Approved: February 21, 2002
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson Representative Kenny Wilk at 9:00 a.m. on February 5, 2002, in Room 514-S of the Capitol.

All members were present except: Representative Tom Klein, Excused
Representative Jeff Peterson, Excused

Committee staff present: Alan Conroy, Legislative Research
Amy Kramer, Legislative Research
Audrey Nogle, Legislative Research
Jim Wilson, Revisor of Statutes
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Barb Hinton, Legislative Post Audit
David C. Riley, Bland and Associates
George Barbee, Kansas Consulting Engineers
Clay Blair, President, Board of Regents
Dr. Kim Wilcox, Board of Regents
Joe Fritton, Facilities Management, DOA
Carey Peterson, Association of General Contractors of KS

Others attending: See Attached

Barb Hinton, Legislative Post Audit, introduced David C. Riley, Bland and Associates, who presented the Performance Audit Report on Medicaid Cost Containment: Controlling Fraud and Abuse (Attachment 1). $1.38 billion in Medicaid claims is made every year by $270,000 Kansans. The federal government is responsible for 60% of the cost while Kansas is expected to make the other 40% payment. There is an estimated $138 million in fraudulent claims made every year in Kansas which costs Kansas tax payers more than $55 million. The Attorney General's Office's Medicaid Fraud and Abuse Division provides the investigative and prosecutorial arm to the State's Medicaid fraud identification process but only through referral. At this point the federal government does not allow this enforcement area to be proactive and seek out fraud. In order to change this position, the law must be changed at the federal level or, in the alternative, the state's have the right to refuse federal funding. He encouraged lobbying at the federal level to get this law changed. Nebraska has a waiver in place regarding the federal funding dollars and the state employees are doing the work.. Mr. Riley recommended that the Kansas legislature adopt a false claim act which would provide empowerment to the Attorney General's office in this area. If a grading system was in place for identifying fraudulent claims, Kansas would receive a C- or a D in this arena.

Both Blue Cross and Blue Shield of Kansas and the Surveillance and Utilization Review (SUR) Unit of SRS were cited as being ineffective in their job charges of watching for Medicaid abuse and fraud. SRS is not managing their units of providers nor profiling trends and abuses through a data base as they have indicated they do not believe fraud is as pervasive in Kansas as has been cited. It was noted that dentists are rarely investigated as there is such a shortage that provide services for Medicaid clients. The most often-cited areas for fraudulent claims are with durable medical equipment, chiropractors who bill as physical therapists, physical therapists, and managed care organizations. The introduction and implementation of the HealthWave program has opened the door to more children and families to be identified as Medicaid eligible.

Continued Hearing on HB 2690– Regents research and development facilities

Jim Wilson, Office of the Revisor of Statutes, presented an explanation of the proposed replacement section in Section 10 of the bill relating to exemption from certain statutory provisions (Attachment 2).

Dr. Kim Wilcox, Executive Director of the Board of Regents, stated that the Regents never intended to be exempted from accountability and construction efficiency as is designated in the statutes. These proposed exemptions remove redundancy but leave in place the safeguards.

George Barbee, Executive Director of Kansas Consulting Engineers, acted as spokesperson for his group as

well as the Kansas Society of Professional Engineers and the Kansas AIA. He reported that all interested parties had met and had come to an agreement regarding the proposed replacement section and exemptions. They were also in agreement that the Board of Regents and the Division of Facilities Management, Department of Administration, should negotiate the scope of services and the percentage fee which would be charged for inspection of plan design, construction documents, and project construction. Even though this project would be tied to the bonding and funds available, the bonds might stretch out for future use.

Clay Blair, President of the Board of Regents, explained that this legislative movement would break the chains of inefficiency of the past by using a format that gathers the educators, professional engineers, architects, and experts on research facilities involved, and have them work together in the most efficient way and economical way. Maximum flexibility is needed to make this venture successful. The State represents only 25% of the transaction with a cap of $50 million. The other partners are the federal government, private enterprise, and the lending institution who are providing oversight at all levels. At this point the money is available at the most economical rate in recent history. If the statutorily-approved method is used for this venture, it will take months to have the designs approved and code inspections would be delayed. The plan is to have an operating oversight group comprised of two regents and 3 lay persons. Measurable outcomes of the success of the program will be available within three to four years after completion of the buildings.

Joe Fritton, Facilities Management Division of the Department of Administration, explained that the current statutes were designed to facilitate the traditional method of construction used in the late 1970's: design, bid, and build. (Attachment 3). He was in agreement to updating the statutes to facilitate new construction processes while ensuring the protection of tax payer dollars. He explained their opposition to a portion of the proposal made by the Board of Regents and provided an amendment which would change the composition of the board of directors of the subsidiary corporation and make the Secretary of Administration in charge of administrative oversight of building design, construction, and code compliance. Also, all deviation from exempted statutes would be presented to and need approval by the Joint Committee on State Building Construction.

During Committee discussion of the proposed amendments, the matter of the Secretary of Administration being given expanded authority was questioned. Mr. Blair agreed that inspections could be provided by the state or local governments on a timely basis but was reluctant to agree to the inflated inspection fee of 1% as charged by the Division of Facilities Management.

Corey Peterson, Association of General Contractors of Kansas, requested that the competitive bidding statutes remain in the bill. The Regents agreed with this request.

Representative Melvin Neufeld moved for the introduction of legislation regarding vaccines being furnished by local health departments. Motion was seconded by Representative Pottorff. Motion carried.

The meeting was adjourned at 10:50 a.m. The next meeting is scheduled for Wednesday, February 6, 2002.

APPROPRIATIONS COMMITTEE GUEST LIST

DATE: Feb 5, 2002

NAME	REPRESENTING
Dan Etzel	Dept of Admin / DFM
Joe Fritton, Director	Dept of Adm / DFM
Mark Stock,	Dof A / DFM
David Ross MD	KMS
[illegible]	KMS
Carolyn Middendorf	Ks St Ns Assn
Nelson Krueger	Western Wireless
Chris Collins	KMS
Melinda Gaul	DOB
Cindy Denton	DOB
Tom Slattery	AGC of Ks
Corey Peterson	AGC of KS
STEVE MOHAN	MOHAN CONSTRUCTION
Trudy ARON	Am Inst of Architects
Mike Lackey	KS Soc of Prof Engrs
George Barbee	Ks Consulting Engrs
JACK BRIER	KDFA
Bill Sneed	UKNA
Mike Huttles	FirstGUARD

PERFORMANCE AUDIT REPORT

Medicaid Cost Containment: Controlling Fraud and Abuse

HOUSE APPROPRIATIONS
DATE 2/5/02
ATTACHMENT 1

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
January 2002

02-08

Legislative Post Audit Committee
Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $9 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

We conduct our audit work in accordance with applicable government auditing standards set forth by the U.S. General Accounting Office. These standards pertain to the auditor's professional qualifications, the quality of the audit work, and the characteristics of professional and meaningful reports. The standards also have been endorsed by the American Institute of Certified Public Accountants and adopted by the Legislative Post Audit Committee.

The Legislative Post Audit Committee is a bipartisan committee comprising five senators and five representatives. Of the Senate members, three are appointed by the President of the Senate and two are appointed by the Senate Minority Leader. Of the Representatives, three are appointed by the Speaker of the House and two are appointed by the Minority Leader.

Audits are performed at the direction of the Legislative Post Audit Committee. Legislators or committees should make their requests for performance audits through the Chairman or any other member of the Committee. Copies of all completed performance audits are available from the Division's office.

LEGISLATIVE POST AUDIT COMMITTEE

Representative Lisa Benlon, Chair
Representative Richard Alldritt
Representative John Ballou
Representative Dean Newton
Representative Dan Thimesch

Senator Lynn Jenkins, Vice-Chair
Senator Anthony Hensley
Senator Dave Kerr
Senator Derek Schmidt
Senator Chris Steineger

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Barbara J. Hinton, Legislative Post Auditor

The Legislative Division of Post Audit supports full access to the services of State government for all citizens. Upon request, Legislative Post Audit can provide its audit reports in large print, audio, or other appropriate alternative format to accommodate persons with visual impairments. Persons with hearing or speech disabilities may reach us through the Kansas Relay Center at 1-800-766-3777. Our office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.

LEGISLATURE OF KANSAS

LEGISLATIVE DIVISION OF POST AUDIT

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January 14, 2002

To: Members, Legislative Post Audit Committee

Representative Lisa Benlon, Chair	Senator Lynn Jenkins, Vice-Chair
Representative John Ballou	Senator Anthony Hensley
Representative Dean Newton	Senator Dave Kerr
Representative Dan Thimesch	Senator Derek Schmidt
	Senator Chris Steineger

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Medicaid Cost Containment: Controlling Fraud and Abuse*.

The report includes several recommendations for the Legislature, Department of Social and Rehabilitation Services, and Attorney General's Office. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

This audit was conducted by the accounting firm of Bland & Associates, P.C., under contract with Legislative Post Audit. Bland & Associates was assisted by the firms of IntegriGuard and Logistics Management Institute, both of which have had experience as Medicare program integrity contractors for the U.S. Department of Health and Human Services.

Legislative Post Audit prepared the following executive summary of the audit report completed by the auditors.

What Does the State Do To Try To Identify Fraud and Abuse Within the Medicaid Program?

The Department of Social and Rehabilitation Services (SRS) is the State agency responsible for administering and supervising the Medicaid Program. *As such, it has primary responsibility for the prevention, detection, and elimination of fraud, abuse, and improper practices in the Program. Medicaid is a joint federal / State program that provides medical care for low-income people, and long-term care for the aged and the disabled. In 2001, more than 270,000 people received Medicaid services, and the amount of claims paid under the Program exceeded $1.3 billion, which is a dollar increase of about 47% in just 3 years. The State pays 40% of these costs.*

...............page 14

National statistics indicate approximately 10% of all Medicare and Medicaid payments are fraudulent. At that rate, potentially more than $138 million of the State's Medicaid claims are potentially fraudulent. If Kansas had a rate of just 2%, the amount of potential fraud would still total more than $27 million.

Common types of fraudulent or abusive practices that have been identified include:

- *billing for phantom patient visits*
- *billing for goods or services that weren't provided, inflating the prices for goods or services that were provided, or billing for them twice*
- *billing for used or old items as new*
- *billing for more hours than there are in a day*
- *billing for medically unnecessary services*
- *paying kickbacks in exchange for referrals*
- *concealing ownership of related companies*
- *falsifying credentials*

SRS has contracted with Blue Cross/Blue Shield as its fiscal agent to process Medicaid claims, and to conduct other reviews and analyses looking for potentially fraudulent or abusive claims or practices. *As part of the claims processing effort, Medicaid claims pass through hundreds of automated edits and checks. They also are subject to other reviews, all of which try to prevent or identify payments to ineligible providers or recipients, payments for services that aren't covered or weren't necessary, and the like. SRS is currently in the process of selecting a new fiscal agent.*

The federal government also requires each state to have a "surveillance and utilization review" function to help identify potential fraud and abuse within the Medicaid Program. *SRS has contracted this function out to its fiscal agent as well. Blue Cross' Surveillance and Utilization Review (SUR) Unit performs the reviews and analyses conducted in the State to identify potentially fraudulent or abusive claims and practices. These reviews and analyses look at such things as Medicaid provider and recipient activities, billing trends, dollar trends, and the like.*

Although housed at Blue Cross, this SUR Unit is supervised by, and receives guidance and direction from, SRS.

The Attorney General's Medicaid Fraud and Abuse Division investigates and prosecutes fraudulent or abusive claims that are referred to it by others. *Those referrals come from SRS, the SUR Unit, and the general public. As required by federal law, it also handles complaints alleging that patients in residential care facilities have been abused or neglected, or that programs receiving Medicaid payments have misappropriated patients' private funds.*

Are the Efforts To Identify Fraud and Abuse in Kansas Reasonable and Sufficient?

The report noted several positive aspects related to the Program–including highly committed staff within all the agencies involved and reasonable assurance that the automated edits and checks were working as intended. Nonetheless, it identified a number of serious problems, as outlined below.

The effectiveness of the SUR Unit's efforts to identify and control Medicaid fraud and abuse in Kansas is questionable. *The report notes the following:*

.... pages 20, 23, 25

- *SUR Unit staff generally don't follow up on computer-generated information that could point to potentially fraudulent or abusive billing practices. SUR Unit staff work with SRS each year to determine which providers will be "profiled," when, and what "results" would be outside the norm. They then run routine reports during the year looking for*

anomalies–such as claims being submitted for an unusually high number of physician visits or services, unusually high dollar amounts, or unusual services for the type of client being served–that might suggest fraudulent or abusive billing practices. For example, one quarterly report identified a Medicaid recipient with an average of 175 physician services, compared with a norm of 22.

The auditors found, however, that the SUR Unit staff generally don't follow-up on the anomalies that are identified. They reported that those staff exhibited a "we receive our direction from SRS" mentality, which meant they didn't take the initiative to follow-up on potential problem claims unless SRS told them to, "nor did SRS anticipate that they would take such initiative." As a result, most such reports end up simply being stored for future reference, rather than being analyzed further or being referred to the Attorney General's Medicaid Fraud and Abuse Division. Unless such reports are used to prompt investigation or additional analysis, they are perfunctory at best.

- *Much of the follow-up work the SUR Unit is doing doesn't focus on the highest risk or most lucrative areas. The auditors noted that the SUR Unit concentrated most of its efforts on cases involving providers of Home and Community Based Services and non-emergency transportation, even though other provider groups had significantly greater impact on the Medicaid budget, and may have great potential for fraudulent or abusive practices.*

- *The SUR Unit generally doesn't do much additional analysis outside the standard reports. The auditors expressed concern that the SUR Unit staff relied so heavily on SRS for direction, and generally didn't take the initiative to more aggressively identify other ways to control or detect Medicaid fraud and abuse.*

  They also questioned whether the SUR Unit staff had a solid understanding of the basic elements of a good fraud and abuse program, of the need to meet measurable objectives, or of the need to focus on analytic approaches and claims that would give the State a significant return on its investment. The auditors concluded that the effectiveness of the SUR Unit in terms of its return on the State's investment was questionable.

SRS hasn't provided sufficient guidance and direction to the SUR Unit staff within Blue Cross, and hasn't followed good contract-management practices in overseeing the contract with Blue Cross. *The auditors noted that SRS' management of the SUR Unit appeared to be reasonably adequate, given the demands placed on the staff person assigned to administer and oversee the contract and supervise the operations of the SUR Unit–the Utilization Review Manager. However, they cited several significant problem areas that hamper the effectiveness of the State's efforts:*

.... pages 18, 22, 25

- *<u>SRS hasn't established quantifiable performance measures and benchmarks for the SUR Unit that would allow it to assess how well this function is working</u>. SRS staff indicated during the audit that they were disappointed by the fiscal agent's lack of initiative in enhancing systems and procedures to more effectively carry out the contracted surveillance and utilization review function. However, SRS has the primary responsibility for establishing performance measurement criteria and benchmarks, and evaluating the SUR Unit's effectiveness against them. That hasn't happened*

  Having good measures and benchmarks would allow SRS to evaluate the work performed in terms of the cost savings associated with this function, the number of cases referred to the Attorney General's Medicaid Fraud and Abuse Division, and the returns to the State for the money spent.

