Office of Medicaid Inspector General

Multi-ID Beneficiary Audit Report

24-01

Office of Kansas Attorney General
Kris W. Kobach

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Letter from the Inspector General

November 29, 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:

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Representative Barbara Ballard
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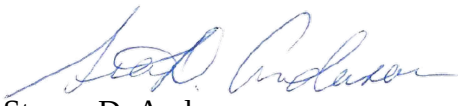
This report contains findings from our performance audit of the Kansas Department of Health and Environment's (KDHE) process for beneficiaries with multiple Medicaid ID numbers. This audit was completed in accordance with the Association of Inspectors General Principles and Standards for Offices of Inspector 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 KDHE have an effective system of tracking beneficiaries with multiple Medicaid identifications numbers? The current system has noted deficiencies that could easily be corrected by updating policies and procedures.

2. Does KDHE identify capitation overpayments and are they following contracts that are in effect? It does not appear that KDHE recoups capitation overpayments in the majority of instances. Managed Care Organizations (MCOs) should not be allowed to keep Medicaid funds that are mistakenly paid to them.

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

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

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

A draft report of our 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.

Background

MEDICAID PROGRAM

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal government and the state jointly fund and administer the Medicaid program in Kansas. At the Federal level, the Centers for Medicare and Medicaid Services (CMS) administers the program. Each State administers their Medicaid program in accordance with a CMS-approved plan. Although the State has flexibility in constructing and operating the program, it must comply with applicable Federal requirements.

KANSAS MEDICAID MANAGED CARE PROGRAM

In Kansas, the State agency that administers the Medicaid program is KDHE. The state uses two methods of pay for Medicaid services; fee-for-service and managed care. Under the fee-for-service method, healthcare providers are paid for each eligible service provided to a Medicaid beneficiary. Under the managed care program, KDHE pays a managed care organization (MCO) a monthly capitation payment per beneficiary to guarantee that each beneficiary enrolled has access to a complete range of medical services. The State of Kansas is contracted with three MCOs; United Healthcare Community Plan of Kansas, Sunflower State Health Plan, and Aetna Better Health of Kansas.

Introduction

The Office of Medicaid Inspector General (OMIG) is required, pursuant to K.S.A. 75-7427(c)(2), to conduct independent and ongoing evaluations of the Kansas Medicaid program, which includes performing audits of state programs to ensure that appropriate payments are made for Medicaid services.

This audit was initiated after beneficiaries with multiple Medicaid identification numbers (IDs) were noted during a review of records. The audit reviewed the files of **53** beneficiaries who had multiple IDs within the audit period. It was noted that eight beneficiaries were fee-for-service and **45** were covered under MCOs. There were also **57** instances of one SSN connected to multiple bene IDs.

Audit Scope & Objectives

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

1. Does KDHE have an effective system of tracking beneficiaries with multiple Medicaid IDs?

2. Does KDHE identify capitation overpayments and are they following contracts that are in effect?

The scope of our audit included all beneficiaries who had multiple Medicaid IDs from January 1, 2019, through June 30, 2022.

Applicable Laws & Policies

FEDERAL LAWS

Section 1903(d)(2)(A) of the Social Security Act requires Federal Medicaid payments to a state to be reduced to make adjustment for prior overpayments.

The Federal Government pays its share of a state's medical assistance expenditures under Medicaid based on the Federal Medical Assistance Percentage, which varies depending on the state's relative per capita income as calculated by a defined formula (42 CFR § 433.10(b)).

The Federal Government reimburses the state for its share of the state medical assistance expenditures according to a defined formula (42 CFR § 433.109(a)). States are responsible for refunding the Federal share of overpayments to Centers for Medicare & Medicaid Services (CMS) (42 CFR § 433.312(a)).

In connection with the Medicaid program, providers are defined as "*any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services*" (42 CFR § 400.203).

A capitation payment is "*a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment*" (42 CFR § 438.2).

