

2023

Office of the Medicaid Inspector General

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June 5, 2023



KANSAS
ATTORNEY GENERAL
KRIS W. KOBACH

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Letter from the Inspector General

June 5, 2023

To: Attorney General Kris W. Kobach

Kansas Department of Health and Environment, Janet Stanek, 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:

Representative Brenda Landwehr, Vice-Chair Senator Beverly Gossage, Chair

Representative Barbara Ballard Senator Michael Fagg

Representative Will Carpenter Senator Molly Baumgardner

Representative Susan Concannon Senator Pat Pettey

Representative Emil Berquist Senator Mark Steffen

Representative Susan Ruiz

This report contains findings from our performance audit of the Kansas Department of Health and Environment's (KDHE) process for discontinuing Medicaid eligibility when a beneficiary is no longer a resident of the State of Kansas. This audit 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 the cooperation and candor of KDHE staff throughout this audit. We also wish to thank the Kansas Department for Children and Families (DCF) and the Kansas Department of Revenue (KDOR) for assisting us during this audit.

We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson

Executive Summary

The Office of the Medicaid Inspector General (OMIG) conducted a performance audit of 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 objectives of this audit were to determine the following:

- (1) Does KDHE have an effective system for tracking Medicaid beneficiaries that have moved out of the State of Kansas?** KDHE's system has gotten better since 2019, but still has room for improvement. Our 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.
- (2) Were reports from the Public Assistance Reporting Information System (PARIS) used effectively and timely to identify Kansas Medicaid beneficiaries that were receiving Medicaid benefits in other states?** KDHE's current process for handling PARIS reports has helped to identify cases of duplicate benefits that otherwise would likely have gone undetected. However, KDHE does not have adequate protocols or guidelines to facilitate critical interstate communication. This makes it difficult to confirm if an individual identified in a match is truly receiving benefits in another state.
- (3) Were capitation payments properly recouped from Managed Care Organizations for Medicaid beneficiaries that had their eligibility terminated?** According to KDHE staff, if an overpayment is identified, staff log the information onto an overpayment spreadsheet in Microsoft Excel. Currently there is no guidance or protocols for coordinating the assessment and collection of any overpayments related to out of state residency.

Reviews of cases that were closed based on residency found that no attempt was made to recoup capitation payments even when it was confirmed the beneficiary had moved to another state and was no longer eligible for KanCare for several months. The existing contracts with the MCOs require the following:

Monthly capitation payments calculated in accordance with the CONTRACT will be paid by the State and the CONTRACTOR(S) may only retain capitation payments for Medicaid eligible Members. CONTRACTOR(S) has sixty (60) days from the date in which the

CONTRACTOR(S) discovers an overpayment to return such overpayment to the State or be subject to appropriate penalty.

The State may recover CONTRACTOR(S)' monthly capitation payments if the Member is subsequently determined to be ineligible for the month in question when the CONTRACTOR(S) actually provided service. Consideration may be given in instances where the CONTRACTOR(S) has paid for services.

KDHE Response: "KDHE is not contractually or statutorily obligated to recoup capitation payments for KanCare members that are later discovered to be residing out of state. The agency may recoup those payments, depending on the facts of the case. In the cases identified in the report, the MCOs remained at risk for medical expenses incurred by the member at all times they were Medicaid-eligible, and therefore the agency did not believe recoupments were in order. The fact that KDHE did not exercise its discretion to recoup capitation payments from the MCOs for the cases identified in the report does not mean improper activity occurred."

Rebuttal: It is recognized that KDHE has discretion concerning whether or not to recoup capitation payments and there are times when the MCOs continued to be financially responsible for claims after the beneficiary had moved out of Kansas. It is recommended that KDHE staff review those situations and recoup capitation payments where no claims were made after the beneficiary had moved from Kansas and was no longer using KanCare.

A good example of this scenario would be where the person was not using KanCare, but was receiving Medicaid benefits in the state where they currently reside. One of the important functions of the PARIS report is to assist states to identify these situations to avoid having beneficiaries being covered by multiple states and to avoid overpayments. These unnecessary overpayments are federal and state tax dollars that should be recouped when possible.

OMIG conducted a review of Medicaid cases where the beneficiary was found to be living in another state and were identified as having Medicaid coverage in the new state of residence. We selected former Kansas Medicaid beneficiaries that had no claims filed using Kansas Medicaid benefits for the confirmed period of them living in another state. The MCOs had no financial risk in these situations. It was determined that on average over \$100,000.00 per quarter could have been recouped from the MCOs. This would result in an annual savings of over \$400,000.00 per year.

Introduction

Medicaid is an entitlement program that was authorized by Title XIX of the Social Security Act. It provides health care coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The Centers for Medicare & Medicaid Services (CMS) is responsible for the overall administration of the program at the federal level. Although the federal government establishes certain parameters for all states to follow, each state administers their own Medicaid program differently, resulting in different variations of coverage throughout the United States.

The Medicaid program is funded by a combination of state and federal dollars. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). In exchange, states must fund their share of Medicaid expenditures in accordance with a CMS approved state plan. States then establish their own Medicaid provider payment rates within federal requirements, and generally pay for services on behalf of Medicaid beneficiaries through a managed care method or a fee-for-service (FFS) method.

Federal and State Medicaid Residency Requirements

Medicaid eligibility in each state is based on residency. Federal regulations prohibit beneficiaries from being concurrently eligible for Medicaid benefits in more than one state. If a beneficiary's residence moves from Kansas to a different state, their Medicaid coverage does not follow them. The beneficiary must establish residency in the state where they are requesting Medicaid. The following is a list of federal and state Medicaid residency requirements:

- **42 CFR § 435.403(a)** - The agency must provide Medicaid to eligible residents of the state, including residents absent from the state on a temporary basis.
- **42 CFR § 435.403(j)(3)** - The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the state if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid.
- **42 CFR § 435.403(m)** - If two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.
- **KAR 129-6-55** - Each applicant or recipient shall be a resident of Kansas. Temporary absence from a state with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of

residence. Residence shall be considered to be retained until abandoned or established in another state.

Kansas Medicaid (KanCare)

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency will often contract with other public or private entities to perform various program functions.¹ KDHE is the designated single state agency for the Kansas Medicaid program (KanCare), the MediKan program, and the State Children’s Health Insurance (also referred to as the “SCHIP” or “CHIP”) program. In addition, KDHE offers several other smaller targeted medical programs for individuals who qualify.

Basic Eligibility Requirements for All Medicaid Programs

As the single state agency, KDHE is responsible for determining Medicaid eligibility, verification of those eligible periodically, and promptly terminating coverage for individuals who are no longer eligible. The following is a list of basic eligibility requirements that apply to all Medicaid programs offered in Kansas that relate to the objectives of this audit.

Application Process

The Medicaid application process includes several steps before an individual is approved or denied for services. All medical applications and reviews are processed in the Kansas Eligibility Enforcement System (KEES) system at the KanCare Clearinghouse. KEES is a tool used for determining eligibility for both medical and social services benefits. A private contractor, Accenture, currently maintains the KEES system.

The KEES system is used by both KDHE and the Kansas Department for Children and Families (DCF). KDHE uses KEES to determine eligibility for the Medicaid program. DCF uses KEES to determine eligibility for social programs such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), formerly known as the “Food Stamp” program. 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, therefore DCF is no longer responsible for Medicaid.²

The KanCare Clearinghouse (also referred to as “the Clearinghouse”) is a centralized processing facility responsible for the operation of a call center in addition to providing support services in the Medicaid eligibility process. The Clearinghouse is operated by a private contractor through a

¹ 42 CFR § 431.10(b)(3)

² 2015 Summary of Legislation published by the Legislative Research Department; July 2015

competitive bidding process, with KDHE staff also stationed onsite to provide oversight. KDHE contracted with the following private contractors during the audit period:

Contractor	Contract and Event ID	Contract Effective Dates
Maximus Health Services, Inc.	Contract ID: 40581 Event ID: EVT0003365	09/02/15 - 12/31/20
Conduent State Healthcare, LLC	Contract ID: 48618 Event ID: EVT0006858	01/01/21 – 12/31/23 with the option to renew for three additional twelve-month periods.

On January 1, 2020, eligibility applications for the Elderly and Disabled (E/D) were forwarded to KDHE from the contractor Maximus for processing due to a large backlog. KDHE carried this responsibility forward into Contract ID: 48618 with Conduent. Those contractual specifications state the following:

The State is responsible for processing eligibility for Elderly, Disabled and Long-Term Care Medical Programs. The Contractor will be responsible for providing support services for all medical programs and processing eligibility for Family Medical programs – Medicaid and the Children’s Health Insurance Program, CHIP. Support services and eligibility processing include data entry and registration for all medical programs, screening, request for information/verification, determination of Family Medical/CHIP and communication with the applicants/consumers as well as other third parties. The contractor will provide services for applications, reviews and case maintenance for Family Medical/CHIP.

Pursuant to 42 CFR § 431.10(b)(3), eligibility determinations for Medicaid funded programs must be made by state staff, therefore the contractor will transfer the application to state staff via the KEES workflow for final determination. If KDHE staff disagree with the screening or are not able to complete the determination, KDHE will follow the case return process. Eligibility determinations for CHIP stand-alone funded programs may be finalized by Contractor staff.³

³ Conduent Contract ID 48618, EVT006858

Tools Used to Identify Out of State Residency

Public Assistance Reporting Information System (PARIS)

The Social Security Act § 1903(r)(3) and 42 CFR § 435.945 (d) provides that all state eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS). The PARIS system is administered by the Administration for Children and Families (ACF) and helps states detect and deter improper payments by identifying beneficiaries with concurrent enrollment in another state.⁴

The PARIS project is designed to match state enrollment data from the Temporary Assistance to Needy Families (TANF) Program, the Supplemental Nutrition Assistance Program (SNAP), the Workers' Compensation Program, the Childcare Program, and Medicaid, with data from other participating states and from a selected group of Federal databases. Each quarterly match consists of the following three data matches based on the individuals Social Security number (SSN) as the unique identifier.

PARIS Interstate Match

- Identifies duplicate assistance for individuals who are receiving Medicaid, TANF, SNAP benefits in other states.

PARIS Federal Match

- Identifies unreported earned or unearned income and misreported medical insurance for active or retired military and civilian employees.

PARIS Veterans Administration (VA) Match

- Identifies veterans (or spouse/survivors) receiving VA benefits, or who may be eligible for VA benefits.

All State Public Assistance Agencies (SPAAs) are required to sign a PARIS Memorandum of Agreement (MOA), which commits the state to submit an active roster of beneficiaries at least once per year, which currently is in August. SPAAs decide the Social Security Numbers (SSNs)

⁴ <https://www.acf.hhs.gov/paris/about>

to submit, quarters with which to participate, and programs to match against. The MOA also requires that data be submitted in a standardized format.

Once PARIS matches are identified, each state is expected to determine whether matched individuals continue to be eligible for benefits in their state and take whatever case action is appropriate. KDHE and DCF staff described the PARIS process as follows:

- Accenture extracts active Medicaid beneficiary information from the KEES system on the second Friday of every February, May, August, and November. Accenture then forwards the information over to the DCF PARIS team.
- The DCF PARIS team puts the data into the required standard format, and forwards the list onto the Defense Manpower Data Center (DMDC).
- The DMDC combines all the participating states active member rosters together. Once all the data is combined, the file is sent back to the DCF PARIS team.
- The DCF PARIS team combines all the matches identified on a spreadsheet and sends the three reports back to KDHE via secured email.

Contracted workers at the Clearinghouse work the interstate report. Each worker is assigned tasks in KEES which notifies them to contact the beneficiary to verify Kansas residency. The worker first attempts to contact the beneficiary by phone. If there is no response, a “Notice of Action” (NOA) is mailed to the beneficiary telling them to contact the Clearinghouse to verify and update their address. If no response is received, the case gets closed by a worker. Per KDHE-DHCF Policy No. 2022-03-01, a beneficiary is now supposed to be given 30 days to respond to the PARIS NOA before being discontinued.