- *<u>SRS hasn't done much with the information it got from the SUR Unit that pointed to potential problems, and it hasn't established sufficient policies and guidelines for the SUR Unit to follow in these and other cases</u>. For example, SRS hasn't established clear expectations for following up when anomalies are found during routine computer runs, or for taking additional initiatives to identify potential fraud and abuse.*

- *<u>the Utilization Review Manager position appears to lack the information, status, and management support to do the job effectively</u>. Establishing quantifiable performance expectations and evaluating the SUR Unit against them would help provide the information needed. But the auditors felt this position lacked the "empowerment...to promote and lead change within the system to better identify Medicaid fraud and abuse vulnerabilities."*

  The report noted that, although the State will get the latest technology for identifying fraud and abuse under its new contract, those efforts won't necessarily be more effective unless SRS exercises the proper oversight and management of the new contractor.

The Attorney General's Medicaid Fraud and Abuse Division is significantly underutilized. *This Division is precluded by federal law from initiating investigative work on its own, and must rely solely on referrals. In 2000, a total of 13 cases were opened as a result of referrals from the SUR Unit. In 2001, that number was 10.*

..... pages 21 and 23

The auditors reported that the types of referrals now being made from the SUR Unit tend to be for providers of Home and Community Based Services and non-emergency transportation. The dollar amounts being recovered for these types of cases aren't large. For example, the Division's annual report for fiscal year 2000-2001 noted that the average recoupment for 4 of 9 cases it prosecuted in the State amounted to just over $4,250. In 1999, Kansas recovered about $9,000 from the Division's prosecutions, and in 1998 it recovered about $75,000.

The auditors noted that other states' Medicaid Fraud and Abuse Divisions apparently exercise more latitude in their roles, including more proactive investigation, modeling, analysis, etc. The auditors felt strongly that the Division's inability to initiate action and investigation shackled its effectiveness and the effectiveness of the State's efforts to identify fraud and abuse. They thought new legislation or a more liberal interpretation of existing statutes was needed.

Assessing the extent to which fraud and abuse is occurring in Kansas would involve significant effort, but the auditors think that effort would be worth it. *Such efforts would involve a significant review of historical files, confirmations of procedures and the validity of claims, and detailed validation of the claims paid. The auditors thought this work also could result in recommendations for additional proactive safeguards in the areas of preauthorizing providers and processing claims, and additional requirements related to after-the-fact analyses of claims paid.* ....page 24

Conclusion ....page 28

Recommendations ....page 28

Appendix A: *Scope Statement* ....page 31

Appendix B: *Auditee Responses* ....page 33

Appendix C: *References* ....page 41

Appendix D: *Relationship Between Medicaid Control Elements* ....page 42

Appendix E: *Acknowledgements* ....page 46

If you need any additional information about the audit's findings, please contact Randy Tongier at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

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Performance Audit Report

Medicaid Cost Containment:

Controlling Fraud and Abuse

A Report to the Legislative Post Audit Committee

And the Legislative Division of Post Audit

State of Kansas

January 2002

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& associates
CPAs

INDEPENDENT MEMBERS OF
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January 7, 2002

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislature of Kansas Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, Kansas 66612-2212

Dear Ms. Hinton

The attached report contains the findings, conclusions, and recommendations from our completed performance audit, *Medicaid Cost Containment: Controlling Fraud and Abuse*. Our performance audit was performed in accordance with requirements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America.

This report contains several recommendations related to the efforts to identify fraud and abuse within the State of Kansas Medicaid Program. The State of Kansas Social and Rehabilitation Services' Surveillance Utilization Review function and the Office of the Attorney General, State of Kansas, Medicaid Fraud and Abuse Division are responsible for detecting, preventing, and prosecuting fraud and abuse within the State's Medicaid Program.

We would be happy to discuss this report, our findings, and our recommendations with representatives of the Legislative Division of Post Audit, the Legislative Post Audit Committee, State of Kansas Legislators, or other State officials.

Very truly yours,

BLAND & ASSOCIATES, P.C.

Jerry M. Bland
Managing Shareholder

Preface

On November 2, 2001, the Legislative Division of Post Audit contracted with Bland & Associates, P.C., Certified Public Accountants, to conduct a performance audit of the State of Kansas system for controlling Medicaid fraud and abuse and to prepare the accompanying report. Bland & Associates, P.C. is an Omaha, Nebraska based firm of Certified Public Accountants primarily performing regulatory auditing services to agencies of the federal government, state governments, and Tribal governments of Native Americans. Upon contract award, Bland & Associates, P.C. solidified a strategic alliance with two key organizations:

- IntegriGuard, an Omaha-based division of CMRI, a California not-for-profit organization. IntegriGuard is a Medicare Program Safeguard Contractor (PSC) and a Medicare Program Integrity Contractor (PIC) for the US Department of Health and Human Services - Centers for Medicare and Medicaid Services (CMS).
- Logistics Management Institute (LMI), a McLean, Virginia not-for-profit organization. LMI is also a Program Integrity Contractor for CMS and is dedicated to improving management of the public sector through research, analysis, and counsel.

This performance audit was performed by and the accompanying report prepared by members of this strategic alliance.

1-11

BLAND & associates

Summary Observations

State of Kansas Performance Audit

Medicaid Cost Containment: Controlling Fraud and Abuse

The Kansas Medicaid Program provided medical assistance to over 272,000 qualifying Kansans in fiscal 2001 at a cost of in excess of $1,380,000,000, an increase over 1998 levels of 47%. With such increases and the heightened national emphasis on fraud and abuse within Medicare and Medicaid Programs, the Kansas Legislature questioned to what extent fraud and abuse is prevalent within the State of Kansas and what is being done to control fraud within the Kansas Medicaid Program.

The two questions posed were:

- ***What does the State of Kansas do to try to identify fraud within the Medicaid Program, and do those efforts appear reasonable and sufficient? and***
- ***Do there appear to be significant instances of fraud within the State's Medicaid Program?***

This performance audit addresses only the first of these questions and was performed using inquiry, interviews, system documentation techniques, and limited claims testing.

Federal and State efforts are occurring to detect, prevent, and control fraudulent practices in Medicare, in Medicaid, and in the private sector. Health care costs, nation-wide, now total over $1 trillion, and are increasing. The nationally estimated fraud rate is approximately 10%, which underscores the importance of fraud detection and its elimination. The Federal government and State governments are now entering into cooperative arrangements to combat fraud and abusive activity by medical care providers and recipient / beneficiaries alike. The State of Kansas has in place systems and procedures to attempt to detect and preclude fraud and fraudulent practices.

The State of Kansas' Department of Social and Rehabilitation Services (SRS) is the designated agency that administers and supervises the Medicaid Program and, as such, is primarily responsible for the prevention, detection, and elimination of fraud within the State's Medicaid Program. The SRS Program Integrity Section has been designated to carryout this function and is led by a Medicaid Utilization Review Manager who supervises a Surveillance and Utilization Review unit (SUR unit), as mandated by Federal requirements. Kansas has outsourced this SUR unit function to Blue Cross / Blue Shield of Kansas, Inc., the contracted Medicaid fiscal agent. The SUR unit is comprised of data analysts, medical professionals (RNs), and a fraud investigator and employs a computer subsystem for provider and recipient profiling to identify potential aberrant practices.

In 1995, the Kansas Attorney General's Office formed a Medicaid Fraud and Abuse Division, a Medicaid Fraud Control Unit (MFCU), in response to Federal requirements to investigate, to prosecute, and to obtain restitution or recoupments. The MFCU function relies on referrals from the SUR unit, from SRS, and from

1-12

the general public as the source for cases since legislative interpretation limits its function to investigation and prosecution of referrals only.

Summary Findings

1. What does Kansas do to identify fraud and abuse within the Medicaid Program?

Management of the Medicaid fiscal agent (BCBSKS SUR Unit) by SRS appears adequate, however much could be done to enhance operational effectiveness of the SUR function by exploiting better contractor management practices.

SRS manages the outsourced SUR unit and the subsystem of the Kansas Medicaid Management Information System (KMMIS), Surveillance and Utilization Review Subsystem (SURS), the computer subsystem employed by the SUR unit for provider and recipient profiling and analysis. The management of the Medicaid fiscal agent's SUR unit by SRS appears reasonably adequate, however, much could be done to enhance the operational effectiveness of the SUR function by exploiting better contractor management practices. We found that the SUR unit relies heavily on "direction" from SRS and found that SRS executives were disappointed by the lack of initiative demonstrated by the fiscal agent in enhancing systems and procedures to more effectively carry out their contracted surveillance and utilization review role. SRS is in the negotiating phase of replacing the present fiscal agent. This change provides an opportunity for SRS to alter processes and the structure required to manage the new fiscal agent's SUR unit with performance measurement criteria, benchmarks, and general contractor management practices.

Provider profile reports with anomalies, generated by the BCBSKS SUR unit, often end up in storage with little or no action initiated to determine whether or not these anomalies are reflective of potentially fraudulent or abusive billing practices. Return on investment, performance measurements, and production criteria are not addressed at the BCBSKS SUR unit.

Provider profile reports with anomalies, generated by the present fiscal agent's SUR unit, often end up in storage with little or no action initiated to determine whether or not these anomalies are reflective of potentially fraudulent or abusive billing practices. This valuable data, based on variations from standards developed jointly with the SRS Utilization Review Manager, is squandered due to lack of prompt follow-up and investigation. Return on investment, performance measurements, and production criteria are not addressed at and appear to be foreign to the present fiscal agent's SUR unit mode of operation. The State of Kansas pays the fiscal agent $1.04 per claim processed. For the period, November 1, 2000 through October 31, 2001, the amount so paid totals in excess of $12.5 million.

The Medicaid Fraud and Abuse Division of the State Attorney General's Office capitalizes on a continuous stream of Medicaid fraud and abuse enforcement opportunities, but any expansion to their functional scope appears to be constrained by the interpretation of existing laws, regulations, and mandates.

The Kansas Attorney General's Office's Medicaid Fraud and Abuse Division, is a well-staffed, talented group of individuals willing to perform functions beyond their legislatively defined role. The Division capitalizes on a continuous stream of Medicaid fraud and abuse enforcement opportunities referred to them by SRS, the SUR unit, and the general public, however, any expansion to their functional scope appears to be limited or impaired by the present interpretation of existing laws, regulations, and mandates. The Division is precluded from initiating provider profiles, recipient profiles, database analysis, etc., and must solely rely on referrals to perform their defined task. This limitation is due in large degree to both Federal and State interpretations of the investigative role of the Division.

2. Are the efforts to identify fraud and abuse in Kansas reasonable and sufficient?

It appears the transition from the current BCBSKS contract to the new Medicaid fiscal agent will yield more effective technology-based tools to reveal and deal with both routine and sophisticated fraud and abuse. However, the current SRS management practices and structure must also evolve to ensure proper oversight and management of the new contractor based on an appropriate set of balanced measures.

The management of the SUR unit function by SRS appears to be functioning as originally intended. Whether due to time constraints placed upon the Utilization Review Manager, the perceived lack of initiative on the part of the fiscal agent, or the sheer volume of information generated and filed for future reference, it appears to be questionable as to the consistent effectiveness of the process in identifying and controlling fraud and abuse within the Kansas Medicaid Program. This is no reflection on the individual occupying the Utilization Review Manager position. It is more of a reflection on the lack of contractor management practices presently employed. Requisite performance measurements should be in place that permit quantifiable evaluation of the work performed by the SUR unit in terms of cost savings, cases referred to the Attorney General's MFCU, returns to the State for the investment made with this outsourced function, and additional requirements for follow-up on deviations noted by the SUR unit as part of their quarterly analysis.

It appears the pending transition from the current Medicaid fiscal agent contract to the new contractor will yield more effective technology-based tools to reveal and deal with both routine and sophisticated fraud and abuse. However, the current SRS management practices and structure must also evolve to ensure proper oversight and management of the new contractor based on an appropriate set of balanced measures.

The effectiveness of the BCBSKS SUR unit is questionable, not for lack of passion on the part of the SUR unit staff, but as a result of following routine versus proactive procedures, a lack of return on investment comprehensions, and a lack of understanding all aspects of a sound fraud and abuse detection system.

The effectiveness of the present fiscal agent's SUR unit is questionable, not for lack of passion on the part of the SUR unit staff, but based upon following routine versus proactive procedures, return on investment evaluations, and understanding all aspects of a sound fraud and abuse detection system. Quarterly reports with deviations exceeding levels of predetermined standards are filed for

future reference. Reviews of these reports are based upon quantitative standards, not qualitative standards with no return on investment criteria entering into the formula. Data analysis does occur at the SUR unit, but the level of data analysis is geared more to the contractually required analysis than to the creative analysis processes. This is not to say that the SUR unit is not proactively concerned with problems within the State Medicaid Program. During our observations, we noted individuals promoting new policy related to areas of provider reimbursement such as a change in mileage reimbursement policy related to non-emergency transportation or identifying the needs for additional edits and audits within the KMMIS system to identify anomalies in claims submitted. The effectiveness of the SUR unit in terms of return on the invested dollars appears questionable, even though these efforts are commendable.

The efforts of the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division to identify and resolve fraud and abuse appear to be reasonable. However, additional actions modeled after other states that have successfully expanded their MFCU roles should be considered in an attempt to review and/or re-interpret currently constraining laws and mandates.

The efforts of the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division to identify and resolve fraud and abuse appear to be reasonable. However, additional actions modeled after other states that have successfully expanded their MFCU roles should be considered in an attempt to review and/or re-interpret currently constraining laws and mandates. The inability of the Division to initiate action and investigation in other than a referral mode literally negates the Division's effectiveness. In order to put "teeth" in the Medicaid Fraud and Abuse Division, either new legislation or a more liberal interpretation of existing statutes, at the Federal and State level, appears to be in order.

3. Is there fraud and abuse in the Kansas Medicaid Program?

National statistics indicate that approximately 10% of all Medicare and Medicaid payments are fraudulent. If these statistics are applied to the fiscal 2001-estimated Medicaid spending level in Kansas, it means approximately $138 million of the State's Medicaid claims are potentially fraudulent. Assuming Kansas is the anomaly and has a 2% incidence of fraud in the Medicaid Program, fraudulent payments would total over $27 million.

Throughout our interview process, we were assured that Medicaid fraud in the State's Medicaid Program was minimal. Comparisons were continuously made to the states of Florida and California where, it was asserted by those interviewed, fraudulent Medicaid practices are rampant. We believe that Kansas is not unique. We believe Medicaid fraud and abusive practices are in each and every state of the Union. The form such practices take may vary from state to state, and the dollars associated with such activity may also vary, however, we have found that medical fraud and abuse is relatively consistent throughout the Nation.

Unfortunately, this performance audit did not encompass the determination of the amount of fraud that may be present in Kansas. To quantify this amount entails significant review of historical files, confirmation of medical procedures and claim validity, and detailed validation of claims paid. The results of such a study and analysis could provide recommendations for additional proactive safeguards in the area of preauthorization of providers, claims processing safeguards, and post payment analysis requirements. Additional referrals to the Attorney General's MFCU could also result.