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 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 Medical Support Manual (KEESM) 11121.1 and the Kansas Family Medical Assistance Manual (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

STATE POLICY

Pursuant to KDHE Policy Memo No: 2015-06-04 Policy 6A, "*every individual recorded in the Kansas Eligibility Enforcement System (KEES) is assigned a Client ID Number. It is much like the Client ID assigned in Kansas Automated Eligibility Child Support Enforcement System (KAECSES) today. Only one Client ID is assigned to each individual and it remains throughout the lifetime of the individual regardless of changes in demographics, situation, circumstances, etc. In addition, the Client ID is the base number for the Medicaid Management Information System (MMIS) Member ID number. The Client ID is assigned through the File Clearance process in KEES. The KEES User Manual provides instruction on assigning a Client ID.*

In KAECSES, medical and non-medical cases share the data base that generates the Client ID with other DCF programs. It is known as the High-Level Client Index (HLCI). All persons who are part of the HLCI will be converted to KEES and will retain their existing Client ID. The converted number is used for any individual subject to File Clearance upon the implementation of KEES. A new number is generated through KEES only when an existing number does not already exist.

It is the intent of DCF and KDHE that medical and non-medical will eventually share a single Client ID service when Phase 3 is live. Until then, separate Client ID services will be used for medical and non-medical with a plan to reconcile the numbers at the time of Phase 3 implementation. Non-Medical will continue to use the existing HLCI service and KDHE will use KEES. So, the same individual can be assigned two numbers if an application is received for a non-medical and a medical program. It is critical that registration staff and others who are responsible for File Clearance follow the protocol regarding the use of the Alternate ID in the KEES User Manual for clean conversion of the Client ID at Phase 3 implementation.

In addition, it continues to be very important to avoid duplicating an existing client in the File Clearance process. There are significant downstream consequences in the event an individual is assigned two or more ID numbers. With the exception of the interim process outlined above, staff should make every effort to avoid creating multiple IDs for the same person. In the event a client is given multiple ID numbers, follow the process outlined in the Duplicate Person Process outlined in the KEES user manual."

Methodology

To accomplish our objectives, we performed the following tasks:

1. Reviewed applicable Federal and State laws, regulations, contracts, and other standards that were relevant to the audit objectives.

2. Reviewed KDHE's policies and procedures on how to assign Medicaid IDs and prevent the assignment of multiple Medicaid IDs to the same beneficiary.

3. The data for the multiple Medicaid ID audit was extracted from the Kansas Modular Medicaid System (KMMS) by finding more than one Medicaid ID linked to the same Social Security Number (SSN). There were **636** SSNs identified as having more than one Medicaid ID. Utilizing the SSNs and the Medicaid IDs; the beneficiaries names, dates of birth, first month of enrollment, last month of enrollment, and case numbers were also collected from KMMS. By comparing the first month of enrollment to the last month of enrollment for each Medicaid ID with the same SSN, any beneficiary with overlapping months of enrollment during the audit period of January 1, 2019 to June 30, 2022, were reviewed in more detail.

    - There were **53** SSNs identified with overlapping months of enrollment during the audit period.

    - It was also found that **57** SSNs had two different people or names associated to one SSN. Comparing the names and/or the date of birth of each Medicaid ID associated to one SSN helped identify the possibility of two different people.

4. Conducted interviews with KDHE officials and various staff to gain more insight into procedures for assigning Medicaid IDs.

5. Utilized KMMS to obtain data analytics on the list of capitation payments to identify beneficiary matches. Calculated the total amount of Medicaid capitation payments not recouped from the MCOs during our audit period.