- A KDHE employee (Program Integrity Specialist) in the Policy Department is assigned to work the Federal and VA match due to the special handling that each report requires. When she first started in the position in June of 2021, there was a baseline process in place. Since her time in the department, she has helped to update the current process.⁵ At this time, there is not a published standard operating procedure that shows how to work the VA and Federal reports.

In addition to the PARIS process, KDHE uses the following additional tools to identify beneficiaries who may no longer reside in Kansas:

⁵ KEESM 1434 and KFMAM 1425; Notice of Actions Resulting from Federal Data Match

Residency Report (CMS)

The residency report is generated by CMS and has information on address and/or state buy-in discrepancies between the Electronic Access to Social Security System (EATSS) and KEES. The EATSS system is primarily utilized by KDHE to verify Social Security Income, disability status and Social Security Numbers (SSN). There are also times where staff navigate this system to review the most recent address reported to the Social Security Office.

Out of State Report (DCF Changes/Updates)

A monthly report is generated to identify beneficiaries who have moved out of state. The report is generated by information taken from the state address information in the KEES system on other state benefit programs such as DCF cash assistance and food stamps. KDHE can accept information from DCF on the report without additional information unless there are concerns. When the out-of-state address has been verified by DCF, KDHE updates the KEES journal to show that DCF was the verification source.

Managed Care Organization (MCO) Spreadsheet Process

If an MCO is aware of an address change, the new information is placed on an Excel spreadsheet and sent to KDHE on a weekly basis via a file transfer protocol (FTP) site.

Returned Mail

When a beneficiary moves without notifying the Clearinghouse of their address change, returned mail may be received.

Annual Reviews/Re-determinations

The review process is a complete re-examination by the agency concerning all factors of eligibility. The purpose of the review is to give the beneficiary an opportunity to bring to the attention of the agency his or her needs and to give the agency an opportunity to re-examine all factors of eligibility in order to determine the household's continuing eligibility for assistance. Assistance is reviewed annually and the beneficiary must report changes that occur in a timely manner.

Audit Objectives and Scope

Our audit covered the period of January 1, 2019, through December 31, 2021, and sought to answer the following questions:

1. Does KDHE have an effective system for tracking Medicaid beneficiaries that have moved out of the State of Kansas?
2. Were reports from the Public Assistance Reporting Information System (PARIS) used effectively and timely to identify Kansas Medicaid beneficiaries that were receiving Medicaid benefits in other states?
3. Were capitation payments properly recouped from Managed Care Organizations for Medicaid beneficiaries that had their eligibility terminated?

Additional analysis was conducted to determine the outcome of any residency fraud referrals that the OMIG sent to KDHE for follow up.

We also reviewed historical driver's license and state identification information from the Department of Revenue for anyone who had surrendered their license or identification for moving out of the state, or who had passed away.

The scope of our audit did not review KDHE's overall internal control structure or the internal controls over the entire KanCare program. We limited our review of the internal controls that were applicable to our objectives.

Applicable Laws and Policies

Medicaid eligibility in each state is based on residency. Federal regulations prohibit beneficiaries from being concurrently eligible for Medicaid benefits in more than one state. If a beneficiary moves from Kansas to a different state, their Medicaid coverage does not follow them. The beneficiary must establish residency in the state where they are requesting Medicaid.

FEDERAL REGULATIONS

42 CFR § 431.211 - Before eligibility is terminated, State agencies must provide advance notice to the beneficiary at least 10 days before the date of action. The date of action is the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective (42 CFR § 431.201).

42 CFR § 431.213(e) - If a State establishes that the beneficiary has been accepted for Medicaid services by another State, the original State may send notice of the termination of the beneficiary's benefits or eligibility no later than the date of the termination

42 CFR § 435.403(a) - The agency must provide Medicaid to eligible residents of the state, including residents absent from the state on a temporary basis.

42 CFR § 435.403(j)(3) - The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the state if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid.

42 CFR § 435.403(m) - If two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.

42 C.F.R. § 435.916 - Requires each Medicaid case to be reviewed at least once every 12 months, in a process called redetermination (also referred to as a "review"). The review process is a complete re-examination by the agency concerning all factors of eligibility. All individuals eligible for Medicaid must have an annual review to determine if they are still eligible.

STATE REGULATIONS

K.A.R. 129-6-39(d) - Medicaid applicants and recipients shall report any change in circumstances within 10 calendar days of the change or as otherwise required by the program. Changes to be reported shall include changes to income, living arrangement, household size, family group members, residency, alienage status, health insurance coverage, and employment.

KAR 129-6-55 - Each applicant or recipient shall be a resident of Kansas. Temporary absence from a state with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of residence. Residence shall be considered to be retained until abandoned or established in another state.

KDHE

KDHE maintains official medical assistance eligibility policy in two manuals. The Medical KEESM (Kansas Economic and Employment Services Manual) contains Elderly, Disabled and Long-Term Care medical policy and the KFMAM (Kansas Family Medical Assistance Manual) contains Family medical policy. The manuals provide policy for the KanCare, MediKan, CHIP and other state medical assistance programs and are used by staff when issuing an eligibility determination for these programs. Both KDHE manuals provide that at the expiration of the review period, entitlement of benefits to assistance ends.⁶

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.⁷ This waiver authority allowed Kansas to move most Medicaid beneficiaries to managed care, with services provided through managed care organizations (MCOs). During the audit period, KDHE contracted with the following MCOs:

Managed Care Organization	Event ID EVT0005464
Aetna Better of Health of Kansas	Contract ID: 45081
Sunflower State Health Plan	Contract ID: 45080
United Healthcare Community Plan of Kansas	Contract ID: 45079

Each MCO receives a monthly capitation payment from the state for each eligible beneficiary enrolled with that MCO, regardless of whether that member incurs any medical costs during that month. The amount of the capitation payment varies depending on the assistance program for which the beneficiary qualifies. Capitation payments are paid in arrears; they are made at the beginning of each month for all eligible beneficiaries from the preceding month.

⁶ <https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/manuals>

⁷ Section 1115 of the Social Security Act (42 U.S.C. 1315) allows the Secretary of the United States Department of Health and Human Services to waive certain requirements in federal law and authorize “experimental, pilot, or demonstration” projects that the Secretary determines are likely to assist in promoting the objectives of federal Medicaid statutes. Section 1115 waivers are also known as demonstration waivers.

Under managed care, Medicaid eligibility runs from month to month. A beneficiary who gains eligibility in the middle of a month will have an eligibility effective date of the first of the month. Similarly, a beneficiary who is determined to be no longer eligible mid-month will have an eligibility termination effective date of the last day of the month. Failure to timely discontinue Medicaid coverage when a beneficiary becomes a resident of another state, can lead to capitation payments being made for ineligible persons.

CONTRACTUAL PROVISIONS

The State's contracts with the three MCOs allow the State to recoup capitation payments that were made for a person later determined to be ineligible. Those contractual specifications state the following:

Monthly capitation payments calculated in accordance with the CONTRACT will be paid by the State and the CONTRACTOR(S) may only retain capitation payments for Medicaid eligible Members. CONTRACTOR(S) has sixty (60) days from the date in which the CONTRACTOR(S) discovers an overpayment to return such overpayment to the State or be subject to appropriate penalty.

*The State may recover CONTRACTOR(S)' monthly capitation payments if the Member is subsequently determined to be ineligible for the month in question when the CONTRACTOR(S) actually provided service. Consideration may be given in instances where the CONTRACTOR(S) has paid for services.*⁸

*The CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(3) by promptly reporting to KDHE-DHCF any information received about changes to a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, the death of the Member, or other information specified by KDHE-DHCF.*⁹

⁸ KS Request for Proposal for KanCare 2.0 BID Event Number: EVT005464 5.13.2(E) and (F)

⁹ KS Request for Proposal for KanCare 2.0 BID Event Number: EVT005464 5.12.1 (G)

Methodology

To accomplish our objectives, we performed the following tasks:

- Communicated with agency officials and various staff members from KDHE and DCF.
- Reviewed federal and state laws, regulations, business practices, policies, procedures, contracts, or other standards that were relevant to the audit objectives.
- Obtained PARIS report interstate matches from DCF for 2019, 2020, and 2021.
- Obtained all residency reports and out of state reports from KDHE that were worked by staff during the audit period.
- Gained an understanding of KDHE’s internal controls over preventing, identifying, and correcting payments that were made on behalf of beneficiaries with concurrent eligibility in another state.
- Obtained a data file from the Kansas Department of Revenue (KDOR) that contained historical driver’s license and state ID information for anyone who had surrendered their ID for moving out of the state, or who had passed away.
- Obtained and reviewed the following documents to determine residency reporting requirements for each MCO under Event ID EVT0005464.
- Created 5 sampling populations for analysis.

Population 1: PARIS Interstate Matches

A random sample was drawn from the Q3 2019, Q4 2020, and Q2 2021 interstate match reports for a total of 642 cases. A beneficiary’s case number was searched in the KEES journal notes to determine the following for all 642 transactions:

- Was the case reviewed in a timely manner after receiving the PARIS report?
- Did the worker attempt to contact the beneficiary when necessary?
- Was the beneficiary discontinued timely?
- Was there adequate written documentation in the KEES journal notes?
- Were there any additional issues identified?

Interstate Match Sample Population	Q3 2019	Q4 2020	Q2 2021	Total
# of Beneficiaries Identified (Adults & Children)	4384	7786	8678	
# of Children Removed	2699	5038	4626	
Total # of Adults after children were removed.	1685	2748	4052	
Percentage of Adult Population Sampled	10%	10%	5%	
Total	168.5	274.8	202.6	
# of Transactions Tested per Quarter	165	275	202	642

- **Q3 2019**

The Q3 2019 PARIS report contained 4384 beneficiaries. The report was filtered down to only look at adults, which left 1685 beneficiaries. A random sample of 165 (10%) beneficiaries were reviewed in further detail.

- **Q4 2020**

The Q4 2020 PARIS report contained 7786 beneficiaries. The report was filtered down to only look at adults, which left 2748 beneficiaries. A random sample of 275 (10%) beneficiaries were reviewed in further detail.

- **Q2 2021**

The Q2 2021 PARIS report contained 8678 beneficiaries. The report was filtered down to only look at adults, which left 4052 beneficiaries. A random sample of 202 (5%) beneficiaries were reviewed in further detail. (Our original sample size was 10% of the population, however we reduced it to 5% due to the significant improvements identified early during testing).

Population 1A: Returned Mail for PARIS Interstate Reports

A random sample of 10% of 642 (64) beneficiaries were tested to determine the amount of returned mail.

Population 2: Residency Reports (CMS)

The January 2021 residency report was chosen to be reviewed in more detail. There were 115 beneficiaries identified on the report. In January of 2022, utilizing the Kansas Modular Medicaid System (KMMS), all 115 beneficiaries were queried to find their medical case number and the last month and year of enrollment.

Any beneficiary whose medical coverage had been discontinued prior to the January 2021 residency report, was not counted. We identified 25 beneficiaries whose coverage had ended before the residency report. A sample selection of the remaining 90 beneficiaries was created. Determination of compliance with KDHE policies and procedures was conducted.

Population 2A: Returned Mail for Residency Reports

115 beneficiaries (100%) were tested to determine the amount of returned mail.

Population 3: Out of State Report (DCF)

The January 2021 out of state report was chosen to be reviewed in more detail. There were 232 beneficiaries identified on the report. A random sample selection of 100 beneficiaries was created. Determination of compliance with KDHE policies and procedures was conducted.

Population 4: KDOR (Driver’s License and State ID)

Obtained a data file from the Kansas Department of Revenue (KDOR) that contained historical driver’s license and state ID information for anyone who had surrendered their ID for moving out of the state, or who had passed away. Compared the file with the KMMS system to see if any matches were identified. If so, reviewed the KEES journal notes and determined compliance with KDHE policies and procedures.

Population 5: OMIG Residency Fraud Referrals Follow-up

Ran a query in the OMIG’s case management system (LawBase) to identify all the reports of fraud sent to the OMIG during the audit period for all case types. Extracted the transactions with a case type of “residency” and created a sample of 50 beneficiaries. Reviewed the KEES journal notes related to each case to see if the KanCare Clearinghouse followed up on the referral and the outcome.