Chapter
1

Scope

Background

Kansas Medicaid Program

The Kansas Medicaid Program was established in accordance with Title XIX of the federal Social Security Act. The Program is designed to provide medical assistance to qualifying recipients in the State of Kansas and funding is shared 60% by the federal government and 40% by the State. In fiscal year 2001, recipients numbered in excess of 272,000. It is anticipated that the number of recipients participating in fiscal year 2002 will only increase.

The Kansas Medicaid Program is second only to education in terms of State funding. In 1998, paid Medicaid claims amounted to over $936,000,000. In the year 2001, the amount of claims paid under the program escalated to over $1,380,000,000, an increase of 47% during this 3-year period. This increase, averaging in excess of 15% per year, exceeds inflationary trends in Kansas as well as national trends. Factoring in additional program services and recipients, the average cost per recipient ($3,700 in 1998 vs. $5000 in 2001) has escalated during this same period by 35%. With such increases and the national attention toward fraud and abuse detection and prevention activities within both the Medicare and Medicaid Programs, the Kansas Legislative Post Audit Committee requested a performance audit of the Kansas Medicaid Program initiatives in controlling fraud and abuse.

Reflecting, we remind the reader that, even though the purpose of the Medicaid Program is to provide healthcare to those who can't afford adequate healthcare for themselves, the Program also produces additional revenue or new economic opportunities to existing and new medical care providers. It, unfortunately, also provides opportunities to the dishonest element of our society.

The Medicaid model is not a traditional economic model where the buyer negotiates for the acquisition of a service or product that the buyer needs. Conversely, the seller, in this case a medical provider, does not provide the service directly to the buyer (the State of Kansas), but instead the services are provided to a beneficiary of the buyer's goodwill or welfare. In turn, the buyer does not have a direct association with its goodwill recipient. The economic model created in the Medicaid environment is highly susceptible to fraud and abusive activities. There are inherent incentives for providers to authorize unneeded services, for providers to create fictitious recipients, and for the creation of fictitious providers. In this environment, the State of Kansas is placed in a situation that requires a unique, almost conflicting role to ensure that its investment and its goals are met.

The State of Kansas utilizes three entities in its program to prevent, detect, and to prosecute Medicaid fraud; the Kansas Department of Social and Rehabilitation Services (SRS), Blue Cross / Blue Shield of Kansas (BCBSKS), the Medicaid fiscal agent, and the Kansas Attorney General's Office – Medicaid Fraud and Abuse Division, the State's Medicaid Fraud Control Unit (MFCU).

These three entities are the auditees of this performance audit.

We noted with great interest that the Kansas Legislature authorized a similar performance audit in 1980, conducted by the Legislative Division of Post Audit. Though this review is dated and the systems in place at the time were rudimentary precursors of the information technology enhancements employed today, interesting correlations with the present performance audit exist. These correlations are as follows:

- The Legislature was interested in the extent of fraud and abuse within the Kansas Medicaid Program. (Similar to Question 2, of the Statement of Work (SOW).)
- The Legislature was interested in the effectiveness of the SRS activities in identifying and controlling fraud and abuse. (Similar to Question 1, of the SOW.)
- The fiscal agent had recently changed between BCBSKS to Electronic Data Systems (EDS). (SRS is presently reviewing responses to a request for proposal to change fiscal agents from BCBSKS to one of two respondents, including EDS.)
- The automated claims processing system, now known as Kansas Medicaid Management Information System (KMMIS), was in it's infancy and included 160 computerized prepayment audits and edits. (The KMMIS system employed by the present fiscal agent utilizes some 807 computerized prepayment audits and edits.)
- A federal assessment of the claims processing system and practices by the U.S. Department of Health, Education, and Welfare was completed the year before the performance audit. (The U.S. Department of Health and Human Services is presently scheduled to conduct a similar assessment in 2002.)

The Legislative Division of Post Audit has conducted other studies and performance audits of the State's Medicaid Program during the ensuing years covering segments of the Program. The SRS Utilization Review Manager has performed additional studies, such as claims payment accuracy reviews, during these years.

Purpose

Statement of Work Requirements

In response to a legislative request, the State of Kansas Legislative Post Audit Committee posed two questions related to fraud and abuse in the Kansas Medicaid Program. Those two questions, contained in the Scope Statement at Appendix A, were:

What does the State of Kansas do to try to identify fraud within the Medicaid Program, and do those efforts appear to be reasonable and sufficient?

This performance audit addresses this question and contains a description of the State's system for preventing, identifying, and prosecuting fraud within the Medicaid Program, and the system for recouping fraudulent payments. It also provides an evaluation of the effectiveness of these systems, describes observations related to the systems, presents our findings as a result of the audit effort, and provides recommendations for improvement. In other words, this performance audit describes the system, provides the Legislative Post Audit Committee with a 'report card' on the Medicaid Program, and provides recommendations for improvement to the systems and procedures in place.

Do there appear to be significant instances of fraud within the State's Medicaid Program?

To effectively evaluate the Kansas Medicaid Program, it is vital to identify the specific extent of fraud and abuse within the State's Medicaid Program. This performance audit, by definition, limited the scope of our work to responding to question 1, above. Therefore, this report does not respond to this question. However, we feel a discussion of this question is merited.

Our experience and national statistics indicate that fraud and abuse in both the Medicare and Medicaid Programs is prevalent in every state in the Nation. Kansas is not immune. Efforts are underway in numerous states to analyze historical claims databases through profiling techniques applied to medical care providers and program beneficiaries and recipients alike. Such efforts are uncovering intentional individual and organized schemes to defraud not only the federal and State programs, but also the medical insurance community. Carrier rates are up due to escalating costs, which, it is generally agreed, include fraudulent claims.

The potential for analyzing a three-year database of claims processed, whether paid or denied, provides the opportunity to isolate and profile provider and recipient practices. It also provides the opportunity to review the practices of the fiscal agent when claims volumes increase and the fiscal agent gets behind the curve in processing those claims. Our experience indicates that, when an agent of an organization is paid primarily on a piecework basis (e.g., per claim processed), incentives exist to speed the process by sacrificing controls. We are not indicating that such was the case with BCBSKS, the SRS fiscal agent. We refer only to other instances where business profit incentive often outweighs prompt fiscal controls.

The level of effort required in determining the amount of fraud and abuse in the Kansas' Medicaid system is significant. The performance of claims validity sample testing requires complete medical records review by nurse specialists. Our experience dictates that approximately 25% of such medical records will also require a physician review for medical necessity, appropriate procedures, etc. Accordingly, the testing of claims statistically sampled for validity review requires more time and effort than contemplated in the existing assignment. Applying statistical inference techniques to this larger audit sample coupled with more extensive testing procedures would quantify the dollar amount for the "report card" to the Legislature.

Further, the most effective means by which fraudulent activities within either Medicaid or Medicare can be isolated or detected is through in-depth studies, evaluations, and analyses of the claims paid database together with confirmation activities to validate the existence of both Medicaid providers and Medicaid recipients. The effort required by data analysts and information technology experts to sort, trend, and analyze the three-year claims database in the State of Kansas, considered necessary to answer question 2, is considerable.

The confirmation process often generates extremely interesting results. Our direct experience in performing vendor confirmations have resulted in numerous undeliverable confirmations due to the non-existence of the provider, a mail drop only, a vacant lot address, landlord comments of "oh, they moved yesterday", and the like. Through our research with insurance company special investigative units, we have confirmed that provider "rings" operate nationwide, defrauding not only carriers, but also Medicare and Medicaid Programs. We do not believe the State of Kansas is exempt from such practices.

Work Performed

As documented above, the purpose and objective of this performance audit is to address the first question of the scope statement (Appendix A) authorized by the Legislative Post Audit Committee in response to a legislative request. The question, again, was as follows:

What does the State do to try to identify fraud within the Medicaid Program, and do those efforts appear to be reasonable and sufficient?

To respond to this question, we conducted interviews with individuals at the Kansas Department of Social and Rehabilitation Services (SRS) – Medicaid Utilization Review function, the Kansas Attorney General's Office – Medicaid Fraud and Abuse Division, and representatives from Blue Cross / Blue Shield of Kansas (fiscal agent for the Department of Social and Rehabilitation Services) – Surveillance and Utilization Review unit (SUR unit). We prepared flow charts of the various systems and procedures employed by each of the groups interviewed to identify best practices, system strengths and weaknesses, and inter-relationships. We performed limited tests of claims processed through the Kansas Medicaid Management Information System (KMMIS), the State-owned data processing system through which all Medicaid claims are processed. We also subjected a limited sample of claims to a test environment processing through this system in order to determine whether or not certain system audits and edits, designed to preclude payment for aberrant claims, produced acceptable results.

Interviews

Through a questioning process, we conducted our interviews in order to determine if the manual and computerized systems in place within the three functions are adequate to accomplish the goal of identifying potential fraudulent or abusive Medicaid billing and payment practices by both medical providers and beneficiaries alike. The results of this process are referred to throughout our report.

Flow-Charting

We utilized flow-charting techniques to assist in understanding the processes and procedures employed, both manual and computerized, in carrying out the designated fraud and abuse identification function and to correlate the inter-relationships between the three entities charged with this responsibility. Overlapping of procedures, duplicate efforts, interdependencies, and communication linkage are a few of the items that normally surface as a result of such flow-charting techniques.

During this process, we noted certain matters related to the functioning of the systems employed that we have addressed in the findings section of this report. We have also provided copies of detail flow charts in Appendix E.

The diagram below is a condensed version of the inter-relationships between the fraud and abuse detection functions at SRS, the Attorney General's MFCU Division, and the SUR unit at Blue Cross / Blue Shield.

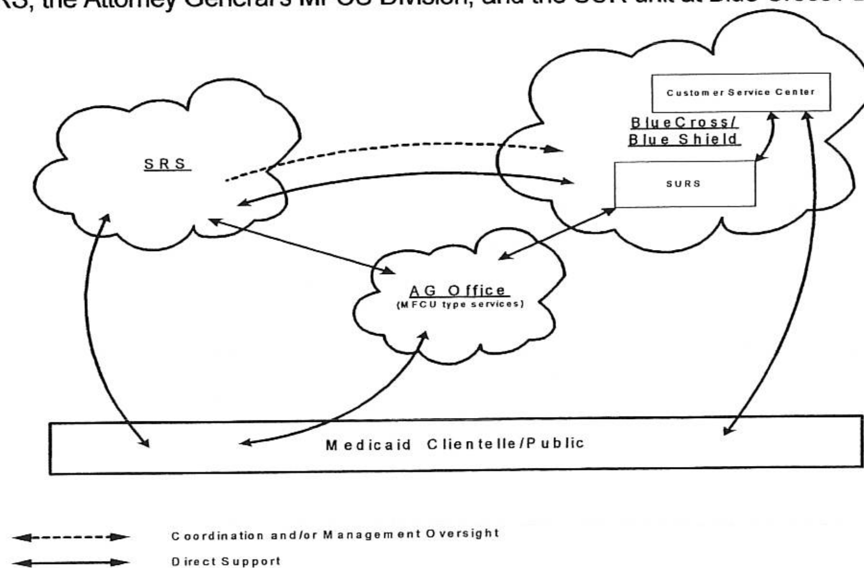

Figure 1 Relationships between Medicaid Support Elements

Testing

In an effort to determine whether or not procedures established to identify aberrant Medicaid claims are functioning, we obtained the claims-processed database for the period from November 1, 2000 through October 31, 2001. We felt this relatively current period would provide the most up-to-date data for review and limited testing purposes. This database consisted of 12,257,425 claims processed, whether paid or denied, during this period. We selected a statistically valid random sample of 250 claims processed and then randomly sampled this sample to select 60 claims processed for detailed testing. We compared the adjudication summary related to our sample against the actual claims document submitted to the fiscal agent for processing, whether electronically submitted or manually submitted and subsequently key punched into electronic medium. We specifically reviewed the processing edits and audits noted on the summary, the exception listings, and the explanation of benefits related to each claim to validate processing appropriateness. The claims were also reviewed for beneficiary eligibility, preauthorization, if applicable, third party liability, pricing, and other claim specific details. We also subjected these 60 claims to a reprocessing through the KMMIS system in a test environment to validate the similarity of results to the actual claims processing.

Chapter
2

Overview

National Perspective

CMS, US Attorney General's Office, & Other States

With annual health care costs in the United States now exceeding $1 trillion, and expected to double to more than $2.2 trillion by 2008, fraud and abuse in the Medicare and Medicaid programs is costing tax payers billions of dollars each year. Efforts to detect, prevent, and control fraud and abuse on a national level have been based on a partnership with states who, in turn, have established cooperative relationships with providers, consumers, and law enforcement. States are beginning to work together by sharing data in an effort to identify patterns of aberrant billing practices. Common themes have begun to emerge. These themes are as follows:

- Billing for phantom patient visits
- Billing for goods and/or services not provided
- Billing for used/old items as new
- Billing for the same services and/or goods twice
- Billing for more hours than are in a day
- Billing for medically unnecessary services
- Paying kickbacks in exchange for referrals
- Inflating the bills for services and/or goods provided
- Concealing ownership of related companies
- Falsifying credentials

In a report titled, "Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles, Malcolm Sparrow, Professor of Practice, John F. Kennedy School of Government, summarized the findings from four Centers for Medicare and Medicaid Services (CMS) regional seminars on the subject of Medicaid fraud and abuse control. Three areas of focus seemed to emerge based on the feedback from 49 states. These areas are as follows:

- Building commitment, understanding, support, and resources for fraud and abuse efforts
- Technology Issues: Obtaining access to claims databases, claims analysis, fraud and abuse detection techniques
- Managed Care: Controlling fraud and abuse in the capitated environment

Comments from these seminars were wide ranged, but suggested an overall lack of support and understanding of the importance of detection and prevention.

> *"We are a provider driven agency. Our agency operates directly under the governor's office and primarily by executive order and therefore is subject to political pressure by providers and associates. This creates difficulty in introducing new programs, new checks and balances, changing rates, policies, and punitive actions."*
>
> *"The largest obstacle we have is top level management of the Division."*
>
> *"The most substantial obstacle facing Medicaid Program Integrity operations is the lack of awareness and understanding of the extent of the problem."*
>
> *"The program integrity budget commitment tends to be crises driven."*
>
> *"The states anti-fraud and abuse efforts (budget driven) are minute in relationship to the size of the program."*

In a National Report for fiscal year 2000, CMS reviewed the program integrity processes for eight states. The eight States were: Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia, and Wyoming. The report found that most states are meeting the program integrity responsibilities satisfactorily. The study also found that numerous resources and administrative authorities are available to all States' program integrity operations. For the most part, states have taken advantage of these resources with the exception of collecting disclosure information from providers relating to subcontractors and suppliers. The study identified that the lack of communication between internal and external partners hampers program integrity efforts. Good communication between the SUR units and Medicaid Fraud Control Units (MCFU) is critical to success. Finally, the report discussed the importance of up-to-date technology and its impact on program integrity. Although some States are using advanced technology, other States' efforts are restricted by outdated systems.