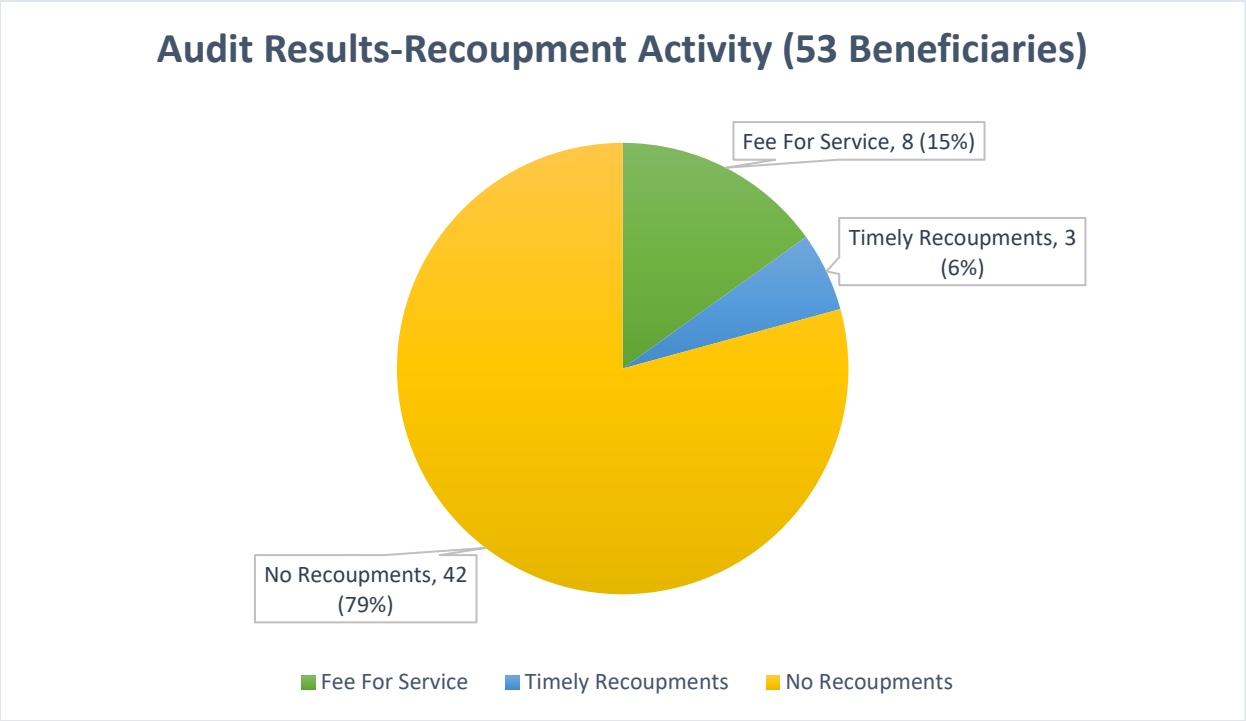
Audit Results

Our testing identified the following issues:

Issue Identified	Description
Aid Code Changes	Six individual cases showed capitation payments under the aid code description of pregnant woman that were either males or underage females. KDHE states that prior to the April 2022 KMMS go-live event, aide code 36 represented all Caretaker Medical populations (Pregnant Woman, Children, Parent or Caretaker). Beginning April 2022 and forward, those populations under code 36 were categorized to more accurately reflect the population: 36-Caretaker Medical Pregnant Woman, B6-Caretaker Medical Children, and B7-Caretaker Medical Parent or Caretaker. The breakout of the Caretaker Medical code caused the description of code 36 to be updated historically, so that it was relabeled as "Caretake Medical-Pregnant Woman" instead of the "Caretaker Medical" definition it had at the time, causing the description of the specific capitation payments to be inaccurate prior to go-live. Eligibility reports reflect accurate code and description. It is unknown if the breakout of the codes contributed to multiple IDs. Five individuals had two IDs and one bene had three IDs, resulting in $11,061.67 overage payments, currently unrecouped.
SSN Keying Errors	Eligibility workers transposed numbers in the SSN. Data entry issues caused 19 instances out of 57 cases reviewed (33%) where an SSN had multiple names attached. Eight instances out of 57 cases reviewed (14%) were caused by either two numbers being transposed or a wrong number being entered.
Lack of Documentation	KEES journal notes were incomplete and incorrect acronyms were often used.
Inadequate Audit Trail	The Case Action History Report is a KEES audit report which showed overrides and workarounds done by staff. The report was not user friendly and was not reviewed on a regular basis.
Multiple Duplicate IDs	Three members of one family were each assigned three different Medicaid IDs, for a total of nine Medicaid IDs.

Issue Identified	Description
Transitioning from Foster Care to Adoption	Multiple names for one SSN (child had one SSN and two different first and last names.) Recoupments were not made for the child that had capitation payments totaling **$18,475.11** made to Sunflower with an overlap from 01/2019 to 3/2021. Recoupments were not made for another child that had capitation payments totaling **$14,261.85** made to Aetna with an overlap from 12/2019 through 7/2021 (child had two different last names.)
Policies and Procedures	The Kansas Medicaid policy and procedure manual has not been updated since 2015. KDHE Policy Memo No. 2015-06-04 references the use of KAECSES and HLCI systems which have been discontinuted. Members of management were not aware of processes or procedures done by eligibility workers. Desk procedures and/or emails were created by supervisors or KDHE employees when issues were found but relatively few were adopted into formal policies and procedures.
Two KanCare Cards	Test Bene 45 had two KanCare cards with two different Medicaid IDs at the same time. One card was dated 09/01/2021, and the other card was dated 09/29/2021.
MCO Recoupments	Within the audit period, the MCOs had a total of 45 unrecouped capitation payments: Sunflower 16 United 16 Aetna 13 The unrecouped capitation payments for the audit period totaled $95,145.21: Sunflower $38,056.24 United $30,053.85 Aetna $27,035.12
Recoupments done incorrectly	Only three recoupments were made. One was made to the wrong aid code.

