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Testimony Concerning Medicaid Fraud

Presented to the Senate Ways and Means
By Steven D. Anderson, CIG, Medicaid Inspector General

March 20, 2024

Chair McGinn and Members of the Committee:

Thank you for the opportunity to appear today and provide neutral testimony concerning Medicaid fraud. My name is Steve Anderson, Medicaid Inspector General, and I am pleased to present the following information.

The Office of Medicaid Inspector General (OMIG) was re-established under the Attorney General's Office in 2017 via Senate Bill 149. The core mission of the OMIG is to identify fraud, waste and abuse in the Medicaid program. This is achieved through audits and performance reviews. I was confirmed as the Medicaid Inspector General in 2021, and I'm here to give an overview of the fraud, waste, and abuse in the Medicaid program my team has identified since 2021.

Since my confirmation as Inspector General, the OMIG released three reviews, four audit reports, and one interim report. In the reports, OMIG identified $211,245,600.93 in wasteful spending, $6,294,158.08 in overpayments, $12,220,651.23 in potential savings, 19 findings, and made 64 recommendations. In a report that is pending release, another $88,497,393.20 in wasteful spending and $12,274,090.00 in savings is identified. These reports, summarized below, can be accessed at https://ag.ks.gov/fraud-abuse/medicaid-inspector-general.

Reporting Fraud to the Clearinghouse, Report 22-01
OMIG conducted a review of the process for the public to report cases of suspected Medicaid eligibility fraud. The KanCare Clearinghouse did not have an option in its call tree to allow a concerned citizen to report fraud. Callers were given several options, however, none of them

included an option to report fraud. The KanCare website was also very difficult to navigate, and there is no obvious link to a website or telephone number to report Medicaid eligibility fraud.

Review of MediKan, Report 22-02
OMIG conducted a review of the MediKan program to determine if KDHE paid any medical claims on behalf of beneficiaries who have exceeded the 12-month lifetime maximum limit. The review identified 912 MediKan beneficiaries who had 13 or more months of eligibility during the review period of January 1, 2018, to April 30, 2021. The failure to timely discontinue MediKan eligibility after the 12-month lifetime limit ended resulted in state funds being used to pay medical claims for ineligible persons in the amount of $1,665,815.43.

As a result of the review, KDHE staff began the process of removing 556 individuals that were identified as no longer eligible for MediKan for an estimated savings of $1,252,520.00 to the MediKan program. We made the following recommendations:

Review of Capitation Payments, Report 22-03
OMIG conducted a review to determine if the KDHE made capitation payments to Managed Care Organizations (MCOs) for deceased beneficiaries. The review determined that $1,313,175.55 in monthly capitation payments were made for the 25 beneficiaries whose dates of death preceded the payment dates and recoupment had not occurred.

We also performed a two-year look back from July 2019 to July 2021 of capitation payments made on behalf of deceased beneficiaries. We found 632 cases where MCOs continued to receive capitation payments. KDHE eventually recouped the capitation payments totaling $19,202,562.21 via an offset with each MCO. There were 56 cases within this group where capitation payments continued for five or more years after the beneficiaries' month of death. We looked at the length of time these overpaid funds were in the possession of the MCOs and conducted a cost analysis. We determined the total cost of money to the State of Kansas to be $1,534,043.17.

Audit of Home and Community Based Services (HCBS), Report 22-04
Our audit determined that 2,854 beneficiaries did not have any HCBS waiver services claims filed on their behalf for a total of 12 or more months during the audit period. The amount of capitation payments made to Managed Care Organizations (MCOs) for the 2,854 beneficiaries identified during the audit period was $193,253,420.91. This is noteworthy due to the requirement that individuals on the waiver programs must use the service at least once a month to remain eligible. The lack of use should have been identified by the HCBS program managers and MCOs, which would have triggered an effort to have the individuals removed from the waiver program.

There is an apparent financial incentive for people to be on HCBS waivers, but they 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.

OMIG observed that procedure code S5161 (Emergency Response System Service Admin Fee) is being billed on a monthly basis. This is for a "Life Alert" system. We identified 560 beneficiaries who had one or more months of S5161 billed without any other additional Medicaid claims. It should be expected that other Medicaid services would be billed in addition to procedure code S5161. 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. By accepting this recommendation, Kansas would save an estimated $8,001,791.16.