It is evident in looking at what is happening on the national perspective that Medicaid is uniquely vulnerable to fraud. This vulnerability is due to a multitude of factors. The first factor is the enormous sum of money that is available for Medicaid programs. The second factor is the variety and sheer number of participating providers. Adding to the issue of volume is the political pressure that providers and their associated organizations are able to apply to policy makers. The third factor is the relationship between risk and return. Although states are starting to work together through working groups like the Medicaid Alliance for Program Safeguards (MAPS), they are also using more sophisticated tools to analyze data, and are exploring civil monetary penalties when intent cannot be sufficiently proven to satisfy a criminal conviction. State and federal authorities rarely prosecute Medicaid fraud cases. This is unfortunate since, in the eyes of the unscrupulous provider or beneficiary, the prospective economic return out-weighs the risk.

Kansas Perspective

SRS, BCBSKS, Kansas Attorney General's Office

SRS is the designated State agency for the administration and supervision of the Medicaid Program with primary responsibility for the prevention, detection, and elimination of all fraud, abuse, and improper practices in the Medicaid Program. SRS has designated a Program Integrity Section and a Medicaid Utilization Manager to oversee the fraud and abuse function at the departmental level. SRS has outsourced the CMS mandated surveillance and utilization review function to Blue Cross / Blue Shield of Kansas, Inc. (BCBSKS), a contracted fiscal agent. The Medicaid Utilization Manager provides supervisory direction to the BCBSKS Surveillance and Utilization Review (SUR) unit. The BCBSKS SUR unit consists of medical professionals (RNs), data analysts, and a designated fraud investigator. This SUR unit is supported by a federally mandated computer subsystem, Surveillance and Utilization Review Subsystem (SURS), to profile providers using SRS criteria and to monitor recipient claims. In addition to SURS, this unit relies on processes and procedures by which the quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards jointly developed by the SRS Medicaid Utilization Review Manager and SUR unit representatives.

The key SRS / BCBSKS SUR unit objectives are:

- Ensure the System Performance Review (SPR) requirements are met for SURS
- Guard against fraud and abuse of the Kansas Medicaid Program by its individual providers and consumers through the coordination of activities with MFCU
- Assure that Kansas Medicaid Program consumers receive necessary medical care at a level of quality consistent with that available to the general population
- Exercise necessary fiscal control over federal and State tax dollars
- Assure provider and consumer compliance with the rules and regulations of the Kansas Medicaid Program through education and corrective action as appropriate
- Maintain a database of case reviews to document findings and action taken on SUR reviews
- Provide input into a database on Corrective Action Plans (CAP) to provide evidence that effective corrective action was taken when indicated
- Monitor the quality of correspondence and case reviews by a peer review process
- Assist with quality assurance processes and programs for HealthConnect and special studies

- Establish a positive interactive customer relationship through quality case presentations monthly, monthly meetings with state personnel to address HCA issues, and a semi-annual meeting with the State to update exception processing

Accomplishing these objectives is done through analysis of computer generated SURS reports, conducting reviews of individual utilization patterns, and following through with appropriate corrective actions when warranted. Figure 2 is a simplified Consumer/Provider Review process flow. Detailed process flow diagrams can be found at Appendix E of this report.

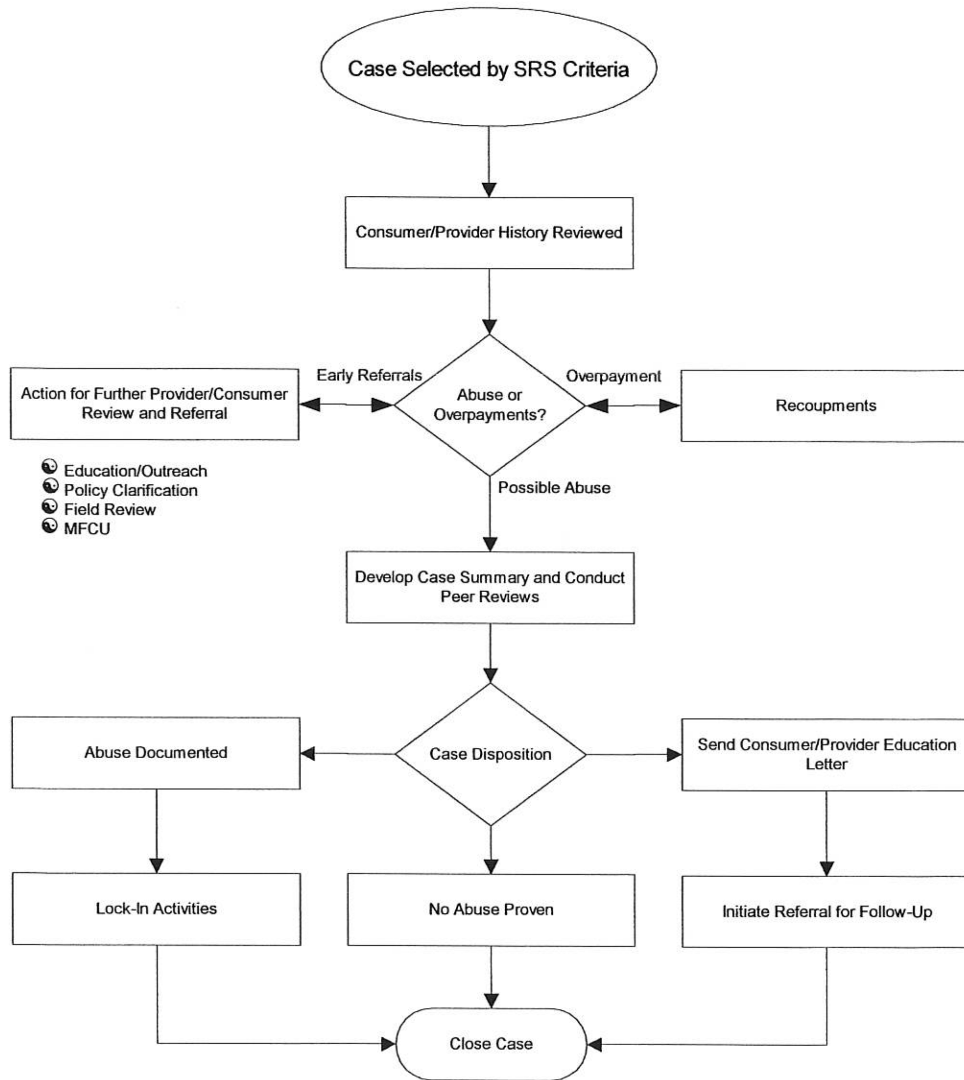

Figure 2 - Simplified Consumer/Provider Review Process

Once the SUR unit has identified claims that appear to be fraudulent or systemically abusive, the SUR unit Data Analyst/Fraud Investigator initiates action to prepare a case folder that is ultimately sent to the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division. The Division is structured to function as a traditional Medicaid Fraud Control Unit, or MFCU. It was established in 1995 and charged with the responsibility for conducting a statewide program for investigating and prosecuting violations pertaining to fraud in the administration of the Kansas Medicaid Program or the activities of Medicaid providers. This

Division also reviews complaints alleging abuse or neglect of patients in care facilities and misappropriation of patient private funds by programs receiving Medicaid payments. This Division is comprised of a Deputy Attorney General as the Division's Director, an Assistant Attorney General, an Auditor, a Research Analyst, a Chief Investigator, and three Fraud Investigators. Referrals are received from SRS, BCBSKS SUR unit, and from complaints received directly and indirectly from the public. This Division is a member of the Health Care Fraud Working Group sponsored by the FBI and the US Attorney's Offices for the District of Kansas and Western Missouri.

If the Attorney General's Office's Medicaid Fraud and Abuse Division accept a case for action, it is processed and investigated to determine if fraud has actually occurred and, if so, is ultimately prosecuted or otherwise resolved legally (see simplified MFCU process flow – Figure 3).

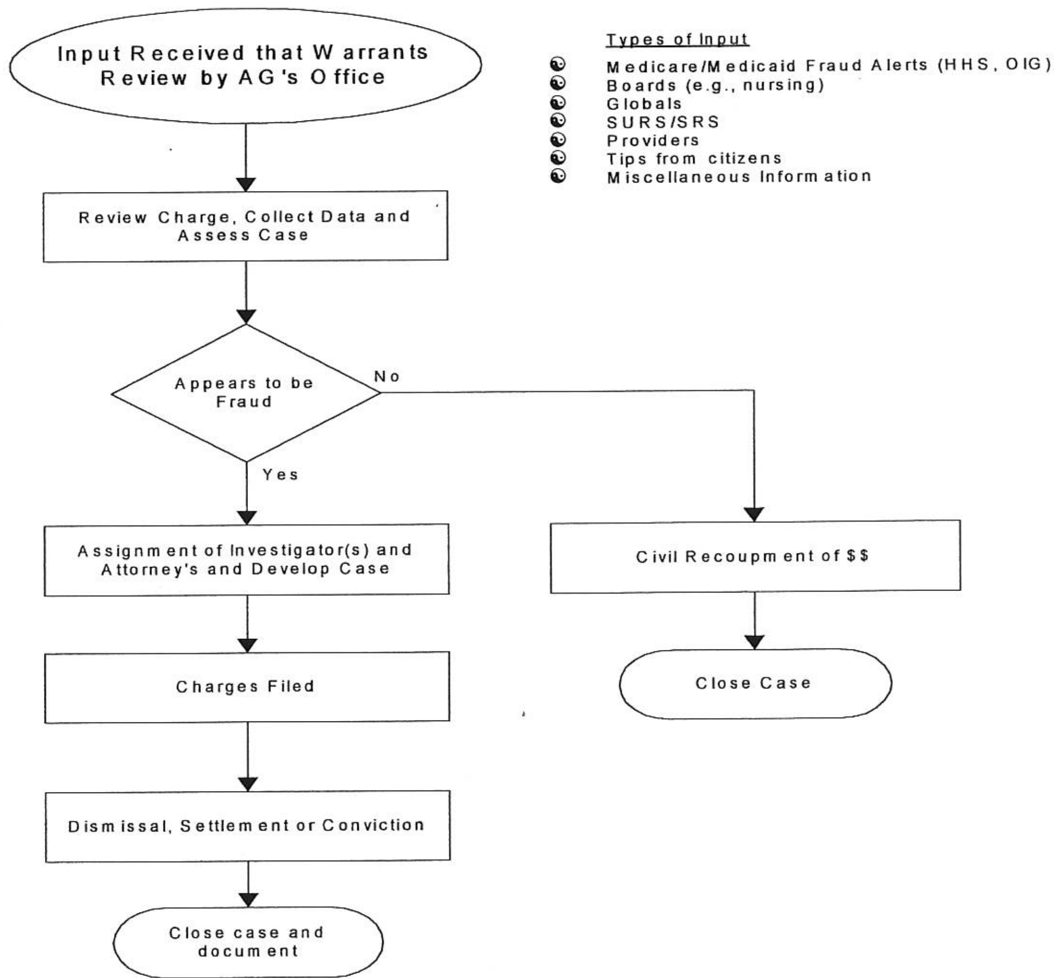

Figure 3 - Simplified MFCU Case Process Flow

The SRS and Kansas Attorney General's Office's Medicaid Fraud and Abuse Division interact pursuant to a Memorandum of Understanding entered into in 1995. This Memorandum of Understanding delineates the responsibilities of SRS and the Division in the review, referral, and prosecution of cases involving Medicaid fraud and abuse. The SRS Utilization Review Manager, the fiscal agent's SUR unit, and the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division are in continuous contact with one another.

Monthly meetings are held wherein potential cases are discussed, referrals to the Kansas Attorney General's Office are made and monitored, and consultation on pending or progressing cases is conducted. This joint cooperative arrangement was employed in an attempt to ensure that the common goal to detect, investigate, and prosecute fraud and abuse within the Kansas Medicaid Program is functioning.

The SRS, the Medicaid fiscal agent's SUR unit, and the Kansas Attorney General's Office's Fraud and Abuse Division also interface with other State agencies, such as the Kansas Department of Health and Environment, the Kansas Department on Aging, and Adult Protective Services.

Chapter
3

Findings

Kansas Medicaid Fraud and Abuse

What does Kansas do to identify fraud and abuse within the Medicaid Program?

SRS

Management of the Medicaid Fiscal Agent (BCBSKS SUR Unit) by SRS appears adequate; however enhancements to operational effectiveness could be achieved.

During our interview with the SRS Utilization Review Manager (the UR Manager), we asked, "who is directly in charge of the SUR unit and SURS operations." The UR Manager responded that her position has the overall day-to-day responsibility. We then focused on operational aspects of the SUR unit, both current and future. The SRS Health Care Policy / Medical Policy Organization Chart dated September 24, 2001 (figure 4) illustrates where the UR Manager position is within the SRS structure (see right-hand call out). Further, as we interviewed specific members of the SUR unit, it became increasingly evident that, despite the UR Manager's contractual responsibility over the SUR operations, in practice, the SUR specialists and first line managers receive guidance and direction from "SRS Program Managers" located elsewhere in SRS (see left-hand call out on figure 4). While this is not necessarily a poor practice, care must be exercised not to provide conflicting direction.

Other questions focused on the UR Manager's knowledge of the annual SUR operating budget and spending activities, determining the cost of processing a claim through the SURS system and SUR unit, and specific, quantifiable performance expectations and measurement practices. The UR Manager appeared to have difficulty responding to these questions. It appears that, due to the UR Manager's placement within SRS and the specific responsibilities of the job description, the UR Manager would not necessarily need this information. However, we feel that someone within SRS, other than the Director, should have a comprehensive overview of the SURS and SUR unit activities, costs, and returns. From our initial contact with SRS, we were directed to the UR Manager as primary SRS contact in reference to the SRS fraud control program. We did meet with the Director of Health Care and found him relatively well informed as to the organizational responsibility of SRS in fraud detection, although these discussions remained at a relatively high level.

While the technology-based systems and processes used today are aging and becoming predictable, efforts are underway within SRS to strengthen the ability to identify Medicaid fraud and abuse using highly advanced technology-based systems. Unfortunately, it is not clear that senior SRS management is committed to improving the processes and structure required to manage a system so rich in repeatable processes, review activities, collaborations, performance measures, and the general employment of best contractor management practices. Our observations are not intended to be a harsh attack on the UR Manager position, but are intended as a flag that the energies expended at SRS are consumed by the effort of managing the day-to-day workload.

88-1

SRS
Health Care Policy / Medical Policy
September 24, 2001

- Janet Schalansky, Secretary
- Laura Howard, Asst. Secretary
- Robert Day, Director of Health Care
  - Nialson Lee, Administrator — Oversight and Supervision of Health Care Delivery Systems & Policy
  - Christiane Swartz, Administrator — Oversight and Supervision of Purchasing and Contract Management
  - Amanda Reichard, Spec. Asst.
  - Michelle Smull, Office Specialist
- Monica Mayer, Administrator, Public Health Affairs
  - Joel Stottlemire, Information Coordinator
  - Robb Baker, Support Staff

Benefits
- Brenda Kuder, Senior Manager
  - Kim Brink, Program Manager
  - Thelma Bowhay, Program Manager
  - Wayne Wallace, Medical Director
  - Terry Davis, Program Manager
  - Vacant, Program Manager
- Bobbie Graff-Hendrixson, Senior Manager
  - Hallie Fosdick, Support Staff
  - Debra Bachmann, Program Manager
  - Chris English, Quality Mgr. for Managed Care
  - Janelle Garrison, Program Manager

Program Managers from other areas within SRS often provide guidance to SURS employees.

