KANSAS ATTORNEY GENERAL

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Office of the Medicaid Inspector General

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OFFICE OF INSPECTOR GENERAL

About

- The Office of Inspector General (OIG) is an independent division of the Kansas Attorney General's Office. The Inspector General reports directly to the Attorney General.

- The OIG has statewide jurisdiction to audit, review, or investigate any matter involving the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP).

- Completed investigations are referred to the Economic Crimes Unit, or the relevant District/County Attorney, for potential prosecution.

- The IG testifies each quarter at the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare on issues that are currently being reviewed, recently completed audits and reviews, and other issues of interest to members of the committee.

OFFICE OF INSPECTOR GENERAL

STEVEN D. ANDERSON

A certified inspector general and senior law enforcement professional with over 30 years of federal and state law enforcement experience conducting and supervising investigations of financial based crimes and employee misconduct.

INSPECTOR GENERAL

1989 — Special Agent, Office of Special Investigations, United States Air Force

1993 — Senior Special Agent, General Services Administration

2001 — Special Agent in Charge, Assistant Special Agent in Charge, U.S. Department of Education

2014 — Special Agent in Charge, U.S. Department of Labor

2016 — Special Agent in Charge, **Medicaid Fraud Control Unit**, Kansas Attorney General

APRIL 2021

OFFICE OF INSPECTOR GENERAL

About

Mission Statement

Conduct audits, investigations, and performance reviews to increase accountability, integrity, and oversight of Kansas Medicaid related programs; assist in improving agency and program operations; and in deterring and identifying fraud, waste, abuse, and illegal acts.

Vision

Pursue positive changes in Kansas Medicaid related programs to better serve the citizens of Kansas.

Goals

- Prevent, detect, and deter fraud, waste, abuse, and illegal acts
- Identify funds for recovery or recoupment
- Provide suggestions for improving efficiency, effectiveness, and integrity
- Identify and refer criminal/civil matters for prosecution
- Foster sound financial practices and reduction of improper payments

OFFICE OF INSPECTOR GENERAL

What does the Inspector General do?

Provide *independent* and *objective* oversight in government to:

Prevent, detect and investigate fraud, waste and abuse.
(Investigations)

Promote economy, efficiency, effectiveness, and integrity.
(Audits)

The OIG "shall be independent and free from political influence . . . ." per K.S.A. 75-7427(b)(1)

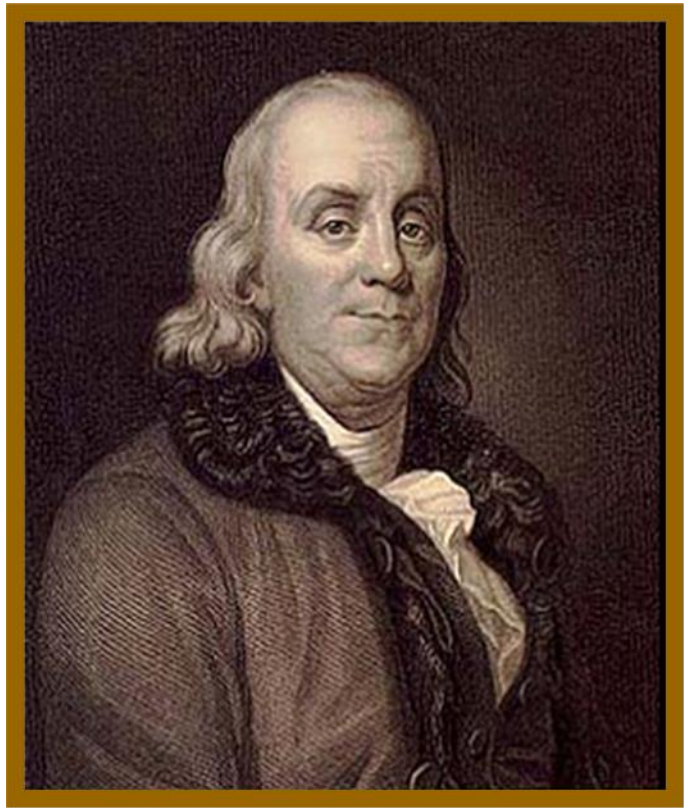
OFFICE OF INSPECTOR GENERAL

Confidentiality

Information shared with the OIG **remains** confidential.

