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**KANSAS
ATTORNEY GENERAL**

DEREK SCHMIDT

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Letter from the Inspector General

April 13, 2022

To: Attorney General Derek Schmidt

Kansas Department of Health and Environment, Janet Stanek, Secretary
Kansas Department of Health and Environment, Sarah Fertig, Medicaid Director
Kansas Department of Aging and Disability Services, Laura Howard, 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
Representative Will Carpenter
Representative Susan Concannon
Representative Megan Lynn
Representative Susan Ruiz

Senator Richard Hilderbrand, Vice-Chair
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Senator Beverly Gossage
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Senator Mark Steffen

This report contains findings from our performance audit of the Kansas Department of Health and Environment's (KDHE) and the Kansas Department for Aging and Disability Services' (KDADS) oversight of Medicaid beneficiaries on the Home and Community Based Services (HCBS) waiver program. 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 and KDADS staff throughout this audit. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Inspector General

Executive Summary

The objectives of this audit were to determine the following:

1. **Does KDHE have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program?** KDHE does not have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program. The number and types of findings identified during the audit indicate control weaknesses which could place Kansas waivers at risk.
2. **Are there Medicaid beneficiaries on the HCBS program who have not used it for more than a year?** There were **2,854** Medicaid beneficiaries identified as being enrolled in an HCBS waiver, but did not have any HCBS claims filed on their behalf for a total of 12 or more months during the audit period of January 1, 2018 through April 30, 2021. We found that **63** of those Medicaid beneficiaries did not have HCBS claims for the entire 40-month audit period.
3. **What are the requirements and responsibilities of the Managed Care Organizations to ensure Medicaid beneficiaries are properly enrolled in the HCBS program?** For the scope of this audit, MCOs are required by contract to monitor Medicaid beneficiaries' use of waiver services and make the proper notifications if services are not being used. It appears, based on the number of Medicaid beneficiaries that are not using waiver services for extended periods of time, this oversight function is not being met.

Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System (KMMS), we identified **34,192** beneficiaries who had six or more months of enrollment in a single HCBS waiver during the audit period of January 1, 2018, through April 30, 2021. Our initial audit period start was July 1, 2018, but we expanded it to include additional files for review. Of the **34,192** identified, the following was noted:

- **262** beneficiaries did not have any Medicaid claims filed on their behalf for a total of 12 or more months of the audit period. This means that no Medicaid claims were identified and no HCBS services were identified. The amount of capitation payments made to Managed Care Organizations (MCOs) for the **262** beneficiaries identified during the audit period was **\$10,651,131.67**.
- **2,854** beneficiaries did not have any HCBS waiver services claims filed on their behalf for a total of 12 or more months during the audit period. The amount of capitation payments made to MCOs for the **2,854** beneficiaries identified during the audit period was **\$193,253,420.91**. This population includes the **262** beneficiaries identified above. It is understood that some waiver participants would qualify for regular Medicaid based upon their income level. A thorough review of each beneficiary's Medicaid case would need to be made to determine the portion of the **\$193,253,420.91** in capitation payments that could have been saved.

This is noteworthy due to the requirement that individuals on the waiver programs must use the service at least once a month to remain eligible. The lack of use should have been identified by the HCBS

program managers and MCOs, which would have triggered an effort to have the individual removed from the waiver program.

Life Alert Concerns – Procedure Code S5161

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

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

Wasteful Payments to FMS Providers

Beneficiaries who self-direct their services must choose a Financial Management Services (FMS) provider to help them perform payroll and employer-related duties. FMS is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. FMS providers are paid a monthly fee for providing administrative and payroll services for beneficiaries. The average monthly fee paid during the audit period was **\$118.00**.

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

Introduction

The Medicaid Program

Medicaid is an entitlement program that was authorized by Title XIX of the Social Security Act in 1965. It provides health care coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The Centers for Medicare & Medicaid Services (CMS) is responsible for the overall administration of the program at the federal level. Although the federal government establishes certain parameters for all states to follow, each state administers their own Medicaid program differently, resulting in different variations of coverage throughout the United States.

The Medicaid program is funded by a combination of state and federal dollars. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). In exchange, states must fund their share of Medicaid expenditures in accordance with a CMS approved state plan. States then establish their own Medicaid provider payment rates within federal requirements, and generally pay for services on behalf of Medicaid beneficiaries through a managed care method or a fee-for-service (FFS) method.

Home and Community Based Services (HCBS) Waivers

The Medicaid Home and Community Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program gives states the option to waive certain specific Medicaid statutory requirements so that they may voluntarily offer to furnish extra services and supports that help qualified beneficiaries receive care in their own home or community, instead of an institution such as a nursing home or hospital.

HCBS services can assist beneficiaries with activities of daily living such as eating, bathing, and dressing. In addition, HCBS services can assist with instrumental activities of daily living such as managing finances or preparing meals. A state's waiver program must be approved by CMS to claim federal reimbursement for services that are not usually covered by Medicaid or other health plans.

Kansas Medicaid (KanCare)

Most Kansas Medicaid beneficiaries are covered by KanCare, the state's Medicaid managed care program. KanCare became effective on January 1, 2013, after the state submitted and received federal approval for a Section §1115 waiver. This waiver authority allowed Kansas to move most Medicaid beneficiaries to managed care, with services provided through MCOs. During the audit period, KDHE contracted with the following MCOs:

- Amerigroup (Contract with KDHE ended 12/31/18)
- Aetna Better Health of Kansas (Contract with KDHE started 01/01/19)
- Sunflower State Health Plan
- United Healthcare Community Plan of Kansas

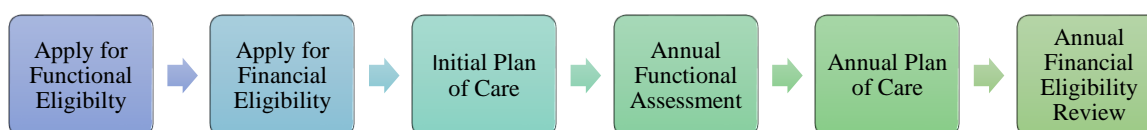
HCBS Waivers in Kansas

Kansas offers seven HCBS waivers to beneficiaries who meet functional and financial eligibility criteria:

- Autism (AU)
- Brain Injury (BI)
- Frail Elderly (FE)

- Intellectual and Developmentally Disabled (IDD)
- Physical Disability (PD)
- Severe Emotional Disturbance (SED)
- Technology Assisted (TA)

Once approved for a waiver, beneficiaries must meet specific requirements to keep receiving HCBS services. The table below explains the application process and the requirements needed to maintain HCBS services once approved:



HCBS Eligibility

Determining eligibility for HCBS services is a two-step process that involves applying for services (functional eligibility) and applying for KanCare (financial eligibility).

Apply for Services (Functional Eligibility)

To qualify for an HCBS waiver, individuals must obtain a functional eligibility assessment. Functional eligibility is determined by assessing entities (Points of Entry) that have contracts with KDADS. Functional eligibility assessments help to establish the type and extent of an individual’s care needs, which assist with the person-centered care planning process.

Each assessing entity uses a variety of assessment and screening tools to determine an individual’s need for services, considering factors such as level of care (LOC) requirements, natural supports available to them, and risk of institutionalization. The following table shows each waiver offered, the associated assessing entity, and the name of the functional assessment conducted:

Waiver	Points of Entry/Assessment Conducted
Autism	KVC Health Systems Functional Assessment - Vineland
Brain Injury	Aging and Disability Resource Centers (ADRC) Functional Assessment - MFEI
Frail and Elderly	Aging and Disability Resource Centers (ADRC) Functional Assessment – FAI
Intellectual Developmentally Disabled	Community Developmental Disability Organizations (CDDO) Functional Assessment - BASIS
Physical Disability	Aging and Disability Resource Centers (ADRC) Functional Assessment - FAI
Serious Emotional Disturbance	Community Mental Health Centers (CMHC) Functional Assessment - CAFAS
Technology Assisted	Independent Qualified Registered Nurses Functional Assessment – MATLOC

Apply for KanCare (Financial Eligibility)

To qualify for KanCare, the income and assets of the person who will be receiving the HCBS services is reviewed by the KDHE financial eligibility team. The ES-3160 and ES-3161 forms have been

specifically designed as communication tools between all entities (KDHE, KDADS, Points of Entry, and MCOs) for beneficiaries who meet HCBS eligibility requirements.

According to KDHE-DHCF Policy No: 2018-06-01, if an individual is found functionally and financially eligible for a waiver, and there is an open space available for the waiver requested, KDHE eligibility staff complete an ES-3160 form and forward it to the MCO that will support the beneficiary in overall service access and care management. If the beneficiary is already receiving HCBS services, the ES-3161 form is used to communicate any changes in HCBS eligibility, including termination. Encrypted email is the method used for sending both forms between all entities. When an individual is approved for an HCBS waiver, they must also apply for KanCare to help pay for their medical care. The KDHE financial eligibility team only considers the income and assets of the person who will receive HCBS services, even for children.