Year	Total Number of Fraud Referrals sent to OMIG (All Case Types)	Sample Population For Case Type: Residency
2019	227	15
2020	650	20
2021	1195	15
Totals	2072	50

- Using KDHE's reporting and analytics tools in the Kansas Modular Medicaid System, and determined capitation payment amounts as needed.
- Accessed alternative online information sources to independently confirm or perform additional analysis as needed.
- Reported draft findings and recommendations to KDHE leadership and reviewed the agency’s responses.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Population 1 Audit Results: PARIS Interstate Match

A random sample was drawn from the Q3 2019, Q4 2020, and Q2 2021 interstate match reports for a total of 642 cases. A beneficiary's case number was then searched in the KEES journal notes to determine the following for all 642 transactions:

- Was the case reviewed in a timely manner after receiving the PARIS report?
- Did the worker attempt to contact the beneficiary when necessary?
- Was the beneficiary discontinued timely?
- Was there adequate written documentation in the KEES journal notes?
- Were there any other issues identified?

Outcome of 642 Sampled Cases (PARIS Interstate Matches)	Q3 2019	Q4 2020	Q2 2021
Discontinued due to the PARIS report	43 or 26%	100 or 36%	69 or 34%
Verified and/or Found KS Address	35 or 21%	83 or 30%	41 or 20%
Case Already Closed, No Action Taken	51 or 31%	66 or 24%	50 or 25%
No Recent Medical Coverage	0 ¹⁰	0	3 or 2%
Never Reviewed	36 or 22%	0	1 or 0%
Transfer to E & D or LTC Department	0 ¹¹	26 or 10%	38 or 19%
Total	165	275	202

- **Discontinued due to the PARIS report:** Medical cases were reviewed and closed by a worker due to one of the following scenarios. The worker was able to contact the beneficiary via phone and confirm that they moved out of state or the beneficiary did not reply to the Notice of Action (NOA) letter sent by the worker at the KanCare Clearinghouse.
- **Verified and/or Found KS Address:** Medical cases were reviewed and remained open because the worker was able to verify KS residency.
- **Case Already Closed, No Action Taken:** Medical cases required no action because the case had already been resolved and no further action was needed. For instance, another worker was waiting on a response from the beneficiary or because the case was already closed several months prior, but keeps showing up on the PARIS report for an unknown reason.

¹⁰ Did not find anyone with this outcome for 2019 and 2020 PARIS report

¹¹ KDHE was not responsible for E&D and LTC until January 1, 2020.

- **No Recent Medical Coverage:** Medical cases reviewed had not recently received coverage therefore no action was taken.
- **Never Reviewed:** Medical cases reviewed did not have any KEES journal notes indicating that a PARIS report was worked.
- **Transfer to E & D or LTC Department:** Medical cases reviewed had KEES journal notes stating that the case was transferred to either the Elderly and Disabled (E/D) department or the Long-Term Care (LTC) department.

Extrapolation of Percentages across PARIS reports (PARIS Interstate Matches)	Q3 2019	Q4 2020	Q2 2021
Discontinued due to the PARIS report	1140	2803	2950
Verified and/or Found KS Address	921	2336	1736
Case Already Closed, No Action Taken	1359	1869	2170
No Recent Medical Coverage	0	0	173
Never Reviewed	964	0	0
Transfer to E & D or LTC Department	0	778	1649
# of Beneficiaries Identified (Adults & Children)	4384	7786	8678

We identified the following concerns during testing of the PARIS interstate reports for the following categories:

- **Case Already Closed, No Action Taken**
A significant number of cases keep appearing on the PARIS report when they have already been closed.
- **Transfer to E/D or LTC Department**
No follow up is being done once the case is transferred to the E&D or LTC Department.

Listed below are examples of cases that brought these issues to our attention:

Example #1: Case Closed in Error, Duplication of Work

On January 26, 2021, a worker made an outbound call to the beneficiary to verify residency. There was no answer at the residence, so the worker sent a PARIS NOA via mail with a due date of February 7, 2021. The beneficiary called the Clearinghouse on February 2, 2021 and spoke to a different worker. The beneficiary reported that she still lives in Kansas and verified that her address on file was correct. The worker made a note and stated that no further action was needed.

On February 3, 2021, the original worker opened the case again and stated in the journal notes that it appears all household members live in Kansas, therefore there was nothing more to do on this case. On February 9, 2021, the same worker made a note stating that there was no response to the PARIS NOA and changed the residency status to show none of the above and closed the medical coverage effective February 28, 2021. As a result, the beneficiary received another notice stating her medical coverage would end, which made her call the Clearinghouse on February 15, 2021, to get her coverage re-established. The worker then opened the case again one more time in February and two more times in March of 2021. (Blue notes indicate the same worker.)

Date	KEES Journal Notes Example	X = Same Worker
01/26/21	Worker called beneficiary. There was no answer, unable to leave message. PARIS NOA sent. Information is due on 02/07/2021	X
02/02/21	Inbound Call from beneficiary about letter received. She states she still lives in KS and verified the address on file is correct. CSR will note. No further action required.	
02/03/21	Per call log on 02/02/21 – appears all household members are in the household and live in Kansas	X
02/09/21	Worker accessed case via report. Because there was no response to PARIS NOA changed residency to show none of the above and closed coverage effective 02/28/2021. NOA sent.	X
02/15/21	Inbound Call regarding: Request to have Determination Reviewed. PA verified SSN#, Address, and PH# PA calling in regards to closure letter about HH being out of state. PA states she has called in several times and reported that they still are in Kansas. CSR advised will submit a redetermination so that ES can reopen case.	
02/16/21	Worker accessed case via report. As case is already closed, no further action is needed.	X
02/18/21	Worker addressed Redetermination. Appears HH was discontinued in error as bene reports making several calls stating they live in KS and at the address on file. Worker reinstated HH CTM coverage. NOA sent.	
03/23/21	Worker accessed case via PARIS report. Worker is conducting research, no further action required.	X
03/30/21	Worker accessed case via PARIS report. Worker is conducting research, no further action required.	X

PARIS interstate reports are only worked once per quarter; therefore, the worker should have been done with researching the above case on 02/03/21 or 02/09/21 at the latest. It is unknown why the same worker accessed the case an additional three more times.

During our testing on other cases, we found similar situations where it appears tasks are being duplicated in KEES and/or a beneficiary will continue to show up on a PARIS report for months at a time, requiring the worker or multiple workers to look at the case. This could be related to a timing issue because multiple steps and agency participation are required.

Example #2: Beneficiary being transferred to E&D with Late Action Taken

The beneficiary appeared on the PARIS report 08/31/21, where the case was transferred to E&D without making a phone call or mailing out an NOA to confirm residency. On 12/08/21, the beneficiary appeared on the PARIS report again. An updated out of state address was found and case was transferred to E&D for discontinuance.

Three months later, 03/09/22, the beneficiary appeared on another PARIS report. An outbound phone call was made which resulted in leaving a voicemail, so an NOA was mailed. Worker transferred to E&D again for coverage discontinuance. Case was accessed again on 03/15/22, due to the NOA being returned. Case was transferred to E&D for discontinuance.

Six months later on 08/12/22, a successful outbound call to the beneficiary confirmed out of state residency. Coverage was set to discontinue 08/31/22. The beneficiary was under the Fee-For-Service model; therefore, no capitation payments were paid.

Date	KEES Journal Notes Example
08/31/21	Worker accessed case per PARIS report. Worker has transferred cased to E&D for processing
12/08/21	Worker access case via 2 nd quarter PARIS report. Per interface, located an address updated within the last 30 days. It appears address in no longer in Kansas. Worker is transferring to E&D
02/09/22	Worker accessed case per 3 rd quarter PARIS report. Outbound call made to PA and NOA sent. Due back 03/06/2022.
03/09/22	Worker accessed case per 3 rd quarter PARIS pending report. Due to no response to PARIS NOA, worker is transferring case to E&D for coverage discontinuance
03/15/22	Worker accessed case per 3 rd Quarter PARIS report. Returned mail task due to PARIS NOA. Worker previously transferred to E&D for coverage discontinuance.

08/12/22	Outbound call to PA and confirmed out of state residency. Coverage was set to discontinue 08/31/2022.
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Example #3: Beneficiary being transferred to E&D with Late Action Taken

The worker accessed the beneficiary’s medical case on 03/12/2021 via PARIS report. The case was rerouted to E&D. On 06/15/2021, the medical case was reviewed again and transferred to E&D for processing.

Three months later on 09/28/2021, the case was accessed via another PARIS report. Worker transferred the case to E&D for processing. Two months later on 12/02/2021, an outbound call is made to the Medical Representative. The Medical representative confirmed that the beneficiary moved to Texas in March of 2021.

Almost two months later on 02/10/2022, the address was updated and the medical case closed due to residency. There has been no effort to recoup capitation payments following the confirmation of the beneficiary living outside of Kansas starting April 2021.

The estimated amount of capitation payments made in error for this beneficiary for the period of 04/01/2021 to 02/28/2022 is \$16,607.02.

Date	KEES Journal Notes Example
03/12/2021	Worker accessed case via PARIS report. This case is ED. Rerouted to ED.
04/27/2021	Worker accessed case via PARIS research. No action taken.
06/15/2021	It appears that this is an E&D case. Worker has transferred to E&D for processing.
09/28/2021	Worker accessed case via 2nd quarter PARIS report. It appears that this is an E&D case. Worker is transferring case to E&D for processing.
12/02/2021	Outbound call to Med Rep confirming beneficiary moved to Texas in March 2021.
02/10/2022	Address was updated in KEES and case was closed due to Residency

Example #4: Beneficiary being transferred to E&D with No Further Action Taken

The worker accessed the beneficiary’s medical case on 02/02/2021 via PARIS report. The worker routed it to E&D. Four months later on 06/10/2021, a worker accessed the case and also transferred it to E&D for processing.

An outbound call was made on 09/28/2021 to have the beneficiary verify residency. The phone number was no longer in service and an NOA was mailed. Information was due on 10/23/2021.

On 10/25/2021, the case was accessed via pending PARIS report. The case was transferred to E&D for processing. A few weeks later on 11/12/2021, the case was accessed again for PARIS research. No action was taken.

A little over four months later, on 03/03/2022, the case was accessed again for another PARIS report. An unsuccessful outbound call was made, and an NOA was mailed with a due date of 03/28/2022. The case was accessed at the end of March on 03/30/2022 and was transferred to E&D for processing following the no response to the PARIS NOA.

Five months later, on 08/31/2022, the worker accessed case due to return mail. The case was added to the COVID tracker for whereabouts unknown. The beneficiary remains active as of October 2022.

Date	KEES Journal Notes Example
02/02/2021	Worker accessed case via report. This case is ED. Rerouted to ED.
06/10/2021	Worker transfers to E&D for processing
09/28/2021	Outbound call made to beneficiary. Phone number is not in service. NOA was mailed with due date of 10/23/2021.
10/25/2021	Worker accessed case via 2nd quarter PARIS pending. Worker is transferring case to E&D for processing.
03/03/2022	3 rd Quarter PARIS report. Outbound call made with no success. NOA is mailed with due date of 03/28/2022
03/30/2022	Worker accessed case via 3 rd Quarter pending. Due to no response to the PARIS NOA, case transferred to E&D for processing
08/31/2022	Case was accessed from return mail. The case was added to the COVID tracker for whereabouts unknown.

Population 2 Audit Results: Residency Reports (CMS)

The January 2021 residency report was chosen to be reviewed in more detail. There were 115 beneficiaries identified on the report. In January 2022, utilizing KMMS, all 115 beneficiaries were queried to find their medical case number and the last month and year of enrollment.

Any beneficiary whose medical coverage had been discontinued prior to the January 2021 residency report, was not counted. We identified 25 beneficiaries whose coverage had ended before the residency report. The remaining 90 beneficiaries were reviewed for determination of compliance with KDHE policies and procedures.

