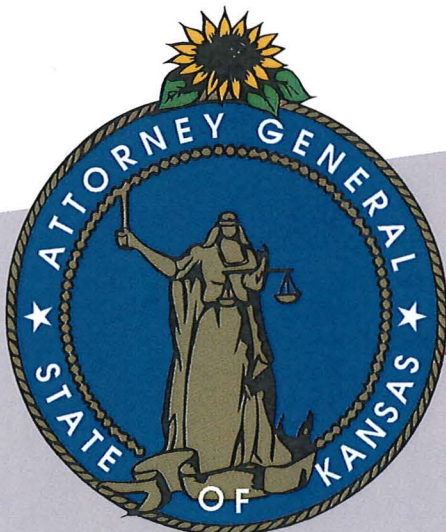


# 2019

## Office of the Medicaid Inspector General

Report No. 20-02

November 13, 2019



**KANSAS  
ATTORNEY GENERAL**

**DEREK SCHMIDT**

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# Letter from the Inspector General

November 13, 2019

TO: Attorney General Derek Schmidt

Secretary of the Kansas Department of Health and Environment, Dr. Lee Norman

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

Senator Gene Suellentrop, Chair  
Senator Ed Berger  
Senator Barbara Bollier  
Senator Bud Estes  
Senator Mary Pilcher-Cook

Representative Brenda Landwehr, Vice-Chair  
Representative Barbara Ballard  
Representative John Barker  
Representative Will Carpenter  
Representative Susan Concannon  
Representative Monia Murnan

This report contains information concerning the current resources available to address cases of Medicaid eligibility fraud. This review 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 welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Sarah Fertig  
Medicaid Inspector General



Lori Knudsen  
Assistant Medicaid Inspector General

## Introduction

On July 31, 2019, the Office of Medicaid Inspector General (OIG) released its first report following the transfer of the OIG from the Kansas Department of Health and Environment (KDHE) to the Kansas Attorney General's Office. That report reviewed emails that were sent to an unmonitored KDHE OIG email account after the OIG moved to the Attorney General's Office. Those emails included reports of suspected Medicaid eligibility fraud that were referred to the KanCare Clearinghouse for follow-up.

During the August 26, 2019, meeting of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, questions were raised concerning the process of enforcement in cases of suspected Medicaid eligibility fraud. This report provides an overview of Kansas' current options for following up on cases of suspected eligibility fraud, including authorities in state and federal law and practical considerations that may affect the handling of such cases.

This report is focused on relevant laws, policies, and resources as they currently exist and is intended for informational purposes only. Whether any change to those laws, policies, or resources is advisable is a question of public policy. Because the OIG is neutral on questions of public policy, our report does not include any recommendations for policy change.



## What is Medicaid Eligibility Fraud?

The term “fraud” carries a specific legal meaning. Fraud typically refers to a “knowing misrepresentation or knowing concealment of a material fact made to induce another to act to his or her detriment.”<sup>1</sup> In the context of Medicaid eligibility, fraud requires an act with the intent to deceive state eligibility workers for the purpose of improperly gaining Medicaid coverage.

Examples of Medicaid eligibility fraud include:

- Attempting to gain Caretaker Medical eligibility by falsely including children as part of the household on the KanCare application;
- Knowingly withholding information about household income for the purpose of falsely meeting financial eligibility requirements; and
- Knowingly understating the value of financial assets for the purpose of falsely meeting the asset limits of programs for the elderly and persons with disabilities.

Medicaid eligibility fraud does *not* exist where the failure of an applicant to provide timely, complete, and accurate information to the Clearinghouse is due to ignorance, misunderstanding, forgetfulness, or an honest mistake.

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<sup>1</sup> Black’s Law Dictionary (11th ed. 2019).

## Criminal Statutes

Some state and federal criminal statutes specifically apply to Medicaid eligibility fraud.

### Federal Law

42 U.S.C. §1320a-7b(a)(1) through (3) provide for penalties of up to \$20,000 in fines and/or imprisonment for up to one year for any person who:

- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program,
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
- (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

Collectively, these provisions cover most, if not all, behaviors that would constitute Medicaid eligibility fraud. Any prosecution under this statute would be brought by the United States Attorney's Office.