Waiver Capacity and Waiting List Management

Since HCBS waiver programs are optional for each state, enrollment may be capped for each waiver. This means that once enrollment hits its funding cap for the waiver, individuals are placed onto a waiting list. Individuals on a waiting list, do not actually receive waiver services until a slot becomes available, however they may be eligible for KanCare services.

According to the KDADS December 2021 HCBS Monthly Summary, (Data as of 01/18/22) there were **4,640** individuals on the IDD waiting list and **2,142** individuals on the PD waiting list. KDADS is responsible for the oversight and management of each waiting list in Kansas. Our audit identified **579** individuals on the IDD waiver and **551** individuals on the PD waiver who had no HCBS claims for at least 12 or more months during the audit period.

Initial Plan of Care (POC)

HCBS must be furnished under a written person-centered service plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.¹ The POC outlines the services the beneficiary will receive, the provider authorized to perform the services, and the rate at which the services will be reimbursed. The POC development and approval is the responsibility of the appropriate MCO Care Coordinator. The total cost of the approved plan is included on the POC/person-centered service plan. This cost, less any standard amount included for acute care costs, is the HCBS cost of care.²

When a beneficiary is new to Medicaid and not previously connected with an MCO, the POC can require additional time to develop and finalize. Eligibility for HCBS is determined with the assumption that the MCO will have the POC completed within thirty days of receiving HCBS eligibility information via the ES-3160 form. Notification is sent to KDHE each week when the MCO is unable to complete the person-centered service plan.

MCO Spreadsheet Process

Since KDHE handles financial eligibility, a spreadsheet process is used as a communication tool between KDHE and each MCO. Excel spreadsheets are sent back and forth between each MCO and KDHE via a File Transfer Protocol (FTP) site on a weekly basis.

¹ 42 CFR § 441.301(b)(1)(i)

² Medical KEESM § 8200.3.

Self-Direction

Some HCBS waiver participants have the option to self-directed care, agency-directed care, or a combination of both. The opportunity for self-directed care is made known to the beneficiary by the MCO Care Coordinator during the POC process. Self-direction allows beneficiaries the decision-making authority to recruit, hire, train and supervise the individuals who furnish their personal care services.

Financial Management Services

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

FMS providers are paid a monthly fee for providing administrative and payroll services to each beneficiary. The average monthly fee paid during the audit period was **\$118.00**. A participant may have only one FMS provider per month.

Monitoring and Continuation of HCBS Waiver Services

In order for a waiver to be approved, a state must submit an initial waiver application to CMS. The application describes the proposed waiver's design and operational features. Once the waiver is approved by CMS, the state must implement the waiver as specified in the approved application.

The state is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver participants and that there are effective systems in place to monitor participant health and welfare. If these assurances are not met, CMS may not grant a new waiver, or may terminate a waiver already granted.

Use Services Monthly

As specified in 42 CFR §441.302(c), the state provides for an initial evaluation (and periodic reevaluations) of the need for the level(s) of care specified for the waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

In order for an individual to be considered to require a level of care specified for the waiver, it must be determined that the person: (a) requires at least one waiver service (as evidenced by the service plan) and (b) requires the provision of waiver services at least monthly or, if less frequently, requires monthly monitoring (as documented in the service plan) to assure health and welfare. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.³

Annual Functional Assessment

42 CFR § 441.302(c)(2) requires that a state agency must provide for reevaluations, at least annually, of each beneficiary receiving HCBS to determine if the beneficiary continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in a hospital,

³ Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria Release
Date: January 2019

a nursing facility, or an intermediate care facility. Yearly functional eligibility is determined by the assessing entities.

KDADS contracted assessors have the responsibility to track reassessment due dates and ensure that functional eligibility redeterminations are completed timely. For five of the seven waivers (IDD, BI, PD, FE, TA), assessments are maintained in the Kansas Assessment Management Information System (KAMIS) to which KDADS contracted assessors have access. The assessments for the SED and Autism waivers are maintained by the contracted assessing entity, with portions uploaded to KAMIS.

It was found that KAMIS only sends out a single notification that annual assessments are due. The system does not automatically generate reports that the annual assessment for a Medicaid beneficiary has not been completed. As discovered during this audit, some Medicaid beneficiaries go for several years without having an annual assessment done and KAMIS does not alert KDADS staff to the problem.

Annual Plan of Care

The person-centered service plan must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.⁴

Annual Financial Eligibility (Reviews)

The review process is a complete re-examination by the agency concerning all factors of eligibility. The purpose of the review is to give the beneficiary 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 determine the household's continuing eligibility for assistance. Assistance is reviewed annually and the beneficiary must report changes that occur in a timely manner.⁵

⁴ 42 CFR § 441.301(c)(3)

⁵ Medical KEESM § 9310

Audit Objectives and Scope

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

1. Does KDHE have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program?
2. Are there Medicaid beneficiaries on the HCBS program that have not used it for more than a year?
3. What are the requirements and responsibilities of the Managed Care Organizations to ensure Medicaid beneficiaries are properly enrolled in the HCBS program?

The scope of our audit included all beneficiaries who had 12 or more months of enrollment in a single HCBS waiver from January 1, 2018 through April 30, 2021. Our initial audit period start was July 1, 2018, but we expanded it to include additional files for review.

The scope of our audit did not review KDHE's overall internal control structure or the internal controls over the entire HCBS program. We limited our review of internal controls that were applicable to our objectives. The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for the services claimed for reimbursement. We did not assess the appropriateness of HCBS payment rates.

Applicable Laws and Policies

The Managed Care System (Capitation Payments)

States establish their own Medicaid provider payment rates within federal requirements, and generally pay for services on behalf of Medicaid beneficiaries through a fee-for-service (FFS) method or a managed care method.

- Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary.
- Under managed care, the state pays a monthly capitation payment to a contracted Managed Care Organization (MCO) for each person enrolled in the plan. The amount of the capitation payment varies depending on the assistance program for which the beneficiary qualifies. The MCO then pays each medical provider for the medical services a beneficiary is provided that are included in the plan's contract with the state.
- A capitation payment is made to each MCO regardless of whether the beneficiary incurs any medical costs during that month. Eligibility is received from KEES, the state's system for determining eligibility. Capitation payments are made based off a rate cell that is set by Population Codes, Level of Care, Age or any combination of those. Members will qualify for HCBS rate cells based off of their Level of Care. For example, beneficiary's capitation rates in the Serious Emotional Disturbance waiver from population 2 below; range from around \$1,100 a month, upwards of \$7,000 a month.
- Failure to timely discontinue Medicaid coverage when a beneficiary is no longer eligible, can lead to capitation payments being made for ineligible persons.
- Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified and approved by CMS.
- Capitation rates are based on actuarial analysis of historical data for all waiver program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The MCOs are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the state's review for cost adjustments.

The state's contracts with the three MCOs allow the state to recoup capitation payments that were made for a person later determined to be ineligible. Monthly capitation payments calculated in accordance with the contract will be paid by the state and the contractor(s) may only retain capitation payments for Medicaid eligible members. Those contractual specifications state the following:

Contract ID 45079 - Event ID EVT0005464, Period of Contract: January 1, 2019 through December 31, 2023; 5.4.11. SPECIAL NEEDS POPULATION details the following:

The CONTRACTOR(S) shall timely recommend voluntary and involuntary closure for HCBS Waiver services to the appropriate State agency using the established notification process as described by the State. Reasons for voluntary and involuntary terminations as defined by the HCBS Waiver service notification of termination policy may include, but are not limited to:

- a. *Member has no assessed need for services upon assessment or reassessment.*
- b. *Client obligation is higher than the cost of service as identified on the integrated service plan.*
- c. *Member has refused to pay client obligation as documented by the Provider to whom the client obligation is to be paid or the Financial Management Services (FMS) Provider and verified by the service coordinator.*
- d. *Member has refused services and supports identified on the integrated service plan as documented and signed by the Member and/or guardian.*
- e. *Member has been institutionalized for longer than the temporary care period of time (the month of Admission and two [2] subsequent months) and is no longer eligible for services.*
- f. *Member is unable to be located or fails to respond per requirements in Section 5.4.11.E.4, to attempts to locate for initial or annual assessment for services.*
- g. *Member refuses to sign the PCSP, the Plan of Service or the WORK Individualized Budget.*
- h. *Member is no longer receiving services under the LTSS program.*
- i. *Member has requested termination of services.*
- j. *Member cannot be contacted or does not respond to reasonable attempts to contact the Member as required by the notification of termination policy.*

Methodology

To accomplish our objectives, we performed the following tasks:

- (1) Communicated with agency officials and various staff members from KDHE and KDADS to gain an understanding of the HCBS program.
- (2) Reviewed federal and state laws, regulations, business practices, policies, procedures, contracts, or other standards that were relevant to the audit objectives.
- (3) Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System (KMMS), identified **34,192** beneficiaries who had six or more months of enrollment in a single HCBS waiver during the audit period. The total population was input onto an Excel spreadsheet. The following data points were extracted:
 - The waiver the beneficiary was enrolled in.
 - The number of months the beneficiary was enrolled in the assigned waiver.
 - The most recent date of a Medicaid claim.
 - The beginning and end dates of enrollment during the audit period.
 - The number of months a beneficiary had zero Medicaid claims.
 - The number of months a beneficiary had no HCBS services.