The Kansas Assessment Management Information System (KAMIS) is the repository for functional assessment information. Five of the seven waivers assessments are maintained in KAMIS, to which KDADS contracted assessors have access. OMIG 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.

Beneficiaries who self-direct their services must choose a Financial Management Services (FMS) provider to help them perform payroll and employer-related duties. FMS is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. FMS providers are paid a monthly fee for providing administrative and payroll services for beneficiaries. The average monthly fee paid during the audit period was $118.00. The amount of money paid out to FMS providers when no personal care services were provided was $1,921,452.03 prior to start of the public health emergency (PHE), January 2018 to February 2020. There was $1,373,140.99 paid out during the PHE, March 2020 to April 2021. This is a combined waste of $3,294,593.02.

Audit of Eligibility Determinations, Report 23-01

The audit of eligibility determinations for Medicaid recipients that have moved out of the State of Kansas identified internal and external deficiencies that hindered KDHE's ability to identify, verify, and terminate Medicaid eligibility on a timely basis. For example, a group of beneficiaries that were identified as moving out of Kansas were not properly processed resulting in an estimated overpayment of $1,370,376.68 in capitation payment to MCOs.

Audit of Multiple Medicaid Beneficiary Identifications, Report 24-01
The audit of KDHE's system for tracking Medicaid beneficiaries with multiple Medicaid identification numbers and KDHE process for recouping capitation overpayments to MCOs found that only 3 instances out of 53 (6%) cases reviewed with multiple beneficiary identifications had been recouped in a timely manner. After accounting for the 8 (15%) who had fee-for-service, 42 (79%) were left with no capitation recoupments totaling $95,145.21 from the MCOs. There were also 57 instances of one SSN connected to multiple beneficiary identifications. KDHE's correction efforts following the start of our audit resulted in 13 beneficiaries whose capitation payments were recouped or stopped. We determined that the savings for a one-year period totaled $105,255.72.

Audit of Transitional Medical Program (TransMed), Report 24-02
The audit of KDHE's system for processing and tracking determinations found numerous control weaknesses placing Medicaid monies at risk. We identified significant compliance and control gaps within the TransMed program, which contributed to a 45% error rate within the TransMed program. We also identified a lack in targeted reviews aimed towards resolving eligibility issues related to the TransMed program. We identified numerous households that went without a review for several years prior to the declaration of the Public Health Emergency (PHE). Out of the 53 review errors identified in our sample, over 50% of the affected beneficiaries have gone without a review since the 2015-2019 timeframe. We identified 9,322 beneficiaries who were enrolled in TransMed during our audit period of January 1, 2019 through December 31, 2021, and had 13 months or more of continuous TransMed coverage. Beneficiaries are limited to only 12 months of continuous coverage. We considered the COVID-19 Federal PHE that was declared on March 2020 and narrowed our review sample to only include the 2,322 beneficiaries who had unallowed coverage prior to the PHE.

Our review identified $16,326,364.59 in estimated capitation payment overages wasted on ineligible persons as of June 2022. The savings in capitation payments for terminating beneficiaries who have remained on TransMed since prior to the PHE would be an estimated $1,574,908.80 over a six-month period.

Interim Report of School Background Checks

The interim report contained information developed during our performance audit of KDHE's management of School-Based Fee-For-Service (FFS) Medicaid reimbursements for the State of Kansas. Approximately, $23.5 million in Medicaid funds are dispersed via Fee-For-Service (FFS) to Kansas school districts each year to reimburse them for providing services to students that are on Medicaid. Medicaid funded services are delivered by various providers who are employees of the school districts or are contractors.

We discovered that of the 231 providers reviewed as part of our audit sample, 72 or 31% did not have proof the background checks were completed at the time of our request for records. Also, five schools completed background checks on 14 providers after receiving our request for records. There is an estimated total of 3,731 providers working directly with children in Kansas public schools. Our sample testing indicates that 31% or 1,157 of those providers may be working without a background check.

The Kansas State Department of Education (KSDE) requires a fingerprint-based criminal history check for licensed staff. There are no State of Kansas statutes that require these checks. We did not find any state level requirements for other school employees to have background checks. This includes other employees, such as therapists, coaches, paraprofessionals, bus drivers, cooks, and janitorial workers.

