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Office of the Medicaid Inspector General

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**KANSAS
ATTORNEY GENERAL**

DEREK SCHMIDT

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Letter from the Inspector General

July 30, 2021

To: Attorney General Derek Schmidt

Kansas Department of Health and Environment, Dr. Lee Norman, Secretary
Kansas Department of Health and Environment, Sarah Fertig, Medicaid Director

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

Senator Richard Hilderbrand, Chair	Representative Brenda Landwehr, Vice-Chair
Senator Renee Erickson	Representative Barbara Ballard
Senator Beverly Gossage	Representative Will Carpenter
Senator Pat Pettey	Representative Susan Concannon
Senator Mark Steffen	Representative Megan Lynn
	Representative Susan Ruiz

This report contains findings from our review of the Kansas Department of Health and Environment's – Division of Health Care Finance (KDHE-DHCF) process for discontinuing MediKan when a beneficiary exceeds the 12-month lifetime maximum limit.

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 greatly appreciate KDHE's cooperation and candor throughout this review. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Medicaid Inspector General

Executive Summary

The Office of Medicaid Inspector General (OMIG) is required to conduct independent and ongoing evaluation of the Kansas Medicaid program, which includes performing audits and reviews of state programs to ensure that appropriate payments are made for Medicaid services.¹

The 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. According to Kansas Administrative Regulations (K.A.R.), MediKan is a totally state-funded program covering all or part of the cost of medical care for disabled individuals who do not qualify for Medicaid.² In addition, assistance under this K.A.R. shall be limited to 12-months in a lifetime.³

Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System (KMMS), we identified 912 MediKan beneficiaries that had 13 or more months of eligibility during our 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 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.

The Kansas Economic and Employment Support Manual (KEESM) is maintained by KDHE and contains official medical assistance eligibility policy for elderly and disabled medical programs. Section 2645 pertains to the lifetime limit of the program. This manual section appears to contradict K.A.R. 129-6-95 concerning how the lifetime limit is interpreted. KDHE staff are currently editing KEESM Section 2645 to bring it in line with the K.A.R.

¹ K.S.A. 75-7427(c)(2).

² K.A.R 129-1-1(i)

³ K.A.R 129-6-95(d)

Background

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. KDHE is the designated single state agency for the Medicaid (KanCare), MediKan, and the Children's Health Insurance Program (CHIP) in Kansas.

KHDE is directly responsible for the purchase of health care services funded through the Medicaid program. Most of the health care services purchased are financed through a combination of state and federal matching dollars. Services are purchased through both managed care and fee-for-service models.

The Managed Care System

Most Kansas Medicaid beneficiaries are covered by KanCare, the state's Medicaid managed care program. KanCare became effective on January 1, 2013, after the state submitted and received federal approval for a section 1115 waiver.⁴ This waiver authority allowed Kansas to move most Medicaid beneficiaries to managed care, with services provided through Managed Care Organizations (MCO's).

Each MCO receives a monthly capitation payment from the state for each eligible beneficiary enrolled with that MCO, regardless of whether the beneficiary incurs any medical costs during that month. The amount of the capitation payment varies depending on the assistance program for which the beneficiary qualifies. Failure to timely discontinue Medicaid coverage when a beneficiary becomes ineligible can lead to capitation payments being made for ineligible persons.

MediKan (Fee-For-Service Model)

The MediKan program provides 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 considered a Fee-For-Service (FFS) plan because health care providers are paid directly for each service they provide.⁵

The MediKan program was implemented by the Department of Social and Rehabilitation Services (SRS) on April 1, 1983. At the time of enactment, all adults receiving General Assistance Unrestricted (GAU) or Transitional General Assistance (TAU) through SRS, were considered automatically eligible for the MediKan program.⁶

The General Assistance program was originally designed to provide assistance for a limited amount of time while clients await eligibility for federal Social Security Disability benefits. In