(4) Created two sampling populations for analysis:

a) Population 1 - No Claims History

Beneficiaries who were enrolled in a waiver during the audit period, but did not have any Medicaid claims filed on their behalf for 12 or more months of the audit period.

- Identified **262** beneficiaries who had a total of 12 or more months without a Medicaid claim during the audit period. Sorted the **262** beneficiaries with the most prolonged amount of time that had passed without any Medicaid claims being filed, and created a sample of the top **50** beneficiaries.
- Conducted controls and compliance testing using the KEES journal notes and ImageNow. ImageNow was used to see if all cases were supported with the appropriate scanned documentation. KEES was used to identify any journal notes related to corresponding HCBS information.

b) Population 2 - No HCBS Services

Beneficiaries who may have had Medicaid claims filed on their behalf during the audit period, but none of the Medicaid claims filed were for HCBS waiver services.

- Identified **2,854** beneficiaries who had a total of 12 or more months without an HCBS claim during the audit period. We also noted **63** of those beneficiaries did not have HCBS claims during the entire 40-month audit period.
- The following HCBS CPT codes were used in our data pull for the following waivers:
Serious Emotional Disturbance - T1019, T2038, S5110, S9485, S5150, H2021
Physical Disability - S5125, S5170, S5185, T1505, S5160, T2025
Frail and Elderly - S5101, S5102, S5130, S5125, S5135, S0315, S0317, S5815, T1001, S5160, T2025, S5190
Brain Injury - H0004, G0515, S5170, S5185, T1505, G0152, S5160, S5125, G0151, T2025, G0153, H2014
Intellectual & Developmentally Disabled - H0045, T1019, T2025, T1000, S5125, H2023, S5190, T2016, T2021
Technology Assisted - T1000, T1001, T1002, T1004, T1005, T1019
Autism - T1005, T1027, S9482
- The following two codes were excluded from our data pull because they are fixed monthly claims:
T2040 - Financial Management Services Self-Directed
S5161 - Emergency Response System Service Admin Fee
- Sorted the **2,854** beneficiaries with the most prolonged amount of time that had passed without any HCBS claims from being filed, and created a sample of the top **10** beneficiaries in each waiver for a total of **70** transactions.
- Conducted controls and compliance testing using the KEES journal notes and ImageNow to determine what type of financial eligibility re-determination was conducted.

- (5) Accessed alternative online information sources to independently confirm or perform additional analysis as needed such as the Thomson Reuters CLEAR program and www.medicaid.gov
- (6) Reported draft findings and recommendations to KDHE and KDADS leadership, and reviewed the agency's responses.
- (7) 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. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Population 1 Audit Results – No Claims History

According to the data we obtained from KMMS, there were **262** beneficiaries who were identified as being enrolled in an HCBS waiver, but did not have any Medicaid claims history for a total of 12 or more months during the audit period. This means that no Medicaid claims were identified, and no HCBS services were identified.

Of the **262** beneficiaries identified, we tested the top **50** with the most prolonged amount of time that had passed without any Medicaid claims being filed. Our testing results determined that **35** (70%) of the **50** cases within our sample population were enrolled in the Serious Emotional Disturbance waiver. The additional cases are summarized in the table below:

Waiver	Total	% of Total
Serious Emotional Disturbance	35	70%
Physical Disability	9	18%
Frail and Elderly	4	8%
Brain Injury	1	2%
Intellectual & Developmentally Disabled	1	2%
Technology Assisted	0	0%
Autism	0	0%
Total	50	100%

One of the **63** beneficiaries with no HCBS claims filed throughout the entire 40-month audit period passed away in October 2017, but their file remained active with KanCare. A death certificate was identified using the Thomson Reuters CLEAR program. KDADS response to this was as follows:

Beneficiary passed away in 2017. Last LOC assessment 11/2016. KDADS Program file indicates document received was 3161 from KDHE 9/7/2021, closing the case 9/30/2021. 3161 reports agency submitter was functional assessor, but form sent 8/30/21 from Care Coordinator at UHC. Reason for closure, consumer no longer wants services.

It was confirmed after reviewing KEES and ImageNow that the deceased person's file was closed and recoupment of **\$229,870.44** from the MCO for the period of November 2017 to September 2021 was completed. The ES-3161 form did document that the reason for closure was "The consumer no longer wants services."

Additional testing was conducted to see if all cases were supported with proper written documentation in the KEES journal notes and/or if the appropriate scanned ES-3161 form was located in the ImageNow system. We then calculated the amount of time it took for an HCBS beneficiary to be removed from the HCBS program after the request for removal was received.

Waiver	A	B	C	D	Total
Serious Emotional Disturbance	5	2	2	26	35
Physical Disability	3	1	3	2	9
Frail and Elderly	1	0	0	3	4
Brain Injury	0	0	0	1	1
Intellectual & Developmentally Disabled	0	0	0	0	0
Technology Assisted	0	0	0	0	0
Autism	1	0	0	0	0
Total	10	3	5	32	50
Percent of Total	20%	6%	10%	64%	100%

Legend

A = No ES-3161 Form, HCBS Still Active

No discontinuance form had been submitted and the beneficiary remained active.

B = No ES-3161 Form, HCBS Discontinued

No discontinuance form was found, but the beneficiary was removed from HCBS waiver.

C = ES-3161 Form Received, HCBS Active

A discontinuance form had been received, but the beneficiary remained active.

D = ES-3161 Form Received, Discontinued

The discontinuance form was found, and the beneficiary was removed from the HCBS waiver.

However, **26** (81%) out of the **32** beneficiaries were not removed from HCBS on a timely basis. See audit results below.

Audit Results:

- **10** (20%) out of **50** beneficiaries did not have an ES-3161 form located in ImageNow or referenced to in KEES journal notes. The beneficiary was not removed from HCBS.
- **3** (6%) out of **50** beneficiaries did not have an ES-3161 form located in ImageNow or referenced to in KEES journal notes, but they were removed from HCBS.
- **5** (10%) out of **50** beneficiaries had an ES-3161 form located in ImageNow or referenced to in KEES journal notes. They were not removed from HCBS.
- **32** (64%) out of **50** beneficiaries had an ES-3161 form on file. The beneficiary was removed from HCBS.
 - **26** (81%) out of the **32** beneficiaries were not removed from HCBS on a timely basis. The average time it took KDHE to remove the beneficiaries identified in the chart below from a waiver was two years and four months. As a result, we believe MCO capitation rates and/or FMS administrative fees, may have been paid in error.

Testing ID	Waiver	Date HCBS Discontinuance was Requested	Actual Date HCBS was Discontinued	Number of Years & Months Between Dates
2	PD	09/21	09/21	0
9	SED	11/20	11/20	0
28	FE	3/21	3/21	0
29	SED	12/19	12/19	0
42	SED	11/20	11/20	0
45	FE	09/20	09/20	0
30	SED	6/19	4/21	1 year, 10 months
31	SED	5/18	3/20	1 year, 10 months
33	SED	1/19	11/20	1 year, 10 months
39	SED	12/17	9/19	1 year, 9 months
41	FE	2/17	9/19	2 year, 7 months
25	SED	6/19	6/21	2 Years
38	SED	5/19	5/21	2 years
44	SED	09/19	09/21	2 years
46	SED	06/18	04/21	2 years, 10 months
8	SED	06/18	05/21	2 years, 11 months
17	SED	6/18	5/21	2 years, 11 months
34	SED	8/17	10/19	2 years, 2 months
32	SED	1/18	4/20	2 years, 3 months
43	BI	01/16	08/19	3 year, 8 months
20	SED	5/18	5/21	3 years
19	SED	4/18	5/21	3 years, 1 month
16	PD	10/17	1/21	3 years, 3 months
11	SED	11/17	4/21	3 years, 5 months
36	SED	11/17	4/21	3 years, 5 months
7	SED	06/17	01/21	3 years, 7 months
15	SED	11/17	8/21	3 years, 9 months
10	SED	05/21	09/21	4 Months
5	SED	08/17	08/21	4 years
27	SED	9/16	11/20	4 years, 2 months
4	SED	01/17	06/21	4 years, 5 months
12	SED	6/16	08/21	5 years 2 months
			Average Time for Removal from HCBS	2 years, 4 months

We do not believe the delay for removal from HCBS was related to the COVID-19 public health emergency because the majority of requests for removal were dated between 2016 and 2019. The national emergency concerning the COVID-19 outbreak was not declared until March 13, 2020. We did identify the following written testimony provided by KDHE on February 15, 2019, at the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight:

“KDHE recently discovered some Maximus staff located at the clearinghouse have not been trained on how to search the imaging system for documents, which may explain why beneficiaries have been told their documents were not received or could not be located. Training has been provided to alleviate this issue, and KDHE is working to create a more efficient system.”