Under Kansas law, any person convicted under this statute is ineligible for Medicaid for a period of one year.<sup>2</sup>

### State Law

The Kansas Medicaid Fraud Control Act<sup>3</sup> prohibits certain acts related to the state Medicaid program, including "any false or fraudulent statement or representation made, with the intent to influence any acts or decision of any official, employee or agent of a state or federal agency having regulatory or administrative authority over the [M]edicaid program."<sup>4</sup> This would include false or

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<sup>2</sup> K.A.R. 129-6-140(b).

<sup>3</sup> K.S.A. 2019 Supp. 21-5925 *et seq.*

<sup>4</sup> K.S.A. 2019 Supp. 21-5927(a)(1)(I).

fraudulent statements made to the Clearinghouse as part of the application process. Violation of that statute is a severity level 9, nonperson felony.<sup>5</sup>

K.S.A. 2019 Supp. 39-720 states, “[a]ny person who obtains or attempts to obtain . . . by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which the applicant or client is not entitled, shall be guilty of the crime of theft, as defined in section K.S.A. 21-5801.” Violation of K.S.A. 2019 Supp. 21-5801 ranges from a class A nonperson misdemeanor to a severity level 5, nonperson felony depending on the value of the property or services stolen. K.S.A. 2019 Supp. 39-720 also requires the person to remit the amount of assistance given to the person due to the fraudulent act.

A conviction under these state statutes does not result in an automatic Medicaid ineligibility period.

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<sup>5</sup> K.S.A. 2019 Supp 21-5927(b)(3).

## Administrative Options

There are a few administrative options available to KDHE in cases of suspected Medicaid eligibility fraud. Each of these options is governed by KDHE's regulations and/or internal policies.

### Eligibility Redetermination

Both federal and Kansas law require each Medicaid case to be reviewed at least once every 12 months, in a process called redetermination (also referred to as "review").<sup>6</sup> The KDHE manual for medical assistance eligibility (known as the "Medical KEESM")<sup>7</sup> provides that "[a]t the expiration of the review period, entitlement of benefits to assistance ends. Further eligibility must be determined through the review process."<sup>8</sup> In other words, Medicaid coverage does not renew automatically. Each beneficiary is required to participate in the redetermination process; failure to respond to the review process or provide information as requested by the Clearinghouse will result in termination of eligibility.<sup>9</sup>

KDHE can initiate a redetermination as often as a need for review is indicated.<sup>10</sup> Therefore, if the Clearinghouse receives a report that a beneficiary misstated a material fact in an application for medical assistance, the Clearinghouse can initiate a redetermination. If it is determined that the beneficiary is currently ineligible for medical assistance, or if the beneficiary fails to cooperate with the redetermination process, the Clearinghouse can discontinue eligibility by providing written notice to the beneficiary no later than 10 days prior to the date eligibility will be terminated.<sup>11</sup> If Medicaid coverage is discontinued, the beneficiary may request a fair hearing to contest the decision.

### Disqualification for Intentional Program Violation

Kansas regulations allow for a Medicaid beneficiary to be disqualified from eligibility due to an intentional program violation.<sup>12</sup> The process, outlined in K.A.R. 30-7-102, involves providing notice to the beneficiary of KDHE's reasons for believing the beneficiary committed an intentional program violation at least 30 days before the date of the disqualification hearing. That notice must include a summary of the evidence supporting a charge of intentional program violation, and instructions on how and where such evidence may be examined. The beneficiary is entitled to present his or her defense at the disqualification hearing, which is held before an administrative law judge (ALJ) at the Office of Administrative Hearings (OAH).

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<sup>6</sup> 42 C.F.R. § 435.916; K.A.R. 129-6-36(c).

<sup>7</sup> [http://www.kdheks.gov/hcf/kancare/Sept\\_2019\\_Output/9-19\\_Final.htm](http://www.kdheks.gov/hcf/kancare/Sept_2019_Output/9-19_Final.htm)

<sup>8</sup> Medical KEESM § 9300.