Audit Pending Release

Audit of Continuing Care Retirement Community (CCRC) Registrations, Report 24-03

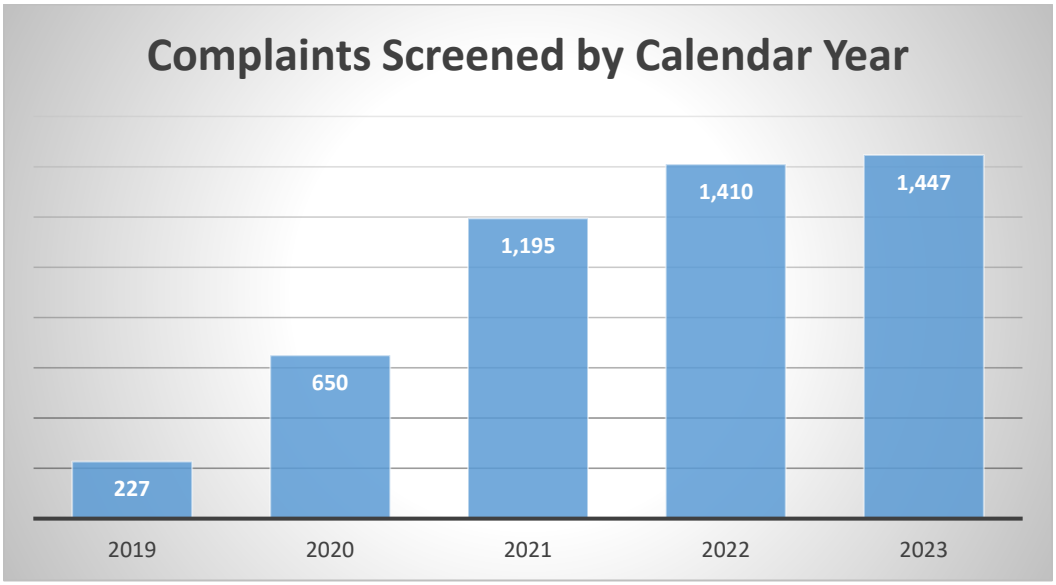
The audit of the Continuing Care Retirement Community (CCRC) registration process revealed 68% of Continuing Care Provider (CCP) registration certificates issued to Skilled Nursing Facilities (SNF) from July 1, 2020 through August 31, 2023, were not in compliance with K.S.A. 40-2231 through K.S.A. 40-2238. The primary cause for not being in compliance was the lack of the required annual audit report from a certified public accountant. Due to SNFs being improperly issued CCP registrations, the State of Kansas lost Quality Care Assessment (QCA) revenue of $87,121,090.00. This resulted in additional loss of QCA Fund interest earnings revenue of an estimated $1,376,303.20. Incomplete applications for CCP registrations resulted in a total loss of QCA revenue of $88,497,393.20.

Our audit revealed that 95 or 23% of the QCAs completed for CCRCs were incorrectly assessed at the reduced QCA rate. Although they were issued certificates of CCP registration, there was no evidence that these self-attested CCRCs were providing continuing care per K.S.A. 40-2231(d). The ambiguity in Kansas statutes for the definition of "continuing care" as it relates to CCPs allowed SNFs to continue to be assessed at the reduced QCA rate by simply claiming CCRC status. This has resulted in an estimated $33,374,400.00 loss of QCA revenue to the State for SFY 2021-2024.

By following updated statutes and recommendations from OMIG, the State of Kansas will save an estimated $12,274,090.00 by properly assessing 37 facilities as not being CCRCs and using the proper QCA of $4,098.00 instead of the incorrect amount of $818.00 per bed.

Complaints Processed and Investigated

The OMIG continues to oversee an increasing number of complaints of fraud, waste, abuse, and illegal acts concerning the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP). The majority of complaints received are submitted by the Kansas Department for Children and Families (DCF) and primarily allege beneficiary eligibility fraud. OMIG staff currently screens each complaint received for substance and jurisdiction. If staff determine there is a need for eligibility clarification, the complaint is forwarded to the KanCare Clearinghouse for review and possible follow-up. The number of complaints processed each calendar year are represented in the bar chart below.



As noted above, in CY 2022 OMIG processed 1,410 complaints with 1,347 complaints involving allegations of beneficiary eligibility fraud. There were 21 of these complaints that, after reviewing the matter, did not involve Medicaid and were referred to the correct agency. These typically involved Medicare only. There were also 15 allegations of beneficiaries committing non-eligibility frauds such as, falsely clocking in a personal care worker. The remaining 48 complaints involved allegations involving providers and contractors.