Population 2 Audit Results – No HCBS Services

We identified **2,854** beneficiaries who had a total of 12 or more months without an HCBS claim being filed during the audit period. This means that Medicaid claims may have been identified; however, no HCBS waiver services were identified. We also noted there were **63** beneficiaries that had no HCBS waiver services during the entire 40-month audit period.

Ordering from the highest to lowest number of months without an HCBS service, the top ten (70) beneficiaries of each waiver were analyzed using KEES and ImageNow. If the beneficiary had already been reviewed in Population 1, they were skipped. We reviewed controls and compliance related to annual re-determinations and HCBS functional assessments. If a passive recertification was granted, then an application would not be required for the given year.

Testing was conducted to see if all cases were supported with proper written documentation in KEES journal notes, and/or if the appropriate scanned ES-3161 form was located in the ImageNow system. We also reviewed information related to annual financial eligibility reviews and HCBS functional assessments.

Waiver	Number of Beneficiaries	% of Total
Serious Emotional Disturbance	845	29.6%
Frail/Elderly	722	25.3%
Physical Disability	551	19.3%
Intellectual Developmentally Disabled	579	20.3%
Brain Injury	68	2.4%
Technology Assisted	30	1.0%
Autism	59	2.1%
Total	2,854	100%

Audit Findings

On February 15, 2022, a draft report of our preliminary findings, recommendations, and conclusions was forwarded to KDHE and KDADS with a response due date of March 1, 2022. Both departments requested an extension of two weeks to make the deadline for response March 15, 2022. The responses were received timely and are attached to this report. The responses from each department to each recommendation are included in this section in italics. Where appropriate, a rebuttal to their responses has been added.

An exit conference was conducted on March 31, 2022. The draft report was amended to clarify items addressed at the exit conference. The amended draft report was provided to each department for an opportunity to review and provide further comments. A letter dated April 7, 2022, was received that was a consolidated response to the report. The letter includes additional comments and explanations from KDHE and KDADS about calculations of capitation payments, Medicaid usage, and internal audits that were conducted.

Finding #1: Non-Compliance with Federal Regulations

The HCBS waivers require beneficiaries enrolled to utilize HCBS services at least monthly in order to remain on the waiver. We identified **34,192** beneficiaries who had six or more months of enrollment in a single HCBS waiver during the audit period of January 1, 2018, through April 30, 2021. Out of the **34,192** identified:

- **262** did not have any Medicaid claims filed on their behalf for a total of 12 or more months during the audit period. This means that no Medicaid claims were identified, and no HCBS services were identified. The amount of capitation payments made to MCOs for the **262** beneficiaries identified during the audit period was **\$10,651,131.67**.
- **2,854** did not have any HCBS waiver services claims filed on their behalf for a total of 12 or more months during the audit period. We also noted there were **63** beneficiaries that had no HCBS claims during the entire 40-month audit period. The amount of capitation payments made to MCOs for the **2,854** beneficiaries identified during the audit period was **\$193,253,420.91**. This population includes the **262** beneficiaries identified above. It is understood that some waiver participants would qualify for regular Medicaid based upon their income level. A thorough review of each beneficiary's Medicaid case would need to be made to determine the portion of the **\$193,253,420.91** in capitation payments that could have been saved.

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

In 2016, KDADS reviewed individuals on the HCBS waivers for anyone who was no longer eligible due to not utilizing HCBS services for an extended period or due to not meeting functional eligibility requirements. KDADS provided KDHE with a list of these individuals for waiver eligibility closure. The one-time project identified **678** individuals that needed to be removed from HCBS. No additional projects of a similar nature have been undertaken.

KDADS HCBS program staff advised us that they do not have access to KEES or ImageNow. They also do not have online access to plans of care or needs assessments that are maintained by the MCOs. Consequently, they do not have access to the systems needed to provide proper oversight of the waivers.

It appears that the KDADS HCBS program is significantly understaffed and does not have the proper tools to provide HCBS program oversight of assessing entities or HCBS participants.

Recommendations:

- 1. KDADS should allocate sufficient staff needed for administrative duties to allow HCBS program managers to properly provide oversight of each waiver.**

KDHE response: KDHE defers response on this recommendation to KDADS.

KDADS response: KDADS agrees with this recommendation. KDADS has initiated the recruitment process for additional positions within its HCBS unit to provide support for administrative and functional eligibility processes in order to allow the HCBS program managers to focus their time and attention on program oversight, including oversight of MCOs in concert with KDHE. The agency will require the addition of ongoing funding to maintain the additional staff.

- 2. HCBS program managers should have access to KEES, ImageNow, and MCOs websites and be trained on the systems. This would increase their capability to properly manage Medicaid beneficiary cases.**

KDHE response: KDHE concurs with the KDADS response on this recommendation. Please also note, once the Kansas Modular Medicaid System (KMMS) is fully operational, the MCOs' Person Centered Service Plans (PCSPs) will be in the state system. HCBS program managers will no longer need access to MCO databases.

KDADS response: KDHE and KDADS have established a structured communication workflow between agency staff that we believe is effective. KDHE hosts an HCBS inquiry e-mail inbox to which information requests can be sent by KDADS program managers. Multiple KDHE eligibility staff have access to the e-mail inbox and KDADS program managers generally receive responses to inquiries within the business day. KDADS program managers can contact KDHE eligibility staff via telephone, as well.

Rebuttal: Interviews of staff found that the e-mail system was not fool proof and e-mails were sometimes overlooked when staff were out of the office. The idea behind giving KDADS program managers access to key systems, such as, KEES and ImageNow is to allow them direct access to the information without involving other people.

3. Conduct yearly program reviews to identify individuals that should be removed from the HCBS program similar to the project conducted in 2016.

KDHE response: KDHE concurs with the KDADS response on this recommendation.

KDADS response: KDADS agrees with this recommendation. KDADS will implement a review of each HCBS waiver at least annually to identify individuals enrolled on the waiver that are not meeting the requirements to utilize one HCBS waiver service per month. Individuals that are not receiving services will be evaluated for removal from waiver enrollment. MCOs will be expected to provide information regarding their respective members who are not receiving the required waiver service per month. KDADS and KDHE will verify the information provided by the MCOs and determine the actions to be taken regarding each individual's continued eligibility. Further, the agencies will utilize the review to evaluate MCO performance with regards to their contractual responsibilities to report for eligibility closure those members not meeting monthly service requirements.

Finding #2: Untimely Removal of Beneficiaries from the HCBS Program

Our sample revealed that 81% of the beneficiaries that had an ES-3161 removal form in ImageNow were not removed from HCBS on a timely basis. The average time it took KDHE to remove a beneficiary from our sample population was two years and four months. As a result, we believe MCO capitation rates and/or FMS administrative fees, may have been paid in error.

We do not believe the delay for removal from HCBS was related to the COVID-19 public health emergency because the majority of requests for removal were received between 2016 and 2019. The public health emergency concerning the Novel Coronavirus Disease (COVID-19) outbreak was not declared until March 13, 2020.

All pertinent events which impact eligibility or the HCBS plan must be communicated to the partner entity. Examples of pertinent events include establishment of initial eligibility, case closure, changes in client obligation, changes in address or living arrangement, significant changes in the cost of the HCBS plan and death. These events shall be communicated timely using an appropriate method of communication. The ES-3160 and ES-3161 have been specifically designed as communication tools between staff. Encrypted email is the method used for communicating between entities. The appropriate form must be included in the encrypted e-mail, a general e-mail describing the change is not sufficient.⁶

To coordinate HCBS services, KDHE uses an Excel spreadsheet process as a communication tool that is sent via a File Transfer Protocol (FTP) site between MCOs. KDHE receives, manages, and stores all MCO processing spreadsheets for eligibility processing. Prior to November 2019, MCO eligibility processing spreadsheets were outsourced to the eligibility contractor.

KDHE, KDADS, and the MCOs each manage their own systems to oversee the HCBS program which causes each organization to share information via email. This does not appear to be an effective method to manage the HCBS program. It was reported that emails get lost and are not always handled timely. This occurs when the person responsible for checking the email box is not available. There is no system

⁶ Medical KEESM § 8200.4

for verifying that ES-3161 forms transmitted via email to another office are properly recorded except by manual means.

Recommendations:

- 1. A central data base should be created or an existing system modified that would allow KDHE, KDADS, and the MCOs to share functional and financial eligibility documentation.**

KDHE response: KDHE concurs with the KDADS response on this recommendation.

KDADS response: KDADS and KDHE will work together to identify and evaluate options to address this recommendation. The agencies have identified existing models that successfully communicate eligibility data between KDADS and KDHE and will explore the benefits of implementing similar processes for the HCBS waivers.

