Office of Medicaid Inspector General

TransMed & HIPPS Audit Report

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Letter from the Inspector General

December 8, 2023

To: Attorney General Kris W. Kobach
Kansas Department of Health and Environment, Janet Stanek, Secretary

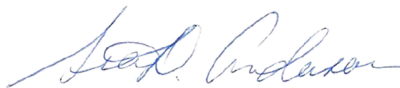
Members of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight:

Representative Brenda Landwehr, Vice-Chair	Senator Beverly Gossage, Chair
Representative Barbara Ballard	Senator Michael Fagg
Representative Will Carpenter	Senator Molly Baumgardner
Representative Susan Concannon	Senator Pat Pettey
Representative Emil Bergquist	Senator Mark Steffen
Representative Susan Ruiz	

This report contains observations and findings from our performance audit of the Kansas Department of Health and Environment's (KDHE) management of the Transitional Medical Program (TransMed) for the State of Kansas. This audit was completed in accordance with the Association of Inspectors General Principles and Standards for Offices of Inspector General: Quality Standards for Inspections, Evaluations, and Reviews, May 2014 Revision.

We greatly appreciate the cooperation and candor of KDHE staff throughout this audit. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Medicaid Inspector General

Executive Summary

The objectives of this audit were to determine the following:

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 that 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 KDHE tracks overpayments on an overpayment Excel spreadsheet tracker but takes no action to recoup overpayments from the MCO's 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.

We extrapolated **25%** from the original **2,322** beneficiaries, leaving **580** who potentially continue to be covered through TransMed. The average monthly payment per beneficiary in June 2023, was **$452.56**. The savings in capitation payments for terminating beneficiaries who have

remained on TransMed since prior to the PHE would be an estimated **$1,574,908.80** over a six-month period.

We identified a lack of consumer education when it comes to the TransMed program. Lack of consumer education presents a barrier to beneficiaries who are working towards gaining meaningful employment and higher wages, due to fear of losing Medicaid coverage. Lack of ease of use was identified on the KanCare website when an attempt was made to locate information on the TransMed program. A prior report issued by the OMIG yielded similar findings and recommendations. OMIG Report No: 22-01, included findings related to lack of ease of use of KDHE's public website and need for it to be updated.

We identified an estimated **116** eligibility determinations were manipulated by staff in a way that improperly benefited the beneficiary when extrapolating our **5%** error rate across the audit universe. We interviewed eligibility program staff who supported our observations by identifying oversight gaps pertaining to KEES system overrides and workarounds, resulting in a negative impact on eligibility determinations.

On August 31, 2023, a draft report of our preliminary observations, findings, and recommendations was forwarded to KDHE. KDHE provided responses to each section by adding comments to the end of this report and in a letter that is attached to the end of this report.

Introduction

The OMIG conducted a review of the TransMed program to determine if Kansas has paid any benefits on behalf of beneficiaries who have exceeded the TransMed 12-month continuous eligibility (CE) limit. Failure to timely discontinue TransMed coverage when a beneficiary becomes ineligible, can lead to state funds being used to cover expenses made for ineligible persons.

TransMed helps provide medical services for individuals who are no longer eligible for Caretaker Medical (CTM) due to an increase in his or her income and potentially could be eligible for transitional medical coverage. We determined the TransMed program is an estimated **$38,613,663.09 (or 7,053 beneficiaries)** program by pulling all active TransMed beneficiaries March 2022 through February 2023.

The TransMed program is designed to provide medical care for adults and children, for a period of 12 months, when the below criteria are met in accordance with Kansas Family Medical Assistance Manual (KFMAM), section 2230:

- The individual meets the definition of a caretaker (KFMAM 2110)
- The individual received CTM coverage in the month prior to the month of determination
- The individual has in increase in their earned income since the last determination
- The income of the Individual Budget Unit (IBU) for the individual exceeds the CTM limits

Transitional Medical Program (TransMed)

The TransMed program is available to caretakers and other individuals for a period not to exceed 12 months when certain eligibility provisions are met. Increases in the amount of earned income will not impact eligibility for TransMed recipients. When a reduction of income is reported, eligibility shall be assessed to determine if the income is again with the limits of Caretaker Medical (CTM). (KFMAM 2230.03)

Establishing TransMed for other household members occurs at the time of application, or when a Medicaid beneficiary is discontinued from coverage under another program. Household members of an individual approved for TransMed are also eligible for TransMed when an individual is not eligible for any other Medicaid program and the individual’s IBU includes the caretaker who originally qualified for TransMed. If a household member is found eligible at the time of the initial TransMed determination, a period of 12 months of coverage is provided. If a household member is being added to an already established TransMed program, coverage is provided through the end of the already established period. However, such person shall not be

granted coverage for more than three months prior to the month of request and must be a member of the IBU and residing in the household during the prior three months.

Children qualify for TransMed coverage if they live with a TransMed eligible parent or caretaker relative and the child is not eligible for the Infants and Children under Age 19 group per C.F.R. §435.118.

Beneficiaries approved for TransMed coverage are continuously eligible for up to 12 months of coverage with one exception. When a reduction of income is reported, eligibility staff shall assess the case to determine if income is again within the limits of CTM. If the individual meets eligibility requirements for CTM, the coverage shall be changed from TransMed to CTM.

Caretaker Medical Program

The Caretaker Medical Program is available for individuals who meet the definition of a caretaker and whose countable income does not exceed 38% of the federal poverty level. To meet this definition, a child must be living in the home with a caretaker. KFMAM Policy No: 2110.01 defines relationship scenarios that fit under the CTM umbrella. All children must be under nineteen years of age to be considered a child for CTM purposes. The child may be considered a child through the month he or she turns nineteen.

As a condition of eligibility in the CTM program, the caretaker who is receiving assistance shall cooperate with the Child Support Services (CSS) division of the Kansas Department of Children and Families (DCF). At the time of initial application, it is assumed that the caretaker will cooperate with CSS.

Health Insurance Premium Payment System (HIPPS)

Administrative regulation 42 U.S.C. 1396e(a) through (e), authorizes the establishment of the Kansas Health Insurance Premium Payment System (HIPPS) program to provide health insurance coverage outside of Medicaid-to-Medicaid enrollees and any family member of Medicaid enrollees, if the department determines that HIPPS program participation would be cost-effective for the State of Kansas.

HIPPS permits states to purchase employer-based health insurance for all clients who have access to such coverage and if it is determined to be cost-effective per KFMAM Policy No: 02540. The purchase of group health insurance is to be determined as cost-effective if the cost of paying for such coverage is expected to be less than the person's or family's medical expenditures that would otherwise be paid by the state Medicaid agency. Where cost-effectiveness is shown, the beneficiary is required to enroll for such coverage and the state would be responsible for paying the cost of the insurance for the client and all Medicaid or Median eligible family members, including the premiums, deductibles, co-insurance, and other cost-sharing obligations.

Once a completed referral is received by the State Fiscal Agent from the individual or State specialist and the availability of coverage is established, the Fiscal Agent contacts employers and insurance companies to determine cost, enrollment restrictions and any restrictions on pre-existing conditions. This information will be used to determine cost-effectiveness. Based on this analysis, including both automated and manual procedures conducted by the HIPPS Unit, the coverage will be either approved or denied for health insurance purchase. Medicaid beneficiaries, including those on the TransMed program, are subject to the HIPPS referral process, if at least one family member is working.

Information provided by KDHE, showed savings for State Fiscal Year (SFY) 2022, for the HIPPS program was **$10,969,199.65**. This figure represents all Medicaid programs for a total of 752 families that were enrolled in the HIPPS program for SFY 2022.

Audit Scope and Objectives

Our objectives were to obtain sufficient evidence to answer the following questions:

1. Does KDHE have an effective system for processing and tracking determinations of Medicaid beneficiaries on the TransMed program?

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

3. Are there Medicaid beneficiaries on the TransMed program that have been in the program for longer than allowed by governing regulations?

The scope of our audit included all beneficiaries who had 13 months or more of continuous enrollment in the TransMed program from January 1, 2019 through December 31, 2021.

Applicable Laws and Policies

Transitional Medical Program (TransMed)
As described in section 1925 of the Social Security Act, TransMed provides up to 12 months of continuous Medicaid coverage to families who become ineligible for Medicaid due to earnings or hours of employment. The protection is designed to encourage individuals to work more and earn more without the disincentive of losing Medicaid coverage. Children are covered through the month of their nineteenth birthday. States are mandated to provide TransMed coverage.

Effective April 16, 2015, Section 1925 42 U.S.C. 1396r–6 of the Social Security Act mandates two extended eligibility periods for TransMed – an "*initial six-month extension*" and an "*additional six-month extension.*" As described in section 1925(b) of the Act, the second six-month extension includes additional requirements related to household income, premium payments, and reporting. States may eliminate these additional requirements by adopting a single TransMed extension period of 12 months in lieu of two six-month periods.

Kansas Statute 39-7,122 was repealed July 1, 2015. It stated, "*The transitional medical care services shall be provided for not to exceed 24 months after a recipient of assistance becomes employed and is no longer eligible for cash assistance unless the recipient is otherwise covered by health benefits. Such transitional medical care services shall be provided with a 25% copayment requirement during the 13th month through the 24th month.*"

Kansas adopted a single TransMed period of 12 months in lieu of two six-month periods after K.S.A 39-7,122 was repealed on July 1, 2015, after the passage of Section 1925 42 U.S.C. 1396r-6.

Under the authority of section 1115(a)(1) of the Social Security Act, waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Kansas to implement KanCare Medicaid section 1115 demonstration for State plan populations and individuals eligible under the current section 1915(c) waivers. Under the act, TransMed is a State plan mandatory for Medicaid eligibility populations under the 1915(c) waivers. Kansas has authority to operate the TransMed program as a 12-month program in lieu of two six-month periods of eligibility. The current 1115 demonstration waiver is effective January 2019 through December 2023.