There were various reasons why a beneficiary had shown up on the residency report but was living in the State of Kansas. The main reasons identified were related to having a Medicare “buy-in” in another state, or a family member of the beneficiary was committing identity fraud in another state. We identified the following issues during testing of the residency report:

Action Taken	Number of Beneficiaries
Active, Verified residency	21
Timely Removal	46
Untimely Removal or Not Removed	23
Total	90

- Several beneficiaries on the residency report were also on the PARIS interstate report. This resulted in cases having to be reworked multiple times wasting worker production efforts in addition to an influx of returned mail.
- Staff did not appear to utilize the “out of state” address listed on the PARIS report or contact the other state agency that was reporting the duplicate coverage.
- A review of KEES journal notes associated with these cases determined that all the beneficiaries on the residency report were dually eligible for Medicare and Medicaid.
- We found indications of possible improper payments in the KMMS system for Medicare premiums, cost sharing, or both, for beneficiaries who no longer reside in Kansas.
- Multiple KEES journal notes indicated beneficiaries were having trouble getting their address updated on a timely basis by the Social Security Administration when they were receiving both Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) concurrently.
- A review of the residency report policy and the PARIS report policy does not mention anything about Medicare premiums.

- KDHE eligibility staff we interviewed stated they were not familiar with any Medicare costs being paid.

Listed below are two examples of cases that brought these issues to our attention:

Residency Report Example #1

- Eleven pieces of returned mail were identified. Mail kept getting sent to the same address even though workers were aware it was wrong. In addition, staff did not appear to utilize the “out of state” address listed on the PARIS report or contact the other state agency that was reporting the duplicate coverage.

Returned Mail History			
07/14/20	11/06/21	08/11/21	02/14/22
07/27/20	06/14/21	01/26/22	04/04/22
11/28/20	07/01/21	01/31/22	

- KMMS showed possible indications that Medicare premiums and/or cost-sharing was being paid on behalf of someone who no longer lives in Kansas. See KEES Journal notes and KMMS screenshot below.

KEES Journal Note Dated 01/11/21 – *“Accessed the case via the residency report. The SSA interface (not up to date, update requested) indicates Kansas buy in but the Medicare information page indicates Florida buy in effective 7/20. Previous attempts to verify the address have resulted in returned mail with no forwarding address and attempts to contact the PA were unsuccessful. As the case has already been added to the COVID tracker to be revisited later, this worker took no action on the case.”*

KEES Journal Note Dated 01/13/22 – *“Worker accessed case via 3rd quarter PARIS Report. Worker was unable to call Pa as no phone is listed. Worker is needing to verify if the PA is/are still living in Kansas as they may have coverage in another state. PARIS NOA sent. Information is due 02/08/2022.”*

KEES Journal Note Dated 01/14/22 - *Outbound Call - Worker contacted PA. Number listed is not for PA. Removed from case. worker called to find out if PA still resided in KS and advised to contact SSA to update Title 1 and Title 2 addresses to current address.*

Member ID	08713312278	Medicare ID	888888-888888	Medicare	A, B	Manag
Name	BRICKNER LEARNE	ID Status	Active	Responsible Person		
SSN	087-13-312278	Linked ID		Hospice	No	
Gender	Male	Case #	8888888888	CSHCN	No	
Date of Birth	08/08/1964	Case Name	BRICKNER LEARNE	TPL	No	
Age	58	Death Date		Level of Care	No	

TXN	Process Date	Medicare ID	BIEC	Bill TXN	Mod	Sub Code	Eff Date	End Date	Premium	RIC	Date to CMS	CMS Reply Date
BILL	04/19/2022	4081704303A		20	51		03/2022	00/0000	\$0.00	F		04/19/2022
OUTB	04/18/2022	4081704303A		51			03/2022	00/0000			04/18/2022	
BILL	05/02/2022	4081704303A	P	17	28		01/2022	05/2022	(\$850.50)	B		
BILL	04/13/2022	4081704303A	P	17	28		01/2022	05/2022	\$0.00	D		04/13/2022
BILL	03/31/2022	4081704303A		41			01/2022	00/0000	\$170.10	B		12/01/2021
BILL	03/31/2022	4081704303A		41			10/2021	00/0000	\$148.50	B		09/01/2021
BILL	04/04/2022	4081704303A	P	11	61		09/2021	05/2022	\$1,444.50	B		
OUTB	03/01/2022	4081704303A	P	61			09/2021	00/0000			03/15/2022	
BILL	03/31/2022	4081704303A		41			07/2021	00/0000	\$148.50	B		06/01/2021
BILL	03/31/2022	4081704303A		11	61		07/2021	00/0000	\$1,401.30	B		02/01/2022

Residency Report Example #2

- Thirteen pieces of returned mail with “no forwarding address” were identified. Mail kept getting sent to the same address even though workers were aware it was wrong. In addition, staff did not appear to utilize the “out of state” address listed on the PARIS report or contact the other state agency that was reporting the duplicate coverage.

Returned Mail History				
05/20/19	03/11/20	08/21/20	02/12/21	07/23/21
06/10/19	04/13/20	09/30/20	04/19/21	
06/24/19	08/12/20	11/03/20	07/12/21	

- KMMS showed possible indications that Medicare premiums and/or cost-sharing was being paid on behalf of someone who no longer lives in Kansas.
- We identified a DCF KEES journal note on the food assistance case dated 07/08/19 that stated the beneficiary started using his EBT card in Colorado on 07/08/19. DCF closed the food assistance case on 10/31/19 due to whereabouts unknown after receiving a 2nd piece of returned mail.
- For the period of 07/01/19 – 08/31/22, an estimated \$17,252.50 was paid out in Medicare premiums and/or cost-sharing for a beneficiary who we believe no longer lives in Kansas. See KMMS journal notes and KMMS screenshot below.

KDHE KEES Journal Note Dated 04/27/21 - Worker accessed case via report. Case was pending from the residency report. We have received returned mail for the 11th time now. Coverage will continue due to the PHE. Case has been added to the COVID tracker to be closed for whereabouts unknown. Notice sent. A system NOA was sent.

KDHE KEES Journal Note Dated 01/27/21 - Eligibility professional working residency report. Interface shows an out of state address with Title I and Title II addresses not matching. Worker is requesting an outbound call be made to the consumer to ask for an updated address. When contact is made and they state they are living in Kansas, please inform the consumer they must contact the Medicaid office of the state they moved from to make sure the case is closed, and they must call the SSA office and update all addresses to reflect KS. When calling the SSA office, the consumer will need to let the SSA representative know their correct address and request that both the Title I and Title II addresses are updated. If they do not do this, they will continue to appear on this report.

KDHE KEES Journal Note Dated 02/17/20 - NOA sent due to residency report, information due 2/29/20. Coverage ended 3/31/20. However, due to PHE policy, coverage was reinstated per federal requirements.

KEES Journal Note Dated 07/01/19 – Return mail recd. Located a new address, updated info and emailed sup KT to have info resent. Mailing Address was updated for beneficiary. The new address is XXXX, KS. The effective date of the new address is 7/1/2019.

Member ID	0171212021	Medicare ID	471212021	Medicare	A, B, D	Ma
Name	SUBJECTT, GARY D	ID Status	Active	Responsible Person		
SSN	573-78-9000	Linked ID		Hospice	No	
Gender	Male	Case #	1071212021	CSHCN	No	
Date of Birth	06/21/1973	Case Name	SUBJECTT, GARY D	TPL	No	
Age	47	Death Date		Level of Care	No	

TXN	Process Date	Medicare ID	BIEC	Bill TXN	Mod	Sub Code	Eff Date	End Date	Premium	RIC	Date to CMS	CMS Reply Date
BILL	03/31/2022	0171212021		41			10/2020	00/0000	\$144.60	B		09/01/2020
OUTB	04/01/2021	0171212021	P	61			10/2020	00/0000			04/25/2021	
OUTB	01/01/2021	0171212021	P	61			07/2020	00/0000			01/25/2021	
BILL	03/31/2022	0171212021		41			07/2020	00/0000	\$144.60	B		06/01/2020
BILL	03/31/2022	0171212021		11	61		07/2020	00/0000	\$1,313.10	B		02/01/2021
BILL	03/31/2022	0171212021		17	28		06/2020	00/0000	\$1,461.60	B		04/01/2021
BILL	03/31/2022	0171212021		11	61		04/2020	00/0000	\$1,301.40	B		11/01/2020
BILL	03/31/2022	0171212021		41			04/2020	00/0000	\$144.60	B		03/01/2020
OUTB	10/01/2020	0171212021	P	61			04/2020	00/0000			10/25/2020	
BILL	03/31/2022	0171212021		17	28		03/2020	00/0000	\$1,449.90	B		01/01/2021

Buy-In Part B Combined X

Prev 1 2 3 4 5 6 7 8 9 10 Next

Due to the number of concerns mentioned above, we conducted further research and identified the following information:

Supplemental Security Income (SSI)

An interview with KDHE staff stated that when a beneficiary calls the Social Security Administration (SSA) for an address change, the SSA representative only looks at the main screen that comes up in their computer system and changes the address. This is okay for one type of Social Security income, however there are two types. The Social Security representative needs to go into a specific screen and manually update that address in order for both records to match and be accurate. Otherwise, the computer system is going to keep updating with the wrong information no matter how many times the consumer calls Social Security. KDHE staff also stated that this has been a problem for several years.

To test this theory, the OMIG called the SSA office at 1-800-772-1213 on July 19, 2022 and waited on hold for 45 minutes before an SSA agent answered the phone. The agent confirmed there are two systems that SSA agents use to update an address by phone if the beneficiary is receiving both types of Social Security concurrently.

Differences between SSDI and SSI	
Social Security Disability Insurance (SSDI)	Supplemental Security Income (SSI)
Eligibility is based on disability AND sufficient work credits through own/family employment	Eligibility is based on being age (65+) OR blindness (any age) OR disability (any age) AND limited/no income and resources
Benefits begin the 6th full month of disability; 6-month period begins with the first full month after the date SSA decides the disability began.	Benefits begin the 1st full month after the date the claim was filed or, if later, the date found eligible for SSI.
Automatically qualifies for Medicare after a 24-month waiting period from time benefits begin.	Automatically qualifies for Medicaid upon receipt of SSI in most states. In Kansas, individuals must apply for benefits.

When the address change is made, both computer systems are updated and will typically show the correct address within 24 hours: however, all living arrangement changes for SSI benefits have to be confirmed with the local Social Security office. Therefore, the SSI case is placed “under review” until it is confirmed with the local Social Security office. If the information is not confirmed, there is a chance that the address will revert back to the previous one depending on each individual case.

The SSA agent also stated that beneficiaries who get Social Security benefits (retirement, survivors, or disability) can update their address online on the SSA website; however, it can take 3 to 4 weeks to show up correctly in the SSA computer system. This service is not currently

available to beneficiaries who receive SSI because all cases have to be reviewed by the local Social Security office, even if they are just moving across the street.

In addition, the SSA agent stated that SSI can be terminated at any time and payments can be reduced by one-third if the beneficiary lives in another person’s household throughout a month and they do not pay for the food and shelter they get from the household. Any address changes for SSI should be reported directly to the SSA office at 1-800-772-1213.

After some additional research, we learned that in many states, SSI recipients are automatically qualified to receive Medicaid and are therefore included in PARIS matches. If a Kansas resident applies for KanCare, they are automatically determined eligible if they are receiving SSI benefits. In addition, beneficiaries on SSI are not always required to renew their applications every 12 months. This could potentially leave Medicare premiums, cost sharing, or both payments ongoing if someone moves out of the state or has their SSI benefits terminated.

Medicare Buy-In

The “state buy-in” program, administered by the Centers for Medicare & Medicaid Services (CMS) through authority delegated by the Department of Health and Human Services (HHS), provides a useful mechanism for states to pay Medicare premiums under Part A and/or Part B for certain individuals.

Medicare often requires recipients to pay certain out of pocket costs such as monthly premiums, annual deductibles, and coinsurance. SSI recipients are automatically eligible for Medicare and CMS automatically adds these individuals to the buy-in program without the states having to make a separate request. In most states, an SSI application is also an application for Medicaid. This means that the Social Security Administration automatically signs people up for Medicaid if they are eligible for SSI.

As noted below, the majority of states have automatic enrollment of Medicare buy-in.

