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Testimony Concerning Medicaid and Public Assistance Fraud

Presented to the House Committee on Welfare Reform
By Steven D. Anderson, CIG, Medicaid Inspector General

January 25, 2024

Chair Awerkamp and Members of the Committee:

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

The Office of Medicaid Inspector General (OMIG) was re-established under the Attorney General's Office in 2017 via Senate Bill 149. Sarah Fertig was confirmed by the Senate in January 2019. Fertig resigned in July 2020. I was appointed in January 2021 and confirmed on April 6, 2021. At the time of my confirmation, the OMIG consisted of the IG, one auditor, and one analyst. A part-time secretary was added on August 23, 2021. Two additional auditors were added on June 13, 2022. They were a critical addition to the OMIG's ability to fulfill part of its core missions of auditing and performance reviews. Two special agents and a financial analyst to conduct investigations of Medicaid eligibility fraud were added beginning FY 2024 in July 2023. The OMIG currently consists of the IG, three auditors, two analysts, two special agents and a part-time secretary.

Information on Performance Audits Conducted

The OMIG released three audit reports and one interim report in calendar year (CY) 2023, one audit report in CY 2022, and three reviews in CY 2021. 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. 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

A review of the process for the public to report cases of suspected Medicaid eligibility fraud was conducted. The KanCare Clearinghouse does not have an option in its call tree to allow a concerned citizen to report fraud. Callers are given several options, however, none of them include an option to report fraud. The KanCare website was also very difficult to navigate. There is no obvious link to a website or telephone number to report Medicaid eligibility fraud.
We recommended the following:

1. The KanCare Clearinghouse telephone tree should include an option to report fraud. The caller should be given the choice to report eligibility or provider fraud and then be provided the telephone number to either the Medicaid Fraud and Abuse Division for provider fraud or the Kansas Public Assistance Hotline for eligibility fraud.
2. The option to report fraud should be clearly indicated on the KanCare home page and not require clicking on several links that are confusing.
3. Add the numbers for the Kansas Public Assistance Hotline and OMIG to the KanCare Phone Contact List.

Review of MediKan, Report 22-02

A review of the MediKan program was conducted 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 that 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:

1. KDHE management should work with the Kansas Eligibility Enforcement System (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 Kansas administrative regulations.
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.

Review of Capitation Payments, Report 22-03

A review was conducted to determine if the KDHE made capitation payments to Managed Care Organizations (MCOs) for deceased beneficiaries. It was 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. Any beneficiary with a capitation payment description of "recoupment" and recorded as deceased was captured. From this list of beneficiaries, we kept beneficiaries where the MCOs received three or more months of capitation payments after the month of death. We found 632 cases where MCOs continued to receive capitation payments. The capitation payments totaling $19,202,562.21 were eventually recouped by KDHE 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 of money analysis. We determined the total cost of money to the State of Kansas to be $1,534,043.17. We made the following recommendations:

1. Review quality control measures and staff training protocols to ensure they are sufficient to confirm staff members know how to effectively and efficiently identify and process cases involving death of a beneficiaries.
2. The failure of KanCare staff to timely and efficiently process cases where Medicaid beneficiaries had died caused a substantial overpayment to the MCOs of $19,202,562.21. Due to this delay, the State of Kansas effectively loaned the MCOs $1,534,043.17 at no interest. KDHE should review the matter and determine if it is feasible to recover these funds.

Home and Community Based Services (HCBS), Audit Report 22-04

The audit detailed seven findings and made 17 recommendations for improvement to the HCBS program. The audit period ran from January 1, 2018 to April 30, 2021. 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.

It is understood that some waiver participants would qualify for regular Medicaid based upon their income level. A thorough review of each beneficiary's Medicaid case would need to be made to determine the portion of the $193,253,420.91 in capitation payments that could have been saved and not wasted. 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 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.

It was observed that procedure code S5161 (Emergency Response System Service Admin Fee) is being billed on a monthly basis. We identified 560 beneficiaries who had one or more months of S5161 billed without any additional Medicaid claims. It should be expected that other Medicaid services would be billed in addition to procedure code S5161. Waiver services are to help beneficiaries who would otherwise be institutionalized in a nursing facility, hospital, or intermediate care facility.

Rental, not the purchase, of this equipment is covered. Maintenance of equipment is included as a part of the rental agreement. This service must be billed at a monthly rate. The average paid amount for the system on a monthly basis was $32.02. 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.

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. It was 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.