Policy Research
- Bob Heintzelman, Senior Manager
  - Harvey Hillin, Policy & Program Analyst
  - Deb Huske, Policy & Program Analyst
  - Greta Hamm, Policy Analyst
  - Wanda Pohl, Support Staff

Fiscal/Financial
- Frank Webb, Senior Manager
  - Vandana Agarwal, Auditor / Assc. Manager
  - Marcia Boswell-Carney, Fiscal Manager
  - Vacant, Research Analyst

Family Medical Eligibility
- Darin Bodenhamer, Senior Manager

Project Management Business Coordination
- Diane Davidson, Senior Manager
  - Maria Montgomery, Project Mgmt. Coord.
  - Kathy Johnson, Project Mgmt. Coord.
  - Rolanda Ellis, Project Mgmt. Coord.

Information Systems & Project Management
- Tom Laughlin, Senior Manager
  - MaryAnn Coulter, Systems Analyst
  - Doug Cornett, Systems Analyst
  - Business Analysis & Testing
    - Tricia Kessler, Sr. Bus. Analyst
    - Rebecca Hermsen, Lead Tester
    - Debbie Clemmons, Acceptance Tester
    - Vacant, Acceptance Tester
    - Vacant, Acceptance Tester

Contracts & Fiscal Agent Operations
- Dan Roehler, Senior Manager
  - Contracts & Regulatory Affairs
    - John Dixon, Contracts Team Mgr.
    - Linda Gronquist, Mgr., Contracts
    - Rita Haverkamp, Mgr., Agreements & Regs.
  - Policy Operations
    - Vacant - Mgr. MC Op's. & MMIS Reporting
    - Gail Giordono, Mgr. Policy Processes/Interfaces
    - Sherry Kearney, Policy Specialist
  - Claims Team
    - Lisa Wessel, Manager
    - Rhonda Kearney, Mgr., Financial Proc.
    - LouAnn Gebhards, Mgr., Utilization Review
    - Mary Siefken, Mgr., Third Party Liability
  - Support Team
    - Dennise Weichert, Support Team Leader
    - Morgan Graham, Receptionist
    - Sabra Loebel, Support Staff
    - Rose Shoulders, Support Staff

This management position oversees all SURS related activities on behalf of SRS.

Eligibility & Enrollment / Customer Services
- Joan Schultz, Senior Manager
  - Dona Marshbank, Manager
    - John Aureli, Mgr. Provider Ops
    - Carolyn Bayless, Mgr. Consumer Ed
    - Dorothy Hunt, Mgr. Cust. Src/QA
  - Margaretta Fosse, Manager — Clearinghouse Eligibility / Enrollment State Staff
    - Karen Carter, Ops. & Contract Spec.
    - Teresa Graber, Ops. & Contract Spec.
    - Melissa Sparks, Ops. & Contract Spec.
    - Kim Wilson, Ops. & Contract Spec.
  - Rachelle Altman, PC-I
    - Kelly Estrada, Eligibility Specialist
    - Sally O'Dell, Eligibility Specialist
    - Gayla Starkey, Eligibility Specialist
    - Sterling Montgomery, Eligibility Specialist
    - Lisa Selbach, Eligibility Specialist
  - Gayle Myers, PC-I
    - Justina Campos, Eligibility Specialist
    - Verna Martin, Eligibility Specialist
    - Ed Sorenson, Eligibility Specialist
    - Beverly Droge, Eligibility Specialist
    - Martha Rodriguez-Hill, Eligibility Specialist
  - Carla Spicka, PC-I
    - Shannon Chermak, Eligibility Specialist
    - Janice Lewis, Eligibility Specialist
    - Phyllis Terry, Eligibility Specialist
    - Reves Labrador, Eligibility Specialist
    - Eduardo Nunez, Eligibility Specialist
    - Sondra Twombly, Eligibility Specialist

Figure 4 - SRS Organization Chart (with specific call-outs)

1-28

SUR Unit

Provider profile reports with anomalies, generated by the BCBSKS SUR unit, often end up in storage with little or no action initiated to determine whether or not these anomalies are reflective of potentially fraudulent or abusive billing practices. Return on investment, performance measurements, and production criteria are not addressed at the BCBSKS SUR unit.

During the audit interview process, representatives from the BCBSKS SUR unit met with the audit team to discuss the processes employed to detect fraud and abuse. Specifically, what do they do to detect fraud and abuse? Various reports were produced that profiled providers who, based on criteria pre-established in an annual meeting with the SRS Utilization Review Manager, were identified as potential aberrant providers or potentially abusive recipients. Generally, these criteria would be number of physician visits, a predetermined dollar amount, number of physician services, number and type of pharmaceutical claims per recipient, etc. Every year both SRS and SUR unit management meet to determine what provider types will be profiled and the timing of such profiling. For example, during the first quarter, the SUR unit may profile dental providers and non-emergency transportation providers. The following quarter, they may profile and analyze long-term care providers, home health services, and physician providers.

When asked, based on these reports, what the SUR unit would do when they found a provider with results greater than the acceptable standard deviations, SUR unit staff indicated that they would look to see if there have been any complaints/referrals made related to this particular provider. If a provider was identified as aberrant and had a complaint/referral, a recommendation would be made to SRS that further review was warranted. If direction were to be received from the SRS Utilization Review Manager, additional profiling or medical review would be initiated. If no direction were received, the reports would be filed in the Computer Output to Laser Disk (COLD) system, an electronic storage medium where reports are archived and available for reference.

As an example, the exception report for the quarter ended September 30, 2001 included a Medicaid recipient with an average number of physician services used amounting to 175. The standard deviation for the number of physician services used in the quarter was 22. Clearly, some action or investigation should be prompted by such a large difference between actual quarterly results and the predetermined deviation criteria. When questioned, the SUR unit representatives again deferred to the direction of SRS, but did indicate that this exception report would be referred to SRS for direction or was filed for future reference.

In a follow-up meeting, the audit team met with the SUR unit's fraud analyst to discuss her role in data analysis. Specific questioning revolved around the specific tools used to perform analysis, how the resulting information is communicated to the SUR unit and to the MFCU, and what results have been achieved. Although it was felt that the analyst played an important role with regard to coordinating referrals to MFCU and serving as a liaison to the SRS, SUR unit, and MFCU team, the actual role of 'fraud analyst' was not being fulfilled. As a result, it is doubtful that the SUR unit is as effective as it could be. Based upon our understanding of the relationship between SRS and the SUR unit, and the "we receive our direction from SRS" mentality exhibited at the SUR unit, it is unlikely that SUR unit staff consistently exhibits follow-up initiatives nor are such initiatives anticipated by SRS. On the other hand, we did note certain initiatives by members of the SUR unit in recommending certain policy changes related to certain provider groups to SRS Program Managers.

A final question posed to the SUR unit staff involved return on investment (ROI). We specifically asked what type of financial impact they felt that they had had on the program to control Medicaid fraud and abuse in the State of Kansas. Although they felt that they had impacted the program and that there was a degree of passion associated with their work, they were unable to quantify the ROI. Additionally, they were also not aware of any performance standards under which they were working nor were they aware of the cost to initiate a provider inquiry/case.

BLAND & associates

CLAIMS REVIEW

The audit team also met with representatives from the claims processing department. The focus of our interview was to better understand how claims were adjudicated through the KMMIS system. In order for claims to be processed they must pass through approximately 807 edits and audits. Some edits and audits are considered fatal. Fatal edits and audits result in a claim being denied. Examples of fatal edits and audits include provider not enrolled, beneficiary not eligible, all mandatory fields on the claim form not completed. Once a claim has passed through these edits and audits, the next phase involves determining if the service provided is a covered benefit, whether the pricing is correct, whether a third-party liability exists, and so forth. The final phase is determining the medical necessity of the service provided.

As discussed in Chapter 1, a test of the claims system was performed. The test consisted of testing a sample of claims processed through the KMMIS system between November 1, 2000 and October 31, 2001. The results of our tests disclosed four pricing anomalies for four separate pharmacy claims paid. These exceptions were subsequently cleared to our satisfaction by explanation in that interim price changes for specific pharmaceuticals had occurred between the date of the claim reviewed and the date of our testing. Accordingly, no additional follow-on review was considered necessary. We did, however, question why certain edits and audits were triggered and how certain of these edits and audits were subsequently over-ridden within the system or manually through interface with the system. It was explained that, with such a diverse number of edits and audits, certain edits and audits perform a distinct role related to specific procedures and recipients that, due to waivers within the Kansas Medicaid Program, are over-ridden if specific criteria is met. We consider this explanation to be reasonable.

We also provided the claims processing department at BCBSKS a copy of our limited claims sample and requested that they process these claims through the KMMIS system in a 'test environment'. Our intent was to validate the edits and audits of claims actually processed to these same claims processed anew. This comparison of the test environment processing to the actual claim adjudication resulted in no explained variations.

MFCU

The Medicaid Fraud and Abuse Division of the State Attorney General's Office capitalizes on a continuous stream of Medicaid fraud and abuse enforcement opportunities but any expansion to their functional scope appears to be limited by the interpretation of existing laws, regulations, and mandates.

The Attorney General's Office's Medicaid Fraud and Abuse Division provides the investigative and prosecutorial arm to the State's Medicaid fraud identification processes.

Federal Law Defines the Responsibilities of the Medicaid Fraud Control Unit

1. Conduct statewide program for investigating and prosecuting violations pertaining to fraud in the administration of the Medicaid Program or the activities of Medicaid providers,

2. Review complaints alleging abuse or neglect of patients in board and care facilities and misappropriations of patients' private funds by programs receiving Medicaid payments, and

3. Maintain staff to include attorneys experienced in investigations or prosecutions of civil and / or criminal fraud, auditors experienced in commercial and / or financial records, investigators experienced in commercial and / or financial investigations, and other professional staff knowledgeable about the provision of medical assistance and the operation of health care providers.

During the performance audit, the audit team validated that the Medicaid Fraud and Abuse Division fulfills their responsibilities according to Federal guidelines. However, the Division seems somewhat hamstrung by legislative interpretation of the statutes creating the Division. According to the Division's Director, the Division cannot, by law, perform investigations unless based upon a referral or complaint. In other words, no profiling of providers or provider practices can occur unless and until a complaint has been lodged. This limits the proactive abilities of the Division and causes the division to be totally reliant upon referrals.

Further, it appears that the major complaints lodged have been limited to cases involving Home and Community Based Services (HCBS), non-emergency transportation, and abuse or neglect of patients. The Division has participated in a number of "global" settlements (State participation in multi-state settlements with multi-state providers such as pharmaceutical chains, etc.), which reflect positively on recoupments achieved. While these "global" settlements provide cost reductions to the program, they do not represent the results of Kansas-based investigations and prosecutions. In the Division's annual report for fiscal 2000 – 2001, the average recoupment for four of nine specific cases prosecuted in the State amounted to just over $4,250.

Though required by Federal law, the emphasis by the Division on abuse and neglect of patients in board and care facilities and misappropriations of patients' private funds by programs receiving Medicaid payments, coupled with the limitations in performing proactive investigations (e.g., provider or recipient profiling) limit the Divisions effectiveness. The individuals interviewed during the performance audit were eager to receive referrals from the SUR unit, SRS, or other collaborative agencies within the State.

Are the efforts to identify fraud and abuse in Kansas reasonable and sufficient?

SRS

It appears the transition from the current BCBSKS contract to the new Medicaid Fiscal Agent will yield more effective technology-based tools to reveal and deal with both routine and sophisticated fraud and abuse. However, the current SRS management practices and structure must also evolve to ensure proper oversight and management of the new contractor based on an appropriate set of balanced measures.

In general, the management by SRS of the BCBSKS SUR unit function appears to be adequate considering the demands placed upon the SRS Utilization Review Manager. However, we feel enhanced operational effectiveness will improve by initiating more effective contractor management practices. While it appears that the Utilization Review Manager has a thorough grasp of the SUR unit architecture, processes, procedures, and routine outcomes, we found the role to be more of a general contracts administrator. The position appears to lack senior management or executive sponsorship, involvement, and empowerment that would, with minimal personal risk, allow the Utilization Review Manager to promote and lead change within the system to better identify Medicaid fraud and abuse vulnerabilities.

It was a bit unclear whether or not the Utilization Review Manager position is empowered to champion the overall responsibility as the SRS "change agent" regarding SUR unit operations or evolving functionality. While realizing that the potential annual program cost savings that are realizable through highly effective and efficient SUR unit activities, it appears that the Utilization Review Manager position lacks all of the components, tools, information, and specific performance expectations to fully engage the SUR unit capabilities. Accordingly, full accountability cannot be vested in the position. Recommendations related to this position are included in Chapter 4 of this report.

After reviewing the recent Request for Proposals (RFP) that sought vendors who could replace the current Medicaid fiscal agent contractor (BCBSKS), we noted that the RFP identified a comprehensive and robust set of advanced technology tools and processes to enhance Kansas' ability to detect and reduce Medicaid fraud and abuse. This new system, the Fraud and Abuse Detection System (FADS), if implemented as specified, appears to have the proper standards, interfaces (e.g., between FADS and the MFCU) and functionality to replace and greatly enhance a SURS-type capability going forward. However, for the same reasons mentioned earlier, unless the day-to-day management structure within SRS is tuned and bolstered, there is a high risk that the return on investment (ROI) envisioned by the employment of a new Medicaid fiscal agent to detect and manage Medicaid fraud and abuse may never be fully realized.

SUR Unit

The effectiveness of the BCBSKS SUR unit is questionable, not for lack of passion on the part of the SUR unit staff, but based upon following routine versus proactive procedures, return on investment comprehensions, and understanding all aspects of a sound fraud and abuse detection system.

The SUR unit in Kansas is not unlike most SUR units across the United States. The SUR unit seeks direction from SRS and hands off the cases to the Attorney General's MFCU. The SUR unit performs reviews based on quantity standards vs. quality standards. It does not consider cost or investment. Its incentives are based on performing a certain number of activities vs. generating a return on investment. This is in stark contrast to the Attorney General's Office's MFCU who proudly display enlarged checks that indicate the dollars returned as a result of their efforts. Unfortunately the large checks displayed relate to global settlements of which the State of Kansas is a recipient as opposed to cases developed and generated by the MFCU.

There did not appear to be a significant amount of data analysis occurring outside of the standard reports. The claims processing department and SUR unit representatives conveyed little knowledge of what each other did leading one to speculate whether there was an understanding of the various roles each of them had with regard to fraud detection or prevention. This was also true when we asked about the provider credentialing process. If the SUR unit does not understand that a sound fraud and abuse program consists of proactive activities such as credentialing, provider education, and preauthorization, pre-payment claims safeguards such as audits and edits, and post payment safeguards such as random medical review, provider profiling, etc., the program will remain mediocre at best.