To qualify for TransMed, a child must:

- Live with a TransMed-eligible parent/caretaker relative (42 C.F.R. §435.4)
- Not be eligible for the Infants and Children under Age 19 eligibility group (42 C.F.R. §435.118).

A state’s income standard for children is frequently higher than its income standard for parents, caretakers, or relatives. When a parent, caretaker, or relative transitions to TransMed, the individual’s children often remain eligible in the Infants and Children under age 19 group. If a child loses eligibility for the infants and children group at any time during the parent, caretaker, or relative’s eligibility period, that child is eligible for and enrolled in TransMed for the remainder of the 12-month established coverage. Additionally, any children born or adopted into the family, and any children returning home after a period of absence, also qualify for the remainder of the parent, caretaker, or relative’s period of coverage.

TransMed continuous eligibility begins with the first month of eligibility in the current review period. Beneficiaries remain eligible for 12 months from the start of their first month of eligibility, through the month of their next review period. Reported income changes can trigger an eligibility redetermination prior to an established review that can result in CTM approval, which would result in a new 12-month CE period for CTM as outlined in KFMAM Policy No: 2312.01.

Review Processing

Concluding the expiration of the review period, entitlement of benefits ends. Further eligibility must be determined though the review process in accordance with KFMAM Policy No: 07300 and 42 C.F.R. §435.916. “*The purpose of the review is to give the client an opportunity to bring to the attention of the agency his or her needs and to give the agency an opportunity to re-examine all factors of eligibility in order to ensure coverage and eligibility levels continue to be correct.*”

The passive review process is an *ex parte* review process that is automatically completed by the Kansas Eligibility Enforcement System (KEES) when a beneficiary is up for their review. In accordance with 42 C.F.R. §435.916(a)(3) and (b) §457.343, if sufficient information is not available to complete a redetermination through the passive review process, or if the state has information indicating the beneficiary may be ineligible, the state Medicaid agency must provide the Medicaid beneficiary with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility.

Prepopulated reviews can be required for TransMed beneficiaries who are approaching the 12-month review due date, if certain data cannot be determined, such as income level. The prepopulated review will determine if the beneficiary is eligible to receive any other Medicaid service or if they should be terminated.

HIPPS Program Eligibility

For TransMed-eligible individuals who have access to employer-sponsored coverage, states have the option to pay the family’s premiums and cost sharing for such coverage. States that elect this option may require enrollment in employer-sponsored coverage. Kansas has elected this option utilizing the HIPPS model.

KEES generates a daily report of leads, on qualified or active Medicaid recipients, through a review conducted within the KEES system that has detected income and found an employer or from those who have self-reported a job.

KEES sends a daily report of HIPPS referral leads to state fiscal agent, Gainwell Technologies. HIPPS analysts at Gainwell review the KEES referral report throughout the month. A HIPPS record is created for any beneficiary who has an employer that provides health insurance. A questionnaire is mailed out to the employer requesting policy information.

The employer has 60 days to respond to the policy questionnaire with at least two request letters going out within the 60-day window. The employer may respond to questionnaires after the 60-day response period has lapsed. The HIPPS analyst reviews the returned information from the employer and reopens the case for cost analysis.

If the employer does not respond, the record that was created for the HIPPS program is deemed invalid and is maintained in the system. If the employer does respond, a Gainwell analyst will utilize actuarial data provided by KDHE, the person's cost of care, how inclusive the policy is, and if the policyholder resides in the household to determine HIPPS coverage. Once the state decides a policy is cost effective, the state will purchase the policy. HIPPS eligibility is reassessed every six months to ensure the policy remains cost effective.

Purchased policies provide cost savings to the state versus the higher monthly capitation payment that would have been expended through Medicaid managed care.

COVID-19 Federal Public Health Emergency (PHE)
As described in KDHE Policy No: 2020-03-01, beginning with the issuance of the directive and continuing throughout the scope of the PHE, eligibility discontinuance will be suspended in all instances except for out-of-state residency, voluntary withdrawal, incarceration, and death.
In accordance with 42 C.F.R. §433.400, states must maintain the Medicaid enrollment of "validly enrolled beneficiaries" in one of the three tiers of coverage. Such enrollment must be maintained through the end of the month in which the PHE for COVID-19 ends. States may terminate individuals not validly enrolled, after providing advanced notice and fair hearing rights per 42 C.F.R. §431(E).

As described in KDHE Policy No: 2020-11-01, coverage found to be incorrectly approved due to agency error as defined in Kansas Economic and Employment Services Manual (KEESM) 11121.1 and KFMAM 8312 should be closed in the soonest available month, allowing for timely notice. Discontinuance of coverage due to agency error is allowed for the following:

1. Eligibility determinations based on applications submitted on or after March 18, 2020
2. Initial determinations made for applications submitted prior to March 18, 2020

3. Renewals or redeterminations made prior to March 18, 2020

Likewise, active coverage resulting from fraud, as evidenced by a fraud conviction, or finding of beneficiary abuse as established by a federal district court, should also be terminated in the soonest available month. Timely notice is not required in these situations.

Note: Discontinuance continues to be suspended in the case of client error as defined in the KEESM 11120 and KFMAM 8313. This would include typical fraud referrals where a conviction has not been established. Instances of client error which may result in a claim include, but are not limited to, the following:

1. Non-willful withholding of information from a one-time failure on the part of a client to report a change timely to the KanCare Clearinghouse, affecting eligibility status.
2. Willful withholding of information such as failure to report changes, incorrect medical coverage payments and misstating information to the KanCare Clearinghouse.

Applicable Federal and State Policies
Social Security Act:
Sec. 408. [42 U.S.C. 608] (a) 408(a)(11)(A),
Sec. 1902. [42 U.S.C. 1396a] (a) (a)(10)(A)(i)(I), (a)(e), (a)(52), (e)(1),
Sec. 1925. [42 U.S.C. 1396r–6] (a) Initial 6-Month Extension (a)(b)
Sec. 1931. [42 U.S.C. 1396u-1] 1931(c)(2)

Code of Federal Regulations (CFR):
42 C.F.R. §433.400
42 C.F.R. §435.110
42 C.F.R. §435.112
42 C.F.R. §435.4 “Caretaker relative”
42 C.F.R. §435.4 “Dependent child”
42 C.F.R. §435.916
42 C.F.R. §455.16

Kansas Economic and Employment Service Manual (KEESM):
KEESM 11120

Kansas Family Medical Assistance Manual (KFMAM):
KFMAM 2110
KFMAM 2230
KFMAM 2300
KFMAM 02540

KFMAM 7300

KFMAM 7441
KFMAM 8313

KDHE Policy Directives:
PD 2020-03-01
PM 2020-11-01
PM 2022-07-01

Methodology

To accomplish our objectives, we performed the following tasks:

1) Communicated with agency officials and various staff members from KDHE to gain understanding of the TransMed program.

2) Reviewed Federal and State laws, regulations, business practices, policies, procedures, contracts, or other standards that were relevant to the audit objectives.

3) Utilized KDHE reporting and analytics tools in the Kansas Medicaid Modular System (KMMS), identifying **9,322** beneficiaries who were enrolled in TransMed during our audit period and have been enrolled in the TransMed program for 13 months or more of continuous coverage. Enrollment and capitation data were extracted through June 2022. The following data points were extracted:

- The beneficiary identification and case number of the beneficiary enrolled in the TransMed program.
- The first and last months of TransMed enrollment, for any members with 13 months or more of continous coverage.
- The 13th month of TransMed enrollment for each beneficiary during the audit period.
- Individual subtype groups and population descriptions for each beneficiary.
- Number of beneficiaries reviewed for HIPPS, number of purchased policies and dates corresponding with TransMed enrollment dates.
- Capitation data, per member, per month.
- Capitation overage amounts for each beneficiary that had 13 months or more of continuous coverage during the audit period.

4) Created a sampling population for analysis:

a) <u>Analysis 1 – 5.5% Sample of beneficiaries with a sum of 13 months or more of continuous TransMed Coverage:</u>

Beneficiaries identified who were enrolled in TransMed for 13 months or more of continuous coverage during the audit period. We did not cite overage errors on beneficiaries who were given extended coverage throughout the extension of the Federal PHE. Beneficiaries whose eligibility was extended throughout the extension of the PHE were only reviewed for eligibility compliance, such as timely and accurate reviews and determinations.

- Identified **9,332** beneficiaries who had TransMed coverage during our audit period of January 1, 2019 to December 31, 2021, and 13 months or more of continuous TransMed coverage.
- Filtered **2,322** out of **9,332** beneficiaries identified to include beneficiaries who had 13 months or more of continuous TransMed coverage prior to the start of the COVID-19 PHE.
- A **5.5%** random sample, consisting of **128** beneficiaries, was reviewed, and tested for eligibility discrepancies and overpayments.
- Conducted controls and compliance testing using KMMS and KEES. KEES was used to identify eligibility related concerns. KMMS was used to identify the number of months beneficiaries went over on the TransMed program, past the 12-month limit.

b) Analysis 2 – HIPPS History
Beneficiaries identified in the sample who were referred to the HIPPS program.

- Identified beneficiaries sampled, who had a recorded referral in HIPPS.
- Identified beneficiaries sampled, who had a recorded referral in HIPPS that coincided with the TransMed enrollment period.

5) Reported draft findings and recommendations to KDHE leadership and reviewed the agency's response.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Analysis 1 Audit Results – Beneficiaries with 13 months or more of continuous TransMed coverage

We identified **9,322** beneficiaries as having 13 months or more of continuous TransMed during the established OMIG audit period of January 1, 2019, through December 31, 2021. Our audit results were filtered down to include individuals with 13 months or more of continuous coverage before the start of the March 2020 COVID-19 Public Health Emergency, which left **2,322** beneficiaries. We took those results and constructed a **5.5%** percent random sample to check for eligibility compliance which accounted for a total sample of **128** beneficiaries.