Issue Identified	Description
Reports locating Multiple Beneficiary IDs	During interviews it was noted that instances of multiple beneficiary IDs for the same beneficiary were only discovered by KDHE workers when a case was reviewed for unrelated reasons. Prior to the audit, reports were not produced to determine if multiple IDs for one beneficiary existed. A report was produced after the start of the audit and it resulted in "45-50" cases being fixed.
MCO Recoupment Process	The 'MCO Recoupment Process 2021' showed a "look back" period of 22 months for recoupments. This process was not followed prior to or during the PHE.



Audit Findings

Finding #1: KDHE does not have adequate processes and controls in place to ensure Medicaid beneficiaries have only one Medicaid ID. During our review, we identified compliance and control gaps. Kansas Medicaid policy and procedure manual has not been updated since 2015. KDHE Policy Memo No. 2015-06-04 referenced KAECSES and HLCI systems; both of these have been discontinued.

We interviewed KDHE employees who stated beneficiaries with multiple IDs were found randomly by workers. One employee stated that in August of 2022, after the audit had started, the employee was presented with a list of beneficiaries requiring consolidation due to multiple IDs. The consolidations done at this time were completed accurately and journaled correctly per KDHE procedures. Employees interviewed stated the report was not generated on a regular basis; however, they would welcome such a report.

There were also **57** instances of one SSN connected to multiple bene IDs. Of those, one beneficiary (adoption situation) had duplicate capitation payments of **$18,475.11** to Sunflower, which were not recouped. One of the most common findings was a child transitioning from foster care to adoption. This occurred **19** times out of **57 (33%)** cases reviewed**,** causing the child to have two names attached to one SSN with two beneficiary IDs.

During our interviews conducted with eligibility employees, it was stated this was an issue and a better solution was needed to prevent this from occurring in the future. In the case of Test Bene 3, the child showed the same SSN with two different names, two beneficiary IDs and unrecouped capitation payments of **$14,261.85**. These two individuals together showed a total of **$32,736.96** that was not recouped from the MCOs.

The KEES User Manual defines an aid code as a combination of the medical program categories along with the medical program subtypes and individual medical subtype descriptions. Aid codes can be overridden by workers. Program staff stated eligibility workers overrode KEES whenever they felt it was warranted. Overrides did not require a supervisor's approval. Program staff acknowledged it was possible that eligibility workers selected the incorrect aid code due to pressures with meeting performance goals. Eligibility staff interviews identified that manipulation and lack of oversight related to KEES was a common occurrence.

Three members of one family (Test Benes 38, 40, and 47) were each assigned three different Medicaid IDs, for a total of nine Medicaid IDs. In one month, the total capitation payments unrecouped was **$4,908.08**.

Test Bene #45 had two KanCare cards with two different Medicaid IDs at the same time. One card was dated 09/01/2021, and the other card was dated 09/29/2021. The error was discovered by the mother and she contacted KDHE. It appears that only one card was used but the MCO was paid two capitation payments, no recoupment was made for the **$690.55** overpayment.

Recommendations:

1) Management should be aware of how the eligibility worker performs duties and should be able to assist workers in eligibility processes. Documenting all significant business practices, processes, and policies would ensure work is accurate and complete.
2) Update the Case Action History Report so that it captures changes or deletions within the record to provide managers with a starting point for performance audits. A readable report would assist management in discovering which workers are using overrides, workarounds, and manipulations of the system.
3) Implement a process to accurately identify the correct original Medicaid ID and merge claims records from the multiple IDs to the correct original Medicaid ID to allow for a complete history of services provided to the beneficiary (e.g. identify with a case flag).
4) Cross training of employees between Eligibility and Operations would lead to a better understanding and appreciation of the work accomplished in each department ensuing better communication and cooperation. Training workers on policies and procedures including desk procedures, current language, aid codes, and multiple beneficiary ID corrections would increase understanding and demonstrate how errors affect capitation payments and the Medicaid program's bottom line.
5) Ensure that all policies and procedures are updated with accurate and current information.