<sup>9</sup> K.A.R. 129-6-36(d).

<sup>10</sup> K.A.R. 129-6-36(c).

<sup>11</sup> K.A.R. 129-7-65(b). *See also* K.A.R. 129-6-36(d) and K.A.R. 129-6-140(c).

<sup>12</sup> K.A.R. 129-7-65(c)(11)(B). *See also* K.A.R. 30-7-102.



If the administrative law judge determines that the beneficiary committed an intentional program violation, KDHE may terminate eligibility by sending written notice to the beneficiary by no later than the date eligibility is terminated.<sup>13</sup>

In the alternative, the beneficiary may waive the right to appear at the administrative disqualification hearing. If the beneficiary chooses to waive the disqualification hearing, he or she shall be disqualified.<sup>14</sup>

Under state law, a finding of an intentional program violation by an ALJ does not result in a period of ineligibility for Medicaid.<sup>15</sup>

### Recovery of Overpayments

The Medical KEESM includes a process by which KDHE may attempt to recover payments, such as monthly managed care capitation payments, that were made by the state as a result of “overstated eligibility.” Overstated eligibility occurs when an individual receives more coverage than they are entitled to receive.<sup>16</sup>

The Medical KEESM defines three types of errors that can lead to overstated eligibility: agency error, client error, and fraud error.<sup>17</sup> *Agency error* involves a mistake made by KDHE that results in overstated eligibility. *Client error* includes the following:

1. Non-willful withholding of information from a one-time failure on the part of a client to report a change timely, which affects eligibility when:
  - a. The worker has reason to believe that the client did not understand his/her responsibility; and
  - b. There was no oral or written misstatement by the client, or
2. Willful withholding of information such as:
  - a. Misstatement (oral or written) made by the client in response to oral or written question from the agency;
  - b. Failure by the client to report a change timely, which affects eligibility;

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<sup>13</sup> K.A.R. 129-7-65(c)(11)(B).

<sup>14</sup> K.A.R. 30-7-103(b).

<sup>15</sup> *But see* K.A.R. 30-4-140(c) (“Each individual who is found to have committed fraud in the temporary assistance for needy families (TANF) program, either through an administrative disqualification hearing or by a court of appropriate jurisdiction, or who has signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in any case referred for prosecution, shall be ineligible for assistance, along with all adult household members.”).

<sup>16</sup> Medical KEESM § 11120, September 2019 revision.

<sup>17</sup> Medical KEESM § 11121.1 through 11121.3 and 11210, September 2019 revision.

- c. Failure by the client to report the receipt of a medical coverage payment which he/she knows, or should know, is incorrect.

A *fraud error* occurs when a beneficiary intentionally:

1. Makes false or misleading statement, misrepresentation, concealment, or withholding of facts for the purpose of improperly establishing or maintaining eligibility; or
2. Misuses medical benefits, including selling, sharing or trading the medical I.D. number for money or other remuneration, signing for services that were not provided to the recipient, or other misuse as determined by the agency.

With respect to fraud errors, the Medical KEESM states, “[a]n individual shall be considered to have committed fraud when the individual has been legally determined to have committed fraud through a court of appropriate jurisdiction. There is no other method of establishing a fraud claim.” Thus, in the absence of a court determination of fraud, a case in which a beneficiary is suspected to have deliberately reported false or incomplete information on an application will be classified as a client error.

How an error is characterized affects the way KDHE handles the overpayment. The Medical KEESM lists specific instances in which an overpayment will not be collected.<sup>18</sup> These instances include: “[o]verstatement of eligibility that occurred as the result of the household failing to report a change in circumstances they were not required to report;” and, “overstated eligibility was the result of agency error and the recipient did not receive any medical services within the month, even if capitation payments have been made on their benefit.”