We found that **57** or **45%** of the sampled **128** beneficiaries had capitation payments made on their behalf totaling of **$899,989.09**, after the 12-month Continuous Eligibility (CE) period had lapsed and prior to the March 2020PHE. The average monthly overage per beneficiary who had 13 months or more of continuous eligibility was **38 months**, meaning 38 additional months of coverage was provided to ineligible beneficiaries. 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.

We determined that **$16,326,364.59** in capitation payments were wasted on ineligible persons when extrapolating the **45%** error rate across the audit universe of **2,322** TransMed beneficiaries, during the audit period (January 1, 2019 through December 31, 2021). These beneficiaries had open coverage through January 2021 or are currently still receiving coverage through June 2022. These cases are summarized in the table below, with monthly overage figures and amounts calculated through June 2022.

***Please Note:** Each capitation figure equals one random beneficiary we sampled from the household. For example, TransMed Testing Identification #1 has two members within the household who were on the TransMed program for 13 months or more of continuous coverage. The sum of each capitation only accounts for one member per, household. The total expended capitation for all members is reflected through extrapolating the total error rate (**45%**) with the audit universe (**2,322** beneficiaries), totaling **$16,326,364.59** in expended capitation payments:

TransMed Testing Bene_ID	Affected Members, per Case Number	TransMed Begin Date	TransMed End Date	Extra Months of Coverage	Sum of Capitation (per sampled bene ID)
1	2	*01/01/17*	*Currently Active*	***54***	***$27,686.52***
2	2	*02/01/19*	*02/01/20*	***1***	***$520.67***
3	*1*	*02/01/17*	*01/01/20*	***55***	***$8,347.66***
4	*3*	*01/01/16*	*03/01/22*	***68***	***$32,846.52***

TransMed Testing Bene_ID	Affected Members, per Case Number	TransMed Begin Date	TransMed End Date	Extra Months of Coverage	Sum of Capitation (per sampled bene ID)
5	*1*	*07/01/16*	*Currently Active*	***60***	***$29,348.64***
8	*1*	*12/01/18*	*01/01/20*	***14***	***$597.91***
9	*1*	*05/01/17*	*01/01/20*	***21***	***$11,375.09***
10	*1*	*01/01/19*	*Currently Active*	***30***	***$5,663.24***
11	*3*	*03/01/18*	*01/01/20*	***11***	***$2,099.94***
12	*5*	*02/01/16*	*04/01/20*	***33***	***$18,896.93***
14	*5*	*04/01/16*	*01/01/20*	***34***	***$6,939.18***
16	*4*	*01/01/15*	*04/01/22*	***76***	***$38,591.79***
22	*3*	*07/01/17*	*Currently Active*	***48***	***$9,467.88***
23	*1*	*12/01/16*	*02/01/20*	***38***	***$14,678.22***
30	*1*	*12/01/18*	*Currently Active*	***31***	***$15,505.30***
31	*1*	*11/01/18*	*12/01/20*	***14***	***$7,282.14***
34	*1*	*04/01/19*	*10/01/21*	***14***	***$6,947.34***
37	*2*	*07/01/15*	*Currently Active*	***72***	***$39,586.38***
39	*1*	*06/01/17*	*01/01/20*	***20***	***$10,390.97***
40	*2*	*03/01/18*	*Currently Active*	***40***	***$23,362.36***
42	*1*	*07/01/15*	*Currently Active*	***72***	***$34,126.29***
44	*2*	*08/01/14*	*Currently Active*	***83***	***$15,662.64***
45	*2*	*12/01/16*	*02/01/20*	***27***	***$14,465.11***
50	*4*	*12/01/16*	*03/01/20*	***28***	***$14,650.08***
51	*1*	*11/01/16*	*Currently Active*	***56***	***$28,517.58***
53	*2*	*05/01/17*	*Currently Active*	***50***	***$29,288.46***
56	*1*	*08/01/17*	*01/01/20*	***18***	***$9,982.21***
58	*2*	*04/01/17*	*01/10/20*	***22***	***$11,433.44***
62	*2*	*12/01/16*	*02/01/20*	***27***	***$13,539.45***
64	*1*	*04/01/17*	*01/01/20*	***22***	***$11,433.44***
65	*5*	*12/01/16*	*Currently Active*	***55***	***$17,560.61***

TransMed Testing Bene_ID	Affected Members, per Case Number	TransMed Begin Date	TransMed End Date	Extra Months of Coverage	Sum of Capitation (per sampled bene ID)
68	1	09/01/16	08/01/21	48	$25,416.30
69	1	08/01/17	01/01/20	18	$3,832.55
74	1	05/01/17	Currently Active	50	$26,678.18
82	2	09/01/15	03/01/20	43	$7,795.83
84	1	03/01/18	01/01/20	11	$6,638.81
85	2	11/01/16	02/01/21	40	$20,192.97
87	1	01/01/17	Currently Active	54	$27,781.23
89	2	01/01/16	03/01/20	39	$8,122.59
90	1	02/01/19	02/01/20	1	$520.16
92	2	11/01/15	01/01/22	63	$30,410.39
93	1	12/01/16	03/01/20	39	$14,409.70
94	1	04/01/17	01/01/20	22	$12,156.99
97	3	11/01/17	02/01/20	16	$9,743.66
99	2	03/01/18	01/01/20	11	$6,958.55
100	1	10/01/17	02/01/20	16	$8,879.33
109	1	05/01/16	04/01/21	48	$28,442.33
111	1	02/01/19	03/01/20	3	$532.39
112	1	11/01/15	Currently Active	66	$35,916.20
113	3	03/01/17	Currently Active	58	$11,206.49
114	2	09/01/16	Currently Active	58	$11,373.84
116	1	02/01/19	02/01/20	1	$614.64
119	1	11/01/17	12/01/21	48	$26,465.80
120	2	02/01/19	09/01/19	1	$204.74
123	1	01/01/17	Currently Active	65	$27,298.47
125	1	05/01/16	09/01/21	64	$27,719.79
127	2	10/01/17	Currently Active	43	$9,883.17
				Total	$899,989.09

Result #1: TransMed Program Discontinuation

We determined that **$16,326,364.59** in estimated capitation payment overages were wasted on ineligible persons after their 12 months of coverage had ended and should not have continued to receive TransMed coverage. We estimated that **1,045** or **45%** of beneficiaries received unauthorized coverage after their 12 months of continuous eligibility expired when extrapolating the **45%** error rate across our audit universe of **2,322**. Please note, unauthorized coverage started prior to the March 2020 PHE.

In accordance with 42 C.F.R. §433.400, states must maintain the Medicaid enrollment of "validly enrolled beneficiaries" in one of the three tiers of coverage. Such enrollment must be maintained through the end of the month in which the PHE for COVID-19 ends. **States may terminate individuals not validly enrolled**, after providing advanced notice and fair hearing rights per 42 C.F.R. §431(E). Requirements under §433.400 state a beneficiary is not validly enrolled if the state Medicaid agency determines that:

1. The determination of eligibility was incorrect at the time it was made due to agency error.
2. Eligibility was erroneously granted due to beneficiary fraud for which the beneficiary has been convicted of fraud or abuse as determined by the agency with existing regulations outlined in C.F.R. §455.16.

KDHE released Policy No: 2020-11-01 in response to §433.400, mandating discontinuance of coverage due to agency error is allowed for the following:

1. Eligibility determination based on applications submitted on or after March 18, 2020
2. Initial determinations made for applications submitted prior to March 18, 2020
3. Renewals or redeterminations made prior to March 18, 2020

Based upon current CMS guidance and KDHE policy, these beneficiaries should immediately be removed from the system.

Result #2: Eligibility Reviews

We found that **53** or **41%** beneficiaries out of **128** households reviewed were identified to have received TransMed coverage where a review had not been completed on the household in 12 months or more in accordance with KFMAM Policy No: 7441. This means an estimated **952** additional household members went unreviewed when extrapolating the **41%** error rate across our audit universe. These households received extended Medicaid coverage, which led to State and Federal funds being used to cover expenses made for ineligible persons.

We identified numerous households that went without a review for several years prior to the declaration of the PHE. Out of the **53** review errors identified in our sample, over **50%** of the affected beneficiaries had gone without a review since the 2015-2019 timeframe.
Children who live with a TransMed eligible parent accounted for nearly half of those we identified as going without a review for several years. Children were either receiving CTM, Poverty Level or CHIP coverage. These children received eligibility in error because accounts were unreviewed for multiple years. Children who have TransMed eligible parents must be monitored closely since the caretaker is over income limits. Children of TransMed eligible caregivers typically qualify for TransMed and CHIP with a possible monthly client obligation.

We interviewed KDHE eligibility program staff over the TransMed program. We selected nine program staff who were familiar with the TransMed program. Program staff noted there was an identified backlog in reviews under Governor Brownback's Executive Reorganization Order No: 43, which transferred all eligibility determinations and services under Title XIX from the Department of Children and Families (DCF) to the Kansas Department of Health and Environment (KDHE), effective January 1, 2016. Program staff were surprised to learn **41%** of our sampled population identified beneficiaries who have gone unreviewed for five or more years. Each person interviewed stated KEES should be automatically triggering passive and prepopulated reviews throughout the entire Medicaid population when a beneficiary is approaching their 12-month review period.

Result #3: PHE Coverage Extension

We determined that only **43** or **33%** of beneficiaries out of **128** were identified as receiving appropriate continuous eligibility extending beyond 12 months, due to the Federal PHE.

KDHE should prioritize these cases Post-PHE and immediately discontinue ineligible persons who were previously extended due to the PHE.

Result #4: Eligibility Determinations

We determined that **26** or **20%** of beneficiaries out of **128** were identified to have received an incorrect TransMed program determination per KFMAM Policy No: 02230.
This means an estimated **465** beneficiaries received incorrect eligibility determination when extrapolating the **20%** error rate across our universe.

We identified beneficiaries who received extended TransMed coverage or were moved to another Medicaid program. When a TransMed recipient moves to another Medicaid program, typically CTM, KDHE has to verify a reported drop in income or loss of a job. TransMed recipients can move off of TransMed during an active CE period if KDHE verifies changes in eligibility status.