- 2. Quality control steps should be taken to ensure that Medicaid beneficiaries are removed in a timely manner.**

KDHE response: KDHE began transitioning the processing of HCBS eligibility from a previous eligibility contractor to the state in October 2019. Processing timeframes have significantly improved, due to the implementation of processing efficiencies and quality control steps. Multiple reports have been introduced, are reviewed, and prioritized appropriately to facilitate timely eligibility action. These reports facilitate streamlined HCBS processing and allow KDHE to identify quickly, eligibility action that may need to be taken.

KDADS response: KDADS defers response on this recommendation to KDHE.

Finding #3 KAMIS System

The Kansas Assessment Management Information System (KAMIS) is the repository for functional assessment information. For five of the seven waivers (IDD, BI, PD, FE, TA), assessments are maintained in the KAMIS to which KDADS contracted assessors have access. The assessments for the SED and Autism waivers are maintained by the contracted assessing entity, with portions uploaded to KAMIS.

It was found that KAMIS only sends out a single notification that annual assessments are due. The system does not automatically generate reports that the annual assessment for a Medicaid beneficiary has not been completed. As discovered during this audit, some Medicaid beneficiaries go for several years without having annual assessment done and KAMIS does not alert KDADS staff to the problem.

Recommendations:

- 1. KAMIS should be updated to automatically notify KDADS staff that an annual assessment has not been completed and to continue to send regular reminders until the beneficiary is removed or the assessment is completed and entered.**

KDHE response: KDHE defers response on this recommendation to KDADS.

KDADS response: KDADS agrees that overdue assessment reports should be available to HCBS staff for follow up with contracted assessors. KDADS will ensure these reports are available to HCBS staff on set interval to ensure beneficiaries either receive an annual reassessment or are removed from waiver services.

2. KDHE and KDADS should review the possibility of modifying KEES to manage the tracking of functional assessments and being able to eliminate KAMIS.

KDHE response: KEES is an eligibility system used to determine financial eligibility. Modifying the KEES system in this manner would be time consuming and costly; KDHE estimates the cost would be approximately \$6,000,000. We believe modifying KEES would less directly resolve the root of issue, which causes us to question if the benefit will outweigh the costs.

KDHE believes the KDADS response to recommendation #1 and #3 would more effectively mitigate the issue presented with this finding.

KDADS response: KDADS defers response on this recommendation to KDHE.

3. KDADS program managers need to ensure contracted assessors are completing assessments timely and that the requests for assessments are sent to the correct assessor.

KDHE response: KDHE defers response on this recommendation to KDADS.

KDADS response: KDADS agrees with this recommendation. KDADS has initiated the recruitment process for additional positions within its HCBS unit to provide support for administrative and functional eligibility processes, which will include assisting program managers with monitoring and oversight of the agency's contracted assessors. The agency will require the addition of ongoing funding to maintain the additional staff.

Finding #4: Lack of Documentation in ImageNow and KEES

At least half of the files reviewed, lacked the necessary documentation in ImageNow. In addition, multiple notes in KEES were either missing, incomplete, or lacked needed information.

According to KDHE-DHCF Policy No: 2018-06-01, the ES-3160 shall be completed for each individual initially requesting HCBS and the ES-3161 is for requesting changes. Our evaluation identified that over the past six months, documentation has significantly improved.

Recommendations:

1. Improve quality control measures and staff training to ensure new eligibility files are properly documented.

KDHE response: KDHE began transitioning the processing of HCBS eligibility from a previous eligibility contractor to the state in October 2019. Documentation has significantly improved, due to the implementation of quality control steps. Targeted training has been developed for select, experienced staff to process HCBS eligibility. Processing checklists have also been developed and shared with staff. These checklists include documentation requirements. In addition, KDHE conducts monthly audits to ensure eligibility casework is reflective of trained policies and procedures.

KDADS response: KDADS defers response on this recommendation to KDHE.

2. Existing files should be reviewed to ensure all required documentation is present.

KDHE response: KDHE will continue to ensure that all files contain the necessary documentation when KDHE staff process HCBS requests. Quality control activities have been implemented since KDHE insourced processing of eligibility for HCBS recipients, as outlined above. We believe the improved documentation referenced in this report is the result of KDHE insourcing this category of work, and our implemented quality control activities.

KDADS response: KDADS defers response on this recommendation to KDHE.

Finding #5: KDHE-DHCF Policy No. 2017-03-01

KDHE should exercise its contractual right to recoup capitation payments made for persons later determined to be ineligible. If a beneficiary is removed from HCBS due to non-compliance, but is still eligible for KanCare, a cost analysis to determine if a recoupment is needed should be considered.

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

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

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

Recommendations:

1. **KDHE should revise the policy to remove any artificial barriers to recoupment of capitation overpayments.**

KDHE response: The current three-month lookback period was established to carefully balance sound management of resources with the full-risk nature of the MCO contracts. KDHE will evaluate and consider this recommendation.

KDADS response: KDADS defers response on this recommendation to KDHE.

Rebuttal: We agree with the need to carefully balance sound management of resources with the full-risk nature of the MCO contracts; however, this should be balanced against the contractual responsibilities of the MCOs to identify Medicaid recipients who should be removed from the waiver programs. Instances where the MCOs properly identified the Medicaid recipient for removal and no or significantly delayed action was taken by KDHE staff should not result in a charge back to the MCOs. In cases where the MCOs did not fulfill their contractual obligations, they should not be allowed to profit and the state should seek to recoup those overpayments. Our analysis indicated that the majority of the 2,854 beneficiaries identified as not receiving services were not reported by the MCOs.

It is understood that some waiver participants would qualify for regular Medicaid based upon their income level. A thorough review of each beneficiary's Medicaid case would need to be made to determine the portion of the \$193,253,420.91 in capitation payments that could have been saved. As noted in Find #1, there is an apparent financial incentive for people to be on HCBS waivers since their income is not included with household income for calculation of financial eligibility. This allows a person that would not otherwise qualify for Medicaid due to household income, to receive full Medicaid services, which includes pharmacy coverage.

2. **Provide training to eligibility staff on any changes to this policy.**

KDHE response: KDHE will ensure training is completed, should the policy change.

KDADS response: KDADS defers response on this recommendation to KDHE.

Finding #6: Wasteful Payments to FMS Providers

Beneficiaries who self-direct their services must choose a Financial Management Services (FMS) provider to help them perform payroll and employer-related duties. FMS is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. FMS providers are paid a monthly fee for providing administrative and payroll services for beneficiaries. The average monthly fee paid during the audit period was **\$118.00**.

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

Recommendations:

- 1. KDADS and MCOs should timely notify KDHE to stop waiver services for individuals that are not using the service and terminate the payment of fees to FMS providers.**

KDHE response: KDHE concurs with the KDADS response on this recommendation.

KDADS response: Implementation of regular review processes as recommended in Finding 1, Recommendation 3, will ensure that individuals that are not receiving at least one HCBS waiver service per month can be evaluated for removal from waiver enrollment. KDADS notes that not only are FMS providers responsible for administrative tasks associated with payroll for direct service workers, FMS providers also serve an information and assistance role for the waiver participant. This includes: (1) Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services; (2) Assistance to the participant or participant's representative in arranging for, directing and managing services; (3) Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services; and (4) Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct support workers (DSW), managing workers, and providing effective communication and problem-solving. Based on these responsibilities, there may be instances where payment of an FMS fee is justified even if a waiver participant does not receive personal care services.

- 2. KDHE should consider recouping fees paid to FMS providers that were not actually providing administrative and payroll services since no services were being used.**

KDHE response: KDHE would refer to KDADS' response to Finding #6, Recommendation #1 above for information about the resources FMS providers provide beyond employer and payroll services. KDHE will consider this recommendation but is concerned about the impact it would have on the FMS provider network. KDHE will focus our efforts on improving communication methods between KDADS, KDHE, and the MCOs to ensure timely closure of HCBS services, including FMS.

KDADS response: KDADS defers response on this recommendation to KDHE.

Rebuttal: It would be understandable to allow the payment of the monthly fee in situations where the Medicaid beneficiary did not have a waiver services for a few months; however, a large number of the instances show that people went for extended periods of time without a DSW. It is difficult to justify payment of the fee to FMS providers that went for over a year and did not process payments to a DSW.

Finding #7: Life Alert Concerns – Procedure Code S5161

It was observed that procedure code S5161 (Emergency Response System Service Admin Fee) is being billed on a monthly basis. There are **560** beneficiaries who had one or more months of S5161 billed, without any additional Medicaid claims. It should be expected that other Medicaid claims would be billed for the beneficiary in addition to procedure code S5161, since states can only provide waiver services to beneficiaries who would otherwise be institutionalized in a nursing facility, hospital, or intermediate care facility.

See breakout below:

- Brain Injury - 5
- Frail & Elderly - 391
- Intellectual - 4
- Physical Disability – 160

HCBS Medical Alert rental is available to some Medicaid program participants. The purpose of this service is to provide support to a consumer who has a medical need that could become critical at any time. The medical alert device is a small instrument carried or worn by the consumer which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help 24 hours a day, 7 days a week.