In 2016, KDADS identified individuals who were currently receiving benefits as HCBS recipients who were no longer eligible for such services. The individuals were determined ineligible for HCBS services for a variety of reasons, including non-recipient of approved services for a specified period of time or failure to meet HCBS screening criteria at the last annual review.

Leadership staff at both KDADS and KDHE agreed that this should be addressed immediately. Because a large number of individuals have been identified over all HCBS waivers, special processes were implemented for a one-time clean up. Cases impacted by the project were identified on a series of reports issued by KDADS. Staff were instructed to limit processing of any retroactive HCBS termination adjustments to a maximum of three months. Exceptions exist for changes involving a date of death or a change to another long term care arrangement. The policy is still in effect and the state's recoupment of capitation payments that were made for a person later determined to be ineligible is still limited to three months.

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.

Eligibility Determinations, Audit Report 23-01

The audit detailed five findings and made 13 recommendations concerning eligibility determinations for Medicaid recipients that have moved out of the State of Kansas. Our audit covered the period of January 1, 2019, through December 31, 2021. The audit identified internal and external deficiencies that hinder 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.

Multiple Medicaid Beneficiary Identifications, Audit Report 24-01

The audit detailed two findings and made seven recommendations concerning KDHE's system for tracking Medicaid beneficiaries with multiple Medicaid identification numbers and KDHE process for recouping capitation overpayments to MCOs. The audit found that only 3 instances out of 53 (6%) cases reviewed with multiple beneficiary identifications had been recouped in a timely manner during the designated audit period of January 1, 2019 to June 30, 2022. 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.

Transitional Medical Program (TransMed), Audit Report 24-02

The audit detailed five findings and made 15 recommendations concerning KDHE's system for processing and tracking determinations for Medicaid beneficiaries on the TransMed program. The number and types of findings identified during the audit indicated control weakness placing Medicaid monies at risk. We identified significant compliance and control gaps within the TransMed program. A lack of oversight has led to staff misunderstanding, which has 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 as being wasted on ineligible persons as of June 2022. We extrapolated 25% from the original 2,322 beneficiaries, leaving 580 who potentially continue to be covered through TransMed. The average monthly payment per beneficiary in June 2023, was $452.56. 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.

School Background Checks, Interim Audit Report

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. The scope of our audit included all Medicaid enrolled students who had services billed on their behalf from a Local Education Agency (LEA) provider within a school-based program from January 1, 2021 through January 31, 2023. 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.

Our sample of providers was taken from 17 of the 287 public schools across Kansas. We added one additional school-based program for a total of 18, due to an associated school cooperative (Co-Op). Schools were picked at random, providing a cross representation in total enrollment and geographical location across the state. It is estimated there is an average of 13 providers per school district in Kansas. Accordingly, 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.

Our research found an attempt to make fingerprint-based checks a statutory requirement. Senate Bill 70 was introduced January 26, 2015. The bill would have required every teacher to have a fingerprint-based background check at the time they apply for their initial teaching license and every time they renew their license (every 5 years). It would also have required teachers convicted of any crimes listed in K.S.A. 72-1397 9(a) or (b), or who entered into a diversion after having been charged with a crime listed in (b), to notify the Kansas State Board of Education and their license would have been revoked. It passed the Senate. On March 23, 2015, it was recommended that the Committee of Education pass the bill as amended. On March 25, 2015, it was stricken from the calendar because of timeliness rule #1507.

We made the following recommendations:

1. All school districts immediately confirm that all employees, regardless of role, have current background investigations on file.
2. All school district employees have fingerprint-based criminal history background investigation performed on a regular, documented cycle of every five years.
3. Fingerprint-based criminal history background investigations on a five-year cycle be a statutory requirement for all school employees.

Performance Audits - Pending

The overall audit of Medicaid reimbursements to schools is ongoing. The scope of our audit included all Medicaid enrolled students who had services billed on their behalf from a Local

Education Agency (LEA) provider within a school-based program from January 1, 2021 through January 31, 2023. The objectives were to obtain sufficient evidence to answer the following questions:

1. Does KDHE have an effective system for processing and tracking school-based Medicaid FFS claim reimbursements?
2. Does KDHE have adequate policies and procedures that promote effective and efficient school-based Medicaid programs?
3. Does KDHE/KSDE have sufficient oversight processes in place to ensure Individual Education Plans (IEP's) are complete, and support medical necessity when services are billed to Medicaid?

OMIG has two additional ongoing performance audits. The first involves the prior authorization process in Kansas for Medicaid recipients. The audit covers the period of January 1, 2021, through December 31, 2022, and will seek to answer the following questions:

1. Are there delays in the peer-to-peer review process under each Managed Care Organization (MCO)?
2. Are Medicaid beneficiaries being placed in observation status when they should be classified as an inpatient?
3. Is there consistency in how each MCO determines the level-of-care (LOC)?