We identified **233** TransMed beneficiaries who were moved from TransMed back to CTM with no recorded drop in income, loss of a job, or any other noticeable change within the household. During our review, over **15%** of the determination errors were related to eligibility workers approving incorrect program eligibility. Examples of determination errors identified include the following:

1. Switching TransMed recipients to CTM during the PHE
2. Switching TransMed recipients at the end of their 12-month eligibility period back to CTM for one month, then switching the recipient back to TransMed for a new set of 12 months of eligibility
3. Erroneous TransMed CE limit overrides
4. Erroneous program aid code overrides
5. Ineligible move from TransMed to CTM
6. Ineligible TransMed coverage for eligible CTM beneficiaries
7. Children receiving TransMed in error when they were eligible for Poverty Level or CHIP coverage
8. Delayed TransMed eligibility for children and spouses of the originating TransMed beneficiary
9. Eligibility status not updated after a completed review
10. KEES/KMMS miscommunication regarding program type

We interviewed KDHE eligibility program staff over the TransMed program. Program staff shared the same concern pertaining to the TransMed program, lack of KDHE staff education. Program staff connected eligibility determination errors to lack of TransMed-specific training and absence of targeted TransMed quality reviews. Program staff admitted the TransMed program is often overlooked when it comes to training and quality oversight. Program Staff expressed their desire for KDHE to offer more training over the TransMed program. Eligibility determination errors have led to State and Federal funds being used to cover expenses for ineligible persons.

Result #5: KEES System Manipulation

We determined that **7** out of **128** eligibility determination reviews in our sample were manipulated by staff in a way that benefited the beneficiary.

We estimated **116** (**5%**) eligibility determinations were manipulated when extrapolating our 5% error rate across the audit universe. During our review, we interviewed eligibility program staff who identified oversight gaps pertaining to KEES system overrides and workarounds, resulting in a negative impact on eligibility determinations.

<u>KEES Automation</u>

KEES is designed to calculate accurate eligibility determinations based on relationship and tax filing status information that is entered by eligibility workers. If the data entry process is

managed correctly by eligibility workers, KEES automation reduces worker involvement during the eligibility determination and review process.

System Workarounds

If a system defect is identified, KEES management approves a work-around that is used by eligibility staff to circumvent the system defect during the eligibility process. Interviewed program staff stated workarounds are not common and are only used when there is a system defect that has not been corrected by KEES management. Workarounds are retired after system defects are resolved by management.

System Overrides

If a system defect is identified within KEES or special circumstances apply, eligibility workers can manually override determinations made by the KEES system.

Manual System Manipulation Frequency

Throughout our review, we identified significant override and work-around activity pertaining to the adjustment of CE limits and TransMed program determination changes. Observations made contradicted expertise provided by interviewed program staff. Program staff stated overrides and workarounds are **not** commonly performed by eligibility staff unless a system defect has been identified, which is a seldom occurrence. We found through analysis in KEES that system manipulation frequency occurs **5%** of the time accounting for **116** TransMed beneficiaries.

Eligibility program staff provided the OMIG with a TransMed Override Report. We found the report did not include specific information that could be used to address quality related concerns pertaining to override activity. The report demonstrated override frequency per eligibility worker but fell short of capturing case specific details including why the override was performed and if supervisory approval was required for each override. When asked if KDHE regularly tracks and approves system overrides, program staff acknowledged weaknesses related to oversight.

Case Action History Report

We conducted a deeper analysis regarding overrides and workarounds by pulling Case Action History Reports from KEES. Reports were pulled on cases that had higher eligibility error rates. Each report was reviewed to analyze the number of systems workarounds, overrides, and deletions that were completed by eligibility staff.

Out of the 14 sampled Medicaid Case Numbers reviewed, 2,139 “hidden field work-arounds” were identified. Some of the cases had less than 25 hidden field workarounds while other cases had 200 or more. OMIG identified concerns with system deletion and override activity in our sampled review. Some cases reviewed had as many as 4 system deletions, other cases had up to 28 system overrides. This reporting feature collects data entry starting in early 2019

through present day. Interviewed staff stated the reporting feature fails to distinguish why the eligibility worker conducted a system override or deletion, which concurred with OMIG's report analysis. Staff also expressed concern with the workers' level of access to conduct system manipulation such as overrides, deletions, and workarounds.

Result #6: Aid Codes

We determined that **3** beneficiaries out of **128** were identified to have received the wrong eligibility aid code during the TransMed eligibility period. The wrong aid codes contribute to skewed data and extended Medicaid coverage.

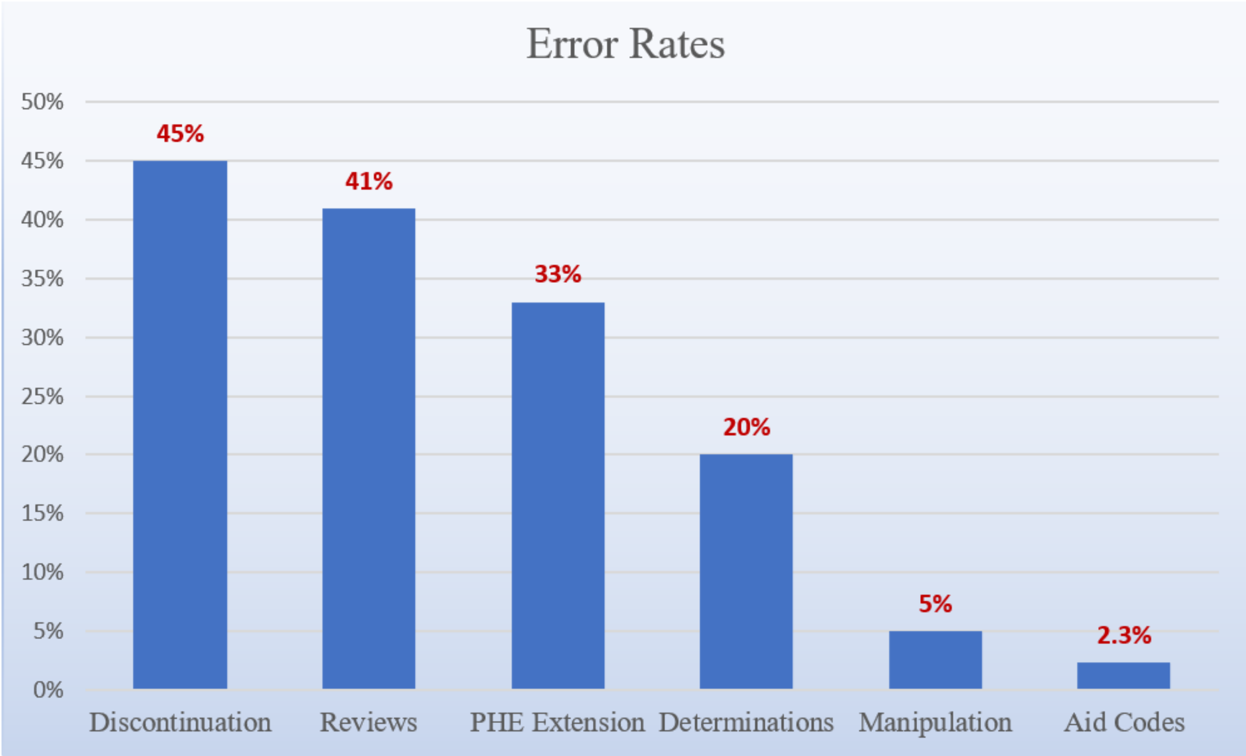
While our findings were low **2.3%**, KDHE should look into this issue across the entire Medicaid population. Eligibility staff who had expertise pertaining to aid codes, noted similar issues as those we found in our review.

Program staff identified weak oversight controls allowing eligibility workers to override aid codes that are populated by the KEES system. When staff override the KEES system, they are prompted to manually select an aid code from a long list of aid codes which are determined by demographics.

Program staff stated eligibility workers can override the system whenever they feel an override is warranted. Overrides do not require a supervisor's approval. Program staff acknowledged it is possible eligibility workers choose the incorrect aid code due to pressures involved with meeting performance goals related to eligibility processing. A general consensus was identified pertaining to KEES manipulation and lack of oversight related to manual manipulation.

Erroneous aid code assignments led to State and Federal funds being used to cover expenses made for ineligible persons. The erroneous aid codes skewed data demographics which are crucial when passing laws and regulations needed to increase quality of care for the most vulnerable Kansans.

Below, is a graph representing error rates we discovered during our TransMed eligibility review. Each error rate is described in results 1-6, listed above:



Analysis 2 Audit Results – HIPPS History

Using the sampled **5.5%** or **128** beneficiary sample, we reviewed how many beneficiaries were referred to the HIPPS program.

Result #1: Recorded HIPPS Referrals

We determined that **90** out of **128** beneficiaries sampled were identified to have a recorded referral within the HIPPS program.

Result #2: HIPPS Referrals Correlating to TransMed Start Dates

We determined that **44** out of **128** beneficiaries were identified as having a recorded referral within the HIPPS program that coincided with the TransMed enrollment period. Our review concluded that TransMed beneficiaries were correctly processed through the HIPPS enrollment process per KFMAM Policy No: 02540. We did note oversight and quality related concerns with the HIPPS referral process while conducting our review. We determined it was important to highlight these concerns so KDHE can take appropriate action.

<u>Referral Process:</u>

KDHE sends a monthly report of HIPPS referral leads to state fiscal agent, Gainwell Technologies. HIPPS analysts at Gainwell review the KDHE referral report once a month. A HIPPS record is created for beneficiaries who have an employer that provides health insurance and a questionnaire is mailed out to the employer requesting policy information. The employer has 60 days to respond to the policy questionnaire with at least two request letters going out within the 60-day window.

If the employer does not respond, the record that was created for the HIPPS program is deemed invalid and is maintained in the system. If the employer does respond, the Gainwell analyst will use actuarial data provided by the KDHE to determine if the policy is cost effective, which is reevaluated every six months.