⁴ <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>

⁵ <https://www.kdheks.gov/hcf/Medicaid/default.htm>

⁶ 1983 SRS Annual Report retrieved from the Kansas State Library

fiscal year 2003, an average of 3,660 adults received cash assistance through the General Assistance program each month.⁷

On July 1, 2005, the Division of Health Policy and Finance (DHPF) within the Department of Administration became the designated single state agency for the Kansas Medicaid Program.⁸ SRS continued to be responsible for the initial financial eligibility determination for Medicaid, MediKan and SCHIP applications filed through any SRS service center. SRS performed this eligibility work in accordance with eligibility requirements and related policy established by the DHPF.⁹

On July 1, 2006, the Kansas Health Policy Authority (KHPA) became the designated single state agency for the Kansas Medicaid Program. In addition, the KHPA implemented the Presumptive Medicaid Disability Determination (PMDD) process to replace the MediKan Program.

Effective September 1, 2006, SRS and KHPA began making internal disability determinations under the Presumptive Medical Disability Determination process (PMDD). Although the rules to make such decisions were strictly tied to SSA's rules, the internal process was designed to issue a decision much quicker. This allowed those persons with the most severe disabilities to gain earlier access to Medicaid coverage. It would also allow some individuals who would otherwise receive state-funded MediKan to receive Medicaid, allowing the state to obtain additional federal funding and provide a full range of services to the beneficiary.

The PMDD process was also utilized for the General Assistance program. The method of determining disability under the GA program was dependent upon the applicant obtaining and submitting an ES-3151 (Statement of Disability). Using the PMDD process for both GA and Medicaid purposes provided a streamlined process.¹⁰

In 2009, the Legislature established a hard, 18-month lifetime benefit limit under MediKan which immediately reduced the MediKan population. In November 2009, as part of his allotment order, Governor Mark Parkinson tightened the lifetime benefit limit even further to 12 months.¹¹

On July 1, 2011, pursuant to Executive Reorganization Order (ERO) No. 38, the Kansas Health Policy Authority was abolished. Powers, duties, and functions were transferred KDHE-DHCF.

Effective July 1, 2011, the General Assistance program no longer included a cash benefit based on budgetary action taken by the Kansas Legislature in 2011. Income and resource guidelines remained the same. The zero cash benefit applied to all GA participants regardless if Tier I, Tier II, Re-integration or pre-release. Medical benefits were not affected by the GA benefit change.

On July 1, 2012, The Department of Social and Rehabilitation Services became the Department for Children and Families (DCF). This transition marked the beginning of a new agency more

⁷ SRS Business Plan - January 2004 retrieved from the Kansas State Library

⁸ KS Legislative Research Department Summary of ERO No. 33 dated February 2, 2005

⁹ SRS Update of Medicaid Transfer Testimony to Senate Ways and Means - January 19, 2006

¹⁰ Summary of Changes for KEESM Revision No. 29, Effective October 1, 2006 obtained from

¹¹ KHPA Medicaid Savings Options Presented to the KS Legislature 03/01/10

centrally focused on the wellbeing of children and families in Kansas. The Disability and Behavioral Health Services Division of SRS, as well as oversight of the five state hospitals moved to the newly named Department for Aging and Disability Services.

On January 16, 2015, Executive Order 43 required all medical eligibility determination functions currently performed by the Economic and Employment Services section of DCF be transferred to KDHE. All medical functions that were performed by DCF (with the exception of Child Welfare cases) became the responsibility of KDHE. This included all types of Medicaid as well as MediKan, Refugee Medical, Pre-Release applications and all other types of coverage.¹²

Executive Reorganization Order (ERO) No. 43 transferred Medicaid eligibility processing responsibility from DCF's Economic and Employment Services (EES) to KDHE effective January 1, 2016.¹³

KDHE received a letter from CMS dated February 17, 2016. The letter stated that Kansas had a backlog of approximately 7,000 eligibility applications. CMS asked KDHE to provide an analysis on a bi-weekly basis that included several pieces of information.