Policy	Enrollment Process	SSI eligibility	Criteria and State
Automatic enrollment	SSA automatically notifies state Medicaid office upon determining that an SSI applicant is eligible for SSI.	Confers categorical eligibility for Medicaid.	<p style="text-align: center;">1634 States</p> Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New

			York, North Carolina, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.
Separate-application/nonrestrictive	SSI applicant must file a separate Medicaid application.	Confers categorical eligibility for Medicaid.	SSI Criteria States Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah.
Separate-application/restrictive	SSI applicant must file a separate Medicaid application.	Does not confer categorical eligibility for Medicaid. State uses at least one eligibility criterion that is more restrictive than those of SSI.	209b States Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.
Source: www.ssa.gov			

This could potentially leave Medicare premium payments ongoing if someone moves out of the state or has their SSI benefits terminated. In addition, KanCare beneficiaries on SSI are not required to renew their applications every 12 months.

Updated State Buy-In Manual

On September 8, 2020, the Centers for Medicare & Medicaid Services (CMS) released an updated version of the Manual for State Payment of Medicare Premiums¹² (formerly called “State Buy-in Manual”). The manual updates information and instructions to states on federal policy, operations, and systems concerning the payment of Medicare Parts A and B premiums (or buy-in) for individuals dually eligible for Medicare and Medicaid. The update to the manual is

¹² <https://www.cms.gov/medicare-medicaid-coordination/medicare-medicaid-coordination-office/state-payment-medicare-premiums>

part of CMS' Better Care for Dually Eligible Individuals Strategic Initiative aimed at improving quality, reducing costs, and improving customer experiences.

The prior version of this manual had not been fully updated since the 1990s. The updated manual clarifies various provisions of statute, regulation, and operations that have evolved over time. The manual also contains transaction codes that describe what the buy-in amount is for.

CMS redesigned the manual content to make it (1) easier for states to discern federal requirements and find information, (2) compliant with federal accessibility standards and (3) fully available online for the first time. The manual is part of the CMS Manual System, specifically Pub. 100-24.

6.1.7 - The State Medicaid Agency (Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20) The responsibilities of the state Medicaid agency include:

- *Conducting Medicaid eligibility determinations and redeterminations;*
- *Establishing internal procedures and systems to identify individuals who are eligible for state buy-in;*
- *Communicating these data to CMS;*
- *Responding to buy-in actions taken by CMS for beneficiaries;*
- *Making timely payments of Medicare premiums on behalf of state residents; and*
- *Assisting the SSA FOs in resolving inquiries on behalf of individuals who are, or may be, eligible for state buy-in.*

In addition, chapter four of the manual contains transaction codes that include detailed descriptions along with the actions that each state agency is required to perform if applicable. ¹³

¹³ <https://www.cms.gov/files/document/chapter-4-code-descriptions.pdf>

Sections from the updated State Buy-In Manual

<i>Transaction Code</i>	<i>Definition/State Action</i>
1728	<p><i>This code informs the state that a beneficiary was deleted from the state's buy-in account because another state submitted an accretion that was accepted by TPS or because the SSI record shows that the beneficiary's state of residence changed.</i></p> <p><i>State Action</i> - <i>The state should examine the Medicaid eligibility record for any beneficiary for whom it receives a code 1728 to ensure that the state's Medicaid eligibility record has been closed. This will prevent a cycle of accretion and deletion actions between states. If the state that received the code 1728 believes it should retain jurisdiction of the case, it must contact the state that submitted the new accretion in order to resolve jurisdictional issues (i.e., to determine in which state the individual currently resides). States receiving the code 1728 deletion will find the Agency Code for the state accreting the beneficiary in position(s) 124-126 of the RIC-B billing record. In addition, daily states receiving a RIC-D will find the state accreting the beneficiary in position(s) 94-96 of the reply record.</i></p>

Source: <https://www.cms.gov/files/document/chapter-4-code-descriptions.pdf>

Listed below is a screen shot from the data warehouse for the residency report example #2 previously mentioned. The manual contains transaction codes that describe what the buy-in amount is for. For example, code 1728 shown below appears as “28” in the KMMS system. It also appears as “28” in the data warehouse.

From the residency report example #2, the beneficiary had received a 1728 transaction code 12 times. It appears that Kansas was having jurisdiction issues with another state for several months. The amount of premium paid is on the far right.

dte_billing	cde_buy_txn	cde_buy_modi	amt_premium
202103	11	61	1313.1
202102	17	28	1449.9
202101	41		148.5
202012	11	61	1301.4
202011	17	28	1446.0
202010	41		144.6
202009	11	61	1301.4
202008	17	28	1147.7
202007	41		144.6
202006	11	61	1003.1
202005	17	28	713.9
202004	41		144.6
202003	11	61	569.3
202002	17	28	280.1

According to the Manual for State Payment of Medicare Premiums, KDHE should be calling the applicable state to confirm residency.¹⁴ Our audit found that KDHE was directing beneficiaries to call other states to close their coverage.

¹⁴ <https://www.cms.gov/files/document/chapter-4-code-descriptions.pdf>

Population 3 - 5 Audit Results

Population 3 – Out of State Report

Of the **100** beneficiaries reviewed, we identified **31** who were removed timely for moving out of state. Two beneficiaries were identified to be out of state in a Brain Injury Rehabilitation Facility (BIRF) and one beneficiary had an out of state address due to having a legal guardian. Sixty-six beneficiaries were marked as being in the household on a medical case, but were not actively receiving medical coverage.

Population 4 Audit Results – Department of Revenue (Driver’s License/State ID)

There were 35 beneficiaries who had died and surrendered their license between January 1, 2019 and December 31, 2021, but were still actively receiving Medicaid as of March 2022.

We queried the data again in May of 2022 and we found that all but seven beneficiaries had been discontinued. While reviewing the KEES journal notes, we noticed that KDHE has developed a new report called the “Date of Death Clean Up Report” that uses information from Vital Statistics. Upon further communication with KDHE on details of the report, they responded as follows:

“As a result of a 2020 OIG audit over member deaths, KDHE implemented process improvements to ensure memberships of deceased individuals are closed in a timely fashion.”

Population 5 Audit Results – OMIG Fraud Referral Follow-Up

K.S.A. 2018 Supp. 75-7427(k)(1) requires the inspector general to “make provision to solicit and receive reports of fraud, waste, abuse, and illegal acts.” To that end, the OMIG has a variety of ways that concerned citizens or state agencies may use to submit such reports. The majority of reports received are submitted by DCF via secured email and primarily allege beneficiary eligibility fraud related to household composition, income, and residency.

OMIG staff currently review each report received and then log the specific details related to each report into LawBase, which is a case management system. If there is a need for eligibility clarification, the report is forwarded to the KanCare Clearinghouse via secured email for review and possible follow-up.

The OMIG ran a query in LawBase and extracted 50 fraud reports related to residency that were sent to the KanCare Clearinghouse for review during the audit period. The KEES journal notes for all 50 residency fraud reports were reviewed to see if the KanCare Clearinghouse followed up on the referral and the outcome. As noted in the table below, a significant improvement has been made between 2019 and 2021.

Year	Amt.	Auditor Notes
2019	15	Over half of the cases reviewed lacked written documentation in the KEES journal notes. Eleven out of 15 cases were discontinued. Ten out of the 11 cases were properly discontinued within 3 months of receiving the referral.
2020	20	Much better documentation in KEES journal notes compared to 2019. Fourteen out of 20 residency referrals were properly handled by either terminating coverage or keeping open depending on the circumstances. Five out of 20 residency referrals did not have a response from the beneficiary so the cases were left open due to COVID Policy Directive 2020-03-01. One residency referral had no evidence of being received at the KanCare Clearinghouse or being reviewed in the KEES journal notes.
2021	15	Adequate KEES journal notes were identified for all 15 cases reviewed. Ten residency referrals were properly handled. Medicaid was either terminated or stayed open depending on the circumstances. Five residency referrals had no responses from the beneficiary so the cases were left open due to COVID Policy Directive 2020-03-01.
Total	50	

Additional Observations

Observation #1: PARIS Federal and VA Matches

As noted earlier, we did not conduct individual testing on the PARIS Federal or VA matches due to the amount of detail that is required to work each report. While conducting interviews with KDHE staff to learn about the entire PARIS process, we identified the following concerns associated with the overall process:

- A Program Integrity (PI) Specialist in the policy department at KDHE is assigned to the Federal and VA match due to the special handling that each report requires. During interviews, KDHE staff stated that they did not start reviewing the Federal and VA reports on a continuous basis until the fall of 2021 due to staffing. At that time, there was a policy in place, but they did not have any procedures established.¹⁵
- An interview with the current PI Specialist revealed that the same beneficiaries can show up on the Federal report or the VA report every quarter, requiring the same beneficiary to be checked several times. After the interviews with KDHE staff, we conducted some research and identified the following:
 - According to the MAGI-Based Eligibility Verification Plan dated 04/10/18, KDHE stated that matches against the Veterans File were currently under review and that data quality issues prevented meaningful use of this file in the past.¹⁶
 - The Federal match file is considered by many States to be the most challenging file with which to work. Results from the national evaluation of PARIS indicated that the use of the Federal file was limited to only a few States, with many State officials noting that the complexity of the file made it difficult to use. Even states that use the Federal file do not do so to its full potential, either because they do not understand its multiple uses or because they do not understand how to use the data.
 - The VA match report is also considered complex due to the general lack of understanding of how the file can be used, the level of coordination with other departments that is required for most of the described activities and the file's additional layers of complexity.

Observation #2 - PARIS Report Concerns Received from Georgia

In June of 2022, the OMIG received a phone call and an email from the Georgia Department of Human Services Office of Inspector General with concerns related to several PARIS inquiries they received from Kansas. Part of the email is referenced below:

“The inquiries received came from the email KS.PARISReports@conduent.com and there was no agency information or contact person attached to the emails. We began receiving the emails

¹⁵ Medical KEESM 1434 and KFMAM 1425 PARIS Matches

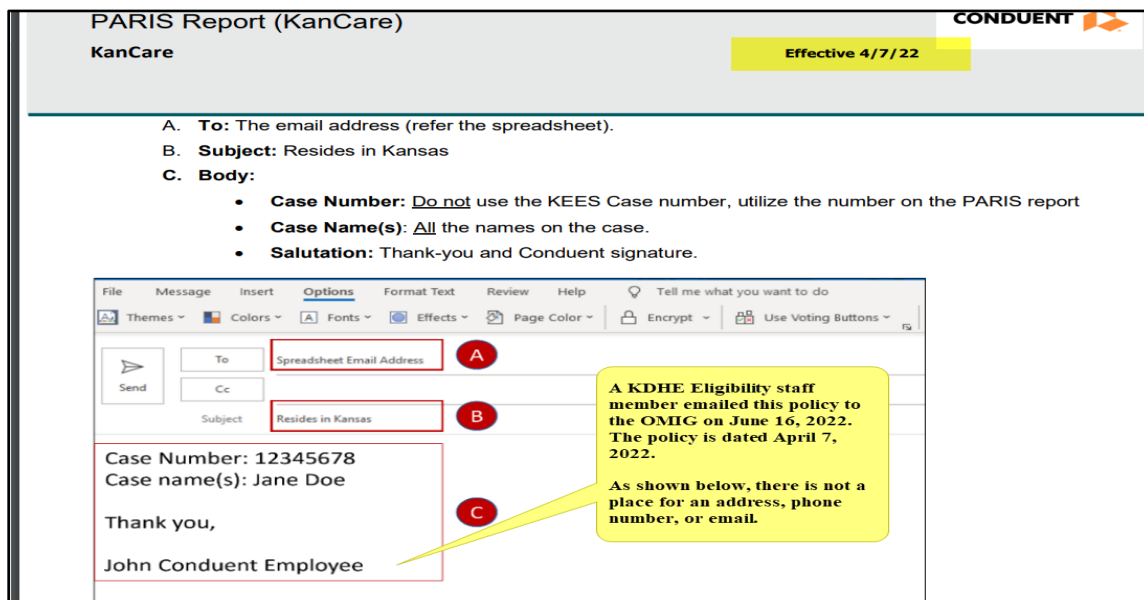
¹⁶ <https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html>


back in February of this year. We made several attempts to make contact and all attempts failed. We did not provide information to the emails as they contained personal information. There were at least 70 emails. We placed the emails in a pending validation box until further notice. On Friday, June 10, 2022, we received more emails from the same email address. They were also placed in the pending email box. I would like to know if you could provide some guidance on how we can resolve this matter. We can only provide information to an agency with the appropriate credentials.”