In CY 2023, OMIG processed 1,447 complaints with 1,377 complaints involving allegations of beneficiary eligibility fraud. There were 38 of these complaints that, after reviewing the matter, did not involve Medicaid and were referred to the correct agency. There was one complaint involving a state agency and two involving state employees. There were also 14 allegations of beneficiaries committing non-eligibility frauds. The remaining 53 complaints involved allegations involving providers and contractors.

The breakdown for how the complaints for CY 2022 and CY 2023 were handled are broken out in the chart below. It must be noted that the public health emergency (PHE) impacted the determination for many allegations. For example, allegations of being over income during the PHE were not considered fraud due to rules in place at the time. The "No Fraud/Jurisdiction" determination is based on our preliminary review of the matter. The referrals sent to the Clearinghouse for additional review may result in additional determinations of no fraud or possible fraud. If staff at the Clearinghouse and KDHE determine there are indications of fraud, they will refer the information back to OMIG for further consideration. OMIG investigative staff, that came on board in July of 2023, are addressing the backlog of open cases and processing new allegations as they are received.

Calendar Year	Complaints Screened	Eligibility Complaints	Sent for Review (CH)	No Fraud/ Jurisdiction	Investigations Opened	Referred to Other Offices
2022	1,410	1,347	1,059	221	27	40
2023	1,447	1,377	1,048	191	112	70

Findings of Fraud and Fraud Investigations to Date

There are currently two special agents and one financial analyst dedicated to conducting eligibility fraud investigations. There have been 186 cases opened for investigation and 67 of those have been closed. One case has been prosecuted that resulted in a diversion agreement with restitution/savings of $9,613.72. Two additional cases have been referred for prosecution. Numerous other investigations are in various stages of completion.

For the 67 closed cases, 13 were closed due to the allegation being disproven, 11 no action due to insufficient evidence, and 43 referred to other agencies (HHS/OIG; SSA/OIG; MFCU). OMIG is also conducting joint investigations with other agencies. There are currently 45 cases open with DCF investigators that involve Medicaid and food assistance fraud. We have also 4 joint investigations with Adult Protective Service, 2 cases with MFCU and 2 with HHS/OIG.

Examples of cases

Medical ID Theft

An example of a case that was recently opened by OMIG is a caller who reported that she suspected someone was using her Medicaid information to get medication and possibly medical services. She stated that recently, the Area Council on Aging called her and informed her that her application for utility and rental assistance had been approved. The caller stated that she never applied for assistance and that she owns her home. The caller stated she went to pick up her

medications and the pharmacist asked if she had prescriptions at another pharmacy. The caller stated that she did not have any prescriptions at any other pharmacy.

The caller also stated that her neurology doctor called her and told her that they could provide medication interaction information about a new medication she asked about. The caller stated that she never asked for this information and that the medication the doctor thought she had inquired about was prescribed for bi-polar disorder and one that the client does not take. She reported the occurrences to local law enforcement who advised her to contact the Fraud Hotline for Medicaid as there is only one officer in her area and he is part-time; therefore, not much could be done by local law enforcement. This matter is under investigation for medical identity theft.

False Pregnancy for Medicaid and Food Assistance Eligibility
An example of a referral received by OMIG and referred for prosecution is a Medicaid beneficiary who applied for coverage on March 8, 2022. She was deemed eligible for poverty level pregnant woman coverage beginning March 1, 2022, due to her claim of pregnancy. Investigation determined that she was not pregnant and she had supplied a forged letter from a doctor to support her claim of pregnancy and a faked positive pregnancy test. Her false claim of pregnancy also made her eligible to receive food assistance. She would not have been eligible for Medicaid or food assistance without the false claim of pregnancy. She had previously attempted to enroll in Medicaid and had been determined to be ineligible. This case has been submitted for prosecution.

False Household Composition and Income to Receive Medicaid and Food Assistance
Subject provided false information about her household income by not reporting her common law husband's income or ownership of their shared residence. She received Medicaid coverage that resulted in $43,372.10 in capitation payments. She also received $27,297.00 in food assistance illegally. She accepted a diversion agreement with the Crawford County DA on September 27, 2023.

Thank you for your time. I will be happy to answer questions.