Finding #2: KDHE does not have a process in place to identify and recoup duplicate payments made in error. The audit found that only **3** instances out of **53 (6%)** cases reviewed with multiple beneficiary IDs had been recouped in a timely manner during the designated audit period. After accounting for the **8 (15%)** who had fee for service, **42 (79%)** were left with no capitation recoupments totaling **$95,145.21** from the MCOs.

KDHE indicated recoupments can be processed; however, only **3** out of **53** recoupments were processed. During this audit, we were sent the 'MCO Recoupment Process 2021' which states that there can be a "look back" period of 22 months *(See Attachment A)*. When asked where this particular time frame originated, we were advised it was based on the MMIS/KMMS functionality. KDHE also noted that this information was found in the 'KanCare Guide Reconciliation Process' for the 834/820 *(See Attachment B)*.

During testing we identified that one recoupment was attempted but the recouped capitation payment was credited to the wrong aid code. The chart below shows Test Bene 4, who had two names and Medicaid IDs due to adoption. The recoupment of **$194.87** should have been made to the Poverty Level-Newborn (PL-Newborn) aid code and not to the Foster Care Medical DCF code.

Three members of one family (Test Benes 38, 40, and 47) were each assigned three different Medicaid IDs, for a total of nine Medicaid IDs. In one month, the total capitation payments unrecouped was **$4,908.08**.

Within the audit period, the MCOs had a total of 45 unrecouped capitation payments:

Sunflower 16
United 16
Aetna 13

The unrecouped capitation payments for the audit period totaled **$95,145.21**:

Sunflower $38,056.24
United $30,053.85
Aetna $27,035.12

KDHE's correction efforts following our audit resulted in **13** beneficiaries whose capitation payments had been recouped or stopped. We determined that for one month the total savings were **$8,771.31**, in a one-year period, a total savings of **$105,255.72**.

Recommendations:

1) KDHE should prioritize recoupment of all overpayments to MCOs. This effort would be aided by updating policies and procedures on recoupments. This will ensure the correct amount of capitation is recouped and/or credited to the correct aid code.

2) Create a provision within the MCO contracts to increase tracking accountability regarding multiple beneficiary IDs with the MCOs. Increased MCO accountability could reduce multiple beneficiary ID error rates.

Process

KDHE (KDHE employees) has advised us to send the recoupment for their review before sending to Gainwell for processing.

- If duplicate IDs are assigned to multiple MCOs (for example: ID 1 is assigned to Aetna and ID 2 is assigned to Sunflower), we send the completed template above directly to (KDHE employees). They will review and determine the Primary ID and Secondary ID with the claims that need to be recouped. Once they have sent this back, we will send to Gainwell via their SNOW as a Service Request.
- If duplicate IDs are assigned to the same MCO (for example: both ID 1 and ID 2 are assigned to United Healthcare), we will review the IDs in MMIS using the considerations below:

Considerations

IDs assigned to multiple MCOs

- Pharmacy claims are very important. Do not choose the ID number that has the most Pharmacy claims for recoupment.
- Paid inpatient claims are very important if the dates of service cross over between MCOs. For example, 1/1/20-3/2/20, MCO X has the member 1/1/20-2/28/20 and MCO Z has the member 3/1/20-99/99/99. Always keep the MCO that has the patient for the beginning of the stay. See comments in the Newborn rule below. If there is only one MCO involved, not multiples, then ignore this rule.
- The MCO recoupment 'look back' period cannot go beyond 22 months.
- Recoup from only one ID number if possible. (certain situations may involve recouping different months from each ID number).
- Newborn Duplicate ID number: Newborn Assignments: The child's 'month of birth' is always Assigned to the Same MCO as the birth Mother's. If the baby's stay in the hospital is less than a week, follow this rule. If the stay is longer, refer to Mendy Jump and Shirley Norris. Give id number, name, etc. in the email.

IDs assigned to the same MCO

- If both ID numbers have no paid Claims in the MMIS, always recoup the Secondary ID number.
- If each ID has paid Claims in the MMIS, you will need to research and decide which ID number should be recouped and for what benefit months.
- If the member has a lot of Pharmacy Claims, lean toward NOT recouping from that ID number for those benefit months.