Staff stated Gainwell does not have a high response rate from employers when it comes to returning letter requests. If the employer does not respond, the beneficiary record that was created for the HIPPS program is deemed invalid.

<u>Staff Observations:</u>

We learned through interviews that Gainwell staff reviews approximately **10%** of referrals worked throughout the calendar month, which are received daily from KEES, eliminating **90%** of referrals received. Gainwell staff cited they only review referrals that include employers who respond to request letters sent by the state to collect policy information and employers who are known to offer private insurance to their employees.

Staff stated retailors, restaurants, long-term care centers, and consignment stores are often rejected from review due to a history of these businesses not offering insurance to employees. While some employers have a long history of not offering insurance policies to the part time staff, benefits flucuate on a constant basis, especially during hiring crises. The availability of private insurance options are increasing in the workplace to meet the demand for higher wages and benefits. Additionally, staff stated referrals are not pursued if the employer historically does not respond to state letters requesting policy information. There is a high nonresponse rate related to state letters requesting insurance policy information. Automatically excluding these types of employers, based on prior experience, eliminated an estimated **90%** of referrals received per year.

Gainwell staff stated there are only two Full Time Employees (FTEs) designated to work monthly HIPPS referrals received from KEES. Gainwell received 366 referrals from KEES during the month of July 2022. Comparatively, a total of 752 families were enrolled in the HIPPS program for SFY 2022. The estimated monthly referral average is between 300-800 referrals per month.

Observations

Observation #1: Overpayments

During our review, we identified overpayments being made on TransMed beneficiaries who had 13 months or more of continuous coverage. According to KDHE program staff, overpayments are tracked on an Excel spreadsheet tracker. However, no action is taken to recoup overpayments from the MCOs or beneficiaries. Our analysis on recoupments for TransMed members with 13 months or more of continuous coverage, supported staffs' claims that KDHE overpayments are not collected.

No attempts have been made to conduct recoupment on capitation overpayments, which has led to State and Federal dollars being wasted. An estimated **$16,326,364.59** in capitation payment overages were identified as being wasted on ineligible persons who received 13 months or more of continuous TransMed coverage.

Recommendations:

1. **KDHE should strengthen provisions when it comes to the overpayment process. KDHE should place special provisions within the State contract to hold MCOs accountable when it comes to tracking TransMed beneficiary's continuous eligibility limits.**
2. **The MCOs should share tracking responsibility with the State of Kansas. Shared tracking responsibilities would reduce Federal and State dollars wasted.**

Observation #2: Pregnant Women

Postpartum Coverage Expansion

With the passing of the American Rescue Plan Act of 2021, under 42 U.S.C. 1396a(e), states now have the option to provide 12 months of extended postpartum coverage to individuals enrolled in either Medicaid or CHIP during their pregnancy. Postpartum coverage expansion was elected by the Kansas Legislature for CHIP and Medicaid plans retroactively effective April 1, 2022.

Throughout our review, we identified concerns with pregnant women who are receiving coverage within the TransMed program. In accordance with KFMAM Policy No: 2301 and KDHE-DHCF Policy No: 2022-07-01, "*eligibility for pregnant adults and minors shall continue through the twelfth calendar month following the month of birth of the child(ren) or termination.*" Prior to recent expansion, the postpartum period was two months of continued coverage following the month of birth or termination.

Program Regulation

TransMed is a 12-month program, which is not to be extended. TransMed beneficiaries who are pregnant and eligible to receive postpartum coverage would cause the beneficiary to remain on the TransMed program for longer than 12 continuous months. The Center for Medicare Medicaid Services (CMS) instructions addressed to State Health Officials (SHO

21-007) on December 7, 2021, outlined Federal eligibility regulation pertaining to 12-month postpartum guidelines. Beneficiaries who receive 12 months of postpartum coverage remain in the eligibility group in which they were enrolled in, including TransMed, throughout the duration of the pregnancy and through the duration of the 12-month postpartum period.

During our review, we interviewed KDHE program staff regarding concerns with pregnant women on the TransMed program. KDHE eligibility program staff stated KDHE has not dealt with pregnant women on the TransMed program, who fall under new postpartum continuous eligibility guidelines.

Recommendations:

1. **We recommend KDHE create a tracking tool for TransMed beneficiaires who fall under new postpartum guidelines. This will ensure continous eligibility guidelines under the TransMed program and postpartum guidelines do not exceed regulation and will prevent state and federal tax dollars from being wasted on ineleigble persons.**
2. **KDHE should consider tracking the postpartum report deligently, for a possible increase in Medicaid fraud. Now that postpartum continous eligibility has been expanded from 2 months to 12 months of postpartum coverage, OMIG is anticipating an increase in fraud pertaining to individiuals falsely claiming a status of pregnant on KanCare applications in order to falsely obtain Medicaid coverage.**

Observation #3: HIPPS Program Referrals

Our audit identified a lack of general oversight pertaining to the HIPPS referral process. This could lead to missed opportunities for the State of Kansas to purchase cost-effective policies.

During the end of SFY 2022, the annual savings reported for the HIPPS program was **$10,969,199.65**. This figure represents all Medicaid programs for a total of **752** families that were enrolled in the HIPPS program for SFY 2022.

The above figure represents an estimated 10% of the total HIPPS referral population. If Gainwell conducted a 100% review of all referrals received, the potential fiscal year cost savings could jump from **$10,969,199.65** to a substantially higher number.

Please note, not all referrals received are cost-effective, nor does it cost the same amount to insure each member. The below criteria have to be met in order for KDHE to purchase a policy:

- Associated policy must be cost effective
- The employer offers insurance
- The employer responds to the State’s request
- The referral source can’t be a babysitter, unknown entity, private or self-employed beneficiary.

Recommendations:

1. **We recommend KDHE enhance contractual guidelines with the State Fiscal Agent to ensure all HIPPS referrals are going through a 100% review to comply with cost-saving measures.**
2. **We recommend KDHE include a provision within the State Fiscal Agent contract that will increase the number of HIPPS Analysts from 2 FTEs to 3 FTEs. Increased analyst positions will help increase the amount of HIPPS referrals reviewed throughout each calendar month.**

Observation #4: Training and Quality

During our review, we identified **191** eligibility errors when reviewing **128** sampled households. These eligibility errors led to program waste including a loss in State and Federal dollars.

Recommendation:

1. **KDHE should enhance training and quality measures when it comes to the TransMed program. Increased training would help reduce staff misunderstanding, which could reduce eligibility error rates. Enhanced quality oversight could help catch possible system discrepancies within the determination process and reduce other eligibility related errors such as untimely discontinuance from the TransMed program.**

Observation #5: Aid Codes

During our review, we identified **3** aid code errors when reviewing **128** sampled households. While our findings were low, less than **2.3%**, KDHE should look into this issue across the entire Medicaid population.

Erroneous aid code assignments have led to State and Federal funds being used to cover expenses made for ineligible persons. The erroneous aid codes skewed data demographics which are crucial when passing laws and regulations needed to increase quality of care for the most vulnerable Kansans.

Recommendation:

1. **We recommend KDHE analyze aid code assignments for potential misutilization.**

Observation #6: Consumer Education

During our review, we identified a lack of consumer education when it comes to the TransMed program. Lack of consumer education presents a barrier to beneficiaries gaining meaningful employment and higher wages, due to fear of losing Medicaid coverage. If more consumer education was present on the KDHE website, members would receive reassurance that they will not be penalized for seeking meaningful job growth and can retain 12 months of coverage through the TransMed program.

We interviewed KDHE program staff who shared concerns regarding consumer education and the TransMed program. Ease of use was identified as insufficient when an attempt was made to locate TransMed program information on the KanCare website.

Prior audits conducted by the OMIG have yielded similar findings and recommendations. OMIG Report No: 22-01, included findings related to ease of use insufficiency on KDHE's public website on how to report Medicaid Fraud. While KDHE has updated their public website to include information on how to contact the Medicaid Fraud Control Unit (MFCU) by phone to report provider fraud, KDHE has not included information on how to contact the OMIG to report beneficiary fraud. The lack of updates to KDHE's public website inhibits public awareness and damages overall trust within the Medicaid program.

Recommendations:

1. **We recommend KDHE update the KanCare website to include more education on the TransMed program and improve the website for ease of use.**
2. **KDHE should consider other ways to educate the population on the TransMed program in an effort to eliminate barriers for Medicaid recipients seeking job growth and income stability.**

Audit Findings

Finding #1: Untimely Removal of Beneficiaries from the TransMed Program

The Transitional Medical Program provides 12 months of coverage for individuals who are no longer eligible for CTM due to an increase in income. We determined that an estimated **1,045** (**45%)** beneficiaries were identified as having 13 months or more of continuous enrollment in the TransMed program when extrapolating our 45% error rate across the audit universe. This allowed beneficiaries who would not otherwise qualify for Medicaid due to household income, to receive full Medicaid services, which includes pharmacy coverage. An estimated **$16,326,364.59** in capitation payment overages were identified as being wasted on ineligible persons.

Under the authority of section 1115(a)(1) of the Social Security Act, waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Kansas to implement KanCare Medicaid section 1115 demonstration for State plan populations and individuals eligible under the current section 1915(c) waivers. Under the Act, TransMed is a State plan, mandatory for Medicaid eligibility populations under the 1915(c) waivers. Kansas has authority to operate the TransMed program as a 12-month program in lieu of two six-month periods of eligibility. Concluding our audit, we identified KDHE is not in compliance with TransMed provisions outlined within the 1915(c) waiver, allowing beneficiaries to remain on the TransMed program past the allowable 12-month period of coverage.