On January 1, 2020, eligibility applications for the Elderly and Disabled were forwarded to KDHE from Maximus for processing due to the backlog.

¹² KDHE-DHCF POLICY NO: 2015-12-01

¹³ 2015 Summary of Legislation published by the Legislative Research Department; July 2015

Applicable Laws & Policies

According to K.A.R.s, MediKan is a totally state-funded program covering all or part of the cost of medical care for disabled individuals who do not qualify for Medicaid.¹⁴ In addition, assistance under this regulation shall be limited to 12-months in a lifetime.¹⁵

KDHE Policies & Procedures

The Medical Kansas Economic and Employment Service Manual (Medical KEESM) contains KDHE's medical eligibility policies and procedures for elderly and disabled medical programs.¹⁶ The manual describes the MediKan program as follows:

2643 Other Assistance - MediKan coverage is not available to an individual who is entitled to SSA disability or SSI benefits, or who is eligible for or receiving Medicaid assistance.

2644 Disability - MediKan eligibility is dependent upon meeting disability criteria. Assistance shall be limited to those individuals meeting the Tier II disability level.

2645 Time Limited - Assistance under the MediKan program shall be limited to a fixed 12-month coverage period beginning with the first eligible month. Once established, the coverage period continues to run even if the individual becomes otherwise ineligible (i.e.: excess income or resources, moved out of state, marries a non-disabled person). There is no MediKan eligibility after the expiration of this period.

2646 Reintegration Program - Reintegration is a special MediKan coverage program that has been established to provide time-limited medical assistance to eligible adults being discharged from Medicaid approved psychiatric hospitals or released from the Larned Correctional Mental Health Facility Central Unit or from the Larned State Security Program.

¹⁴ K.A.R 129-1-1(i)

¹⁵ K.A.R 129-6-95(d)

¹⁶ <https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/manuals>

Scope, Objective, & Methodology

The scope of our review included any beneficiaries who had 13 or more months of MediKan enrollment between January 1, 2018, and April 30, 2021. The objective of our review was to determine if Kansas paid any benefits on behalf of MediKan beneficiaries who exceeded the 12-month lifetime maximum limit.

To accomplish our objective, we performed the following tasks:

- Reviewed federal and state laws, regulations, and guidance.
- Reviewed KDHE policies and procedures related to MediKan eligibility obtained from KDHE staff members.
- Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System (KMMS), identified 912 beneficiaries who have been enrolled in the MediKan program for 13-months or more between January 1, 2018 and April 30, 2021. Extracted the billed and paid amounts from KMMS for the months of enrollment that the MediKan beneficiary did not meet eligibility criteria.
- Created a sample of 88 MediKan beneficiaries who were identified as exceeding the lifetime maximum limit of 12-months, and had payments made on their behalf in the amount of \$5,000.00 or more.
- Accessed the following KDHE systems to independently confirm or perform additional analysis on the sample of 88 MediKan beneficiaries: Medicaid Management Information System (MMIS), Kansas Eligibility Enforcement System (KEES), KMMS, and ImageNow.
- Communicated with various KDHE staff members via email and conducted interviews through Microsoft Teams.
- Reported draft findings to KDHE and discussed suggested corrective actions.

Issues and Observations

The OMIG identified the following issues during our review:

Issue #1: KDHE Staff did not discontinue MediKan eligibility timely:

KDHE did not discontinue MediKan eligibility after the 12-month lifetime limit ended. State general funds were used to pay \$1,665,815.43 in medical claims for 912 ineligible persons' medical care from January 1, 2018 to April 30, 2021. The OMIG sampled 88 (9.6%) of the 912 beneficiaries who had 13 or more months of MediKan and had claims paid totaling \$5,000.00 or more. The sample of 88 ineligible persons had medical claims totaling \$1,019,361.95.