We reached out to KDHE eligibility staff to inquire about this and received the following reply from a KDHE employee along with a copy of the policy in question.

“I believe that not only were the signature blocks for the emails insufficient, but we are set up much differently from Georgia. They were expecting to see the PARIS inquiries coming DCF not Conduent. I explained that Conduent is the contractor that is contracted to take these kinds of actions on Medicaid cases in Kansas and explained how our program is set up. Once they understood how we are set up and I explained that we would be adding a more descriptive signature block and contact number to future PARIS inquiries, she agreed to go ahead and process our inquiries as she had a better understanding who Conduent was and why the emails were coming from their staff.”

In looking at the policies and procedures we received when we first began this audit, the signature line is filled out. In addition, we found an email dated 08/20/21 that the Operations Manager at Conduent emailed to a member of the KDHE training team. This document shows a full signature line as well, so we are not sure why the Eligibility Department has a policy that doesn't have a signature line referenced. Listed below is a screenshot of the policy that was attached to the email from KDHE eligibility staff dated 04/07/22.



KanCare **CONDUENT** 

To Spreadsheet Email Ad...

Cc

Subject Resides in Kansas

12345678
Jane Doe
Resides in Kansas

Good day,

First Name Last Name
Position, Project

Conduent
3231 SE 6th Street
Topeka, KS 66607
Office:
Mobile:
Yours@conduent.com

The Operations Manager from Conduent emailed this policy to a KDHE Eligibility staff member on August 20, 2021.

As shown below, the signature line is complete. The policy is dated July 1, 2021.

b. If a response email is received from the other State, this should be imaged to the case. (Communications through the designated email box should be monitored daily).

5. Take Necessary Actions if No Response has Been Received

a. If no response has been received by the due date, discontinue coverage for ALL case members identified on the PARIS Report for whom no response was received and send a closure notice.

b. Update the PARIS Report as completed for that case.

c. Skip to [Step 7](#).

6. No Action Needed

a. If the case has already been closed or addressed, create a case log that indicates the case was on the PARIS report and has already been addressed and no further action was taken.

b. Update the PARIS Report as completed for that case.

Page 5 of 6 Updated 7/1/2021

Observation #3: Audit Finding for KS – September 2022 Report #A-05-20-00025

According to the U.S. Department of Health & Human Services Office of Inspector General, Kansas made capitation payments for beneficiaries who were concurrently enrolled in a Medicaid managed care program in two states.¹⁷

Mo./Year	# of Benes Concurrently Enrolled in KS and another State	Total Value of Cap Payments
Aug 2019	4,311	\$2,735,737
Aug 2020	5,807	\$3,342,754
Total	10,118	\$6,078,491

¹⁷ HHS OIG Report No. A-05-20-00025

HHS OIG recommended the following:

- CMS provide states with matched Transformed Medicaid Statistical Information System (T-MSIS) enrollment data that identify Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.
- Assist States with utilizing the data as needed to reduce future capitation payments made on behalf of beneficiaries concurrently enrolled in two States.
- According to the report, CMS did not concur with this recommendation because the PARIS interstate match already allows states to compare eligibility with other State Medicaid programs to identify concurrently enrolled beneficiaries, and the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to States, especially considering the existing statutory and regulatory framework underlying State monitoring of concurrent enrollments through PARIS.
- CMS also stated that it is committed to working with states to ensure the accuracy of Medicaid eligibility determinations and will continue to provide guidance and technical assistance to states as needed, but it stated that the PARIS interstate match already allows states to compare eligibility with other State Medicaid programs.

KS OMIG Comments:

We concur with HHS OIG's recommendations due to the following:

- Every year, public assistance programs make millions of dollars in improper payments. Some of these improper payments are made because state and local agencies that administer the programs lack adequate, timely information to determine recipients' eligibility for assistance. PARIS is only designed to identify people after they are already on the rolls, it does not prevent improper payments from being made in the first place. In addition, the PARIS system does not operate in real-time.
- Match hits involving duplicate benefits can occur because Medicaid beneficiaries often do not notify KDHE when they move out of state. Therefore, a beneficiary will stay on the rolls until it is discovered that they have moved. The PARIS system cannot currently be accessed in real time, nor on an individual basis. In addition, PARIS reports do not provide eligibility dates. Therefore, state Medicaid agencies cannot use PARIS during the initial verification process for new applicants or at each beneficiary's regular renewal.
- KDHE accepts self-declaration of residency and does not require the applicant or beneficiary to provide any documentation to substantiate that they actually reside in Kansas. An individual is only required to give an explanation/or provide physical documentation if the information provided is questionable or conflicting with current records or electronic data sources. While the policy to allow applicants to self-declare residency can result in rapid enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false residency statements. As such, there are

inherent challenges in trying to provide Medicaid benefits quickly while still ensuring the accuracy of eligibility determinations.

Finding #1: Participation in the PARIS Process is Inadequate

KDHE does not have adequate procedures or guidelines to facilitate proper processing of information available via the PARIS reports. Reviews of the Federal and VA matches were not conducted due to no staffing until the fall of 2021. At that time, there was a policy in place, but they did not have any procedures established. There is the potential to save significant Medicaid funds and to provide additional income to veterans if the VA match is properly considered and used to its full benefit. The Federal match should have been used to identify Medicaid beneficiaries with additional income and benefits that were unreported.

Recommendations:

- **KDHE should reach out to other states it has communicated with to see if there was a similar issue to what Georgia experienced with requesting information for the PARIS Interstate reports.**

KDHE Response: The applicable job aid has been updated to mitigate the chance of this issue recurring, whether with Georgia or any other state. Additionally, contact with the other state is either by email or phone, depending on the other state's preference. KDHE will take steps to ensure that the case journals reflect when contact has been made with the other state and whether by email or phone.

- **Update all applicable policies to reflect what the signature block should look like to include the Conduent 9.46 Job Aide for PARIS Reports and any applicable additional documents.**

KDHE Response: The Conduent job aid has been updated. KDHE will review to determine if any other job aids are impacted.

- **Assist in the creation of a working group across multiple agencies to include KDHE, DCF, VA and related contractors to fully utilize and identify VA funds available to veterans and their family members.**

KDHE Response: KDHE has previously participated in conversation with DCF and other states to identify best practices. KDHE currently review the Federal and VA PARIS report for unreported funds. As the audit report mentions, the reports are complex. KDHE currently utilize the reports to the extent that resources allow.

Finding #2: The Residency Report Process Needs Reviewed

Medicaid is the “payer of last resort,” meaning that Medicaid only pays for covered care and services if there are no other sources of payment available. Several beneficiaries were identified on the PARIS interstate report and the residency report for months at a time. One of the beneficiaries had an estimated **\$17,252.50** that was possibly paid out in error for their Medicare buy-in.

On September 8, 2020, the Centers for Medicare & Medicaid Services (CMS) released an updated version of the Manual for State Payment of Medicare Premiums (formerly called “State Buy-in Manual”). The manual updates information and instructions to states on federal policy, operations, and systems concerning the payment of Medicare Parts A and B premiums (or buy-in) for individuals dually eligible for Medicare and Medicaid.

According to the Manual for State Payment of Medicare Premiums, KDHE should be calling the applicable state to confirm residency.¹⁸ Our audit found that KDHE was directing beneficiaries to call other states to close their coverage.

Recommendations:

- **KDHE should perform an evaluation to determine compliance with federal regulations.**

KDHE Response: KDHE will review for compliance with federal regulations. The audit report indicates \$17,252.50 were paid out in error in premiums for a KanCare member. KDHE disputes this finding. The member in question received ongoing medical assistance correctly as the result of an updated in-state address being located after the agency received returned mail. Seven months later, the individual appeared on the CMS residency report. The applicant did not respond to KDHE requests to confirm residency; however, there are CMS imposed restrictions that limit the state’s ability to discontinue eligibility in this scenario.

Rebuttal: An email was received from KDHE eligibility staff on October 18, 2022, with clarification as to why Medicaid eligibility continued for the beneficiary identified in example #2 of the Residency report. The following information was provided by KDHE.

A new address was found on 7/1/19, as the result of eligibility staff researching returned mail. Eligibility continued correctly. On 02/17/20, an NOA sent due to residency report, with information due on 02/29/20. Coverage ended

¹⁸ <https://www.cms.gov/files/document/chapter-4-code-descriptions.pdf>

3/31/20. However, due to PHE policy, coverage was reinstated per federal requirements.

After reviewing KDHE's comments, we determined that KDHE is correct as far as the journal notes are concerned. A correction has been made to the journal notes that shows the worker found a new address on 07/01/19, updated the computer system with the new address, and continued Medicaid eligibility. However, this does not change why the finding was issued.

The finding was issued because it appears that Kansas could be making millions of dollars in improper payments for Medicare premiums and/or cost-sharing for beneficiaries who no longer live in Kansas. **Although this issue is outside of the scope of this audit, the purpose of this finding is to bring this issue to leadership's attention for possible corrective action.**

- **Change the script that eligibility workers use to advise beneficiaries on updating their address with the Social Security Administration.**

KDHE Response: KDHE acknowledges this recommendation.

- **Contact other states pertaining to the necessary transaction codes from the Manual for State Payment of Medicare Premiums.**

KDHE Response: KDHE acknowledges this recommendation.

- **Review the Residency Report Checklist policy in accordance to the CMS Manual for State Payment of Medicare Premiums.**

KDHE Response: KDHE acknowledges this recommendation.

Finding #3: Returned Mail has Resulted in Wasteful Spending

Mail was sent to the beneficiary even though workers were aware the address was incorrect. Staff stated this was due to a misinterpretation of CMS policies, which has been corrected.

- 30% of beneficiaries on the PARIS interstate report had at least one or more pieces of returned mail.
- 38% of beneficiaries on the residency report had at least one or more pieces or returned mail.
- Staff did not send mail to the “out of state” address listed on the PARIS report, or contact the other state agency that reported the duplicate coverage. (The PARIS report has several pieces of important information that is not being utilized.)

The repeated sending of mail to addresses that were known to be incorrect resulted in time, effort, and resources being wasted by KDHE employees and contractors. Each piece of mail that is sent and subsequently returned created extra work for an already very busy group. The cost of postage and envelopes should also be considered.

Recommendations:

- **Retrain workers to suspend any mail from being sent if they are aware that the address is incorrect.**

KDHE Response: KDHE must comply with CMS policy, which requires that the mail is resent to the address on file in certain scenarios, even when return mail has been previously received. KDHE will take steps to ensure staff understand when it is necessary to resend mail, per federal policy.

Rebuttal: On October 21, 2021, LaTonya Palmer, Director of Eligibility, sent an email to Michala Walker, CMS concerning a question about preventing inappropriate terminations. The entire email chain is attached to this report as Appendix II. Palmer questions, based upon training slides from CMS, what is required to move forward with discontinuing eligibility.

*“We have historically also mailed notices asking the member to contact us (based on our interpretation of 42 CFR § 435.95242). The notice is sent to the address on file (of which we already received returned mail). This seems a bit **redundant and inflates [emphasis added]** our workload. Given the presentations given by CMS, I’m questioning if this extra step is federally required.”*

The CMS response on November 19, 2021, stated *“States are not required to conduct outreach to a beneficiary whose mail is returned without a forwarding address, and as a result, do not have to send a notice to the address on file in an attempt to confirm their*

address. States are strongly encouraged to attempt to locate beneficiaries whose mail is returned without a forwarding address prior to discontinuing coverage based on a determination that a beneficiary's whereabouts are unknown. ~~Even~~ [sic] However, if the state attempts, but is unable to reach the beneficiary via phone call and has performed other steps in an attempt to obtain a current address – if a beneficiary cannot be located, and there is no forwarding address, the state may terminate eligibility. In accordance with § 431.213(d), the state does not need to send advance notice to a beneficiary whose whereabouts are unknown. However, the state must send notice no later than the date of action via the beneficiary's elected/preferred modality (e.g., electronic or regular mail to the address on file with the state). If a beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the state must reinstate coverage (per §431.231(d)).”