For those instances in which the Medical KEESM directs staff to pursue collection efforts, agency error and client error claims are initiated by calculating the amount of the claim<sup>19</sup> and sending the household a repayment agreement.<sup>20</sup> If the household is unable or unwilling to make a voluntary repayment to KDHE, a special spenddown shall be imposed.<sup>21</sup>

The Medical KEESM requires suspected fraud errors to be referred to the KDHE-DHCF legal division for review and possible referral for prosecution.<sup>22</sup> If the legal division decides not to refer the case for prosecution, it will be labeled a client error and handled as such.<sup>23</sup> Fraud claims are handled in the same manner as other claims for overpayment.<sup>24</sup>

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<sup>18</sup> Medical KEESM § 11122.

<sup>19</sup> Medical KEESM § 11124.

<sup>20</sup> Medical KEESM § 11125.

<sup>21</sup> Medical KEESM § 11126.1.

<sup>22</sup> Medical KEESM § 11125.

<sup>23</sup> Medical KEESM § 11200.

<sup>24</sup> Medical KEESM § 11126.2.

## Practical Considerations

Although Kansas law provides avenues by which the state may pursue cases of suspected Medicaid eligibility fraud through prosecution or administrative disqualification, those courses of action may not be feasible in each case. The following are some of the practical considerations that may affect how a particular case is handled.

### KDHE's Investigative Resources

Neither KDHE-DHCF nor its predecessor agency, the Kansas Health Policy Authority, have ever had dedicated investigators on staff. When KDHE receives a complaint of suspected eligibility fraud, Clearinghouse staff look into the complaint using resources available to them, which includes online resources, information from other governmental agencies, and requesting information from the beneficiary.

The goal of the Clearinghouse's investigation is not to determine whether a beneficiary's behavior meets the legal definition of fraud; it is to determine whether the beneficiary is eligible for medical assistance. Clearinghouse staff are not authorized – or trained – to conduct criminal investigations, and their job duties do not include performing field work such as surveillance, in-person interviews, etc.

Unlike KDHE, the Kansas Department for Children and Families (DCF) currently has 16 FTE investigators in its Fraud Investigations Unit. The investigators are stationed across four regions and are able to conduct field work when necessary to verify eligibility information or substantiate a fraud complaint. The unit has been in existence since the late 1970's; under Governor Brownback, the number of fraud investigators more than doubled.

Prior to 2016, KDHE was able to request assistance from DCF investigators for Medicaid eligibility investigations, by virtue of DCF's ongoing role in processing Medicaid applications. However, Executive Reorganization Order No. 43,<sup>25</sup> effective January 1, 2016, severed that relationship by transferring all Medicaid eligibility duties to KDHE-DHCF without transferring any investigative staff to KDHE. A statement posted on the DCF website reads:

The mission of the Fraud Investigations Unit is to aggressively investigate, detect, prevent, and prosecute welfare recipient fraud in all public assistance programs administered by the Department for Children and Families including cash

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<sup>25</sup> L. 2015, Ch. 114.

assistance, food assistance, child care assistance, *medical assistance*, and utility LIEAP assistance.<sup>26</sup>

While this statement clearly predates ERO 43, it indicates that the unit was historically intended to assist with investigations related to Medicaid eligibility. DCF fraud staff have informed us that prior to ERO 43, they occasionally worked on Medicaid eligibility cases.

#### Prosecutorial Discretion and Resources

If, after a preliminary investigation is conducted, there is reason to believe that a Medicaid beneficiary has defrauded the Medicaid program, KDHE is required to refer the case to the appropriate law enforcement agency.<sup>27</sup> However, simply referring a potential fraud case to local prosecutors does not guarantee that a prosecution will result.

Whether the case is actually prosecuted depends on a host of factors, including the availability of local investigative resources, existing case load, and whether the prosecutor believes sufficient evidence of fraud exists. It is within the local prosecutor's discretion to decide whether a criminal case should go forward. KDHE does not have legal authority to prosecute cases of eligibility fraud.

#### The Role of the Attorney General's Office

Federal regulations prevent one division of the Attorney General's Office, the Medicaid Fraud Control Unit, from prosecuting eligibility fraud cases.<sup>28</sup> However, K.S.A. 75-766, enacted in 2017, allows the Attorney General's Office to enter into agreements with any state agency to bring criminal actions in the name of the state of Kansas. Although the Attorney General's Office presently lacks resources to partner with KDHE to prosecute Medicaid eligibility fraud cases, the legal authority to do so does exist.

