Approved: 4-23-91
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson George Teagarden at 1:45 p.m. on March 18, 1991

in room 514-S of the Capitol.

All members were present except: Representatives Pottorff, Goossen, Helgerson, Blumenthal, Hochhauser, Vancrum, Adam, Hensley, Solbach, Lowther, and Kline (all excused).

Committee staff present:
Ellen Piekalkiewicz, Legislative Research Department
Debra Duncan, Legislative Research Department
Jim Wilson, Revisor of Statutes
Susan Miller, Administrative Aide
Sue Krische, Committee Secretary

Conferees appearing before the committee:

Gary Stotts, Secretary, KDOT
John Alquest, Acting Commissioner of Income Support and Medical Services, SRS

Others attending: see attached list.

HB 2572 - State finance, transfers from the State General Fund to state highway fund, adjustments.

Gary Stotts, Secretary, KDOT, explained that HB 2572 is the Governor's proposal and part of the Governor's tax package. The bill will provide the same level of funding to the State Highway Fund as estimated under current sales and compensating use tax laws. If the sales tax base is expanded, the Highway Fund could realize a significant increase in revenues; however, HB 2572 would eliminate that possibility while providing the same level of funding as projected during passage of the Comprehensive Highway Plan. HB 2572 changes the date of the 10 percent sales tax transfer from quarterly to twice annually and changes the 1/4 cent sales and compensating tax receipts from daily deposits to semi-annual revenue transfer. The transfers are to occur on January 15 and May 15 of each year.

For FY92 and FY93 the amount of the transfers are fixed and based on the FY92 consensus estimate of sales and compensating tax receipts and the FY93 "mini-consensus" estimate of sales and compensating tax receipts respectively. The transfer amounts will be adjusted when actual figures are available. In response to a question, Secretary Stotts stated bond agents do not feel these adjustments will impact the rating of the highway bonds.

HB 2258 - Audit of medical claims of certain providers.

Representative Patrick spoke in support of HB 2258 and provided written testimony (Attachment 1). The bill requires the audit of all claims submitted to SRS for payment out of state funds for the medical care of needy persons. He explained that the bill provides that the Secretary of SRS "shall" enter into one or more agreements with one or more agents or intermediaries to provide fiscal agent services for the medical assistance program. Current law provides that the Secretary "may" enter into "an agreement with an agent or intermediary." The bill would therefore allow, but not require, the Secretary to split contracted functions between two or more fiscal agents. Representative Patrick advised this is the same bill that passed the House last session. He noted that the system he is proposing, which is used in Georgia, is no cost to the state, as the auditing firm is not paid unless they find a savings or an error.

John Alquest, Acting Commissioner, Income Support/Medical Services, SRS, appeared to provide informational testimony on HB 2258 (Attachment 2). He advised that making it mandatory that SRS enter into contracts for the purpose of paying and reviewing provider claims will have no effect on the current operations of the agency. Mr. Alquest described in his testimony current contracts SRS has with EDS-Federal for payment and review of Medicaid claims and with the Kansas Foundation for Medical Care (KFMC) for the purpose of reviewing inpatient hospital claims. In response to a question, Mr. Alquest stated he could separate the costs of the processing function and the review function by EDS-Federal and provide that information to the Committee. Representative Patrick asked how many staff at SRS are engaged in auditing activities of medical claims and Mr. Alquest stated four FTE.

INTRODUCTION OF BILLS

Representative Turnquist requested introduction of a bill identical to HB 2499 which was inadvertantly struck in the process of rereferring bills following the first House deadline. Representative Turnquist moved

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS, room 514-S Statehouse, at 1:45 p.m.

on March 18, 1991.

introduction of the bill. Representative Dean seconded. Motion carried.

Representative Wisdom requested introduction of a bill regarding the Kansas Sports Hall of Fame Board of Trustees. Representative Wisdom moved introduction of the bill. Representative Chronister seconded. Motion carried.

Representative Chronister moved approval of the minutes of February 27 and 28 and March 1, 1991 as written. Representative Gatlin seconded. Motion carried.

The meeting was adjourned at 2:55 p.m. The next meeting is scheduled for Wednesday, March 20 at 1:30 p.m. in 514-S.