K.S.A. 75-7427(o) makes "*all information and records of the inspector general that are made, maintained, kept, obtained or received under any investigation or audit . . Shall be confidential, except as required or authorized under [K.S.A. 75-7427].*"

Words of Wisdom from Ben Franklin



“There is no kind of dishonesty into which otherwise good people more easily and frequently fall than that of defrauding the government.”

Common Medicaid Fraud Schemes

- Phantom patients
- Billing for services or goods not provided
- 8 days a week, 25 hours a day
- Unnecessary tests
- Kickbacks
- Concealing ownership in a related company
- Double-billing
- False income or household information for eligibility
- Sharing your Medicaid ID
- Altering records

Who Commits Fraud, Waste, & Abuse?

- Officials, Owners, Financial Managers, and Employees
- Contractors
- Suppliers
- Drug Companies
- State of Kansas Employees
- Providers
- Beneficiaries
- **EVERYONE**

Fraud Defined

- An **<u>intentional</u>** distortion of the truth in an attempt to obtain something of value. Does not have to result in monetary loss.
- ***Layman's terms:***

  Lying, cheating, or stealing.

Waste Defined

- Waste means over-utilization of services, or practices that result in unnecessary costs.
- Waste also refers to useless consumption or expenditure without adequate return, or an act or instance of wasting.
- The intentional or unintentional, thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of State resources to the detriment or potential detriment of the State.

Abuse Defined

The excessive or improper use of a thing, or to employ something in a manner contrary to the natural or legal rules for its use.

Acts of abuse include, but are not limited to, the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources such as tools, vehicles, computers, printers, etc., or extravagant or excessive use of one‘s position or authority.

Medical Identity Theft Defined

The appropriation or misuse of a patient's or provider's unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.

Patient Access and Medicare Protection Act; If anyone without proper authority "knowingly and willfully purchases, sells or distributes, or arranges for the purchase, sale, or distribution" of any provider or beneficiary identification number under Medicare, Medicaid, or Children's Health Insurance Program max penalties are 10 years in prison and $500,00 fine.

Sources of Allegations

- ✓ Hotline
- ✓ MEDICAID Program Offices and related companies (FMS Providers)
- ✓ **Private Citizens (former associates)**
- ✓ Competing Vendors
- ✓ Other State and Federal Agencies
- ✓ U.S. Attorney's Offices
- ✓ Other OAG Investigations
- ✓ State and Local Law Enforcement Agencies

Types of Providers

- Medical Doctors
- Dentists
- Hospitals
- Nursing Homes
- Pharmacies
- Durable Medical equipment sellers
- Mental Health
- Drug and Alcohol Treatment
- Home Health Care
- Ambulance Companies
- Transportation Companies
- Anyone else who bills the Medicaid program for health care goods and services provided to Medicaid Recipients

How are audits selected?

- Suggestions from:
  - State and Federal Government Agencies
  - Kansas Legislative Committees and Legislators
  - Medicaid Contractors
- News and Media
- Discoveries during other Audits and/or Investigations

What are the results of an audit?

- Make recommendations and suggestions for improvement of quality and efficiency.
  - Recoup identified misappropriated State funds.
  - Can lead to investigations for prosecution.
  - Can identify additional audits needed.
  - Interim reports
- Confirm an agency is performing with quality and efficiency.

Audit Reports

MediKan Payments for Ineligible Beneficiaries - Published July 30, 2021

An audit to determine if the Kansas Department of Health and Environment (KDHE) paid medical claims for beneficiaries that exceeded the 12-month lifetime limit.

- It was determined that **$1,665,815.43** in medical claims were paid for 912 MediKan beneficiaries from January 1, 2018 to April 30, 2021.
- As a result of our review, KDHE staff began the process of removing 556 individuals that were identified as no longer eligible for MediKan. An estimated savings of **$1,252,520.00** to the MediKan program was based on the amount of claims for these individuals for the past one-year period and extended out for six months.

Audit Reports

Capitation Payments for Deceased Beneficiaries - Published September 17, 2021

An audit to determine if the Kansas Department of Health and Environment (KDHE) made capitation payments to Managed Care Organizations (MCOs) for deceased beneficiaries.

- The scope of the audit included any capitation payments made to MCOs between **February 2015** and **September 2020** for beneficiaries who were identified as no longer enrolled in Medicaid and the capitation payments had not been recouped.
- It was determined that **$1,313,175.55** in monthly capitation payments were made for **25** beneficiaries whose dates of death preceded the payment dates and recoupment had not occurred.