Recommendations:

1. **Based upon current CMS guidance outlined in 42 C.F.R. §433.400 and KDHE Policy No: 2020-11-01, these beneficiaries should immediately be removed from the system if they are not eligible for another program at the time of review.**
2. **Quality control steps should be formulated to ensure Medicaid beneficiaries are removed from the TransMed program in a timely manner.**
3. **KDHE should consider implementing a monthly review, that includes a batch run to identify TransMed beneficiaries who have 13 months of more of continuous coverage. This quality review process would cut down on TransMed program waste, improve the TransMed program, and help identify KEES discrepancies with the review process.**
4. **KDHE should recoup capitation payments that were wasted on individuals who had 13 months or more of continuous TransMed coverage.**
5. **We reviewed the records for beneficiaries who have been on TransMed continuously for more than 13 months and should be removed from the active roles immediately. The potential savings in capitation payments for terminating this unauthorized coverage, concluding at the end of the PHE, would be an estimated $1,574,908.80 over just a six-month period.**

Finding #2: KEES System Manipulation

We determined an estimated **116** eligibility determinations were manipulated by staff in a way that improperly benefited the beneficiary when extrapolating our 5% error rate across the audit universe.

During our review, we interviewed eligibility program staff who identified oversight gaps pertaining to KEES system overrides and workarounds, resulting in a negative impact on eligibility determinations. Our analysis confirmed staff members claims, showing a **5%** frequency of KEES system manipulation across **116** TransMed beneficiaries.

Lack of oversight related to staff workarounds caused an erroneous extension in TransMed program coverage or extended coverage for those who would normally be ineligible. Additionally, lack of oversight allowed opportunity for determinations to be manipulated in a way that improperly favored the beneficiary or statistical outlook of the overall program.

Recommendations:

1. **KDHE should strengthen oversight related to KEES staff's manipulation activity by requiring a tracked approval process. Requiring supervisor approval would ensure system manipulation is appropriate and concurs with KDHE policy. Implementing a tracking tool would provide increased staff oversight and reduce errors.**
2. **KDHE should properly update and utilize an approved list of overrides and work-arounds, paired with a step-by-step processing guide on how to complete the override or work-around. Having an approved list will solidify worker understanding and reduce error rates related to human error.**
3. **KDHE should consider restricting the amount of manual manipulation workers are allowed to conduct within the KEES system. Manual manipulation should be granted to those who have authority to make changes in the system, such as supervisors and the policy and quality teams.**

Finding #3: Review Processing

We determined that **952 (41%)** beneficiaries were identified as going without an eligibility review past the 12-month renewal regulation. More than a quarter of the beneficiaries we reviewed went unreviewed for several years between 2014 and 2018.

We looked at the entire household, in addition to members receiving TransMed coverage, when testing for eligibility compliance. Our review showed while one member of the household had TransMed coverage, other members were receiving CTM, CHIP or Poverty Level Medicaid Coverage.

Our review identified TransMed beneficiaries whose coverage was erroneously extended due to the passive review process. This process does not follow pre-populated review regulations outlined in C.F.R. §435.916.

Recommendation:

1. **KDHE should place an edit within the KEES system to prevent passive reviews for TransMed beneficiaries. The pre-populated review process should be the default for TransMed beneficiaries in order to ensure eligibility is reviewed and terminated timely.**

Finding #4: Incorrect TransMed Eligibility Determinations

We determined that **465 (20%)** beneficiaries were identified as having incorrect eligibility determinations. Our review found the following incorrect eligibility determination trends:

1. Beneficiaries switching from CTM back to TransMed in error
2. Beneficiaries switching from TransMed to CTM in error
3. Determination discrepancies pertaining to children's CHIP versus TransMed eligibility
4. Erroneous TransMed CE limits

These have led to people being removed from the TransMed program and placed on the CTM program inappropriately. These have also led to people being given inappropriate extensions beyond the 12 months of continuous eligibility allowed under the TransMed program.

Recommendations:

1. **Quality control steps should be taken to ensure accurate determinations are being made when establishing TransMed eligibility.**
2. **Quality control steps should be taken to ensure accurate eligibility determinations are being made when transitioning TransMed beneficiaries back to CTM.**

Finding #5: Compliance and Controls

During our review, we identified significant compliance and control gaps within the TransMed program. The lack of policies and procedures have led to staff misunderstandings, which have contributed to a **45%** error rate. We also identified a lack in targeted reviews aimed towards resolving eligibility issues related to the TransMed program.

We interviewed eligibility program staff and asked each person to provide input on how they would improve the program. The consensus between each individual interviewed was to increase TransMed training, reviews, and quality controls. Staff also expressed the need to boost consumer education regarding the TransMed program.

Interviewed KEES program staff acknowledged a history of established workarounds that were designed to correct the system for assigning TransMed coverage erroneously. Throughout our review, we identified high levels of worker involvement in TransMed eligibility determination cases. KEES is designed to automatically assign the correct program to a beneficiary if eligibility workers input correct relationship and tax filing status within the system. KEES automation eliminated an eligibility worker from manually having to work an eligibility determination from start to finish and reduce eligibility determination errors.

Identified issues within the automated KEES passive review process, along with worker involvement, have caused TransMed beneficiaries to go unreviewed and remain eligible for TransMed for 13 months or more of continuous coverage.

Deficiencies in compliance and controls have caused beneficiaries to remain on the TransMed program longer than governing regulations allow and have erroneously granted beneficiaries coverage when they otherwise would have been ineligible.

Under the authority of section 1115(a)(1) of the Social Security Act, waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Kansas to implement KanCare Medicaid section 1115 demonstration for State plan populations and individuals eligible under the current section 1915(c) waivers. Under the Act, TransMed is a State plan, mandatory for Medicaid eligibility populations under the 1915(c) waivers. Kansas has authority to operate the TransMed program as a 12-month program in lieu of two six-month periods of eligibility. Concluding our audit, we identified KDHE is not in compliance with TransMed provisions outlined within the 1915(c) waivers.

Recommendations:

1. **KDHE should review and update TransMed policies and procedures to clarify staff understanding. Policies and procedures should match KEES logic to eliminate work-arounds and worker involvement.**
2. **KDHE should review KEES logic to ensure the system is assigning TransMed coverage correctly and issuing pre-populated reviews.**
3. **KDHE should consider implementing a monthly targeted review of the TransMed program. Implementing a targeted review would ensure KEES controls are working effectively, cases are discontinued timely, and determinations are made in compliance with State and Federal policies.**
4. **Quality control steps should be taken to ensure eligibility staff understand how to properly complete TransMed eligibility determinations and how to set CE limits when manually overriding the system. Increased staff understanding will reduce eligibility determination errors and prevent CE limits from being extended erroneously. KDHE should allocate TransMed-specific training to increase staff understanding and reduce error rates.**

KDHE Response

Observation #1: Overpayments

Recommendations:

KDHE should strengthen provisions when it comes to the overpayment process. KDHE Response: KDHE acknowledges this recommendation. The KDHE KMMS system automatically recoups capitation payments up to two years, retroactively, when eligibility is updated. In April of 2022, KDHE created a more structured overpayment process. Steps in that process include:

1. Staff use the *Overpayment Referral Template* to send potential overpayments to their supervisor or designated point of contact.
2. Supervisors or someone with eligibility knowledge confirm that an overpayment exists.
3. Supervisor/POC enters the referral into the *Revamped Master Overpayment Spreadsheet.*

From May to July of 2023, all contractor and KDHE eligibility staff completed Medicaid fraud training that brought awareness to overstated eligibility. The Family Medicaid team held small group discussions on correctly tracking overpayments.

KDHE should place special provisions within the State contract to hold MCOs accountable when it comes to tracking TransMed beneficiary's continuous eligibility limits. KDHE Response: KDHE acknowledges this recommendation, however, MCOs are not responsible for the eligibility of a beneficiary; that responsibility lies with KDHE. KDHE should maintain tracking and ensure follow up. The CMS rules around this are complex. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed.

The MCOs should share tracking responsibility with the State of Kansas. Shared tracking responsibilities would reduce Federal and State dollars wasted. KDHE Response: KDHE acknowledges this recommendation, however, the tracking of TransMed cases by MCO is not within the scope of MCO functions. KDHE should maintain tracking to ensure Federal and State dollars are not wasted. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed.

Observation #2: Pregnant Women

Recommendations:

We recommend KDHE create a tracking tool for TransMed beneficiaries who fall under new postpartum guidelines. This will ensure continuous eligibility guidelines under the

TransMed program and postpartum guidelines do not exceed regulation and will prevent state and federal tax dollars from being wasted on ineligible persons. KDHE Response: KDHE acknowledges this recommendation. KDHE is in compliance with CMS regulations surrounding continuous eligibility guidelines for post-partum TransMed beneficiaries. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed and eligibility processing returns to non-PHE regulations.

KDHE should consider tracking the postpartum report diligently, for a possible increase in Medicaid fraud. Now that postpartum continuous eligibility has been expanded from 2 months to 12 months of postpartum coverage, OMIG is anticipating an increase in fraud pertaining to individuals falsely claiming a status of pregnant on KanCare applications in order to falsely obtain Medicaid coverage. KDHE Response: KDHE acknowledges this recommendation. KDHE is in compliance with CMS regulations surrounding continuous eligibility guidelines for post-partum TransMed beneficiaries. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed and eligibility processing returns to non-PHE regulations.

Observation #3: HIPPS Program Referrals

Recommendations:
We recommend KDHE enhance contractual guidelines with the State Fiscal Agent to ensure all HIPPS referrals are going through a 100% review to comply with cost-saving measures. KDHE Response: KDHE acknowledges this recommendation. KDHE DHCF is responsible for refreshing the actuarial data and has moved that refresh to every three years. Previously KDHE DHCF refreshed the data every ten years. A 100% review cannot be completed on all HIPPS referrals due to:

1. Not all employed people work for employers that offer health care coverage. An example would be Long John Silvers, Subway, staffing agencies.
2. Self-employed persons – babysitters, farmers, pastors, are all responsible for purchasing their own coverage.
3. Not all employers that offer coverage respond to the fiscal agent. Employers are not required to respond but are highly encouraged.
4. The KEES file may be missing information. For example, it may state the employer is McDonalds, but not indicate which McDonalds. McDonalds are franchises and each offer different coverages.

