STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

DEREK SCHMIDT
ATTORNEY GENERAL

MEMORIAL HALL
120 SW 10TH AVE., 2ND FLOOR
TOPEKA, KS 66612-1597
(785) 296-2215 • FAX (785) 296-6296
WWW.AG.KS.GOV

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

Medicaid Inspector General Update
April 22, 2021

Chairman Hilderbrand and Members of the Committee:

Thank you for the opportunity to appear today and discuss the Office of the Medicaid Inspector General (OMIG) with you this morning. My name is Steve Anderson. I was confirmed by the Kansas Senate to serve as Medicaid Inspector General on April 6, and I am pleased to present this update regarding the Office of the Medicaid Inspector General.

OMIG Staffing

Following my confirmation, the Office is back to a full staff of three (3); we hope to eventually recruit more staff members as appropriations allow.

Our current staff members are as follows:

Steve Anderson - Medicaid Inspector General - I served over five years as the Special Agent in Charge (SAC) for the Medicaid Fraud and Abuse Division (MFCU). Prior to that assignment, I was the SAC for the U.S. Department of Labor, Office of Labor Racketeering and Fraud Investigations, SAC and Assistant SAC for the U.S. Depart of Education, Office of Inspector General, Senior Special Agent for the General Services Administration, Office of Inspector General, and Special Agent for U.S. Air Force Office of Special Investigations. In total, I have over 30 years of experience in law enforcement, with more than 20 years in a supervisory capacity. The majority of that experience was working in an Inspector General's Office conducting program fraud investigations.

Lori Knudsen - Assistant Medicaid Inspector General. She will have two years with the OMIG in June. Prior to joining the OMIG, she worked at the Kansas Department for Children and Families as a Lead Auditor in the Office of the General Council. She is currently working on earning the Certified Fraud Examiner (CFE) credential through the Association of Certified Fraud Examiners (ACFE). Once complete, she is planning on attending the Inspector General Institute, in hopes of earning the Certified Inspector General Auditor (CIGA) credential through the Association of Inspectors General.

Josh Saathoff – Data Analyst. He has been with the OMIG since February 2020. Prior to joining the OMIG, he worked at Cerner Corporation which is a supplier of health information technology services, devises, and hardware. Josh recently attended a virtual three-day course held via Zoom by the Medicaid Integrity Institute (MII) called "Trends in Medicaid: COVID-19 Vulnerabilities." The MII provides a unique opportunity for the Centers for Medicare & Medicaid Services (CMS) to offer substantive training, technical assistance, and support to the States in a structured learning environment. Only a few select individuals from each state are given the opportunity to attend these all-expense paid training courses provided by the MII.

Annual Report

The OMIG released its 2020 annual report on February 17, 2021. The report provides an overview of the responsibilities of the OMIG, explains the fraud report complaint processes and related statistics, and outlines the oversight activities that took place January 1 through December 31, 2020.

In CY 2020, the OMIG screened a total of 650 fraud reports for substance and jurisdiction. Out of the 650 fraud reports screened, 629 (97%) were submitted by the Kansas Department for Children and Families (DCF). In CY 2019, the OMIG screened a total of 227 fraud reports which were primarily submitted by DCF as well. That is an increase of more than 186% in one year.

In CY 2020, the OMIG attended a total of four (4) committee meetings. During each meeting, the OMIG presented reports from reviews and provided updates of the OMIG's current activities to the committee. Listed below are the dates of each meeting along with a short description of each review described in the annual report.

ID	Date of Meeting	Subject	Type	Formal Report Issued	Report No.
1	02/28/20	Analysis of Transportation Grievances	Review	No	N/A
2	06/22/20	HHS OIG Exclusion List	Review	Yes	20-03
3	09/28/20	Overlapping PCA & Inpatient Claims	Investigation	No	N/A
4	09/28/20	Follow-Up Review of Appriss	Review	No	N/A
5	12/09/20	Capitation Payments Made After Beneficiaries' Deaths	Review	No	N/A

Analysis of Transportation Grievances – A review of 33 "No Show" grievances that were filed in the third quarter of 2019 found that only three of the 33 grievances appeared to be true instances in which the scheduled transportation never arrived.

HHS OIG Exclusion List – Our review found that four excluded individuals were hired to provide personal care services (PCA) under Home and Community Based Services. Three of these individual received payment of Medicaid funds totaling $6,044.12. The three PCAs were referred to the MFCU for possible prosecution.

Overlapping PCA & Inpatient Claims – Claims data from January 1, 2019, to June 30, 2020 was reviewed to determine if any PCAs billed for services on the same day as inpatient hospital stays. The OMIG identified $49,294.67 in possible improper payments that were claimed by thirty different PCAs. The 30 PCAs were referred to the MFCU for possible prosecution.