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

Recommendations:

- 1. Determine if services were actually provided and are in accordance with an approved person-centered plan of care and agreed to by the beneficiary. In addition, identify any improper claims and handle accordingly.**

KDHE response: Managed Care Organizations are contractually required to review member functional assessments and establish Person-Centered Service Plans during initial contact with members. Based on these tools, MCOs provide benefits for services determined to be necessary and appropriate in accordance with language contained in CMS-approved waivers. Because the life alert device is permitted as the sole monthly service required to remain on applicable

waivers for our aged 65+ HCBS population, we believe the best use of our resources is to evaluate member utilization requirements for possible waiver changes.

KDADS response: KDADS defers response on this recommendation to KDHE.

- 2. Clarify in the policy manual if S5161 can be billed monthly by itself, or if another HCBS service is required to remain on the waiver. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.**

KDHE response: KDHE concurs with the KDADS response on this recommendation.

KDADS response: KDADS has reviewed the current approved waiver language and notes that S5161 (Personal Emergency Response System or PERS) may be provided by itself and it is not currently required that another HCBS service be accessed in order to remain on the waiver. The approved waiver language does require that a waiver participant have an assessed need for the service to receive it. Further, this service is limited to individuals aged 65 and older. Any change to the service definition as contained in the HCBS waivers would require a waiver amendment approved by CMS.

Rebuttal: Our review found 147 individuals outside of the FE waiver who were under 65 and receiving PERS. It also seems unusual that a person would only need the PERS service and would require no other type of DSW assistance with activities of daily living.

- 3. Consider paying for medical alert equipment via fee for service and removing any beneficiary from HCBS waivers that are only on the waiver to receive this service.**

KDHE response: It is unclear whether this recommendation is asking the agency to consider carving medical alert equipment out of KanCare and into the fee-for-service system, or to remove the service as a waiver service and cover it under the Medicaid state plan instead.

If the former, the agency has concerns about carving specific services out of KanCare, which is intended to be a comprehensive program, as well as the administrative costs of the carve-out.

If the latter, it would require an amendment of the HCBS waiver and the Medicaid state plan, and would likely have a fiscal impact if the service was opened to all Medicaid beneficiaries rather than being restricted to waiver participants.

KDADS response: KDADS defers response on this recommendation to KDHE.

Conclusions

Our audit objectives were to obtain sufficient appropriate audit evidence to answer three questions. Each question is listed below along with our conclusions.

(1) Does KDHE have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program? No.

KDHE does not have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program. The number and types of findings identified during the audit indicate control weaknesses which could place Kansas waivers at risk.

(2) Are there Medicaid beneficiaries on the HCBS program who have not used it for more than a year? Yes.

- **262** were enrolled in an HCBS waiver, but did not have any Medicaid claims filed on their behalf for 12 or more months of the audit period.
- **2,854** were identified as being enrolled in an HCBS waiver, but did not have any HCBS claims filed on their behalf for a total of 12 or more months during the audit period. There were also **63** beneficiaries that did not have HCBS claims for the entire 40-month audit period.

(3) What are the requirements and responsibilities of the Managed Care Organizations to ensure Medicaid beneficiaries are properly enrolled in the HCBS program?

For the scope of this audit, MCOs are required by contract to monitor Medicaid beneficiaries' use of waiver services and make the proper notifications if services are not being used. It appears, based on the number of Medicaid beneficiaries that are not using waiver services for extended periods of time, this oversight function is not being met.

Appendix: KDHE and KDADS Responses

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Laura Howard, Secretary

Laura Kelly, Governor

March 15, 2022

Steven Anderson, Medicaid Inspector General
Office of the Medicaid Inspector General
120 SW 10th Avenue, 2nd Floor
Topeka, KS 66612-1597

Re: KDADS Response to HCBS Audit Report

Dear Medicaid Inspector General Steven Anderson,

The Kansas Department for Aging and Disability Services has reviewed the Home and Community Based Services (HCBS) program performance audit conducted by the Office of the Medicaid Inspector General. We appreciate the opportunity to respond to the findings and recommendations contained within the report. KDADS will leverage this assessment to improve our oversight of the HCBS Medicaid programs we operate.

Finding 1, Recommendation 1: KDADS should allocate sufficient staff needed for administrative duties to allow HCBS program managers to properly provide oversight of each waiver.

Response: KDADS agrees with this recommendation. KDADS has initiated the recruitment process for additional positions within its HCBS unit to provide support for administrative and functional eligibility processes in order to allow the HCBS program managers to focus their time and attention on program oversight, including oversight of MCOs in concert with KDHE. The agency will require the addition of ongoing funding to maintain the additional staff.

Finding 1, Recommendation 2: HCBS program managers should have access to KEES, ImageNow, and MCOs websites and be trained on the systems. This would increase their capability to properly manage Medicaid beneficiary cases.

Response: KDHE and KDADS have established a structured communication workflow between agency staff that we believe is effective. KDHE hosts an HCBS inquiry e-mail inbox to which information requests can be sent by KDADS program managers. Multiple KDHE eligibility staff have access to the e-mail inbox and KDADS program managers generally receive responses to inquiries within the business day. KDADS program managers can contact KDHE eligibility staff via telephone, as well.

Finding 1, Recommendation 3: Conduct yearly program reviews to identify individuals that should be removed from the HCBS program similar to the project conducted in 2016.

Response: KDADS agrees with this recommendation. KDADS will implement a review of each HCBS waiver at least annually to identify individuals enrolled on the waiver that are not meeting the requirements to utilize one HCBS waiver service per month. Individuals that are not receiving services will be evaluated for removal from waiver enrollment. MCOs will be expected to provide information regarding their respective members who are not receiving the required waiver service per month. KDADS and KDHE will verify the information provided by the MCOs and determine the actions to be taken regarding each individual's continued eligibility. Further, the agencies will utilize the review to evaluate MCO performance with regards to their contractual responsibilities to report for eligibility closure those members not meeting monthly service requirements.

Finding 2, Recommendation 1: A central data base should be created, or an existing system modified that would allow KDHE, KDADS, and the MCO's to share functional and financial eligibility documentation.

Response: KDADS and KDHE will work together to identify and evaluate options to address this recommendation. The agencies have identified existing models that successfully communicate eligibility data between KDADS and KDHE and will explore the benefits of implementing similar processes for the HCBS waivers.

Finding 2, Recommendation 2: Quality control steps should be taken to ensure that Medicaid beneficiaries are removed in a timely manner.

Response: KDADS defers response on this recommendation to KDHE.

Finding 3, Recommendation 1: KAMIS should be updated to automatically notify KDADS staff that an annual assessment has not been completed and to continue to send regular reminders until the beneficiary is removed or the assessment is completed and entered.

Response: KDADS agrees that overdue assessment reports should be available to HCBS staff for follow up with contracted assessors. KDADS will ensure these reports are available to HCBS staff on set interval to ensure beneficiaries either receive an annual reassessment or are removed from waiver services.

Finding 3, Recommendation 2: KDHE and KDADS should review the possibility of modifying KEES to manage the tracking of functional assessments and being able to eliminate KAMIS.

Response: KDADS defers response on this recommendation to KDHE.

Finding 3, Recommendation 3: KDADS program managers need to ensure contracted assessors are completing assessments timely and that the requests for assessments are sent to the correct assessor.

Response: KDADS agrees with this recommendation. KDADS has initiated the recruitment process for additional positions within its HCBS unit to provide support for administrative and functional eligibility processes, which will include assisting program managers with monitoring and oversight of the agency's contracted assessors. The agency will require the addition of ongoing funding to maintain the additional staff.

Finding 4, Recommendation 1: Improve quality control measures and staff training to ensure new eligibility files are properly documented.

Response: KDADS defers response on this recommendation to KDHE.

Finding 4, Recommendation 2: Existing files should be reviewed to ensure all required documentation is present.

Response: KDADS defers response on this recommendation to KDHE.

Finding 5, Recommendation 1: KDHE should revise the policy to remove any artificial barriers to recoupment of capitation overpayments.

Response: KDADS defers response on this recommendation to KDHE.

Finding 5, Recommendation 2: Provide training to eligibility staff on any changes to this policy.

Response: KDADS defers response on this recommendation to KDHE.

Finding 6, Recommendation 1: KDADS and MCOs should timely notify KDHE to stop waiver services for individuals that are not using the service and terminate the payment of fees to FMS providers.

Response: Implementation of regular review processes as recommended in Finding 1, Recommendation 3, will ensure that individuals that are not receiving at least one HCBS waiver service per month can be evaluated for removal from waiver enrollment. KDADS notes that not only are FMS providers responsible for administrative

tasks associated with payroll for direct service workers, FMS providers also serve an information and assistance role for the waiver participant. This includes: (1) Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services; (2) Assistance to the participant or participant's representative in arranging for, directing and managing services; (3) Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services; and (4) Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct support workers (DSW), managing workers, and providing effective communication and problem-solving. Based on these responsibilities, there may be instances where payment of an FMS fee is justified even if a waiver participant does not receive personal care services.