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: 3-18-91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
John Alquest	Topeka	SRS
PATRICK J. HURLEY	TOPEKA	Economic Lifelines
Gena Coulter	Topeka	Ks Good Roads
Woody Moses	Topeka	Ks Agg Producers
JOE FURJANIC	TOPEKA	KCA
Michelle Liester	Topeka	John Peterson & Associates
BILL HENRY	Topeka	KS Engineering Society
Anne Smith	Topeka	Ks. Assoc. of Counties

STATE OF KANSAS

KERRY PATRICK
REPRESENTATIVE, TWENTY-EIGHTH DISTRICT
JOHNSON COUNTY
10009 HOWE DRIVE
LEAWOOD, KANSAS 66206

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY AND NATURAL RESOURCES
LABOR AND INDUSTRY
LOCAL GOVERNMENT
JOINT COMMITTEE ON SPECIAL CLAIMS AGAINST THE STATE

To: Senate Public Health & Welfare Committee

Date: March 20, 1990

From: Kerry Patrick

Re: House Bill ~~2824~~ 2258 - Requiring the audit of all claims submitted to SRS for payment out of state funds for the medical care of needy persons

I. **Rationale**:

No business, particularly a business with over $800 million in costs, can survive without those costs being subject to scrutiny or an audit. Yet that is taking place today in the Department of Social and Rehabilitative services.

a. **Payments made to "health care providers", to nursing homes, etc. are not subject to any systematic audit or review to see if those charges are reasonable and within the law**.

1. Cheating could be taking place and we not even know it because of the archaic bookeeping and payment system that we use in Kansas. It is an open invitation for overcharging, fraud and abuse.

2. With costs for MediKan and nursing homes running in the tens of millions of dollars over projected costs, an outside audit of those charges and how the state is reimbursing them is clearly, now more than ever, in order.

b. **A review of a December 29, 1989 article in the *Wall Street Journal* shows the need for such an audit program and the benefits that it would bring to the people of the state of Kansas. Let's look at some excerpts from that story.**

1. Since 1985, Medicare payments for physician services in the U.S. have increased by 77% while the number of beneficiaries have risen only 8%.

2. Article refers to "upcoding" by certain Health care providers in an attempt to charge more for a patient visit than the

HA
3-18-91
Attachment 1

rules allow. Some physicians or their business managers have even attended schools on how to "upcode" and thus generate more fee income.

My mother recently died of colon cancer and I consider myself a fairly intelligent person but I have been unable to decipher the billing code of the Hospital and the attending physicians in an attempt to figure out what is a proper charge to pay and what isn't. If I can't figure it out how can we expect some overworked and underpaid bookeeper in SRS to do so?

3. The Health Care Financing Administration (HCFA) decided to have the new administrator for Medicare payments contract with an outside watchdog company to scrutinize suspect claims in the State of Georgia. Medicare is now doing something which private insurers have done for years, that is, they hire outside claims examiners to review claims.

C. Honest health care providers have nothing to fear from this bill only the unscrupulous ones who take advantage of the system and charge more than the rules require. Further the honest ones are helped by reducing costs and we are placed in a better position to pay valid bills on time.

Shouldn't we be doing that very same thing in Kansas?

1. Shouldn't we proceed in a more business like manner so that the taxpayers get their monies worth?

2. By avoiding overpayment, might we be able to prevent a situation that just occurred when many social welfare recipients faced cuts or elimination of some or all of their benefits?

Kerry Patrick 28th Dist.

MEDICINE

Georgia Doctors Are Undergoing A Medicare Test

By JAMES R. SCHIFFMAN
Staff Reporter of THE WALL STREET JOURNAL

ATLANTA — Doctors in Georgia are guinea pigs of sorts these days, and they don't like it one bit.

The Health Care Financing Administration, which oversees Medicare, is using the state to try out a system of intensified scrutiny of doctors' charges, all in an effort to rein in costs. The result: Medicare claims are being denied, delayed and "downcoded," or reimbursed at lower rates than doctors expect. In some cases, doctors have had to refund money to patients.

"It's been a nightmare really," says Charles Harrison, an Atlanta internist who, like many compatriots, complains of extra paper work and the dread of having every move put under a microscope.

Nightmare or not, it could be a glimpse of the future for Medicare, the federal health-care insurance program for the elderly that pays about a quarter of the nation's doctor bills. The HCFA says the Georgia experiment is a pilot that may be extended, perhaps even nationwide.

Altering Behavior

Other states face cost-control tactics, too. The Medicare administrator in North Dakota is looking for ways to identify suspicious combinations of procedures and diagnoses. In New York and Massachusetts, Medicare administrators write letters to doctors who perform more of certain procedures than is typical in those areas. "The intent is to change physician behaviors," says Barbara Gagel, director of the HCFA's bureau of program operations.