The second audit involves reviewing the Continuing Care Retirement Community (CCRC) registration process for potential fraud, waste, and abuse. Our audit covers the CCRC registration certificates processed from July 1, 2020, to July 31, 2023, and will seek to answer the following questions:

1. Are there currently issues within the legislative language that are allowing these facilities to falsely claim they are a part of a CCRC?
2. Are there currently proper procedures in place to monitor compliance within the CCRC statutes?
3. Are there measures that can be taken to stop potential fraud, waste, and abuse of Federal matching funds?

Recommendations to move responsibility for the CCRC registration process from the Kansas Insurance Department to KDADS was based on preliminary results of the audit. Suggested changes were provided to the Revisor of Statutes as requested by Representative Landwehr.

Findings of Fraud and Fraud Investigations to Date

OMIG did not have investigative staff until July 2023. 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.

Agency Policy or Procedure Changes Recommended to Reduce Incidents of Fraud Identified by the OMIG.

Numerous policy and procedure changes have been recommended during reviews and audits conducted OMIG. As noted above, OMIG audits and reviews have resulted in 19 findings and 64 recommendations to KDHE and KDADS operations.

For example, KDHE did not have adequate processes and controls in place to ensure Medicaid beneficiaries have only one Medicaid ID. During our review, we identified compliance and control gaps. Kansas Medicaid policy and procedure manual had not been updated since 2015. KDHE Policy Memo No. 2015-06-04 referenced KAECSES and HLCI systems; both of these have been discontinued.

We interviewed KDHE employees who stated beneficiaries with multiple IDs were found randomly by workers. One employee stated that in August of 2022, after the audit had started, the employee was presented with a list of beneficiaries requiring consolidation due to multiple IDs. The consolidations done at this time were completed accurately and journaled correctly per KDHE procedures. Employees interviewed stated the report was not generated on a regular basis; however, they would welcome such a report.

OMIG recommended that KDHE update the Case Action History Report so that it captures changes or deletions within the record to provide managers with a starting point for performance audits. A readable report would assist management in discovering which workers are using overrides, workarounds, and manipulations of the system. KDHE leadership agreed with recommendation and is in the process of updating the report.

In another example there was untimely removal of beneficiaries from the Transitional Medical Program (TransMed). TransMed provides 12 months of coverage for individuals who are no

longer eligible for Caretaker Medical due to an increase in income. We determined that an estimated 1,045 (45%) beneficiaries were identified as having 13 months or more of continuous enrollment in the TransMed program when extrapolating our 45% error rate across the audit universe. This allowed beneficiaries who would not otherwise qualify for Medicaid due to household income, to receive full Medicaid services, which includes pharmacy coverage. An estimated $16,326,364.59 in capitation payment overages were identified as being wasted on ineligible persons.

We further determined that 952 (41%) beneficiaries were identified as going without an eligibility review past the 12-month renewal regulation. More than a quarter of the beneficiaries we reviewed went unreviewed for several years between 2014 and 2018. Our review identified TransMed beneficiaries whose coverage was erroneously extended due to the passive review process. This process does not follow pre-populated review regulations outlined in C.F.R. §435.916.

OMIG recommended that KDHE should place an edit within the KEES system to prevent passive reviews for TransMed beneficiaries. The pre-populated review process should be the default for TransMed beneficiaries in order to ensure eligibility is reviewed and terminated timely. KDHE agreed with this recommendation. The system allows TransMed beneficiary cases to go through the reviews batch and be found as Passive. However, our rules have been written and updated to prevent a beneficiary from receiving an additional 12 months of TransMed.

In OMIG's audit of the Home and Community Based Services (HCBS) program it was found that beneficiaries enrolled in HCBS were not utilizing services at least monthly in order to remain on the waiver. We found that 262 did not have any Medicaid claims filed on their behalf for a total of 12 or more months during the audit period. This means that no Medicaid claims were identified, and no HCBS services were identified. The amount of capitation payments made to MCOs for the 262 beneficiaries identified during the audit period was $10,651,131.67. We found that 2,854 did not have any HCBS waiver services claims filed on their behalf for a total of 12 or more months during the audit period. We also noted there were 63 beneficiaries that had no HCBS claims during the entire 40-month audit period. The amount of capitation payments made to MCOs for the 2,854 beneficiaries identified during the audit period was $193,253,420.91. This population includes the 262 beneficiaries identified above.