According to Palmer, this clarification was addressed in a March 2022 policy.

- **Ensure updated policies concerning mail handling procedures are in place for returned mail that conform to CMS guidance.**

KDHE Response: KDHE acknowledges this recommendation.

Finding #4: MCO Contracts Need Updated

According to KDHE staff, if an overpayment is identified, staff log the information onto an overpayment spreadsheet in Microsoft Excel. Currently there is no guidance or protocols for coordinating the assessment and collection of any overpayments related to out of state residency.

Reviews of cases that were closed based on residency found that no attempt was made to recoup capitation payments even when it was confirmed the beneficiary had moved to another state and was no longer eligible for KanCare for several months.

Recommendations:

- **KDHE should recover improper Medicaid payments if staff determine that an overpayment has been made due to out of state residency.**

KDHE Response: Please refer to KDHE's response letter for comments.

- **Eligibility workers should ask for the date the beneficiary officially moved out of the state. This date can be used to discontinue capitation payments to the MCO.**

KDHE Response: KDHE acknowledges this recommendation.

- **Update MCO contracts to strengthen and clearly state the shared responsibility for MCOs to identify Medicaid beneficiaries that have moved out of Kansas.**

KDHE Response: KDHE acknowledges this recommendation.

Finding #5: E/D and LTC Policies Need Clarified

While reviewing the Q4 2020 and Q2 2021 PARIS interstate reports, it was noted that workers who identified the case was a part of E&D or LTC, forwarded it on to that department without calling or mailing an NOA to the beneficiary to confirm residency. It was found that either nothing was done by E&D and LTC or there was a huge delay in determining residency. This leads to possible over payments of capitation to the MCOs or improper payments for Medicare buy-in. It was not until 2022 that workers started calling and mailing letters prior to forwarding the cases to E&D and LTC.

By finding the error rate from our sample size and expanding it across our estimated total E&D and LTC populations from the Q4 2020 and Q2 2021 PARIS reports, we estimate a combined overpayment of **\$1,370,376.68**.

A review of the policies and procedures related to the PARIS process, did not identify anything that specifically mentions that the KanCare Clearinghouse needs to do the preliminary work on these cases.

Recommendation:

- **KDHE should improve control activities by updating policies and procedures related to the PARIS interstate match process for E/D and LTC beneficiaries.**

KDHE Response: KDHE acknowledges this recommendation.

Appendix I - KDHE Response Letter

Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Suite 900 N
Topeka, Kansas 66612-1220

Janet Stanek, Secretary



Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov

Laura Kelly, Governor

October 31, 2022

Steven D. Anderson
Kansas Medicaid Inspector General
Office of the Attorney General
120 SW 10th Ave, 2nd Floor
Topeka, KS 66612-1597

Dear Mr. Anderson:

Thank you for the opportunity to provide input on the Office of Medicaid Inspector General's (OMIG) performance audit of KDHE's handling of eligibility determinations for Medicaid beneficiaries who have moved outside of Kansas. As always, we appreciate your team's professionalism as we work together to improve the integrity of Medicaid.

We have provided responses within the body of the report on specific issues/recommendations, but there are some high-level concerns that we wish to bring to your attention. While we agree that there is always room for process improvement, we disagree with some of the OMIG's conclusions because we do not believe they are supported by the evidence presented in the report.

First, after reviewing the analysis in the report, the agency believes the answer to the three questions posed under the Executive Summary should be "yes."

- Does KDHE have an effective system for tracking Medicaid beneficiaries that have moved out of the State of Kansas? The report states that the answer is no. The audit correctly notes that the federal rules governing residency for Medicaid are complicated and turn on whether the beneficiary intends to return to Kansas after a temporary absence. It is often not clear from a single report whether the beneficiary has changed residency. For that reason, it is difficult to determine with certainty when a case *should* have been discontinued. The audit further notes that:
 - Starting in 2020 all cases identified in the PARIS match reports were worked by eligibility staff;
 - Effective 2021 all referrals from your office were worked;
 - Effective 2022 all Department of Revenue death reports are now worked; and
 - 92 of 115 cases on the CMS population report were handled correctly in the OMIG's opinion.

Based on this, the agency is unsure of the OMIG's basis for concluding that KDHE lacks an effective system for tracking Medicaid beneficiaries who move out of state. We agree that our system does not always yield perfect results, but we do not believe it can be characterized as ineffective. The report highlights issues related to federal agencies, with which we generally agree, but this finding is specific to KDHE.

- Were reports from the Public Assistance Reporting Information System (PARIS) used effectively and timely to identify Kansas Medicaid beneficiaries that were receiving Medicaid benefits in other states? The report states that the answer is no. The OMIG sampled 642 cases from PARIS interstate match reports and, of those 642

cases, identified four (4) where the OMIG believes the KanCare Clearinghouse should have taken different, or quicker, action. Assuming the Clearinghouse's action was erroneous in each of these four cases, we do not believe a 0.6% error rate (4/642) leads to a conclusion that the PARIS system is being used ineffectively.

- Were capitation payments properly recouped from Managed Care Organizations for Medicaid beneficiaries that had their eligibility terminated? The report states that the answer is no. As we discussed during a virtual meeting on October 17, and as noted in the audit report, KDHE is not contractually or statutorily obligated to recoup capitation payments for KanCare members that are later discovered to be residing out of state. The agency *may* recoup those payments, depending on the facts of the case. In the cases identified in the report, the MCOs remained at risk for medical expenses incurred by the member at all times they were Medicaid-eligible, and therefore the agency did not believe recoupments were in order. The fact that KDHE did not exercise its discretion to recoup capitation payments from the MCOs for the cases identified in the report does not mean improper activity occurred.

In regard to Finding #1, the report notes that Federal and VA matches were not conducted until 2021, and identifies as a control gap the fact that the agency lacks specific written procedures on how to process those matches. But the report identifies no eligibility determination errors that occurred due to the lack of written procedures, and therefore the agency does not believe Finding #1 is supported by the evidence presented in the report.

Finding #3 states that the agency wasted funds by sending letters to addresses for which returned mail had been received. During our October 17, 2022, meeting with the OMIG we noted that that during the audit period, CMS rules required the agency to send mailings to the address on record, even if mailings sent to that address were returned. However, that fact is not mentioned in the report, and we believe it should be because it materially impacts this audit finding. The agency was granted a Public Health Emergency-related waiver in September 2022 that newly allows KDHE to update address information based on returned mail information. We shared the September 23, 2022, letter from CMS granting that waiver with the OMIG but the report makes no reference to it, which could mislead readers. We therefore do not believe Finding #3 is supported by the evidence presented in the report.

We appreciate the opportunity to provide responses to the audit report, so that readers can have complete information. Our other comments are incorporated into the body of the report.

Respectfully,

Sarah Fertig
Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
900 S.W. Jackson
Topeka, KS 66612

KDHE Response to Findings

Finding #1: Participation in the PARIS Process is Inadequate

KDHE does not have adequate procedures or guidelines to facilitate proper processing of information available via the PARIS reports. Reviews of The Federal and VA matches were not conducted due to no staffing until the fall of 2021. At that time, there was a policy in place, but they did not have any procedures established. There is the potential to save significant Medicaid funds and to provide additional income to veterans if the VA match is properly considered and used to its full benefit. The Federal match should have been used to identify Medicaid beneficiaries with additional income and benefits that were unreported.

Recommendations:

- KDHE should reach out to other states it has communicated with to see if there was a similar issue to what Georgia experienced with requesting information for the PARIS Interstate reports.

Response: The applicable job aid has been updated to mitigate the chance of this issue recurring, whether with Georgia or any other state. Additionally, contact with the other state is either by email or phone, depending on the other state's preference. KDHE will take steps to ensure that the case journals reflect when contact has been made with the other state and whether by email or phone.

- Update all applicable policies to reflect what the signature block should look like to include the Conduent 9.46 Job Aide for PARIS Reports and any applicable additional documents.

Response: The Conduent job aid has been updated. KDHE will review to determine if any other job aids are impacted.

- Assist in the creation of a working group across multiple agencies to include KDHE, DCF, VA and related contractors to fully utilize and identify VA funds available to veterans and their family members.

Response: KDHE has previously participated in conversation with DCF and other states to identify best practices. KDHE currently review the Federal and VA PARIS report for unreported funds. As the audit report mentions, the reports are complex. KDHE currently utilize the reports to the extent that resources allow.

Finding #2: The Residency Report Process Needs Reviewed

Medicaid is the "payer of last resort," meaning that Medicaid only pays for covered care and services if there are no other sources of payment available.

Two beneficiaries were identified on the PARIS interstate report and the residency report for several months. One of the beneficiaries had an estimated \$17,252.50 that was paid out in error during that time period.

On September 8, 2020, the Centers for Medicare & Medicaid Services (CMS) released an updated version of the Manual for State Payment of Medicare Premiums (formerly called “State Buy-in Manual”). The manual updates information and instructions to states on federal policy, operations, and systems concerning the payment of Medicare Parts A and B premiums (or buyin) for individuals dually eligible for Medicare and Medicaid. The update to the manual is part of CMS’ Better Care for Dually Eligible Individuals Strategic Initiative (PDF) aimed at improving quality, reducing costs, and improving customer experiences.

The prior version of this manual had not been fully updated since the 1990s. The updated manual clarifies various provisions of statute, regulation, and operations that have evolved over time. The manual contains transaction codes that describe what the buy-in amount is for. From the residency report, example #2 on page 24, the beneficiary had received a transaction code 1728 twelve times.

According to the Manual for State Payment of Medicare Premiums KDHE should be calling the applicable state to confirm residency. 16 Our audit found that KDHE was directing beneficiaries to other states to close their coverage.

Recommendations:

- KDHE should perform an evaluation to determine compliance with federal regulations.

Response: KDHE will review for compliance with federal regulations. The audit report indicates \$17,252.50 were paid out in error in premiums for a KanCare member. KDHE disputes this finding. The member in question received ongoing medical assistance correctly as the result of an updated in-state address being located after the agency received returned mail. Seven months later, the individual appeared on the CMS residency report. The applicant did not respond to KDHE requests to confirm residency; however, there are CMS imposed restrictions that limit the state’s ability to discontinue eligibility in this scenario.

- Change the script that eligibility workers use to advise beneficiaries on updating their address with the Social Security Administration.

Response: KDHE acknowledges this recommendation.

- Contact other states pertaining to the necessary transaction codes from the Manual for State Payment of Medicare Premiums.

Response: KDHE acknowledges this recommendation.

- Review the Residency Report Checklist policy in accordance to the CMS Manual for State Payment of Medicare Premiums.

Response: KDHE acknowledges this recommendation.

Finding #3: Returned Mail has Resulted in Wasteful Spending

Mail was sent to the beneficiary even though workers were aware that that address was incorrect. This was due to a misinterpretation of CMS policies, which have been corrected. The repeated sending of mail to addresses that were known to be incorrect resulted in time, effort, and resources being wasted by KDHE employees and contractors. Each piece of mail that is sent and subsequently returned created extra work for an already very busy group. The cost of postage and envelopes should also be considered.

- Our audit found that 30% of beneficiaries on the PARIS Interstate report had at least one or more pieces of returned mail.
- Our audit found that 38% of beneficiaries on the Residency report had at least one or more pieces of returned mail.

Recommendations:

- Retrain workers to suspend any mail from being sent if they are aware that the address is incorrect and return mail policies.

Response: KDHE must comply with CMS policy, which requires that the mail is resent to the address on file in certain scenarios, even when return mail has been previously received. KDHE will take steps to ensure staff understand when it is necessary to resend mail, per federal policy.

- Ensure updated policies concerning mail handling procedures are in place for returned mail that conform to CMS guidance.

Response: KDHE acknowledges this recommendation.

Finding #4: MCO Contracts Need Updated

According to KDHE staff, if an overpayment is identified, staff log the information onto an overpayment spreadsheet in Microsoft Excel. Currently there is no guidance or protocols for coordinating the assessment and collection of any overpayments related to out of state residency.