We recommend KDHE include a provision within the State Fiscal Agent contract that will increase the number of HIPPS Analysts from 2 FTEs to 3 FTEs. Increased analyst positions will help increase the amount of HIPPS referrals reviewed throughout each calendar month. KDHE Response: KDHE acknowledges this recommendation. One additional staff person to the two committed to HIPPS would be helpful, to ensure at least two staff people

are working on HIPPS at all times. KDHE has taken this under consideration but may require a staff enhancement request from the legislature to add an FTE.

Observation #4: Training and Quality

Recommendation:

KDHE should enhance training and quality measures when it comes to the TransMed program. Increased training would help reduce staff misunderstanding, which could reduce eligibility error rates. Enhanced quality oversight could help catch possible system discrepancies within the determination process and reduce other eligibility related errors such as untimely discontinuance from the TransMed program. KDHE Response: KDHE acknowledges this recommendation. Reviews Training was conducted in February and March 2023 to prepare all eligibility staff for the resumption of reviews, which is where TransMed is determined and/or discontinued. Computer-Based Training (CBT) was developed to bring awareness to all eligibility staff the policy surrounding TransMed eligibility and the program. This was virtually trained in March 2023.

Observation #5: Aid Codes

Recommendation:

We recommend KDHE analyze aid code assignments for potential misutilization. KDHE Response: KDHE acknowledges this recommendation. KDHE currently analyzes and reviews aid code assignments for potential misutilization through the quality review process at both the State Level and the Federal CMS level. The KDHE Quality team will continue to do so. With three of 128 in the wrong category, there is not sufficient evidence to warrant additional action.

Observation #6: Consumer Education

Recommendations:

We recommend KDHE update the KanCare website to include more education on the TransMed program and improve the website for ease of use. KDHE Response: KDHE acknowledges this recommendation. TransMed is covered in the Medicaid trainings available to the public. Additionally, we will draft a TransMed program fact sheet that will be available to the public on the KanCare website.

KDHE should consider other ways to educate the population on the TransMed program in an effort to eliminate barriers for Medicaid recipients seeking job growth and income stability. KDHE Response: KDHE acknowledges this recommendation. TransMed is covered in the Medicaid trainings available to the public. Additionally, we will draft a TransMed program fact sheet that will be available to the public on the KanCare website.

Audit Findings

Finding #1: Untimely Removal of Beneficiaries from the TransMed Program

Recommendations:

Based upon current CMS guidance outlined in 42 C.F.R. §433.400 and KDHE Policy No: 2020-11-01, these beneficiaries should immediately be removed from the system if they are not eligible for another program at the time of review. KDHE Response: KDHE agrees with the finding; however, we would like to restate that the Federally imposed PHE had a strong impact on our not having removed all beneficiaries immediately if they were not eligible for another program at review. Due to the PHE, reviews were not being executed and would resume during unwinding. The unwinding period is the federally established 12-month timeframe granted to states for the resumption of normal eligibility operations following the end of the continuous coverage requirement related to the PHE. It includes requirements for full Medicaid and CHIP renewals and discontinuances of coverage for ineligible consumers. We began sending reviews to households in the month of April 2023. As these households come up for review, we are taking action on these cases. As we have moved through the first months of the unwinding period and the actions being asked of our consumers, the agency in coordination with guidance from CMS has decided not to run the discontinuance batch in order for us to remove some barriers for getting these applications processed correctly to not negatively impact the consumers. We have sent reviews for April, May, June, July, August (Passive Only) September and October 2023. We have only discontinued beneficiaries who had reviews due for the months of April and May 2023. The discontinuance for April 2023 reviews happened in May 2023 and May 2023 reviews, we did that in July 2023.

Quality control steps should be formulated to ensure Medicaid beneficiaries are removed from the TransMed program in a timely manner. KDHE Response: KDHE agrees with this finding. This audit did highlight that the eligibility system has some issues related to reviews not being sent for some households. If the reviews had been sent timely that would have allowed us to accurately and more timely determine if the beneficiaries were qualified for other medical programs. Some of these households impacted by the system issue did not receive the review and action was not taken prior to the PHE beginning. Once the PHE began, KDHE was unable to close anyone that had coverage as of 3/18/2020. In these instances, the coverage continued due to PHE rules and will be reassessed with a review post-PHE. KEES review logic was reviewed, and changes put in place to fix the identified issues in November of 2020. As previously mentioned, we were unable to fully execute this logic until reviews resumed in April of 2023.

KDHE should consider implementing a monthly review, that includes a batch run to identify TransMed beneficiaries who have 13 months of more of continuous coverage. This quality review process would cut down on TransMed program waste, improve the TransMed program, and help identify KEES discrepancies with the review process. KDHE

Response: KDHE agrees with this finding. Due to CMS regulations, a batch run would not be an appropriate action to take for these beneficiaries because they have to be given a review or chance to be reviewed for other program eligibility prior to discontinuance. KDHE will produce a monthly report of TransMed beneficiaries who are over the consecutive 12-month timeframe to be researched and worked timely to allow applicable action to be taken which allows removal of these beneficiaries who may have coverage extended incorrectly.

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KDHE should strengthen oversight related to KEES staff's manipulation activity by requiring a tracked approval process. Requiring supervisor approval would ensure system manipulation is appropriate and concurs with KDHE policy. Implementing a tracking tool would provide increased staff oversight and reduce errors. KDHE Response: KDHE disagrees with this finding. Approval is required prior to staff performing overrides in KEES unless pre-approval has been granted through written instructions, which are documented in the KEES User Manual and accessible to all. During the PHE, due to section 6008 of the FFCRA continuous eligibility requirement, overrides were performed to maintain eligibility.

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the PHE, due to section 6008 of the FFCRA continuous eligibility requirement, overrides were performed to maintain eligibility.

Finding #3: Review Processing

Recommendation:

KDHE should place an edit within the KEES system to prevent passive reviews for TransMed beneficiaries. The pre-populated review process should be the default for TransMed beneficiaries in order to ensure eligibility is reviewed and terminated timely.
KDHE Response: KDHE agrees with this recommendation. The system allows TransMed beneficiary cases to go through the reviews batch and be found as Passive. However, our rules have been written and updated to prevent a beneficiary from receiving an additional 12 months of TransMed.

Finding #4: Incorrect TransMed Eligibility Determinations

Recommendations:

Quality control steps should be taken to ensure accurate determinations are being made when establishing TransMed eligibility. KDHE Response: KDHE agrees with this recommendation. Review's training was conducted in February and March 2023 to prepare all eligibility staff for the resumption of reviews, which is where TransMed is determined and/or discontinued. Computer-Based Training (CBT) was developed to bring awareness to all eligibility staff the policy surrounding TransMed eligibility and the program. This was virtually trained in March 2023.

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KDHE began internally auditing the TransMed program during Summer 2023, as a follow-up to these audit findings and will repeat this audit in the summer of 2024. Findings, as well as data from the new tool, will be used to determine the need for continued auditing and/or training.

Quality control steps should be taken to ensure accurate eligibility determinations are being made when transitioning TransMed beneficiaries back to CTM. KDHE Response:

KDHE agrees with this recommendation. KDHE will add curriculum to case maintenance and review training to improve the accuracy of eligibility determinations.

Finding #5: Compliance and Controls

Recommendations:

KDHE should review and update TransMed policies and procedures to clarify staff understanding. Policies and procedures should match KEES logic to eliminate workarounds and worker involvement. KDHE Response: KDHE agrees with the recommendation. TransMed Refresher training, as indicated above, was virtually delivered in March of 2023. The training included clarification of approved policies and numerous case examples. The KEES update in November2020 eliminated the need for workarounds for TransMed and aligned KEES with the current policy on TransMed. Additionally, workers are permitted to use documented overrides (in the KEES User Manual) in KEES when EDBC produces incorrect results.

KDHE should review KEES logic to ensure the system is assigning TransMed coverage correctly and issuing pre-populated reviews. KDHE Response: KDHE agrees with this recommendation. A review of the TransMed logic and removal of associated workarounds was conducted in November 2020. KEES updates were put in place to ensure reviews were sent timely. A group of cases appearing in this audit were identified as cases who received additional TransMed coverage because KEES was not working properly until November of 2020. Due to the PHE, reviews were not being executed and would resume once states received federal direction to begin unwinding. The unwinding period is the federally established 12-month timeframe granted to states for the resumption of normal eligibility operations following the end of the continuous coverage requirement related to the PHE. It includes requirements for full Medicaid and CHIP renewals and discontinuances of coverage for ineligible consumers.

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Quality control steps should be taken to ensure eligibility staff understand how to properly complete TransMed eligibility determinations and how to set CE limits when manually overriding the system. Increased staff understanding will reduce eligibility determination errors and prevent CE limits from being extended erroneously. KDHE should allocate TransMed-specific training to increase staff understanding and reduce error rates.

KDHE Response: KDHE agrees with this recommendation. Eligibility audits, reminders, coaching, and trainings are ongoing. TransMed Refresher training, as indicated above, was virtually delivered in March of 2023. The training included clarification of approved policies and numerous case examples. Previous responses provide details around quality control and training steps, both executed and planned.