- You will have situations where you recoup different benefit months from each the Primary ID and Secondary ID number.
- The MMIS screens we have been reviewing for these considerations:
- PMP Assignment History
- Reviewing assignment dates, MCO providers, determining the assignment with the most history, determining the overlap period
- Beneficiary Eligibility
- Reviewing Eligibility dates
- Claim Inquiry
- Entering the FDOS and TDOS for the being and end dates of the overlap period to view claims only billed during the overlap period
- Reviewing Claim Types and ‘Paid’ Status claims

Attachment B

Capitation Adjustments

Capitation adjustments are created when an MCO has been paid too little or too much in capitation for a member assigned to them. Adjustments can be triggered by the following:

- Retro Eligibility Changes
    - Benefit Plan, Pop Code, Level of Care, Medicare
- Member date of birth corrections
- Patient Liability Changes
    - Adjustments will not be made if the change in patient liability does not cause a change in the net payment made to the MCO.
- Mass Rate Changes
- Member passes away
    - Only the months *after* the month of death are recouped

Adjustments, whether positive or negative, will be limited to no more than 22 months based upon the benefit month and not including the current month except with a date of death. For example, an adjustment to be processed in July of 2016 could only be adjusted as far back as September of 2014. Some examples that would result in a capitation payment adjustment (including recoupments) are capitation category changes or end-dating MCO member assignment retroactively.

On a monthly basis, the adjustment process goes through ***all*** MCO assignments that were modified at some point during a specified period.

Active Status - For each of the assignments, the capitation process determines if a capitation payment was made and also if it is correct according to the information currently on file for the member during the capitation month.

- If a payment was missed, then an adjustment transaction is created for the correct amount.
- If the amount that was originally paid was incorrect, an adjustment is created that recoups the original amount and another transaction is generated that pays for the correct amount.

Invalidated Status - If an assignment is found that was invalidated (should not have been created), the capitation process verifies the total amount paid for the assignment during the capitation month is not greater than zero.

- If the total amount paid is greater than zero, an adjustment is generated for the amount that is greater than zero.

Refer to the section Reconciliation Process Examples for more examples and detailed information related to the capitation reconciliation process.

Attachment C

Test Benes	MCO	Capitation
1	United	$393.86
2	Aetna	$1,199.52
3	Aetna	$14,261.85
4	Aetna	$0.00
5	Aetna	$566.49
6	United	$2,395.96
7	United	$2,921.33
8	Aetna	$2,451.71
9	Fee for Service	$0.00
10	Fee for Service	$0.00
11	United	$419.62
12	United	$15,100.21
13	United	$0.00
14	Sunflower	$393.06
15	United	$194.87
16	Sunflower	$6,521.96
17	Aetna	$2080.4
18	United	$828.42
19	Sunflower	$530.32
20	Fee for Service	$0.00
21	Sunflower	$724.34
22	United	$2,081.05
23	Sunflower	$148.33
24	Sunflower	$4,972.26
25	Fee for Service	$0.00
26	Fee for Service	$0.00
27	Fee for Service	$0.00
28	Aetna	$194.87
29	Aetna	$194.87

Test Benes	MCO	Capitation
30	Fee for Service	$0.00
31	United	$201.56
32	Sunflower	$365.40
33	Sunflower	$764.05
34	Fee for Service	$0.00
35	Sunflower	$3,581.69
36	United	$268.13
37	Sunflower	$67.63
38	Aetna	$2,845.12
39	United	$762.23
40	Aetna	$1,081.48
41	United	$191.69
42	Sunflower	$193.57
43	Sunflower	$1,030.58
44	Sunflower	$1,228.56
45	Aetna	$690.55
46	Aetna	$386.78
47	Aetna	$1,081.48
48	Sunflower	$2,409.18
49	Sunflower	$9,532.33
50	United	$3,048.31
51	Sunflower	$5,592.98
52	United	$0.00
53	United	$1,246.61
	Total	**$95,145.21**

KDHE Response

Finding #1: Medicaid Multiple ID Numbers

Recommendations:

KDHE's management should be aware of how the eligibility worker performs duties and should be able to assist workers in eligibility processes. Documenting all significant business practices, processes, and policies would ensure work is accurate and complete.

KDHE Response: KDHE agrees with this finding. KDHE agrees with the finding of Multiple Medicaid ID Numbers, however, the recommendation to document business practices, processes and policies is currently in place. We will continue our continuous improvement efforts. KDHE has been working to identify and close gaps in our eligibility processes as part of our efforts to continuously improve eligibility accuracy. Those efforts have been very successful; the Kansas Medicaid eligibility error rate decreased from 27.54% in 2019 to 6.82% in 2022. Any policy, procedure or systematic updates are shared both internally and externally prior to implementation for feedback/review. Once finalized, it then gets distributed from KDHE Management down to the worker. KDHE Training and Quality team share Quality data and any identified issues with KDHE Leadership and contract Leadership to help resolve any processing deficiencies.