Basic numbers underscore the desire: Since 1985, Medicare payments for physician services in the U.S. have increased 77%, while the number of beneficiaries has risen only 8%.

The endeavor in Georgia is the most controversial so far. The experiment came about at the beginning of 1989 when the HCFA switched its Medicare administrator in the state. When the agency made the change, it decided to have the new administrator, Aetna Life Insurance Co., contract with an outside watchdog company to scrutinize suspect claims. Medicare is taking a tip from private insurers, which have used outside claims examiners for years.

Aetna chose HealthCare Compare Corp., a claims-scrutinizer based in Downers Grove, Ill. HealthCare Compare, which came on the scene in January,

Please Turn to Page B3, Column 1

Continued From Page B1

quickly began hitting Georgia physicians in their pocketbooks by taking a jaundiced look at claims for "comprehensive" consultations.

Such visits should be rare because they involve an intensive look at a patient, including the taking of a full medical history, says Robert J. Becker, a physician who is chairman of HealthCare Compare. Yet the HCFA's own statistics show that in 1987, Georgia doctors billed for comprehensive visits 23% more than the U.S. average.

The suspicion was that some doctors were "upcoding," or charging Medicare for comprehensive visits—at more than $100 a shot—when they should have been billing in the $30 range for simpler consultations.

In one case, Dr. Becker recounts, a doctor treating a 92-year-old patient for dementia billed for 72 comprehensive visits in two months. In another, a physician filed for 17 comprehensive visits in as many days for treatment of a single patient. Yet another doctor billed Medicare for seven emergency-room visits on the day his patient had a heart attack. "If they had been reimbursed, it would have been an outrageous expenditure of Medicare funds," Dr. Becker says.

Doctors concede there may be a few among them who make inappropriate claims, but they say the scrutiny is uncalled for. Moreover, they say, dealing with Aetna has been a bureaucratic disaster. And HealthCare Compare, they charge, is arbitrarily withholding payments to impress the HCFA in hopes of landing contracts if the review program expands. HealthCare Compare rejects the accusation.

Paul Shanor, executive director of the Medical Association of Georgia, also takes issue with statistics showing that doctors bill for too many comprehensive visits. And he questions the general fairness of the new procedure. One physician in Newnan, Ga., spent more than two hours in the middle of the night with a heart-attack victim, he says, only to be reimbursed $23 by Medicare. "That doesn't seem like a very fair amount to me," Mr. Shanor says.

Moreover, physicians say they have been made to feel like criminals and have been subjected to long delays in receiving legitimate payments. Take the case of Mary Sper, a 68-year-old who was hospitalized for six weeks late last year for gallbladder surgery. Because she had a history of heart trouble, her cardiologist, Wm. Michael Brown, visited her daily in the hospital. But it wasn't until August, after several appeals of payment denials and the submission of reams of documentation, that the cardiologist collected the $1,000 he sought from Medicare. "It was a headache on that one," says Mabel K. Kim, Dr. Brown's office manager.

Aetna does accept some blame. As a new Medicare administrator, the carrier faced a huge backlog of claims and admits mistakes in processing at the start. Aetna says the problems have largely been overcome, but only a few weeks ago a computer glitch resulted in erroneous underpayments for laboratory tests. The medical association calls the incident an example of Aetna's "bad faith."

The changes have shocked physicians, who had grown accustomed to certain givens in billing. Linton H. Bishop Jr., a cardiologist here, says he charged his "usual consulting fee of $117" to see a 73-year-old patient who was hospitalized for prostate surgery. The patient paid, but Medicare later said a comprehensive visit wasn't necessary and authorized payment of only $30. In this case, Dr. Bishop had to reimburse the patient the difference between the higher and lower fee.

Some doctors now protect themselves by forcing patients to sign waivers, making them responsible if Medicare denies payment. Exactly that happened to Grady Rutherford, a 75-year-old retired carpenter who had to fork over $85 for a "downcoded" visit to his internist. "I just feel like my Medicare insurance isn't doing justice one way or the other," a distressed Mr. Rutherford says.

Intensified Examinations

Dr. Becker of HealthCare Compare dismisses the criticisms, saying his company is only ensuring that physicians aren't paid for unnecessary services. "Some of the people who have made some of the most noise are people who in fact are overutilizing and upcoding," he says.