The largest area of concern is the lack of initiative. Yes, the SUR unit is doing what other states are doing. Is that sufficient? Based simply on the total dollars returned, the answer is clear. No, it is not enough! For it to be enough, statistical profiling that is used routinely would be required. Profiles produced must generate required action, not just storage. Focusing on provider groups with a larger impact to the overall Medicaid budget would be required. The overt concentration on HCBS and non-emergency transportation providers would be expanded to include other provider groups with significantly greater impact on the Medicaid budget. Having the authority and initiative to work with other states, track results, and consider all aspects of fraud and abuse detection will be necessary. A window of opportunity exists with the new SUR unit, to be organized under the new Medicaid fiscal agent contactor, to enhance the SUR function with new, more effective and proactive policies that can be established, monitored, and evaluated.

MFCU

The efforts of the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division to identify and resolve fraud and abuse appear to be reasonable. However, additional actions modeled after other states that have successfully expanded their MFCU roles should be considered in an attempt to review and/or re-interpret currently constraining laws and mandates.

The efforts of the Kansas Attorney General's Office's Medicaid Fraud and Abuse Division to identify fraud and abuse, given the current restrictions placed on them by law, appear to be reasonable. However, based upon our experience and the latitude provided similar Medicaid Fraud Control Units in other states, the Division efforts do not appear to be sufficient to proactively identify the fraud and abuse within the Kansas Medicaid Program. In order for the Division's efforts to be sufficient, legislative interpretation or modifying legislation, possibly at the Federal level, may be required to put "teeth" in the Division's investigatory procedures. The Division's inability to generate provider profiles, beneficiary profiles, billing trends, dollar trends, and other analyses, limits the Division's effectiveness. As stated previously, this well-staffed and talented Division of the Attorney General's Office can only react to complaints received or to referrals from other State agencies (e.g., SRS, Department on Aging, etc.). For example, cases opened as a result of referrals from the SUR unit 2000 totaled 13 and, in 2001, totaled 10. To be truly effective, this Division should be empowered to perform certain proactive, "watchdog" procedures and analyses in concert with the SUR unit and SRS representatives.

We recognize that providers and recipients have certain rights granted them in civil rights legislation. However, we also recognize the need to "arm" the departments and divisions within the State of Kansas charged with the responsibility of identifying, investigating, and prosecuting those that would use these rights to defraud the State and its citizens of significant dollars. We feel that the Medicaid Fraud and Abuse Division should be so empowered.

Analyzing past performance, we compared the Kansas MFCU to national averages. The following table, taken from the State Medicaid Fraud Control Units Annual Report prepared by the Office of Inspector General, US Department of Health and Human Services (dated June 2000) contrasts the reported results achieved by the Kansas MFCU to these nation-wide averages:

Year	Kansas Unit Cost Actual	U.S Unit Cost Average	Kansas Unit Staff Actual	U.S. Staff Averages	Kansas Convictions Actual	U.S. Convictions Average	Kansas Recoveries Actual	U.S. Recoveries Average
1997	$831,000	$1,713,981	12	37	3	18	$4,470,570	$3,141,325
1998	$968,000	$1,825,401	12	21	2	21	$ 75,127	$1,779,268
1999	$784,000	$1,908,590	12	28	6	19	$ 8,906	$1,888,049

*SMFCU Annual Report FY 1997, 1998, 1999 (U.S. DHHS – OIG)

The results reported in the Medicaid Fraud and Abuse Division, Annual Report for 2000 – 2001, issued by the Kansas Attorney General's Office reflect a break-even scenario when comparing receipts and disbursements from inception through September 30, 2000. In other words, costs have been covered by recoveries since inception. The Division's goal is to have recoveries exceed costs by substantial margins, whether from cases successfully prosecuted in Kansas or from global case settlements.

Is There Fraud and Abuse in Kansas?

In assessing the system employed by the State of Kansas in detecting and preventing Medicaid fraud and abuse, the question should be asked, is there Medicaid fraud and abuse in Kansas?

National statistics conservatively indicate that approximately 10% of all Medicare and Medicaid payments are fraudulent. If these statistics are applied to the fiscal 2001-estimated Medicaid spending level in

Kansas, it means that over $138 million of the State's Medicaid claims are potentially fraudulent. Assuming Kansas is the anomaly and has but a 2% incidence of fraud in the Medicaid Program, fraudulent payments would total over $27 million.

The SRS published a "Payment Accuracy Review" report in April 2000. This report cited the results of a sampling of claims paid in one month (March 1999) and noted a specific case related to a Home and Community Based Services (HCBS) provider with potential overpayment of $160,000. This case was referred to the Attorney General's Office's Medicaid Fraud and Abuse Division. Had statistical inference techniques been employed to the entire population of Medicaid claims paid for all of 1999 utilizing these results, it is reasonable to assume that the one-month sample results could occur in each month of the year.

This performance audit only addresses the question: What does the State do to try to identify fraud within the Medicaid Program, and do those efforts appear to be reasonable and sufficient? It was not intended, due to limited funding available, to address the question: Does there appear to be significant instances of fraud within the State's Medicaid Program? The answer to this question would quantify the dollar amount of potential Medicaid fraud in the State of Kansas. Further, with such testing and analyses, the State could demonstrate that the level of fraud and abuse in the Medicaid Program is under the national average.

As discussed earlier, to properly provide this assessment would require a complete analysis of the claims paid database available through the KMMIS system. This database contains three years of claims paid information and provides a virtual gold mine of information from which detailed analysis and statistical sampling could occur.

During our interview process, the resounding theme we continued to hear was that the Medicaid fraud in the State's Medicaid Program was minimal. Comparisons were continuously made to the states of Florida and California where, it was asserted, fraudulent Medicaid practices are rampant. Our experience and national data leads us to believe that Medicaid fraud and abusive practices are in each and every state. The form such practices take may vary from state to state, and the dollars associated with such activity may also vary, but the simple fact is that no state is exempt from Medicaid Fraud. If Kansas is unique, as asserted during our interviews, such an assessment would evidence the uniqueness and demonstrate the effectiveness of the programs do detect and prevent fraud and abuse.

Another theme prevalent throughout our interviews indicated that the most prevalent fraud occurs in the areas of HCBS and non-emergency transportation. The overwhelming opinion was that these two areas, due in large part to the non-professional qualification requirements of the providers, were most susceptible to intentional fraudulent practices. While we agree that these areas are susceptible to such practices, we feel that no area of provider services is exempt from abusive activity. For example, we were informed that, since a Durable Medical Equipment (DME) provider is required to have a "store front" location in order to obtain licensing, the likelihood that fraudulent practices would occur is minimal. Our experience with Medicare DME providers is quite frankly the opposite. DME is considered to be a "ripe" area for fraudulent billing practices. The cost to equip and open a "store front" location is considered minimal compared to the rewards produced by fraudulent claims that can be billed through the Medicaid Program.

The Association of Insurance Special Investigative Units, at a recent regional meeting, reported another example of the attitude of those who would defraud insurance companies, Medicare, and Medicaid alike. A convicted felon reported how simple it is to enter a community, set up an MRI (Magnetic Resonance Imaging) center, and commence fraudulent billings. He explained that the cost to set-up an MRI center was "pocket change, only $500,000", and he was able to "recoup" that investment within the first three to four months through billings for phantom MRI services at "just under the radar screen" of detection technology. He used the MRI center as just an example of how easy it is to defraud carriers, state Medicaid systems,

and Medicare. This individual also indicated that his previous associates in crime were not identified or prosecuted at the time of his arrest. They are, he said, operating in every state in the Union, "bar none".

Other Observations

Transitional Systems and Activities

The State of Kansas SRS is currently in the process of replacing the Medicaid fiscal agent (BCBSKS) with a new contractor (yet to be determined) by mid-year of calendar year 2002. BCBSKS chose not to respond to the recent RFP. Consequently, BCBSKS is sustaining day-to-day operations while concurrently planning for the transition to the new contractor.

For at least the near term, BCBSKS' "lame duck" status looms over the potentially affected citizens of Topeka and must logically be having some level of negative operational impact on the employee base. This challenge is not only distracting to the BCBSKS SUR unit employees, but also consumes a great deal of management cadre energy within SRS who must devote time to planning, negotiations, and coordination of meetings during this protracted transition period.

During our audit activities, we reviewed the current contract specification with BCBSKS along with the proposed specification for the new contract in order to understand contractual expectations of SRS and BCBSKS and to compare/contrast the old methods for effectively managing the contract to the new way business will evolve over the next 12 to 24 months. As stated earlier in the findings, we were pleased that the RFP identified a comprehensive and robust set of advanced technology tools and processes to enhance Kansas' ability to detect and reduce Medicaid fraud and abuse. The new Fraud and Abuse Detection System (FADS), if implemented as specified, appears to have the proper standards, interfaces (e.g., between FADS and the MFCU) and functionality to replace and greatly enhance a SURS-type capability going forward. However, as we compared specific contractual management procedures, reviews and responsibilities, very little will change according to the new specification. The auditors see this as a potential "missed opportunity" unless these contract management performance gaps are evaluated, understood and fixed. Areas of focus should include:

- The effectiveness of communication loops between SUR Unit type activities and SRS (e.g., who does what with specific pieces of information; how are suggestions or report findings from the SUR Unit cataloged and tracked; how are informal task assignments from SRS conveyed, tracked and measured). Are there expectations and incentives for SRS management to take this information and continually look for ways to make SUR unit type operations more effective and efficient? It was not evident to the auditors.

- The employment of "balanced measures". *Meaningful* metrics, practices, methods and techniques should be developed and tracked based on a core set of strategic goals and values (e.g., customer satisfaction, employee satisfaction and business results). The review process for these balanced measures must be proactive and must consist of the right mix of managers, administrators and executives. It appears the current list of performance expectations in the RFP is almost entirely administrative and not crafted to spark innovative thinking or to achieve higher performance of fraud detection/prevention.

- How to better incite the contractor to detect and/or prevent Medicaid fraud and abuse. It appears their primary contractual motivation (both old contract and new) is to just process as many claims as possible. This metric is only one leg of a three-legged stool...

Unless the day-to-day management structure within SRS is tuned and bolstered, there is a high risk that the return on investment (ROI) envisioned by the employment of a new Medicaid fiscal agent to detect and manage Medicaid fraud and abuse may never be fully realized.

Educational Initiatives

We noted that the "Payment Accuracy Review of the Kansas Medical Assistance Program – Final Report" dated April 2000, as prepared by SRS, cited a significant number of rejected claims from HCBS providers. Such claims required reprocessing following attempts to obtain documentation. Accurate and complete submissions could theoretically yield significant cost savings (and/or cost avoidance) to the claims review and processing activities. The cost to the State of Kansas as charged by BCBSKS to process a claim through the KMMIS system amounts to $1.04 per claim. The potential savings could therefore be significant if the provider adheres to the policy of "getting it right the first time" and the cost of an enhanced customer/provider outreach, education, and marketing program (potentially structured under the new Medicaid fiscal agent contract) would be minimal while the return on investment would likely be very favorable. This recommendation should be an area of further analysis/consideration by SRS and adopted if deemed appropriate.

Chapter
4

Summary Conclusions

Kansas Medicaid Fraud and Abuse

At the beginning of this report, we were reminded that the Kansas Medicaid Program is second only to education in terms of State funding. The Program is not trivial by any stretch of the imagination. After reviewing the SRS oversight and management processes, the SUR unit operation, and the Attorney General's Office's Medicaid Fraud and Abuse Division, we feel that overall, the Program is maintaining at least a minimally acceptable level of performance, and in specific areas, exhibits certain above average business practices. However, it appears that much can still be done to strengthen Program effectiveness, efficiencies, and can ultimately achieve a much higher return on investment.

The State of Kansas is experiencing budgetary challenges similar to other states. Accordingly, the Kansas' Legislature's interest in processes within the State to control fraud and abuse within the Medicaid Program is heightened. The pending change in Medicaid fiscal agents provides a window of opportunity to bolster and refine the processes and raise performance standards and contractor management effectiveness, which will result in investment dollar savings.

Recommendations

A task of this magnitude should consider immediate actions to strengthen its commitment to program success and should leverage best-in-class management practices. The following are examples of actions, processes, and structure that could fill existing program management gaps:

- ***Appoint a strong advocate who will exercise "ownership" of meeting program goals. This person could be someone from either within SRS or outside of SRS by design (e.g., Inspector General's office or equivalent). This person would not necessarily need to be wrapped into all day-to-day operations; however, he or she would be held responsible for Program success and goal achievement. He/she could also act as the independent interface between the Attorney General's office and other organizations such as the Legislative Division of Post Audit***

- ***Strengthen communications channels between SRS and the SURS***

- ***Establish clear and quantifiable performance expectations and measurements jointly agreed upon between the Contractor and SRS***

- ***Ensure positive oversight of contractor activities***

- ***Structure leadership involvement to clearly articulate the goals of the Kansas Medicaid Program along with the associated customer benefits***
- ***Create and properly use incentives for the contractor to do more with less, suggest thoughtful and creative new processes, procedures, and customer facing features.***

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Appendix
A

Medicaid Cost Containment:

Controlling Fraud and Abuse

SCOPE STATEMENT

The Legislative Division of Post Audit provided the following 'Scope Statement':

Medicaid is a federal / State matching-funds program for preventive, primary, and acute health services for low-income individuals, children, and families. The Medical Policy / Medicaid Program is the third largest purchaser of health services in Kansas, after Medicare and Blue Cross / Blue Shield, and the single largest purchaser of children's health care services. For fiscal year 2001, the total Medicaid budget was $1.3 billion.

In addition to funding health care services, Medicaid is the major source of financing for other programs in Kansas. For example, more than $583 million was spent on long-term care programs for the elderly and disabled in fiscal year 2000. All services provided by the Medical Policy / Medicaid Program are financed through a combination of State and federal dollars under Title XIX (Medicaid) and Title XXI (State's Children's Insurance Program, or HealthWave).

Medicaid costs have risen sharply in recent years. For example, medical assistance costs rose from $544 million in fiscal year 1999 to an expected $730 million for fiscal year 2002, a 34% increase in four years. These increases have prompted legislative concern that Kansas is not doing all it could to contain Medicaid expenditures. Audits examining cost containment in the Program would focus on five key areas:

- Controlling growth in caseloads
- Controlling the types and cost of covered medical services (including mental health and substance abuse treatment)
- Controlling the provision of residential services (including nursing homes, hospitals, and group homes)
- Controlling fraud and abuse
- Controlling the cost of prescription drugs

An audit looking at fraud within the State's Medicaid Program would address the following questions:

1. **What does the State do to try to identify fraud within the Medicaid Program, and do those efforts appear to be reasonable and sufficient?** To answer this question, we would evaluate SRS and the Medicaid fiscal agent's system for identifying Medicaid-related fraud

against best practices and practices in other states. We would assess whether those systems appeared to be reasonably designed to identify potential fraud and whether sufficient resources have been devoted to these efforts, assess whether those systems actually were being followed, and determine what types of fraud or other problems these efforts were uncovering. We also would evaluate the adequacy of the State's efforts to recoup fraudulent payments. We would perform other test work as necessary.