KDHE should update the Case Action History Report so that it captures changes or deletions within the record to provide managers with a starting point for performance audits. A readable report would assist management in discovering which workers are using overrides, workarounds, and manipulations of the system.

KDHE Response: KDHE agrees with this finding. KDHE is in the process of updating the Case Action History Report systematically through a KEES Change Request (CR) to ensure the report is usable for both medical and non-medical programs. Once the CR is released into KEES, the report will be user friendly, provide additional insight into changes made at case level and person level, along with more readability. With these changes, KDHE will be able to better identify when changes or deletions are made within records in KEES for appropriate coaching and feedback/correction. Due to PHE Unwinding, there is no tentative completion date.

KDHE should Implement a process to accurately identify the correct original Medicaid ID and merge claims records from the multiple IDs to the correct original Medicaid ID to allow for a complete history of services provided to the beneficiary (e.g., identify with a case flag).

KDHE Response: KDHE agrees with this finding. Through our ongoing efforts to improve eligibility accuracy work we learned that when the KEES eligibility system launched in 2015, the system design did not include an automated process to alert an eligibility worker when they are about to assign a duplicate Medicaid ID to an existing beneficiary.

KDHE is currently assessing the projected cost and timeline of adding this functionality. Adding a duplicate ID alert could be the most effective way to eliminate duplicate IDs going forward.

Social Security number functionality to inform staff that a number is already in the database to aid additional checks for that member on other cases, was added to KEES in August 2017. There have been defects at various points in time that may have allowed a duplicate SSN to be assigned under certain

circumstances. However, through submission of tickets to KEES Helpdesk, these issues are researched and examined to resolve duplicate ID issues with the system developer. As defects are resolved, the duplicate IDs are linked to the correct beneficiary ID in KEES to avoid downstream fiscal impact later.

Eligibility staff follow a process of performing a person search prior to registering a new beneficiary ID. Person searches are manual, and matching potential duplicates is a complex process, but these steps are necessary to prevent and identify duplicates. KDHE has worked with our vendor, Accenture, on developing logic that scores matching on key fields. Although that matching logic helps identify possible duplicates, each ID number requires research. If eligibility staff discover duplicate IDs for a member, a ticket is submitted to the KEES Helpdesk who identify which ID should be used going forward. It has been added as part of the process when linking the correct ID, to evaluate possible capitation overpayments and forward these to the Operations Business Analyst team for adjustment for recoupment. KDHE will explore the use of a monthly ad hoc report pulled from KEES to help further identify duplicate IDs.

At this time, merging claims history would require a significant system change. Because this would not affect claims payments or capitation payments, a cost benefit analysis would be critical in evaluating this decision.

KDHE should cross training of employees between Eligibility and Operations would lead to a better understanding and appreciation of the work accomplished in each department ensuing better communication and cooperation. Training workers on policies and procedures including desk procedures, current language, aid codes, and multiple beneficiary ID corrections would increase understanding and demonstrate how errors affect capitation payments and the Medicaid program's bottom line.

KDHE Response: KDHE agrees with this finding. KDHE will modify existing training curriculum to include the importance of registering applications and/or new requests for coverage at review to avoid duplicate IDs because of the fiscal impact to the State of Kansas. Additionally, KDHE Training and Quality will review existing registration material, along with quality reminders and redistribute to all staff by end of 2023. This will bring awareness to existing duplicate ID issues.

KDHE should ensure that all policies and procedures are updated with accurate and current information.

KDHE Response: KDHE agrees with this finding. In early 2023, with the onboarding of a new manager over KDHE Training and Quality, material review measures were put into place to allow members from various departments access to documents prior to distribution and publishing for all staff. These measures include multiple rounds of both internal and external feedback (policy, training, quality, operations, systems). As feedback is provided, the training department and/or department responsible for the development of the material will make the updates and submit for review and final approval. Once complete, the documents are published and distributed to staff.

Additionally, KDHE Training is in the process of completing a KanShare Mass Cleanup project. KanShare is the document repository for all training material, operational processes, and other various policy related material. This process began in May of 2023 and is expected to be fully executed by the end of December 2023, barring no additional priorities as a growing response to PHE Unwinding. This project also entails identifying appropriate parties responsible for ensuring the material is up to date and accurate. For any material that is outdated, it will be documented and tracked by KDHE Training (using a material tracking tool) to ensure we are updating materials with current information and/or removing materials that are no longer pertinent to the project. To date, over 100 documents have been removed.