Dr. Becker adds that it's going to get tougher for physicians before it gets easier. Starting in January, he says, scrutiny will be intensified for Georgia doctors who do tests and surgical procedures.

Meanwhile, the issue is spilling into politics. Responding to the medical lobby, Georgia congressmen persuaded Rep. Henry Waxman to examine the state's Medicare situation before his health and environment subcommittee. The inspector general of the Health and Human Services Department, the agency housing the HCFA, also is conducting a probe, as is the General Accounting Office.

But don't expect too much sympathy for Georgia's generally well-heeled physicians. Says Michael Cadger, managing consultant in Atlanta for A. Foster Higgins & Co., a benefits consultant: "Doctors are finally getting caught and they don't like it."

1-3

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary

House Appropriations Committee
House Bill 2258

House Bill 2258 requires the Secretary of Social and Rehabilitation Services to enter into contracts for the purpose of paying medical providers and auditing claims thought to be in error.

Social and Rehabilitation Services is currently engaged in these activities and fulfilling the requirements of HB 2258. We have a contract with EDS-Federal to process claims for payment and to review, through a variety of methods, providers claims thought to be in error. A contract is also in place with the Kansas Foundation for Medical Care (KFMC) for the purpose of reviewing inpatient hospital claims.

Making it mandatory that SRS enter into contracts for the purpose of paying and reviewing provider claims will have no effect on the current operations of the agency.

John W. Alquest
Acting Commissioner
Income Support/Medical Services
(913) 296-6750

HA
3-18-91
Attachment 2

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Division of Medical Services

Cost Management through the Medicaid Management Information System

A Medicaid Management Information System or MMIS is a mechanized claims processing and information retrieval system which provides an important and comprehensive management tool for the Medicaid Program. EDS Federal Corporation operates the Kansas MMIS, which has been certified since 1979. Three components of the MMIS are explained below because of their cost containment aspects.

Third Party Resource Subsystem

The Medicaid Program is the payor of last resort. All other resources available and liable for the costs of Medical care for persons eligible for Medicaid should be utilized prior to Medicaid making a payment. Third Party Resource (TPR) information is identified at the time of eligibility determination and is stored in the MMIS TPR file. Additional insurance information is collected from claims during claims processing and from data matches with workers compensation and other data files. Accurate computation of dollars saved due to this system is not possible because you can't count that which is never submitted. However, savings resulting from post payment collections can be counted and are provided below.

FY 88	$569,000
FY 89	$742,000
FY 90	$966,000

Surveillance and Utilization Review Subsystem

The Surveillance and Utilization Review Subsystem (SURS) has the responsibility to guard against fraud and abuse of the Medicaid Program. It is also the goal of SURS to ensure that medical services rendered to Medicaid recipients are at a level of quality consistent with that available to the general public. SURS reviews providers and recipients in the Medicaid Program who have been identified by the MMIS SUR Subsystem as potential mistuilizers. Savings resulting from recoupments of money inappropriately paid to providers and through dollars not spent wastefully on services for recipients who misutilize their medical cards are provided below.

FY 88	$1,180,000
FY 89	$ 974,000
FY 90	$2,275,000

Medical Assessment Review

The Medical Assessment Unit (MAU) assures that services rendered to recipients in the Medicaid Program are medically necessary. Medical necessity criteria, against which claims for services are reviewed, is developed in conjunction with a committee of Kansas health care professionals with special knowledge of the services being reviewed. Savings resulting from denial of reimbursement for services determined to be not medically necessary are provided below.

FY 88	$1,660,000
FY 89	$3,106,000
FY 90	$5,866,000

Medicare Repricing

The state purchases Medicare Part B coverage for Medicaid eligible individuals from Social Security through a process called the Buy-in. Medicaid claims for these dually eligible persons are first processed by Medicare and then sent to Medicaid for payment. Beginning September 15, 1986, Medicare claims were processed in the same way as claims with private insurance as the third party payor. If the claim was for a service non-covered by the Medicaid/MediKan program, payment is denied. If the payment made by Medicare is equal to or more than the maximum SRS reimbursement rate, the claim is denied. If the payment was less than the SRS maximum reimbursement rate, a Medicaid payment is made in the amount of the difference between the Medicare payment and the maximum SRS rate of reimbursement up to the co-insurance and deductible amount.

FY 88	$4,600,000
FY 89	$6,100,000
FY 90	$6,800,000

1/7/91