessment for a Medicaid beneficiary has not been completed. As discovered during this audit, some Medicaid beneficiaries go for several years without having annual assessment done and KAMIS does not alert KDADS staff to the problem.

In 2016, KDADS identified individuals who were currently receiving benefits as HCBS recipients who were no longer eligible for such services. The individuals were determined ineligible for HCBS services for a variety of reasons, including non-recipient of approved services for a specified period of time or failure to meet HCBS screening criteria at the last annual review.

Leadership staff at both KDADS and KDHE agreed that this should be addressed immediately. Because a large number of individuals have been identified over all HCBS waivers, special processes were implemented for a one-time clean up. Cases impacted by the project were identified on a series of reports issued by KDADS.

Staff were instructed to limit processing of any retroactive HCBS termination adjustments to a maximum of three months. Exceptions exist for changes involving a date of death or a change to another long term care arrangement. The policy is still in effect and the state's recoupment of capitation payments that were made for a person later determined to be ineligible is still limited to three months.

Beneficiaries who self-direct their services must choose a Financial Management Services (FMS) provider to help them perform payroll and employer-related duties. FMS is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. FMS providers are paid a monthly fee for

providing administrative and payroll services for beneficiaries. The average monthly fee paid during the audit period was \$118.00.

The amount of money paid out to FMS providers when no personal care services were provided was \$1,921,452.03 prior to start of the public health emergency (PHE), January 2018 to February 2020. There was \$1,373,140.99 paid out during the PHE, March 2020 to April 2021. This is a combined waste of \$3,294,593.02.

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 2022 aggregate provider billing and payment information from KDHE's website.

Total Medicaid provider payments: \$4,859,228,793.00

Total MediKan provider payments: \$4,970,725.00

Total SCHIP provider payments: \$133,115,885.00

KanCare Capitation Payments:

Total Medicaid managed care capitation payments: \$4,178,107,517.00

Total SCHIP managed care capitation payments: \$179,815,407.00

The number of audits of Medicaid, MediKan, and SCHIP and the dollar savings, if any, resulting from those audits. One audit was completed in CY 2022 and the OMIG released the report, which is summarized in detail above. In the audit, it is reported that an estimated savings of over \$8 million would result from switching payments for life alert systems from capitation payments to fee for service. We also identified \$3,294,593.02 in wasteful spending in the form of payments to FMS providers.

Health care provider sanctions, in the aggregate, including terminations and suspensions. No providers were sanctioned as a result of OMIG activities in CY 2022.

A detailed summary of the investigations undertaken in the previous fiscal year. During FY 2022, 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 or special agent to conduct investigations. However, the OMIG opened 25 investigations in FY 2022, with 18 of the investigations involving Medicaid eligibility fraud. The other cases involved Medicaid providers and Medicaid beneficiaries committing fraud involving the Medicaid program. One case involved the application of a KADAD's policy involving the evaluation of a person with a brain injury.

One investigation from FY 2021 is still open pending legal action. 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.

The following cases were all opened in FY 2022:

IG-21-000606: Allegation received that Medicaid beneficiary was living in Missouri for the past year, but continued to claim Kansas residency to maintain benefits. Investigation is ongoing.

IG-21-000608: Allegation received that Medicaid beneficiary was not reporting all their income and would not be eligible for Medicaid. Investigation determined that all income was reported and allegation was disproven. Case closed.

IG-21-000619: Allegation received that Medicaid beneficiary's funds were not being used to pay nursing home costs and were being taken by son for personal benefit. Investigation determined that funds were properly used and a spend down had occurred. Case closed.

IG-21-000728: Complainant reported that the ADRC in Wichita would not evaluate her husband for the brain injury waiver because she did not have a DPOA or court order for guardianship. Investigation determined ADRC had misinterpreted policy. A policy correction was made by KDADS and the situation was resolved. Case closed.

IG-21-000821: Allegation received that the owner of an adult transition home was suspected of fraud and possible exploitation of residents. Investigation is ongoing.

IG-21-000832: Allegation received that Medicaid beneficiary is committing fraud involving the HCBS program and does not actually need services. Investigation is ongoing.