***Executive Summary Notable, page 3 of report, 14 members left on TransMed 13+ months. Please see data analysis on page 42.**

Possible still active TransMed Members					
Bene ID	**Case Number**	**Review Month**	**Monthly Overage as of 6/2023**	**Current Program**	**Review Received**
100486749	12589400	Aug-23	0	Closed 06/2023	Case closed for consumer moving out of state prior to review being due.
101936585	11870479	May-23	1	Closed 07/2023	Review sent and not received. Case was closed for not providing the review. Discontinuance for May was run in July
103420940	12589058	Sep-23	0	Closed 09/2023	Case closed for consumer moving out of state prior to review being due.
103457430	11851013	Jul-23	0	Closed 10/2023	Review completed
110145463	12249113	May-23	0	Closed 07/2023	Case was closed when the May Discontinuance was run in July. A review has now been received and waiting to be processed.
100098080	12095608	Feb-24	0	TMD	Review not due yet
100125727	11573313	Mar-24	0	TMD	Review not due yet
100324795	11942421	Dec-23	0	TMD	Review not due yet
101162632	12073086	Nov-23	0	TMD	Review not due yet
110089492	12551148	Apr-24	0	TMD	Review not due yet
100207147	11908551	Jun-23	0	TMD	Review sent and not received.**Case remains open as KDHE has not run the Discontinuance batch for June at this time.
100729383	12444632	Jul-23	0	TMD	Review sent and not received.**Case remains open as KDHE has not run the Discontinuance batch for July at this time.
102274738	12127976	Jun-23	0	TMD	Review sent 05/06/23, received unsigned. **Coverage remains open as KDHE has not run the Discontinuance batch for June at this time.
102430766	11740675	Jul-23	0	TMD	Review sent and not received.**Case remains open as KDHE has not run the Discontinuance batch for July at this time.

**Reviews have sent been sent for April, May, June, July, August (Passive Only) September and October.

**We have only discontinued reviews due months of April and May. That discontinuance for April happened in May and for the May Review dues we did that in July.

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Janet Stanek, Secretary

Laura Kelly, Governor

September 26, 2023

Mr. Steven Anderson
Kansas Medicaid Inspector General
Office of the Attorney General
120 SW 10th Ave. 2nd Floor
Topeka, KS 66612-1597

RE: KDHE Response to Audit Report – TransMed/HIPPS

Dear Mr. Anderson,

Thank you for the opportunity to respond to the Office of the Medicaid Inspector General's (OMIG) performance audit of KDHE's management and oversight of Medicaid members enrolled in a Transitional Medical Assistance and/or Health Insurance Premium Payment program. We always appreciate combining efforts with your team to ensure the State continues its high standard of quality assurance over our Medicaid Program.

KDHE has taken your five (5) audit observations under strong consideration. These are 1) Overpayments, 2) Pregnant Women, 3) HIPPS Program Referrals, 4) Training and Quality, and 5) Aid Codes. You will find our response to the related recommendations beginning on page 35 of your report titled, "KDHE Response." For your convenience, we have also included our responses below. We will continue evaluating the need to make appropriate modifications to our programs, as necessary.

Observation #1: Overpayments

Recommendations:

KDHE should strengthen provisions when it comes to the overpayment process. KDHE Response: KDHE acknowledges this recommendation. The KDHE KMMS system automatically recoups capitation payments up to two years, retroactively, when eligibility is updated. In April of 2022, KDHE created a more structured overpayment process. Steps in that process include:

1. Staff use the *Overpayment Referral Template* to send potential overpayments to their supervisor or designated point of contact.
2. Supervisors or someone with eligibility knowledge confirm that an overpayment exists.
3. Supervisor/POC enters the referral into the *Revamped Master Overpayment Spreadsheet*

From May to July of 2023, all contractor and KDHE eligibility staff completed Medicaid fraud training that brought awareness to overstated eligibility. The Family Medicaid team held small group discussions on correctly tracking overpayments.

KDHE should place special provisions within the State contract to hold MCOs accountable when it comes to tracking TransMed beneficiary's continuous eligibility limits. KDHE Response: KDHE acknowledges this recommendation, however, MCOs are not responsible for the eligibility of a beneficiary; that responsibility lies with

KDHE. KDHE should maintain tracking and ensure follow up. The CMS rules around this are complex. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed.

The MCOs should share tracking responsibility with the State of Kansas. Shared tracking responsibilities would reduce Federal and State dollars wasted. KDHE Response: KDHE acknowledges this recommendation, however, the tracking of TransMed cases by MCO is not within the scope of MCO functions. KDHE should maintain tracking to ensure Federal and State dollars are not wasted. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed.

Observation #2: Pregnant Women

Recommendations:

We recommend KDHE create a tracking tool for TransMed beneficiaries who fall under new postpartum guidelines. This will ensure continuous eligibility guidelines under the TransMed program and postpartum guidelines do not exceed regulation and will prevent state and federal tax dollars from being wasted on ineligible persons. KDHE Response: KDHE acknowledges this recommendation. KDHE is in compliance with CMS regulations surrounding continuous eligibility guidelines for post-partum TransMed beneficiaries. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed and eligibility processing returns to non-PHE regulations.

KDHE should consider tracking the postpartum report diligently, for a possible increase in Medicaid fraud. Now that postpartum continuous eligibility has been expanded from 2 months to 12 months of postpartum coverage, OMIG is anticipating an increase in fraud pertaining to individuals falsely claiming a status of pregnant on KanCare applications in order to falsely obtain Medicaid coverage. KDHE Response: KDHE acknowledges this recommendation. KDHE is in compliance with CMS regulations surrounding continuous eligibility guidelines for post-partum TransMed beneficiaries. KDHE will explore the use of a monthly ad hoc report pulled from KEES, once the unwinding activities have been completed and eligibility processing returns to non-PHE regulations.
.

Observation #3: HIPPS Program Referrals

Recommendations:

We recommend KDHE enhance contractual guidelines with the State Fiscal Agent to ensure all HIPPS referrals are going through a 100% review to comply with cost-saving measures. KDHE Response: KDHE acknowledges this recommendation. KDHE DHCF is responsible for refreshing the actuarial data and has moved that refresh to every three years. Previously KDHE DHCF refreshed the data every ten years. A 100% review cannot be completed on all HIPPS referrals due to:

1. Not all employed people work for employers that offer health care coverage. An example would be Long John Silvers, Subway, staffing agencies.
2. Self-employed persons – babysitters, farmers, pastors, are all responsible for purchasing their own coverage.
3. Not all employers that offer coverage respond to the fiscal agent. Employers are not required to respond but are highly encouraged.
4. The KEES file may be missing information. For example, it may state the employer is McDonalds, but not indicate which McDonalds. McDonalds are franchises and each offer different coverages.

We recommend KDHE include a provision within the State Fiscal Agent contract that will increase the number of HIPPS Analysts from 2 FTEs to 3 FTEs. Increased analyst positions will help increase the amount of HIPPS referrals reviewed throughout each calendar month. KDHE Response: KDHE acknowledges this recommendation. One additional staff person to the two committed to HIPPS would be helpful, to ensure at least two staff people are working on HIPPS at all times. KDHE has taken this under consideration but may require a staff enhancement request from the legislature to add an FTE.

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Recommendation:

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Likewise, our comments on the five (5) formal findings can be found in the "KDHE Response", section of your report. These findings include 1) Untimely Removal of Beneficiaries from the TransMed Program, 2) KEES System Manipulation, 3) Review Processing, 4) Incorrect TransMed Eligibility Determinations, and 5) Compliance and Controls. We also placed our responses to findings below, for the reader's convenience.

Finding #1: Untimely Removal of Beneficiaries from the TransMed Program

Recommendations:

Based upon current CMS guidance outlined in 42 C.F.R. §433.400 and KDHE Policy No: 2020-11-01, these beneficiaries should immediately be removed from the system if they are not eligible for another program at the time of review. KDHE Response: KDHE agrees with this finding; however, we would like to restate that the Federally imposed PHE had a strong impact on our not having removed all beneficiaries immediately if they were not eligible for another program at review. Due to the PHE, reviews were not being executed and would resume during unwinding. The unwinding period is the federally established 12-month timeframe granted to states for the resumption of normal

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KDHE should consider implementing a monthly targeted review of the TransMed program. Implementing a targeted review would ensure KEES controls are working effectively, cases are discontinued timely, and determinations are made in compliance with State and Federal policies. KDHE Response: KDHE disagrees with this recommendation. Part of the validation of the KEES release includes testing at both the system and end-user level. KDHE has a help-desk process in place for the reporting of defect management for KEES. KDHE will do a validation of TransMed timely discontinuances post-unwinding.

Quality control steps should be taken to ensure eligibility staff understand how to properly complete TransMed eligibility determinations and how to set CE limits when manually overriding the system. Increased staff understanding will reduce eligibility determination errors and prevent CE limits from being extended erroneously. KDHE should allocate TransMed-specific training to increase staff understanding and reduce error rates. KDHE Response: KDHE agrees with this recommendation. Eligibility audits, reminders, coaching, and trainings are ongoing. TransMed Refresher training, as indicated above, was virtually delivered in March of 2023. The training included clarification of approved policies and numerous case examples. Previous responses provide details around quality control and training steps, both executed and planned.

As you know, Medicaid eligibility is complex, with many programs to process and policy to follow. We realize during your interviews of KDHE staff it appeared there was a lack of knowledge on the part of our eligibility team members as they attempted to answer your interview questions. Please know, staff have resources to refer to during a normal business day to confirm the accuracy of day-to-day action. Staff are not expected to be able to answer all questions about all programs, without referring to resources and time to research.

We would like to thank you for supplying our office with the data you used to develop your observations and findings. KDHE continues conducting data validation (as is always the case with audits). Currently, we can respond to one (1) specific notable in your report.

In the Executive Summary section on page 3 of your report, you noted 14 members were still questionably TransMed-active as of June 2023. We have had an opportunity to review these members and can confirm for you that not all members were continued on TransMed without review. Five members were not (are not) due for a review. Four members were sent redetermination materials but did not respond completely or did not respond at all. Five cases were reviewed and closed. Our analysis table can be found on the last page of the "KDHE Response", section of your report. If additional data validation exceptions are identified by KDHE following the publication of your formal audit report, we will share them with you.

On behalf of our entire Medicaid team, we again thank you for the opportunity to participate in the audit of these most important programs. We appreciate your continued partnership, your professionalism, and your desire for Kansas to maintain the upmost quality-driven Medicaid program.

Respectfully,

Christine Osterlund/yrc

Christine Osterlund

Interim Medicaid Director/ Deputy Secretary of Agency Integration and Medicaid

CC: Donna Wills
Yvonne Case