2. **Do there appear to be significant instances of fraud within the State's Medicaid Program?** To help determine the types of things we could check for and the types of problems being found, we would review audit work or other reviews performed by SRS, various federal agencies, or other entities. We would work with the Department and Blue Cross / Blue Shield (the fiscal agent) to try to identify payments for Medicaid services that appeared to be unusual or "outliers", such as double billings for the same services, excessive levels or costs of services, unusual or uncommon services being provided to certain types of clients, billings by providers for more hours than there are in a day, and the like. We also would look at complaints or reports about potentially fraudulent activities. For a sample of these payments, we would review available documentation and interview relevant people to determine whether the payments appeared to be appropriate. We would perform test work as needed. (*Note: in this audit, we would not be able to look at a number of areas where Medicaid fraud could be occurring, such as providers billing for goods or services that weren't provided, billing for phantom patient visits, billing for medically unnecessary tests, or billing for supplies that weren't ordered or used.)*

Estimated time to complete: 12 – 14 weeks, depending on the availability of data

(Note: The present performance audit, awarded on November 1, 2001, was limited in scope to responding to question 1, only, with an estimated completion time of between 8 and 9 weeks)

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

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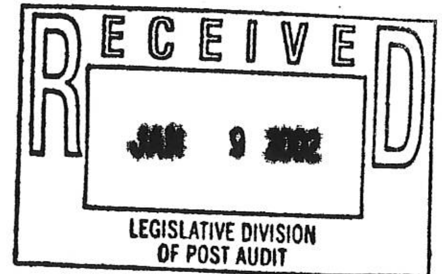
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LEGISLATIVE DIVISION OF POST AUDIT

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislature of Kansas Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, Kansas 66612-2212

Ms. Hinton:

RE: Legislative Post Audit Performance Audit Report, Medicaid Cost Containment: Controlling Fraud and Abuse

Thank you for the opportunity to respond to the draft report and recommendations of this report. Reviews such as these afford us the opportunity for critical self-assessment and the continuous improvement of our program.

The findings and recommendations of the report pose a philosophy that we are very much in agreement with. That is that fraud and abuse control should be based on a proactive approach, with sound performance standards and a regard for return on investment. The report challenges the Kansas Medicaid program to think broadly, to take little for granted in its utilization review efforts, and to demand performance from its Fiscal agent. It also proposes a broadening of the role for the Attorney General's Medicaid Fraud and Abuse unit. We take no exception with any of these perspectives.

One caution is in order however when considering Return on Investment (ROI). An accurate ROI can be hard to ascertain for a fraud and abuse program because of the inability to place a dollar value on the deterrent effect the existence of a SURS has on provider behavior.

We believe however, that due in part to the highly limited population interviewed for this assignment, that the perspective offered in this analysis is skewed. It offers a better recount of where Medicaid has been than where it is now or where it is headed. The report portrays the approach of the current fiscal agent SURS staff as passive, and briefly mentions the 'lame duck' status of Blue Cross, which is being replaced as the fiscal agent in six months time. Only in passing does the report mention the heightened expectations we have of the new fiscal agent through a more comprehensive Fraud and Abuse system to replace the current SURS system. SRS intends to fully take advantage of the opportunities offered by the change in Fiscal Agent.

Appendix B

Auditee Responses

State of Kansas

Office of the Attorney General

MEDICAID FRAUD AND ABUSE DIVISION

120 S.W. 10TH AVENUE, 2ND FLOOR, TOPEKA, KANSAS 66612-1597

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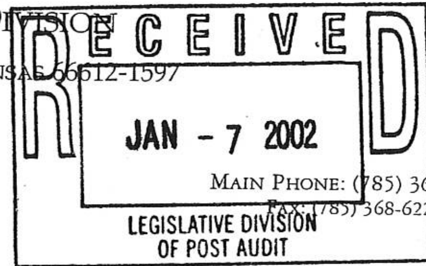


January 7, 2002

David C. Riley
Bland and Associates
8712 W Dodge Road Suite 200
Omaha , NE 68114

FAX: (402) 397-8649

Re: Draft Performance Audit Report

Dear Mr. Riley:

As we discussed I am sending you our responses to a few points in your draft report.

On pages 1,2,3, 20,21,& 22, the report correctly notes that there are limitations placed upon the Medicaid Fraud and Abuse Division by federal regulation concerning the ability to screen claims or analyze patterns of practice. As you know, this limitation is imposed upon all state Medicaid Fraud Control Units by the United States Department of Health and Human Services Office of Inspector General ("HHS/OIG"). State Medicaid Fraud Control Units are 75% funded by the federal government and subject to federal regulation. Pursuant to HHS/OIG regulation, the units are prohibited from attempting to "identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were received." 42 C.F.R. §1007.19(e)(2). This limitation is not the result of our interpretation of the regulation, rather, it is a mandate from the federal authority overseeing our funding.

As the enclosed letter from the General Counsel for the National Association of Medicaid Fraud Control Units makes clear, this limitation is not unique to Kansas.

Page 19 of your draft report also suggests that our division's fraud investigations are based solely upon complaints. It is more accurate to state that the majority of cases arises from complaints made by the public, providers or matters brought to our attention by the single state agency and the fiscal agent. As we discussed, however, rather than simply waiting for specific complaints, we actively monitor prosecutions by other states and federal agencies across the country. We also receive and review fraud alerts from the federal government. We then review available information to determine whether similar patterns of fraud exist in the Kansas Medicaid Program and pursue them accordingly.

More significantly, the report is most critical of SRS management and its support for the utilization review management function. While the report includes an organization chart, the auditors elected not to interview any of the utilization review manager's next three levels of management to ascertain what the strategic direction of the division was. Had they done so, they would have learned that much is already underway to shift toward the type of organization they envision:

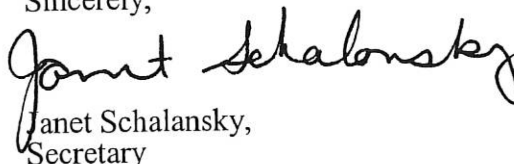
1) The decision to re-procure Medicaid Fiscal Agent services was based on the limitations and inflexibilities of the current MMIS system, and its impacts on staff's ability to perform their functions (including those of fraud and abuse management.) While the competitive RFP was being prepared, we utilized this opportunity to raise the expectations of the current SURS unit to a more modern and comprehensive approach of Fraud and Abuse Detection System (FADS). The report acknowledges that the FADS specified in our RFP should address many of the current concerns with the current utilization review approach.

2) The report suggests SRS initiate "better contractor management processes" (pg. 20). The Contracts and Fiscal Agent Operations section, which contains the utilization review function, has adopted as its new standard, a comprehensive Contract Administration Plan approach to planning and monitoring contractor performance. Formal certificate level training of staff through George Washington University has taken place within the last few months. This approach will undoubtedly strengthen the Division's capacity for holding the fiscal agent accountable for the higher expectations we hold in our recent RFP.

3) The report also suggests a greater emphasis be placed on being a "change agent" with more accountability for setting "specific performance expectations (pg. 20)." The Senior Manager of Contracts and Fiscal Agent Operations has already established a clear expectation of proactive management and accountability, by scheduling throughout 2002 monthly, two-hour planning sessions with each of the four sections, including Claims Management, for these specific purposes.

SRS Medicaid is receptive to several of the good suggestions offered by this report. We are willing to broaden our perspective and learn from our colleagues in other States about their approaches to controlling fraud and abuse. We will continue to support efforts at multi-state networking and collaboration toward this end. We can also learn much about statistical inference research techniques, as they apply in identifying potential fraud incidents. We can also learn from CMS about the types of performance measures other States are using to manage their programs. These initiatives, coupled with the efforts already underway in Kansas Medicaid, should ensure that SRS makes significant progress in satisfying the objectives of controlling Medicaid fraud and abuse in Kansas.

Sincerely,



Janet Schalansky,
Secretary

JS:RMD:dsw

cc: Robert M. Day, Ph.D.
SRS File Copy

On page 20 of your draft report, you state that the "average" recoupment from "four of nine"specific cases prosecuted amounted to just over $4,250. Using an average figure of recoveries does not fully reflect the functions and results of prosecutions. In fact, since the unit began, it has obtained restitution orders in criminal cases totaling over four million dollars. Your report also does not fully address the efforts of the division in recovering monies in multi-state settlements. To date, the division has participated in cases producing recoveries of over one and one half million dollars. Finally, the report does not address the potential civil recoupments identified by the Medicaid Fraud and Abuse Division. This category includes those cases that do not have a basis for criminal prosecution but a civil recovery is possible. Since the state of Kansas does not have a civil false claims act, we refer them to either the federal government or SRS. This figure was not tracked until last year. Since that time, the unit has referred cases for proposed recoupments totaling over $98,000.

Your report relies heavily upon the annual report submitted by the Medicaid Fraud and Abuse Division to the federal government for the 2000-2001 time frame. As we discussed, we do not suggest reliance upon that particular year because the Medicaid Fraud and Abuse Division lost nearly half of its personnel in a very short period of time due to attrition. In fact, since the time after that report the division has obtained restitution orders in criminal cases totaling over $40,000.

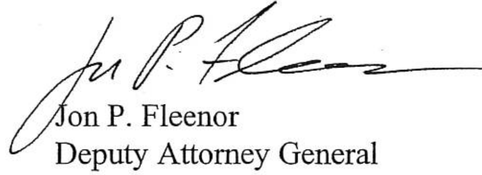
Page 20 of your draft report states that the division places an emphasis on cases involving abuse and neglect of patients in board and care facilities. However, the majority of open investigations and cases prosecuted by the division in fact are cases involving fraud. While we have seen an increase in complaints involving abuse and neglect they have not exceeded the number of cases of fraud being investigated. Further, we do not believe that resources used for investigating and prosecuting cases involving elderly victims, perhaps some of the most vulnerable citizens, is misplaced nor does it detract from our ability to pursue fraud investigations.

Based upon our conversations I believe you agree with these points, and the report is complimentary of our unit and staff. We believe that this additional information will assist you and provide a more specific context for your report and avoid possible misconceptions.

Thank you for your assistance. If you have any questions or need additional information, please feel free to contact me at anytime.

Sincerely,

OFFICE OF THE ATTORNEY GENERAL
CARLA J. STOVALL



Jon P. Fleenor
Deputy Attorney General

JPF:dw

cc: Randy Tongier
Audit Manager

NATIONAL ASSOCIATION OF Medicaid FRAUD CONTROL UNITS
750 FIRST STREET NE SUITE 1100
WASHINGTON, DC 20002
(202) 326-6020
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BARBARA L. ZELNER
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Pennsylvania Attorney General's Office

IMMEDIATE PAST PRESIDENT
ELLYN STERNFIELD
Assistant Attorney General
Director, MFCU
Oregon Attorney General's Office

January 4, 2002

David Riley
Bland and Associates
8712 W Dodge Road Suite 200
Omaha , NE 68114

Re: Performance Audit Report

Dear Mr. Riley:

The Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office has informed me about portions of your draft performance audit report about containing fraud and abuse in the Kansas Medicaid program. I am writing to provide some clarification concerning portions of that report.

The National Association of Medicaid Fraud Control Units (NAMFCU) represents the 48 state Medicaid Fraud Control Units, including the District of Columbia, that investigate and prosecute Medicaid provider fraud. The Kansas Medicaid Fraud and Abuse Division is a member and I am familiar with its activities. It adheres to the federal regulations that all Units must follow in order to receive 75% federal funding for its operating budget.

In the past, other states have been criticized for attempting to perform functions suggested in your draft report such as profiling providers or analyzing patterns of practice because such activities are prohibited by federal regulation. The federal regulations governing the MFCUs, 42 CFR Chap. V (Part 1007), make clear, federal funding is not available for Medicaid Fraud Control Units to make efforts to "identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with the recipients whether the services billed by providers were actually received..." 42C.F.R.1007.19(d)(3). The Office of Inspector General, U.S. Department of Health and Human Services, which has oversight for the MFCUs, has made this clear on several occasions in meetings with the states. States that attempt to perform such functions risk losing federal funding for those activities.

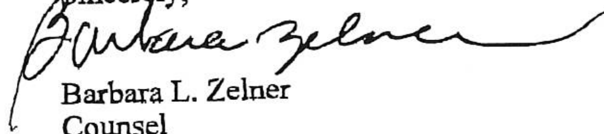
David Riley
January 4, 2002
Page 2

In addition, OIG issued a policy transmittal on MFCU detection activities in 1980, which is still in effect. This policy transmittal states that "efforts to identify situations in which a question of fraud may exist" are ineligible for FFP only if they are the usual and proper program monitoring function of the Medicaid agency (routine computer screening, routine desk review of patterns of practice of providers "flagged" by screens, etc.).

The activities outlined above and suggested in your draft report cannot be implemented by state Medicaid Fraud Control Units because they are functions of the single state agency that administers the Medicaid program.

I hope this information provides some clarification and assistance to you.

Sincerely,



Barbara L. Zelner
Counsel

cc: Jon P. Fleenor
Charles W. Gambrell, Jr.
President, National Association of Medicaid Fraud Control Units

Appendix C

References

Controlling Fraud and Abuse

"Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles", Malcolm Sparrow, Professor of Practice, John F. Kennedy School of Government

"Medicaid Managed Care Fraud and Abuse," Inspector General, June Gibbs Brown, Office of Inspector General, June 1999

"Let's Stop Medicaid Fraud," Attorney General, Charlie Condon, South Carolina Attorney General's Office, 1999

"Medicaid Fraud and Abuse Division Annual Report – 2000 – 2001", Office of the Kansas Attorney General, Carla J. Stovall

"Payment Accuracy Review of the Kansas Medical Assistance Program Annual Report – April 2000", Kansas Medical Policy Department, Social & Rehabilitation Services, Robert Day, Director, Lou Ann Gebhards, Utilization Review Manager, Becky Stauffer, Utilization Management Fiscal Agent

"State Health Facts *Online*", The Henry J. Kaiser Family Foundation

"United States Department of Health and Human Services, Catalog of Federal Domestic Assistance – CFDA 93.775: State Medicaid Fraud Control Units"

"Report to the Medicaid and Public Assistance Fraud Oversight Task Force for 2001", Texas Health and Human Services Commission

"Fraud in Medicare", Idea House

"The Goal of Program Integrity is to 'Pay it Right'", Medicare Medical Review Program