#### Collection Efforts

As noted above, the Medical KEESM describes procedures to initiate collection actions for overstated eligibility claims.<sup>29</sup> However, "[r]ecovery may only be initiated if there are countable resources that are currently available."<sup>30</sup> In other words, KDHE will not initiate collection efforts in cases where recovery is not possible. KDHE staff have informed us that in many cases, the beneficiary has few, if any, resources that the agency can recover. In those cases, KDHE makes a

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<sup>26</sup> <http://www.dcf.ks.gov/Agency/GC/Pages/Fraud/Fraud-Investigation-Unit.aspx>, accessed on October 24, 2019 (emphasis added).

<sup>27</sup> 42 C.F.R. § 455.15(b).

<sup>28</sup> 42 C.F.R. § 1007.19(e)(5).

<sup>29</sup> Medical KEESM § 11120 *et seq.*, September 2019 revision.

<sup>30</sup> Medical KEESM § 11126.



record of the overstated eligibility but will not attempt to collect any overpayments from the beneficiary.

### Redetermination vs. Administrative Disqualification

It is not necessary for KDHE to first establish fraud before terminating eligibility for a person suspected of providing false information on his or her Medicaid application. As described above, the Clearinghouse may redetermine eligibility at any point during the 12-month review period, and if it appears that the beneficiary is not eligible, the case can be closed by providing written notice at least 10 days before the date eligibility is to be terminated. The beneficiary may request a hearing before an ALJ to contest KDHE's decision. If a hearing is requested, eligibility continues until the request for hearing is withdrawn or a decision is rendered by the ALJ. The Clearinghouse informs us that most requests for a hearing are from applicants who were denied nursing home coverage due to excess resources. The Clearinghouse further states that most of the time, a case can be resolved before going to a hearing, either by educating the applicant on eligibility requirements, or by the Clearinghouse reviewing and reversing its earlier decision.

If KDHE chooses to pursue an administrative disqualification, a hearing must be held before an ALJ, and KDHE must pay OAH for those services. Under this process, KDHE may terminate eligibility after the judge renders a finding of intentional program violation. This process takes time: after KDHE determines that an intentional program violation exists, a disqualification hearing must be scheduled. At least 30 days' written notice must be provided to the beneficiary before the date of the disqualification hearing, and the ALJ has 90 days after that to render a decision in the case.<sup>31</sup> As previously noted, a determination by an ALJ that a Medicaid beneficiary committed an intentional program violation does not result in a period of ineligibility for Medicaid.<sup>32</sup>

From an efficiency standpoint, the redetermination process provides a quicker and less expensive means of terminating eligibility than administrative disqualification. Accordingly, while administrative disqualification remains an option for Medicaid eligibility cases, it is not used.

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<sup>31</sup> K.A.R. 30-7-102(k)(2).

<sup>32</sup> Some states have adopted regulations that allow for Medicaid disqualification periods. *See, e.g.*, Okla. Admin. Code 317:35-13-7 (providing for the suspension of Medicaid eligibility upon a finding of program abuse).

## Summary

State and federal law provide various options for KDHE to address cases of suspected eligibility fraud. There are practical considerations that affect how each case is handled.

In terms of time and cost, the most efficient means of terminating eligibility is through the redetermination process. Depending on the facts of the case, KDHE may also decide to pursue recovery of payments made on behalf of the beneficiary. Clearinghouse staff may also refer a case of suspected fraud to KDHE's legal division for review and possible referral for prosecution. However, Clearinghouse staff are not authorized, or trained, to conduct a criminal investigation to support a possible prosecution.

Whether a case of suspected Medicaid eligibility fraud is prosecuted depends on the prosecutor to whom the case is referred. Kansas law allows the Attorney General's Office to enter into agreements with other state agencies to provide prosecution services; however, this option has not been exercised with respect to Medicaid eligibility fraud, and no resources have been allocated for the Attorney General's Office to do so.