STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

KRIS W. KOBACH
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

Response to Question from the Committee
July 19, 2023

Chair Gossage and Members of the Committee:

A question was asked during my testimony on April 21, 2023, concerning the amount of money the Office of the Medicaid Inspector General (OMIG) has saved the State of Kansas. The information provided below for FY 2022 and FY 2023 can be obtained from published audit reports and annual reports filed each year and can found at this link. https://ag.ks.gov/fraud-abuse/medicaid-inspector-general

In FY 2022, OMIG issued four reports that included $193,253,420 in potential overpayments, $1,665,815 in improper payments, $9,254,311 in potential savings, $1,534,043 in lost interest, $3,294,593 in wasteful spending and 26 recommendations for improvement.

In FY 2023, OMIG issued one report that included $1,370,376 in overpayments, $400,000 in annual savings, and 13 recommendations for improvement.

The approved budget for OMIG for FY 2024 is $982,466. OMIG received an additional $340,000 in FY 2024 to support the hiring of two special agents and a financial analyst to conduct Medicaid eligibility fraud and other criminal investigations. Prior to this FY, OMIG lacked the staffing to conduct this type of work. It is anticipated the additional funding will be offset by recoveries and savings derived by the investigations. Also, the deterrent effect of conducting the investigations cannot be estimated in the form of financial savings, but there will be an impact on people either committing fraud or considering ways to defraud the Medicaid program. This increased fraud initiative would also help support the efforts of concerned citizens reporting suspected fraudulent activity by allowing them to see positive actions are taken based on their reports of fraud.

The number of estimated cases that will be submitted for prosecution or administrative action is approximately 15-24 per year. The potential savings per case is $10,056 (12mos X $838) per year based on stopping the capitation payments made to the Managed Care Organizations (MCOs) for beneficiaries fraudulently receiving Medicaid. This is based on the average monthly capitation payment of $838.00 for FY2022. This would result in approximately $150,000 to $240,000 being saved each year in capitation payments. Since Medicaid enrollments under fraudulent circumstances can continue for numerous years, the potential savings will accumulate each year.

Year 1 $150,000 - $240,000
Year 2 $300,000 - $480,000 (Savings from cases closed in Year 1 combined Year 2 cases)
Year 3 $450,000 - $720,000 (Savings from Years 1 & 2 combined with Year 3 cases)

There are also investigations that will result in court ordered restitution to the Medicaid program. The average restitution ordered per case is estimated to be approximately $15,000.00. This could result in an estimated $150,000 to $250,000 per year being returned to the Medicaid program in addition to the savings referenced above.

Respectfully submitted,

Steven D. Anderson
Medicaid Inspector General