IG-21-000848: Allegation received that Medicaid beneficiary is falsifying transportation reimbursements for her children's trips for medical appointments. Investigation is ongoing.

IG-21-001024: Allegation received that Medicaid beneficiary is falsely claiming to be disabled and is hiding financial assets that would render him ineligible for Medicaid and HCBS. Investigation is ongoing.

IG-21-001129: Allegation received that Medicaid beneficiary provided false information about household income, marriage status, living arrangements. The unreported husband is in the army. Investigation is ongoing.

IG-21-001163: Allegation received that Medicaid beneficiary was concealing sources of income and likely would not be eligible for Medicaid. Investigation found that beneficiary had unreported income. Report sent to KDHE to have the beneficiary added to the list of people to be removed from Medicaid after the PHE ends. Case closed.

IG-22-000055: Allegation received that a Medicaid provider had his medical license suspended by the Board of Healing Arts and continued to write prescriptions for people on Medicaid. Investigation is ongoing.

IG-22-000096: Allegation received that Medicaid beneficiary is providing false information about household income. If the income level was truthfully reported the beneficiary would not be eligible for Medicaid. Investigation is ongoing.

IG-22-000160: Allegation received that Medicaid beneficiary provided false income information in order to qualify family for Medicaid. The beneficiary allegedly owns over 1000 acres of land and makes over \$140,000 per year. Investigation is ongoing.

IG-22-000208: Allegation received that Medicaid beneficiary provided false information concerning their residency and now live in Missouri, but continue to receive KanCare. Investigation is ongoing.

IG-22-000238: Allegation received that Medicaid beneficiary is receiving benefits fraudulently due to concealing income that would place them over the financial threshold. Investigation is ongoing.

IG-22-000255: Allegation received that Medicaid beneficiary was providing false documents to support residency in Kansas while actually living in Texas. Investigation is ongoing.

IG-22-000297: Allegation received that Medicaid beneficiary was continuing to clock her PCA in under HCBS after he died. The allegation was reviewed and forwarded to the Medicaid Fraud and Abuse Division for prosecution. The beneficiary plead guilty to Medicaid Fraud and was sentenced to 12 months' probation, five hours per week of community service, and ordered to pay \$15,064.28 in restitution. Case closed.

IG-22-000316: Allegation received that Medicaid beneficiary provided false information about income level. The beneficiary was identified as committing food assistance fraud and removed from the program. Investigation is ongoing.

IG-22-000319: Allegation received that Medicaid beneficiary provided false information about her disability and did not disclose substantial income and assets. Investigation is ongoing.

IG-22-000359: Allegation received that Medicaid beneficiary provided false information about disability to be placed on HCBS and did not disclose his income. Preliminary investigation supported the allegation of fraud. Case file referred to SSA/OIG Disability Investigation Unit for action.

IG-22-000365: Allegation received that Medicaid beneficiary has PCA using a false name to provide PCA services under HCBS. Preliminary investigation supported the allegations. The case was referred to the Medicaid Fraud and Abuse Division for further investigation and prosecution.

IG-22-000439: Allegation received that Medicaid beneficiary is selling her prescription medications, medical supplies, and equipment. The beneficiary is also demanding their PCA split their paycheck with them and to clock in for more hours than actually worked. Investigation is ongoing.

IG-22-000452: Allegation received that Medicaid beneficiary provided false information about income and household composition. Preliminary investigation supported the allegations of unreported income and that the beneficiary was married and the father of two of the children in the household. After becoming aware of the investigation, the beneficiary voluntarily terminated Medicaid coverage. Investigation is ongoing.

IG-22-000599: Allegation received that Medicaid beneficiary provided false information concerning a pregnancy in order to be placed on Medicaid and food assistance. Preliminary investigation found that the beneficiary provided a forged letter from a doctor's office and phony picture of a positive pregnancy test to support her claim of being pregnant. She would not have been eligible for Medicaid or food assistance unless she was pregnant. The file has been submitted to the Fraud and Litigation Division for prosecution.

Office of the Medicaid Inspector General

120 SW 10th Ave, 2nd Floor

Topeka, KS 66612-1597

www.ag.ks.gov/medicaid-ig