Audit Reports

Home and Community Based Services (HCBS) - Published April 13, 2022

An audit was conducted of the HCBS program for a period of **40** months from **January 1, 2018** through **April 30, 2021**.

- The audit found that, during the review period, the HCBS program had **2,854** individuals enrolled in an HCBS waiver, but did not have any HCBS claims filed on their behalf for 12 months or more.
- The capitation payments to the MCOs for these beneficiaries was more than **$193 million**.
- The MCOs were paid to provide life alert services to 560 beneficiaries at a cost of **$8,057,560**.
- The same service could have been paid via fee for service for **$55,769**.

Audit Reports

Out of State Residency - Published June 05, 2023

A performance audit of eligibility determinations for Medicaid recipients that had moved out of the State of Kansas from **January 2019** through **December 2021**. The audit found:

- KDHE did not have adequate protocols or guidelines to confirm if an individual identified by the Public Assistance Reporting Information System (PARIS) was truly receiving benefits in another state.
- KDHE did not have adequate protocols or guidelines for coordinating the assessment and collection of any overpayments related to out of state residency.
- Beneficiaries were identified that moved out of Kansas but did not have their Medicaid coverage discontinued, resulting in an estimated **$1,370,376.68** in capitation payment to MCOs.

Audit Reports

Transitional Medical (TransMed) program – Published December 08, 2023

A review of the TransMed program identified **2,322** beneficiaries that had **13** months or more of continuous TransMed coverage.

- TransMed beneficiaries are limited to **12** months of continuous coverage.
- For the review period, an estimated **$16,326,364.59** in capitation payments relating to the **2,322** beneficiaries was paid to MCOs.
- A follow-up review conducted one year later found that an estimated **580** (**25%**) of the **2,322** beneficiaries originally identified were still active TransMed members
  - It was estimated that from the date of the audit report to the date of the follow-up review the identified **580** beneficiaries potentially cost the State of Kansas **$1,574,908.80** in capitation payments to the MCOs.

Audit Reports

Continuing Care Retirement Communities (CCRC) – Published April 02, 2024

The CCRC and Continuing Care Provider (CCP) regulations, statutes, and an assessment of the eligibility for a reduced Quality Care Assessment rate (QCA), also known as bed tax, for any registered CCP certificate holder in the State of Kansas from July 1, 2020, through August 31, 2023, was conducted.

The QCA rate for each SNF is $4,908 per licensed bed. The rate is reduced to $818 per licensed bed if the SNF meets any of the following criteria:

- Small SNF, any facility with fewer than 46 licensed skilled nursing beds.
- High Medicaid Volume SNF, or any facility that provided more than 25,000 days of nursing care to Medicaid recipients.
- SNF that is a part of a CCRC.

Audit Reports - CCRCs (cont.)

The audit results revealed:

- During the audit period, 68% of CCP Registration certificates issued to SNFs were not in compliance with State of Kansas regulations and/or statutes.
- The primary cause of non-compliance was identified as failure to provide an annual audit report from a certified public accountant (CPA), as required by law.
- Due to SNFs being improperly issued CCP registrations, the State of Kansas lost QCA revenue of **$87,121,090**.
  - Improperly issued CCP registrations, only for providers claiming to be a CCRC when no "continuing care" was identified, resulted in an estimated **$33,374,400** loss of QCA revenue to the State of Kansas during the audit period.
  - An estimated **$12,274,090** will be saved this fiscal year based on nursing home facilities being properly assessed the correct bed tax.

The audit recommended changes to Kansas law to correct the identified issues, including moving the CCP registration process from KDOI to KDADS. Legislation was introduced during the 2024 Kansas Legislative Session, and approved on May 10, 2024, by Governor Kelly.

Complaints

In CY 2024, OMIG processed 1,454 complaints:

- 1,318 eligibility fraud
- 22 non-eligibility fraud
- 76 provider and contractor fraud
- 1 state agency
- 1 state employee
- 36 did not involve Medicaid and were referred to the correct agency

Investigations

In CY 2024, OMIG opened 105 investigations and identified $236,454.52 in savings and recoveries. Seven cases have been referred for prosecution.

81 beneficiary eligibility fraud

11 beneficiaries committing non-eligibility frauds

12 providers

1 state employee

27 cases have been closed

11 for allegation disproven

4 for no action due to insufficient evidence

4 agency error

8 were referred to another agency for action

Thank you/Questions?

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https://www.ag.ks.gov/divisions/medicaid-inspector-general/publications