In 2016, KDADS reviewed individuals on the HCBS waivers for anyone who was no longer eligible due to not utilizing HCBS services for an extended period or due to not meeting functional eligibility requirements. KDADS provided KDHE with a list of these individuals for waiver eligibility closure. The one-time project identified 678 individuals that needed to be removed from HCBS. No additional projects of a similar nature have been undertaken.

OMIG recommended that KDHE and KDADS conduct yearly program reviews to identify individuals that should be removed from the HCBS program similar to the project conducted in 2016. KDHE and KDADS leadership agreed with the recommendation and noted that KDADS will implement a review of each HCBS waiver at least annually to identify individuals enrolled on the waiver that are not meeting the requirements to utilize one HCBS waiver service per month. Individuals that are not receiving services will be evaluated for removal from waiver enrollment. MCOs will be expected to provide information regarding their respective members who are not receiving the required waiver service per month. KDADS and KDHE will verify the information provided by the MCOs and determine the actions to be taken regarding each individual's continued eligibility. Further, the agencies will utilize the review to evaluate MCO performance with regards to their contractual responsibilities to report for eligibility closure those members not meeting monthly service requirements.

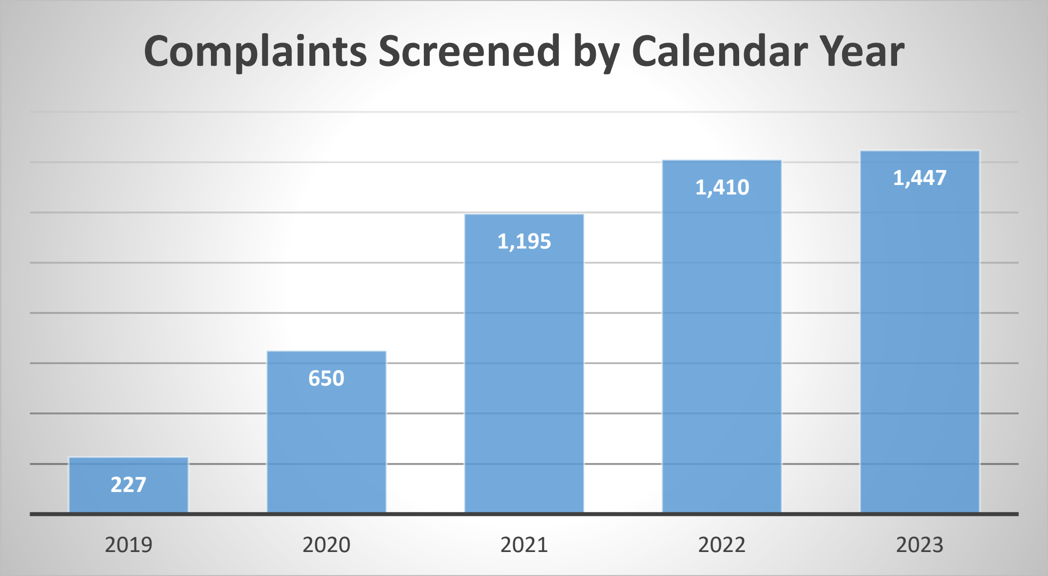
Training Provided to KDHE That Would be of Interest to the Committee

In cooperation with KDHE, the OMIG developed fraud, waste, and abuse awareness training that was provided to KDHE and contract employees. In calendar year 2022, OMIG completed six training sessions and provided the training to 196 employees. In calendar year 2023, OMIG conducted 19 training sessions and provided the training to 831 people.

The training is offered on a regular basis to KDHE employees and contract employees. Some sessions are open to the public. The purpose of the training is to ensure everyone is better prepared to identify fraud, waste, and abuse and how to report it.

Data on Complaints Processed and Investigated That Would Also Shed Light on the Volume of Complaints Received and the Nature of the Complaints

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 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 also 15 allegations of beneficiaries committing non-eligibility frauds, such as, falsely clocking in a personal care worker; 48 complaints involved allegations involving providers and contractors; and 21 complaints that after reviewing the matter did not involve Medicaid and were referred to the correct agency. These typically involved Medicare only.

In CY 2023, OMIG processed 1,447 complaints with 1,339 complaints involving allegations of beneficiary eligibility fraud; 14 allegations of beneficiaries committing non-eligibility frauds; 53 complaints involved allegations involving providers and contractors; and 38 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.

The breakdown for the 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 determines there are indications of fraud, they will refer the information back to OMIG for further consideration. OMIG investigative staff came on board in July of 2023. They 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	1,339	1,048	191	112	70

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