The Medicaid eligibility provisions of the Families First Coronavirus Response Act conditions a temporary Federal Medical Assistance Percentage (FMAP) increase of 6.2% on the state not terminating Medicaid eligibility for any reason other than (1) the beneficiary requests a voluntary termination, or (2) the beneficiary ceases to be a resident of the state. As a result of the COVID-19 public health emergency, KDHE continued MediKan eligibility past the 12-month lifetime limit as per policy outlined in PD2020-03-01.¹⁷ MediKan is funded 100% by the state and does not receive federal matching funds. Therefore, KDHE was not required to extend MediKan eligibility past the 12-month lifetime limit policy.

Our review of the 88 sample beneficiaries found that 79 had coverage continue past the 12-months lifetime limit due to Policy Directive 2020-03-01. This directive was changed with Policy Directive 2020-10-01¹⁸ which authorized discontinuance of MediKan eligibility. Our review found that KDHE staff were still referencing Policy Directive 2020-03-01, after Policy Directive 2020-10-01 was issued.

Additional reviews of the remaining nine sample beneficiaries revealed the following:

- Three received MediKan numerous times over different periods. There were no notes in their case file explaining how or why they were approved for additional coverage.
- One was “wrongfully given MediKan coverage” with no further explanation in the file.
- Five had coverage periods set with the wrong expiration month.

Issue #2: KDHE Staff were not properly notified of a significant change in policy:

As noted in the above paragraphs, our review found that in 79 of the cases from the sample of 88 beneficiaries their eligibility was continued due to Policy Directive 2020-03-01 being referenced by staff after Policy Directive 2020-10-01 was issued. Interviews of KDHE staff revealed that Policy Directive 2020-10-01 was transmitted to supervisory staff, but was not adequately addressed with staff that processed eligibility cases every day. There was no specific training provided to staff on the change in policy.

¹⁷ [PD2020-03-01](#)

¹⁸ [PD2020-10-01](#)

Issue #3: KDHE Staff did not properly annotate the KEES Journal Notes:

Our review of the 88 sample beneficiary files revealed that 45 (51.13%) of the 88 files did not have journal notes at all or were missing information about why MediKan was approved, denied, or changed. This lack of documentation makes it very difficult for anyone reviewing the file at a later date to understand why previous decisions were made and what would be a proper action to take on the case.

Issue #4: KDHE's system of timely discontinuing MediKan eligibility is not effective:

The computer system used by KDHE staff lacks an automatic or computer generated notification system concerning the end of a beneficiary's eligibility period. The process is manually completed by staff and errors do occur.

Issue #5: KDHE's KEESM 2645 was confusing and appeared to contradict the K.A.R.:

The current wording of KEESM 2645 makes it seem that once a person's eligibility starts, it continues for the 12-month lifetime limit and is not stopped for any reason. K.A.R. 129-6-95(d) states "Assistance under this regulation shall be limited to 12 months in a lifetime." We did not find any specific examples in our review, but it is possible that an otherwise eligible person would be denied MediKan if they tried to stop their MediKan coverage after a few months and then tried to get back on MediKan at a later date beyond the 12-month period. KDHE staff are currently reviewing the wording of KEESM 2645.

Savings

As a result of OMIG's 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. How quickly KDHE processes the cases and terminates their eligibility will impact the estimated savings.

Recommendations

This review identified five issues that resulted in MediKan recipients receiving benefits beyond the 12-month lifetime limit and claims for payment of services continued to be paid. We make the following recommendations to address those issues:

1. KDHE management should work with the KEES team to have a report automatically generated on a monthly basis that indicates the current amount of eligibility remaining for each beneficiary.
2. Review existing policy and procedures to ensure there are no conflicts with K.A.R.s.
3. Ensure that changes to policies, procedures, and directives are published and transmitted to all staff members. This should receive a special emphasis when new systems are implemented or when substantial changes occur.
4. Review quality control measures and staff training protocols to ensure they are sufficient to confirm staff members know how to properly document case files and are actually completing the task.