Follow-Up Review of Appriss Notifications – A previous OMIG Audit (Report No. 20-01) determined that KDHE had improperly made capitation payments to Managed Care Organizations (MCO) in the amount of $184,997.43 for incarcerated beneficiaries. The follow-up review determined that the Appriss system appeared to be an effective tool for providing real-time information on the incarceration status of beneficiaries. This allowed the KanCare Clearinghouse to make timely and informed decisions regarding the Medicaid eligibility of individuals who are in the custody of law enforcement agencies.

Capitation Payments Made After Beneficiaries' Deaths – This review was to determine if KDHE made capitation payments to MCOs on behalf of deceased beneficiaries between February 2015 to September 2020. The OMIG identified $1,313,175.55 in monthly capitation payments that were made on behalf of 25 beneficiaries whose dates of death preceded the payment dates. In some cases, the improper payments continued for as long as five years after the date of death.

KanCare Clearinghouse staff made changes to the beneficiary files that resulted in an automatic offset of $1,142,196.84 from the three current MCO's monthly capitation payments. An additional $170,975.71 overpayment was made to former MCO Amerigroup.

Complaint Process and Reports of Investigation

The OMIG continues to oversee 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). Since the last meeting of this committee, the OMIG has received 164 complaints, the majority of which allege Medicaid eligibility fraud. All but seven complaints received were from DCF.

Complaints submitted to the OMIG may include a wide range of wrongdoing and may include allegations of more than one type of misconduct committed by an entity or individual. As investigations proceed, new allegations of wrongdoing may be discovered and other individual or entities may become part of an investigation. Some types of wrongdoing do not fall under the OMIG's jurisdiction. In these instances, we refer the complaint along to the appropriate entity capable of handling the situation. For instance, the MFCU at the attorney general's office handles issues related to provider fraud.

As noted in the annual report, the OMIG has been working on a process improvement plan that will provide more insight to policymakers about the types, amounts, and

outcomes of the fraud reports received. This is a work in progress, so additional information will be provided when it is available.

COVID-19 Monitoring

The COVID-19 pandemic has created new opportunities for fraud. As mentioned earlier, our data analyst recently attended a three-day course called "Trends in Medicaid: COVID-19 Vulnerabilities." This course provided viewers with additional knowledge related to COVID-19 emerging fraud schemes and potential vulnerabilities. Most of the topics discussed were related to provider fraud for example:

- Claims being paid with a place of service "School" when school was not in session.

- Two different procedure codes being billed on the same day for the same beneficiary. For example: HCPCS code, H0036 Community psychiatric supportive treatment, face-to-face, per 15 minutes billed with CPT code, 90837 Psychotherapy, 60 minutes with patient and/or family member.

To date we have found no evidence that the practices mentioned above are occurring in Kansas; however, we are regularly reviewing encounter data related to COVID-19 to identify any improper activity. Please note that this is not a real-time process due to the lag time between when the testing actually occurs and when the encounter data is entered into the Medicaid Management Information System (MMIS).

The OMIG is constantly reviewing data to look for irregularities, trends, or errors related to COVID-19. Any instances of provider fraud that are identified will be forwarded to the MFCU for their review. Updated information on this topic will be provided at the next committee meeting.

MediKan Review Update & Program Description

The OMIG has been conducting a review of the MediKan program to determine if Kansas has paid any benefits on behalf of beneficiaries who have exceeded the twelve (12) month lifetime maximum limit. Failure to timely discontinue MediKan coverage when a beneficiary becomes ineligible, can lead to state funds being used to cover expenses made for ineligible persons.

MediKan helps provide medical services for people with physical or mental disabilities who do not qualify for KanCare. The MediKan program is designed to provide medical care in acute situations and during catastrophic illnesses for adults 18 – 64 years of age whose applications for federal disability are being reviewed by the Social Security Administration.

- MediKan is limited to a twelve (12) month lifetime maximum limit, beginning with the first eligible month.

- Individuals who previously received less than twelve (12) months of MediKan coverage who re-apply, may be approved (if otherwise eligible) for the remaining months of coverage.

- There is no hardship provision allowing coverage to extend beyond the twelve (12) month limit.

- MediKan Reintegration is NOT considered when determining if the beneficiary has already received twelve (12) months of MediKan. The MediKan Reintegration Program provides presumptive time-limited MediKan coverage to residents being discharged from state psychiatric hospitals.

- MediKan is funded 100% by the state and does not receive federal matching funds.

- MediKan beneficiaries are not assigned to a Managed Care Organization (MCO), therefore capitation payments are not made on their behalf.

- MediKan is considered a Fee-For-Service (FFS) plan which means that health care providers are paid directly for each service they provide.

We intend to issue a report with the results of our findings on this topic when we have completed our analysis.

Thank you for your time this morning. As always, we welcome any suggestions from the Committee on audit or investigation topics.