Finding 6, Recommendation 2: KDHE should consider recouping fees paid to FMS providers that were not actually providing administrative and payroll services since no services were being used.

Response: KDADS defers response on this recommendation to KDHE.

Finding 7, Recommendation 1: Determine if services were actually provided and are in accordance with an approved person-centered plan of care and agreed to by the beneficiary. In addition, identify any improper claims and handle accordingly.

Response: KDADS defers response on this recommendation to KDHE.

Finding 7, Recommendation 2: Clarify in the policy manual if S5161 can be billed monthly by itself, or if another HCBS service is required to remain on the waiver. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.

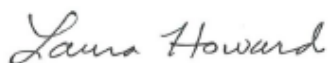
Response: KDADS has reviewed the current approved waiver language and notes that S5161 (Personal Emergency Response System or PERS) may be provided by itself and it is not currently required that another HCBS service be accessed in order to remain on the waiver. The approved waiver language does require that a waiver participant have an assessed need for the service to receive it. Further, this service is limited to individuals aged 65 and older. Any change to the service definition as contained in the HCBS waivers would require a waiver amendment approved by CMS.

Finding 7, Recommendation 3: Consider paying for medical alert equipment via fee for service and removing any beneficiary from HCBS waivers that are only on the waiver to receive this service.

Response: KDADS defers response on this recommendation to KDHE.

Should you have any questions regarding these responses, please contact Amy Penrod, Commissioner of Long Term Services & Supports at Amy.Penrod1@ks.gov. Again, we appreciate the opportunity to respond to the findings and recommendations contained in your report.

Sincerely,



Laura Howard, Secretary
Kansas Department for Aging and Disability Services

Cc: Sarah Fertig, Medicaid Director, KDHE
Amy Penrod, Commissioner, KDADS

**KDHE Response to
Kansas Medicaid Inspector General
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Audit Findings

Finding #1: Non-Compliance with Federal Regulations

The HCBS waivers require beneficiaries enrolled to utilize HCBS services at least monthly in order to remain on the waiver. We identified 34,192 beneficiaries who had six or more months of enrollment in a single HCBS waiver during the audit period of January 1, 2018, through April 30, 2021. Out of the 34,192 identified:

- 262 did not have any Medicaid claims filed on their behalf for 12 or more months of the audit period. This means that no Medicaid claims were identified, and no HCBS services were identified. The amount of capitation payments made to MCO's for the 262 beneficiaries identified during the audit period was \$10,651,131.67.
- 2,854 did not have any HCBS waiver services claims filed on their behalf for 12 or more months of the audit period. The amount of capitation payments made to MCO's for the 2,854 beneficiaries identified during the audit period was \$193,253,420.91. This population includes the 262 beneficiaries identified above.

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

In 2016, KDADS reviewed individuals on the HCBS waivers for anyone that was no longer eligible due to not utilizing HCBS services for an extended period or due to not meeting functional eligibility requirements. KDADS provided KDHE with a list of these individuals for waiver eligibility closure. The one-time project identified 678 individuals that needed to be removed from HCBS. No additional projects of a similar nature have been undertaken.

KDADS HCBS program staff advised us that they do not have access to KEES or ImageNow. They also do not have online access to Plans of Care or functional assessments that are maintained by the MCO's. Consequently, they do not have access to the systems needed to provide proper oversight of the waivers.

It appears that KDADS HCBS program staff are significantly understaffed and do not have the proper tools to provide HCBS program oversight of assessing entities or HCBS

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participants.

Recommendations:

1. KDADS should allocate sufficient staff needed for administrative duties to allow HCBS program managers to properly provide oversight of each waiver.

KDHE defers response on this recommendation to KDADS.

2. HCBS program managers should have access to KEES, ImageNow, and MCO's websites and be trained on the systems. This would increase their capability to properly manage Medicaid beneficiary cases.

KDHE concurs with the KDADS response on this recommendation.

Please also note, once the Kansas Modular Medicaid System (KMMS) is fully operational, the MCOs' Person Centered Service Plans (PCSPs) will be in the state system. HCBS program managers will no longer need access to MCO databases.

3. Conduct yearly program reviews to identify individuals that should be removed from the HCBS program similar to the project conducted in 2016.

KDHE concurs with the KDADS response on this recommendation.

Finding #2: Untimely Removal of Beneficiaries from the HCBS Program

Our sample revealed that 81% of the beneficiaries that had an ES-3161 removal form in ImageNow were not removed from HCBS on a timely basis. The average time it took KDHE to remove a beneficiary from our sample population was two years and four months. As a result, we believe MCO capitation rates and/or FMS administrative fees, may have been paid in error.

We do not believe the delay for removal from HCBS was related to the COVID-19 public health emergency because the majority of requests for removal were received between 2016 and 2019. The public health emergency concerning the Novel Coronavirus Disease (COVID-19) outbreak was not declared until March 13, 2020.

All pertinent events which impact eligibility or the HCBS plan must be communicated to the partner entity. Examples of pertinent events include establishment of initial eligibility, case closure, changes in client obligation, changes in address or living arrangement, significant changes in the cost of the HCBS plan and death. These events shall be communicated timely using an appropriate method of communication. The ES-3160 and

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ES-3161 have been specifically designed as communication tools between staff. Encrypted email is the method used for communicating between entities. The appropriate form must be included in the encrypted e-mail, a general e-mail describing the change is not sufficient.²

To coordinated HCBS services, KDHE utilizes an Excel spreadsheet process as a communication tool that is sent via a File Transfer Protocol (FTP) site between MCOs. KDHE receives, manages, and stores all MCO processing spreadsheets for eligibility processing. Prior to November 2019, MCO eligibility processing spreadsheets were outsourced to the eligibility contractor.

KDHE, KDADS, and the MCOs each manage their own systems to oversee the HCBS program which causes each organization to share information via email. This does not appear to be an effective method to manage the HCBS program. It was reported that emails get lost and are not always handled timely. This occurs when the person responsible for checking the email box is not available. There is no system for verifying that ES-3161 forms transmitted by via email to another office are properly recorded except by manual means.

Recommendations:

1. A central data base should be created, or an existing system modified that would allow KDHE, KDADS, and the MCO's to share functional and financial eligibility documentation.

KDHE concurs with the KDADS response on this recommendation.

2. Quality control steps should be taken to ensure that Medicaid beneficiaries are removed in a timely manner.

KDHE began transitioning the processing of HCBS eligibility from a previous eligibility contractor to the state in October 2019. Processing timeframes have significantly improved, due to the implementation of processing efficiencies and quality control steps. Multiple reports have been introduced, are reviewed, and prioritized appropriately to facilitate timely eligibility action. These reports facilitate streamlined HCBS processing and allow KDHE to identify quickly, eligibility action that may need to be taken.

Finding #3: KAMIS System

The Kansas Assessment Management Information System (KAMIS) is the repository for functional assessment information. For five of the seven waivers (I/DD, BI, PD, FE, TA), assessments are maintained in the KAMIS to which KDADS contracted assessors have access. The assessments for the SED and Autism waivers are maintained by the

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contracted assessing entity, with portions uploaded to KAMIS.

It was found that KAMIS only sends out a single notification that annual assessments are due. The system does not automatically generate reports that the annual assessment for a Medicaid beneficiary has not been completed. As discovered during this audit, some Medicaid beneficiaries go for several years without having annual assessment done and KAMIS does not alert KDADS staff to the problem.

Recommendations:

1. KAMIS should be updated to automatically notify KDADS staff that an annual assessment has not been completed and to continue to send regular reminders until the beneficiary is removed or the assessment is completed and entered.

KDHE defers response on this recommendation to KDADS.

2. KDHE and KDADS should review the possibility of modifying KEES to manage the tracking of functional assessments and being able to eliminate KAMIS.

KEES is an eligibility system used to determine financial eligibility. Modifying the KEES system in this manner would be time consuming and costly; KDHE estimates the cost would be approximately \$6,000,000. We believe modifying KEES would less directly resolve the root of issue, which causes us to question if the benefit will outweigh the costs.

KDHE believes the KDADS response to recommendation #1 and #3 would more effectively mitigate the issue presented with this finding.

3. KDADS program managers need to ensure contracted assessors are completing assessments timely and that the requests for assessments are sent to the correct assessor.

KDHE defers response on this recommendation to KDADS.

Finding #4: Lack of Documentation in ImageNow and KEES

At least half of the files reviewed, lacked the necessary documentation in ImageNow. In addition, multiple notes in KEES were either missing, incomplete, or lacked needed information.

According to KDHE-DHCF Policy No: 2018-06-01, the ES-3160 shall be completed for each individual initially requesting HCBS and the ES-3161 is for requesting changes. Our evaluation identified that over the past six months, documentation has significantly improved.