Finding #2: MCO Recoupments

Recommendations:

KDHE should prioritize recoupment of all overpayments to MCOs. This effort would be aided by updating policies and procedures on recoupments. This will ensure the correct amount of capitation is recouped and/or credited to the correct aid code.

KDHE Response: KDHE agrees with this finding. Each potential recoupment must be carefully considered to minimize downstream effects to providers and other household members. The KDHE KMMS system automatically recoups capitation payments up to two years, retroactively, when eligibility is updated. This 22-month policy described in the report was established to balance the recoupment interests. If it is determined that a duplicate ID was created, the incorrect ID will be terminated systematically and the incorrect MCO will recoup the monetary balance. Once the correct MCO is identified, additional work with providers will take place to get the claims paid correctly using the correct ID.

KDHE should create a provision within the MCO contracts to increase tracking accountability regarding multiple beneficiary IDs with the MCOs. Increased MCO accountability could reduce multiple beneficiary ID error rates.

KDHE Response: KDHE agrees with this finding, however, the KDHE MCO contracts allow for state discretion in recouping capitation payments from MCO's in eligibility cases because it is not a black and white process. MCOs are not responsible for tracking eligibility of a beneficiary. This is not within the scope of the MCO functions. This tracking responsibility lies with KDHE.

October 23, 2023

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

RE: KDHE Response to Audit Report —Multiple Medicaid ID Numbers

Dear Mr. Anderson,

KDHE appreciates the opportunity to review your final audit report on Medicaid beneficiaries with multiple ID numbers. We appreciate our ongoing partnership to ensure the State continues its high standard of quality assurance over our Medicaid Program.

KDHE does not dispute your team's findings which include Medicaid Multiple ID Numbers and MCO Overpayments. You will find our response to the related recommendations beginning on page 23 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.

Finding #1: Medicaid Multiple ID Numbers

Recommendations:

KDHE's management should be aware of how the eligibility worker performs duties and should be able to assist workers in eligibility processes. Documenting all significant business practices, processes, and policies would ensure work is accurate and complete.

KDHE Response: KDHE agrees with this finding. KDHE agrees with the finding of Multiple Medicaid ID Numbers, however, the recommendation to document business practices, processes and policies is currently in place. We will continue our continuous improvement efforts. KDHE has been working to identify and close gaps in our eligibility processes as part of our efforts to continuously improve eligibility accuracy. Those efforts have been very successful; the Kansas Medicaid eligibility error rate decreased from 27.54% in 2019 to 6.82% in 2022. Any policy, procedure or systematic updates are shared both internally and externally prior to implementation for feedback/review. Once finalized, it then gets distributed from KDHE Management down to the worker. KDHE Training and Quality team share Quality data and any identified issues with KDHE Leadership and contract Leadership to help resolve any processing deficiencies.

KDHE should Implement a process to accurately identify the correct original Medicaid ID and merge claims records from the multiple IDs to the correct original Medicaid ID to allow for a complete history of services provided to the beneficiary (e.g., identify with a case flag).

KDHE Response: KDHE agrees with this finding. Through our ongoing efforts to improve eligibility accuracy work we learned that when the KEES eligibility system launched in 2015, the system design did not include an automated process to alert an eligibility worker when they are about to assign a duplicate Medicaid ID to an existing beneficiary.

KDHE is currently assessing the projected cost and timeline of adding this functionality. Adding a duplicate ID alert could be the most effective way to eliminate duplicate IDs going forward. Social Security number functionality to inform staff that a number is already in the database to aid additional checks for that member on other cases, was added to KEES in August 2017. There have been defects at various points in time that may have allowed a duplicate SSN to be assigned under certain circumstances. However, through submission of tickets to KEES Helpdesk, these issues are researched and examined to resolve duplicate ID issues with the system developer. As defects are resolved, the duplicate IDs are linked to the correct beneficiary ID in KEES to avoid downstream fiscal impact later.

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On behalf of our entire Medicaid team, we again thank you and appreciate your continued partnership, your professionalism, and your desire for Kansas to maintain the upmost quality-driven Medicaid program.
Sincerely,

Christine Osterlund/yrc

Christine Osterlund
Interim Medicaid Director/Deputy Secretary of Agency Integration and Medicaid
Kansas Department of Health and Environment