Reviews of cases that were closed based on residency found that no attempt was made to recoup capitation payments even when it was confirmed the beneficiary had moved to another state and was no longer eligible for KanCare for several months.

Recommendations:

- KDHE should recover improper Medicaid payments if staff determine that an overpayment has been made due to out of state residency.

Response: Please refer to KDHE's response letter for comments.

- Eligibility workers should ask for the date the beneficiary officially moved out of the state. This date can be used to discontinue capitation payments to the MCO.

Response: KDHE acknowledges this recommendation.

- Update MCO contracts to strengthen and clearly state the shared responsibility for MCOs to identify Medicaid beneficiaries that have moved out of Kansas.

Response: KDHE acknowledges this recommendation.

Finding #5: E/D and LTC Policies Need Clarified

While reviewing the Q4 2020 and Q2 2021 PARIS reports, it was noted that workers who identified the case was a part of E&D or LTC, forwarded it on without calling or mailing an NOA to the beneficiary to confirm residency. It was found that either nothing was done by E&D and LTC or there was a huge delay in determining residency. This leads to possible over payments of capitation to the MCOs. It was not until 2022 that workers started calling and mailing letters prior to forwarding the cases to E&D and LTC.

By finding the error rate from our sample size and expanding it across our estimated total E&D and LTC populations from the Q4 2020 and Q2 2021 PARIS reports, we estimate a combined overpayment of \$1,370,376.68.

A review of the policies and procedures related to the PARIS process, did not identify anything that specifically mentions that the KanCare Clearinghouse needs to do the preliminary work on these cases.

Recommendation:

- KDHE should improve control activities by updating policies and procedures related to the PARIS Interstate match process for E/D and LTC beneficiaries.

Response: KDHE acknowledges this recommendation.

Appendix II - Palmer Email to CMS

From: LaTonya A. Palmer [KDHE]
To: Anderson, Steven D.
Cc: Donna Wilk [KDHE]
Subject: FW: Question - Preventing Inappropriate Terminations
Date: Tuesday, May 3, 2022 12:24:57 PM
Attachments: image001.png

Good afternoon. As a follow-up to our interview, this email contains the clarification rec'd from CMS, surrounding returned mail with no forwarding address. It looks like this was addressed in the March 2022 policy – time has flown by. Let me know if there are additional questions.

Thanks,

Latonya Palmer, Director of Eligibility
Phone: (785) 368 - 6394

From: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Sent: Tuesday, February 1, 2022 2:34 PM
To: Erin Kelley <Erin.Kelley@ks.gov>; LaTonya A. Palmer [KDHE] <LaTonya.Palmer@ks.gov>
Cc: Jessica Pearson [KDHE] <Jessica.Pearson@ks.gov>; Sara Reese [KDHE] <Sara.Reese@ks.gov>; Amanda Corneliussen [KDHE] <Amanda.Corneliussen@ks.gov>; Shawna M. Pilkington [KDHE] <Shawna.Pilkington@ks.gov>
Subject: RE: Question - Preventing Inappropriate Terminations

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Hi Erin, Here's the answer that just came in from the SMEs:

Consistent with § 431.231(d), states must reinstate services that were discontinued due to a beneficiary's whereabouts being unknown if the beneficiary's whereabouts become known prior to the beneficiary's next regular renewal under § 435.916. In this situation, coverage should be reinstated back to the date of termination (not the date the beneficiary's whereabouts became known). States must provide notice to beneficiaries whose Medicaid benefits are reinstated per § 435.917(a).

A state does not need to re-verify an individual's eligibility on the basis of their whereabouts becoming known, if whereabouts become known prior to the beneficiary's next regular renewal. However, 435.916(d)(1) requires that if the state receives information about a potential change in circumstance that may impact eligibility, then the state must act on that information. For example, if the state receives information that the individual was not a resident of the state during their whereabouts unknown period, per §435.952(c)(2), the state must provide the individual an opportunity to reasonably explain the change in circumstance or provide other documentation to refute the state's evidence. The state must limit any requests for additional information from the individual to information relating to such change in circumstance. 435.916(d)(1)(i). If the individual either does not respond to this request or provides an insufficient response, then the state is required to provide the individual proper notice and hearing rights per §431 subpart E before taking any adverse action.

Please note, however, during the Public Health Emergency, the state must satisfy the continuous enrollment requirement in order to be eligible for the 6.2% FMAP increase. To be consistent with this requirement, the state may not terminate coverage if a beneficiary fails to provide requested information. However, §433.400(d)(1)(ii) provides an exception for beneficiary identified through a data match with the Public Assistance Reporting Information System (PARIS), provided that the state takes all available reasonable measures detailed in the preamble to the regulation to determine state residency prior to termination, and the beneficiary fails to respond to a request for information to verify their residency, as outlined in CFR §433.400(d)(3)(ii). See the preamble to CMS-9912-IFC for additional detail on how other data sources can be used after a PARIS match has been triggered (<https://www.cms.gov/files/document/covid-vax-ffc-4.pdf>).

Tell me if you have questions or need anything further!

Michala

From: Erin Kelley <Erin.Kelley@ks.gov>
Sent: Friday, January 28, 2022 9:24 AM
To: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>; LaTonya A. Palmer [KDHE] <LaTonya.Palmer@ks.gov>
Cc: Jessica Pearson [KDHE] <Jessica.Pearson@ks.gov>; Sara Reese [KDHE] <Sara.Reese@ks.gov>; Amanda Corneliussen [KDHE] <Amanda.Corneliussen@ks.gov>; Shawna M. Pilkington [KDHE] <Shawna.Pilkington@ks.gov>
Subject: RE: Question - Preventing Inappropriate Terminations

Good morning, Michala!

I hope you are well! Just wanted to check in to see whether you had heard anything back from the SMEs regarding our questions on the reinstatement policy.

Thank you!

Erin Kelley

Senior Manager of Medicaid Policy
Kansas Department of Health & Environment
Division of Health Care Finance

From: Erin Kelley
Sent: Thursday, December 9, 2021 2:09 PM
To: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>; LaTonya A. Palmer [KDHE] <LaTonya.Palmer@ks.gov>
Cc: Jessica Pearson [KDHE] <Jessica.Pearson@ks.gov>; Sara Reese [KDHE] <Sara.Reese@ks.gov>; Amanda Corneliussen [KDHE] <Amanda.Corneliussen@ks.gov>; Shawna M. Pilkington [KDHE] <Shawna.Pilkington@ks.gov>
Subject: RE: Question - Preventing Inappropriate Terminations

Good afternoon, Michala!

As requested during the SOTA call yesterday, below are a couple follow-up questions we have related to the reinstatement policy when a beneficiary's whereabouts become known during their original eligibility period.

We interpret 431.231(d) to mean that eligibility is reinstated if the beneficiary's whereabouts become known within their original eligibility period. For example, the beneficiary's eligibility period is 2/2021 – 1/2022. Their whereabouts become unknown with no forwarding address on returned mail and no response to attempted contact by telephone in 4/2021. Eligibility was discontinued effective 4/30/2021. Then, the beneficiary's whereabouts became known in 11/2021 prior to their scheduled renewal in 1/2022. Eligibility is reinstated, but is it reinstated effective in the month the beneficiary's whereabouts

became known (11/2021) or is it reinstated back to the month following the month of discontinuance (5/2021)?

In addition, do we need to confirm whether or not the beneficiary had ever left the state during those months. I.e. Does reinstatement only apply to those who never left the state of Kansas? Would we need to determine the length and/or reason for leaving to determine if they would be considered temporarily absent (per 435.403(j)(3))?

Please let mw know if there are any questions or if additional information is needed. We appreciate your help with obtaining responses to our questions from the CMS SMEs!

Thank you!

Erin Kelley

Senior Manager of Medicaid Policy
Kansas Department of Health & Environment
Division of Health Care Finance

From: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Sent: Friday, November 19, 2021 4:10 PM
To: Erin Kelley <Erin.Kelley@ks.gov>; LaTonya A. Palmer [KDHE] <LaTonya.Palmer@ks.gov>
Subject: RE: Question - Preventing Inappropriate Terminations

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Hi Erin and Tonya,

Below please find the answer to your question from October about preventing inappropriate terminations. Thanks!

From: Weissfeld, Josef (CMS/CMCS)
Sent: Friday, November 19, 2021 3:49 PM
To: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: OConnor, Sarah M. (CMS/CMCS) <Sarah.OConnor@cms.hhs.gov>; Stephens, Jessica O. (CMS/CMCS) <Jessica.Stephens@cms.hhs.gov>
Subject: RE: Question - Preventing Inappropriate Terminations

Hi Michala,

Happy Friday. We wanted to share an answer for our colleagues in KS on this question regarding action when a beneficiary's mail is returned without a forwarding address. Please let us know if you have any questions or need anything else.

Best,

Joe

States are not required to conduct outreach to a beneficiary whose mail is returned without a forwarding address, and as a result, do not have to send a notice to the address on file in an attempt to confirm their address. States are strongly encouraged to attempt to locate beneficiaries whose mail is returned without a forwarding address prior to discontinuing coverage based on a determination that a beneficiary's whereabouts are unknown. Even However, if the state attempts, but is unable to reach the beneficiary via phone call and has performed other steps in an attempt to obtain a current address – if a beneficiary cannot be located, and there is no forwarding address, the state may terminate eligibility. In accordance with § 431.213(d), the state does not need to send advance notice to a beneficiary whose whereabouts are unknown. However, the state must send notice no later than the date of action via the beneficiary's elected/preferred modality (e.g., electronic or regular mail to the address on file with the state). If a beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the state must reinstate coverage (per §431.231(d)).

From: Walker, Michala M. (CMS/CMCS)
Sent: Friday, October 22, 2021 12:04 PM
To: OConnor, Sarah M. (CMS/CMCS) <Sarah.OConnor@cms.hhs.gov>
Subject: FW: Question - Preventing Inappropriate Terminations

Hi Sarah,

Is someone on your team the SME who would answer this question about discontinuing eligibility? If yes, can you help me get it to that person?

From: LaTonya A. Palmer [KDHE] <LaTonya.Palmer@ks.gov>
Sent: Thursday, October 21, 2021 3:13 PM
To: Walker, Michala M. (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Erin Kelley <Erin.Kelley@ks.gov>
Subject: Question - Preventing Inappropriate Terminations

Good afternoon Michala. Can you assist us with the below question, please?

Below is a slide taken from the "Preventing Inappropriate Terminations..." presentation that was presented by CMS. As it relates to the third bullet, if eligibility staff attempt but are unable to reach the beneficiary via phone call and have performed other steps in an attempt to obtain a current address (researching the case file, reviewing the address on record and comparing with the returned mail), would it be acceptable to move forward with discontinuing eligibility? We understand that during the PHE, to qualify for the enhanced FMAP under section 6008 of the FFCRA, we are not allowed to discontinue eligibility. Post PHE, and under normal circumstances, would a phone attempt suffice as making a reasonable effort to reach the member? We have historically also mailed notices asking the member to contact us (based on our interpretation of 42 CFR § 435.95242). The notice is sent to the address on file (of which we already received returned mail). This seems a bit redundant and inflates our workload. Given the presentations given by CMS, I'm questioning if this extra step is federally required.

State Obligations in Response to Returned Mail (Continued)

Scenario #3: USPS returned mail does not contain a forwarding address

- If USPS returned mail does not contain a forwarding address, the state may take a variety of actions to confirm that the beneficiary's whereabouts are unknown, including:
 - Confirming that the address on the envelope is associated with the beneficiary;
 - Attempting to confirm the accuracy of the address by pinging program data within the eligibility system to see whether the beneficiary provided an updated address; and
 - Attempting to contact the beneficiary through other means such as phone calls or electronic notices.

The state does not need to send advance notice to a beneficiary whose whereabouts are unknown and for whom USPS returns mail with no forwarding address, but must send a notice no later than the date of termination. (42 CFR § 431.213(d)). If the beneficiary's whereabouts become known within the beneficiary's eligibility period, the state must reinstate Medicaid enrollment.

Thanks,

Latonya Palmer, Director of Eligibility

KDHE <https://www.kdheks.gov/>

KanCare <https://www.kancare.ks.gov/>

Phone: (785) 368 - 6394