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Recommendations:

1. Improve quality control measures and staff training to ensure new eligibility files are properly documented.

KDHE began transitioning the processing of HCBS eligibility from a previous eligibility contractor to the state in October 2019. Documentation has significantly improved, due to the implementation of quality control steps. Targeted training has been developed for select, experienced staff to process HCBS eligibility. Processing checklists have also been developed and shared with staff. These checklists include documentation requirements. In addition, KDHE conducts monthly audits to ensure eligibility casework is reflective of trained policies and procedures.

2. Existing files should be reviewed to ensure all required documentation is present.

KDHE will continue to ensure that all files contain the necessary documentation when KDHE staff process HCBS requests. Quality control activities have been implemented since KDHE insourced processing of eligibility for HCBS recipients, as outlined above. We believe the improved documentation referenced in this report is the result of KDHE insourcing this category of work, and our implemented quality control activities.

Finding #5: KDHE-DHCF Policy No. 2017-03-01

KDHE should exercise its contractual right to recoup capitation payments made for persons later determined to be ineligible. If a beneficiary is removed from HCBS due to non-compliance, but is still eligible for KanCare, a cost analysis to determine if a recoupment is needed should be considered.

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

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

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

Recommendations:

1. KDHE should revise the policy to remove any artificial barriers to recoupment of capitation overpayments.

The current three-month lookback period was established to carefully balance sound management of resources with the full-risk nature of the MCO contracts. KDHE will evaluate and consider this recommendation.

2. Provide training to eligibility staff on any changes to this policy.

KDHE will ensure training is completed, should the policy change.

Finding #6: Wasteful Payment to FMS Providers

Beneficiaries who self-direct their services must choose a Financial Management Services (FMS) provider to help them perform payroll and employer-related duties. FMS is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. FMS providers are paid a monthly fee for providing administrative and payroll services for beneficiaries. The average monthly fee paid during the audit period was \$118.00.

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

Recommendations:

1. KDADS and MCO's should timely notify KDHE to stop waiver services for individuals that are not using the service and terminate the payment of fees to FMS providers.

KDHE concurs with the KDADS response on this recommendation.

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2. KDHE should consider recouping fees paid to FMS providers that were not actually providing administrative and payroll services since no services were being used.

KDHE would refer to KDADS' response to Finding #6, Recommendation #1 above for information about the resources FMS providers provide beyond employer and payroll services. KDHE will consider this recommendation but is concerned about the impact it would have on the FMS provider network. KDHE will focus our efforts on improving communication methods between KDADS, KDHE, and the MCOs to ensure timely closure of HCBS services, including FMS.

Finding #7: Life Alert Concerns – Procedure Code S5161

It was observed that procedure code S5161 (Emergency Response System Service Admin Fee) is being billed on a monthly basis. There are 560 beneficiaries who had one or more months of S5161 billed, without any additional Medicaid claims. It should be expected that other Medicaid claims would be billed for the beneficiary in addition to procedure code S5161, since states can only provide waiver services to beneficiaries that would otherwise be institutionalized in a nursing facility, hospital, or intermediate care facility.

See breakout below:

Brain Injury - 5
Frail & Elderly - 391
Intellectual - 4
Physical Disability – 160

HCBS Medical Alert rental is available to some Medicaid program participants. The purpose of this service is to provide support to a consumer who has a medical need that could become critical at any time. The medical alert device is a small instrument carried or worn by the consumer which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help 24 hours a day, 7 days a week.

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

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Recommendations:

1. Determine if services were actually provided and are in accordance with an approved person-centered plan of care and agreed to by the beneficiary. In addition, identify any improper claims and handle accordingly.

Managed Care Organizations are contractually required to review member functional assessments and establish Person-Centered Service Plans during initial contact with members. Based on these tools, MCOs provide benefits for services determined to be necessary and appropriate in accordance with language contained in CMS-approved waivers. Because the life alert device is permitted as the sole monthly service required to remain on applicable waivers for our aged 65+ HCBS population, we believe the best use of our resources is to evaluate member utilization requirements for possible waiver changes.

2. Clarify in the policy manual if S5161 can be billed monthly by itself, or if another HCBS service is required to remain on the waiver. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.

KDHE concurs with the KDADS response on this recommendation.

3. Consider paying for medical alert equipment via fee for service and removing any beneficiary from HCBS waivers that are only on the waiver to receive this service.

It is unclear whether this recommendation is asking the agency to consider carving medical alert equipment out of KanCare and into the fee-for-service system, or to remove the service as a waiver service and cover it under the Medicaid state plan instead.

If the former, the agency has concerns about carving specific services out of KanCare, which is intended to be a comprehensive program, as well as the administrative costs of the carve-out.

If the latter, it would require an amendment of the HCBS waiver and the Medicaid state plan, and would likely have a fiscal impact if the service was opened to all Medicaid beneficiaries rather than being restricted to waiver participants.

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Conclusions

Our audit objectives were to obtain sufficient appropriate audit evidence to answer three questions. Each question is listed below along with our conclusions.

- (1) **Does KDHE have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program?** No

KDHE does not have an effective system for tracking the redetermination of Medicaid beneficiaries on the HCBS program. The number and types of findings identified during the audit indicate control weaknesses which could place Kansas waivers at risk.

- (2) **Are there Medicaid beneficiaries on the HCBS program that have not used it for more than a year?** Yes

- 262 were enrolled in an HCBS waiver, but did not have any Medicaid claims filed on their behalf for 12 or more months of the audit period.
- 2,854 were identified as being enrolled in an HCBS waiver, but did not have any HCBS claims filed on their behalf for 12 or more months of the audit period.

- (3) **What are the requirements and responsibilities of the Managed Care Organizations to ensure Medicaid beneficiaries are properly enrolled in the HCBS program?**

For the scope of this audit, MCO's are required by contract to monitor Medicaid beneficiaries' use of waiver services and make the proper notifications if services are not being used. It appears, based on the number of Medicaid beneficiaries that are not using waiver services for extended periods of time, this oversight function is not being met.

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Janet Stanek, Secretary

Laura Kelly, Governor

April 7, 2022

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

Re: Audit of Medicaid Waiver Members Receiving Home and Community-Based Services

Dear Mr. Anderson,

I am writing today to extend our agency's appreciation for the recent opportunity to meet with you and discuss findings from your audit of Medicaid members receiving 1915(c) waiver HCBS services. We agree that there are multiple opportunities for improvement and appreciate your close attention to this critical part of the Medicaid program.

During our exit conference on March 31, 2022, the state agencies offered comments surrounding the draft data presented on member non-utilization of HCBS services. We noted that the revised draft clarifies that the 12-month period does not mean 12 consecutive months, but rather 12 total months counted during the audit period. We also noted that the revised draft includes an explanation that the capitation rate paid for each HCBS member includes "base" Medicaid coverage as well as HCBS waiver services, and therefore it is difficult to determine what portion, if any, of a particular capitation payment might be considered for recoupment. We very much appreciate these clarifications as they help to provide a complete understanding of the complexities of the HCBS waiver programs.

We do, however, wish to respectfully request that additional clarifying language be added to the draft report to ensure that readers are not misled by the audit findings. Specifically, we learned during the March 31 exit conference that the data pull used to develop the draft audit findings did not exclude instances in which the Medicaid member was placed in a hospital, PRTF, or other non-community setting for the entire month. We believe a statement explaining that the audit data includes instances in which an HCBS member was in a hospital or other institutional setting is critical to your final report, because those are legitimate circumstances under which waiver members may not be using HCBS services; for example, if a person is hospitalized, they understandably would not be receiving in-home nursing services. Without such a statement, a reader may mistakenly conclude that every identified case involved improper or wasteful spending.

With respect to your recommendation to recapture capitation payments made to our Managed Care Organization for members not utilizing HCBS services, we would like to restate that, although a member might

not receive HCBS services during a particular month, the MCOs are still responsible for payment for any other services, e.g., medical services, prescriptions, etc., received by the member during that month. These services are included in monthly capitation payments. There can be legitimate reasons for a member to not receive certain services during any given month.

KDHE has methods to determine if a member should be retroactively removed from a waiver but even in that event, if the member is still eligible for traditional Medicaid, we will continue to cover and pay capitation for that member. A great deal of research goes into removing a member from a waiver. If our eligibility workers identify a case requiring a continued eligibility review based on policy, it is reported for examination and a longer lookback period may be in order. Capitation payments are a single rate cell, and we cannot recoup a partial capitation payment.

One final noteworthy addition to the audit report involves your statement about our 2016 audit of waiver members' non-utilization of HCBS services and subsequent removal of 678 members, as having been the only review of this type conducted in recent years. We would like to correct this statement (page 23, paragraph 1 of your report) to note that a number of internal audits over non-utilization of services have been conducted since 2016, as recently as 2021.

In summary, we believe the verbal comments we contributed during the audit exit conference provide additional clarity on the topic of Medicaid waiver membership and again, we respectfully ask they be offered to readers alongside your report.

On behalf of KDHE and KDADS, we thank you for your consideration,

Donna J. Wills

Donna J. Wills, Medicaid Program
Kansas Department of Health and Environment
Department of Health Care Finance

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