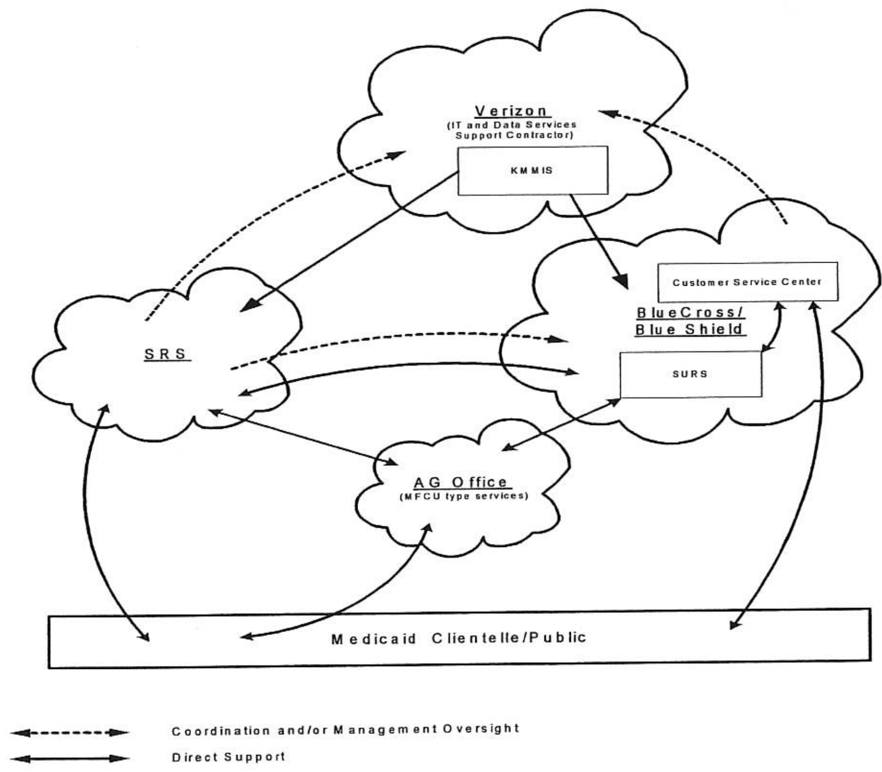
"Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program", Health and Human Services Commission and the Office of the Attorney General

"Medical Fraud Cost the Nation $100 Billion Annually", Project Censored - 1995

Appendix
D

Relationship Between Medicaid Control Elements

D1

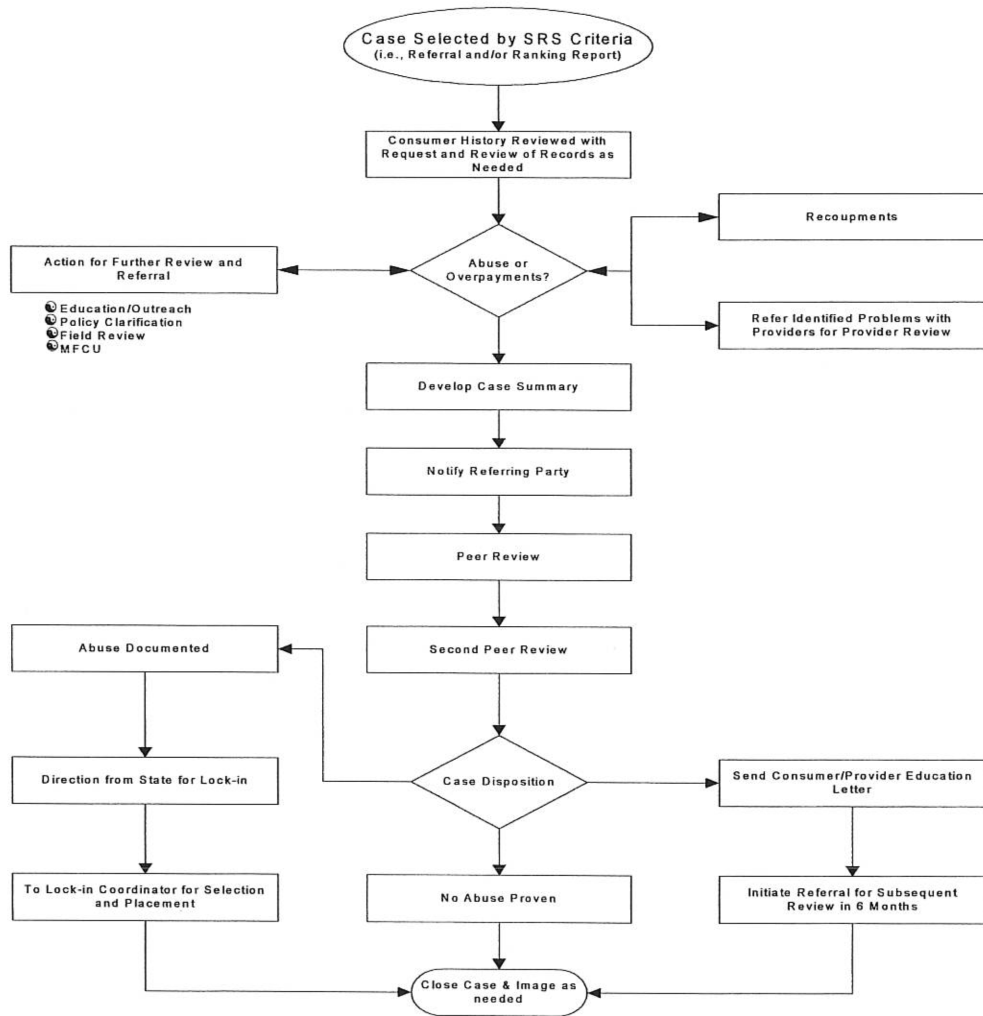


Coordination and/or Management Oversight
Direct Support

1-50

SURS Desk Review Process

D2



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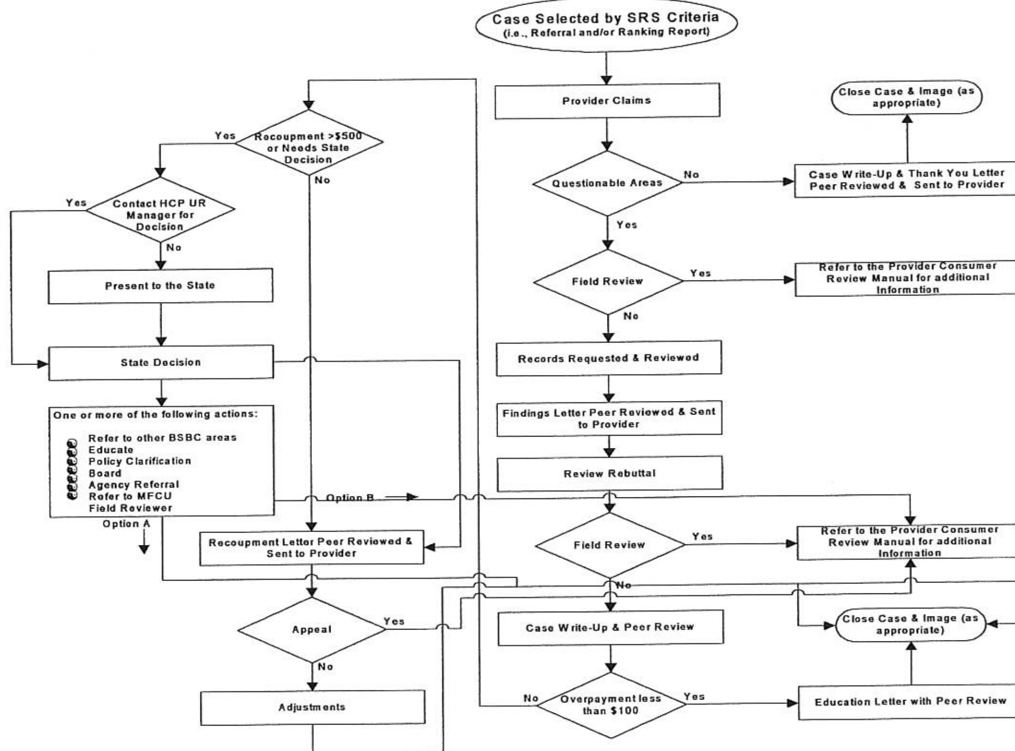
Provider Review Process

D3



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BLAND & associates

Appendix
E

Acknowledgements

Controlling Fraud and Abuse

Due to the short timeframe associated with this audit task, interviews, data collection, and analysis were often requested with little or no notice. We would like to thank everyone associated with SRS, BCBSKS (specifically the SUR unit employees), the Medicaid Fraud and Abuse Division of the Attorney General's Office, and the Legislative Division of Post Audit, who assisted in minimizing any negative operational impact during the audit process. We would like to specifically recognize the efforts of the following individuals for their assistance, personal involvement, candor, thoughtfulness, and overall cooperation during this performance audit:

State of Kansas Department of Social and Rehabilitation Services

Dr. Robert Day, Director of Health Care

Ms. LouAnn Gebhards, Utilization Review Manager

Kansas Attorney General's Office

Mr. Jon Fleenor, Director, Medicaid Fraud and Abuse Division

Blue Cross / Blue Shield of Kansas, Inc. – Medicaid Fiscal Agent

Ms. Sherry Kesel, Claims Processing

Ms. Sharon Anschutz, SUR unit data analyst

Ms. Lona Hoffsommer, Assistant Manager, Utilization Management

Kansas Legislative Division of Post Audit

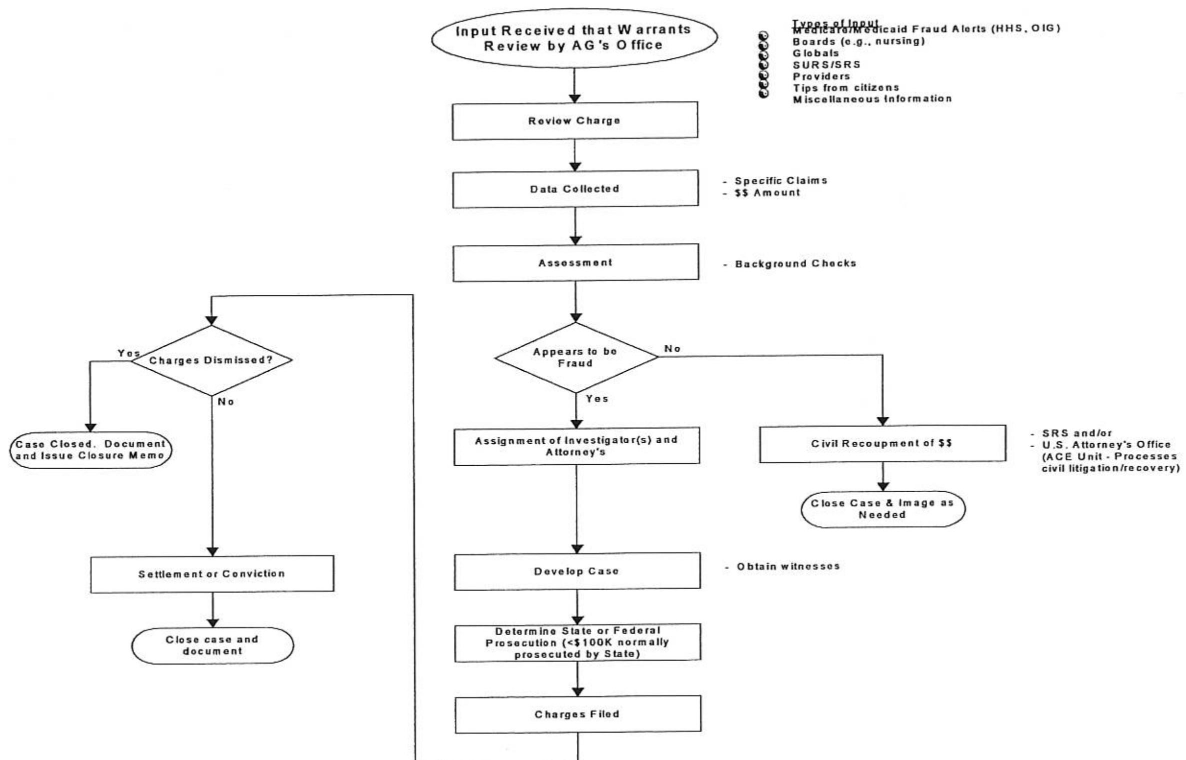
Ms. Barbara Hinton, Legislative Post Auditor

Ms. Cindy Lash, Audit Manager

BLAND & associates

MFCU Case Management Process

D4



1-53

Memorandum

TO: Committee on Appropriations
FROM: Jim Wilson, First Assistant Revisor
DATE: February 4, 2002
SUBJECT: HB2690 – **University Research and Development Enhancement Act**
Section 10 – Exemption from certain statutory provisions
PROPOSED REPLACEMENT SECTION

Generally, the proposed amendment would delete provisions that exempted the Architectural and Engineering Services Negotiating Procedures and related procedures. Also, the Professional Services Sunshine Act and the requirement for publication of notice in the Kansas Register would continue to apply.

The existing section 10 of 2002 HB 2690 would be deleted and be replaced by the following PROPOSED REPLACEMENT SECTION:

Sec. 10. The board of regents is exempt from the provisions of K.S.A. 75-1269, 75-3738 through 75-3741b, 75-3742 through 75-3744, 75-3776 through 75-3779, 75-3783, 75-3799 through 75-37,101, 75-37,103, 75-37-104, and 75-4101 through 75-4114, and amendments thereto, when acting under authority of this act. No contract entered into by the board of regents under authority of this act shall be subject to approval under any other statute. No fees charged by the department of administration, or any division or other unit thereof, other than fees charged for copies of documents provided by the department of administration, shall apply to any project or any purchase for a scientific research and development facility entered into by the board of regents under authority of this act.

The PROPOSED REPLACEMENT SECTION would EXEMPT the state board of regents when acting under the act from this list of statutory provisions:

K.S.A. 75-1269	Fees for architectural and other services provided by the secretary of administration for certain projects [1% fee]
K.S.A. 75-3738 thru 75-3741b	Division of Purchases - bidding, capital improvements, contract guidelines, restrictions procedures, change orders
K.S.A. 75-3742	Division of Architectural Services - assistance in preparing written program statements
K.S.A. 75-3743 and 75-3744	Leases, procurement contracts, Attorney General approval as to contract form; execution and other approvals
K.S.A. 75-3776 through 75-3779	Reorganization of Architectural Services [1978 act] -Transfer of powers, duties and functions to Secretary of Administration
K.S.A. 75-3783	Secretary of Administration to establish criteria and procedures

HOUSE APPROPRIATIONS
DATE 2/5/02
ATTACHMENT 2

	for evaluating the qualifications and performance of architectural, engineering and construction services contractors for state capital improvement projects; issue stop work orders; adopt standards for inspection of building projects and qualifications for inspectors; and establishing standards for planning, design and construction of and improvements to buildings for state agencies
K.S.A. 75-3799	Financial services for state agencies, negotiations
K.S.A. 75-37,100	Contracts for credit cards, negotiations
K.S.A. 75-37,101	Certificates of participation financing personal property
K.S.A. 75-37,103	Debarment of contractors by Secretary of Administration
K.S.A. 75-37,104	Prequalification of contractors in cooperation with the Director of Purchases
K.S.A. 75-4101 through 75-4114	Committee on Surety Bonds and Insurance, purchase of insurance for state agencies

TESTIMONY TO
HOUSE COMMITTTEE ON APPROPRIATIONS
BY JOE FRITTON, P.E.
DIRECTOR, DIVISION OF FACILITIES MANAGEMENT
February 5, 2002

Mr. Chairman and Members of the Committee,

Thank you for the opportunity for the Department of Administration to discuss HB 2690 with you. My name is Joe Fritton and I am the Director of the Division of Facilities Management. My Division is responsible for design, operations and maintenance of the facilities in the Capitol Complex and for providing administrative oversight of all state funded building construction projects in the State of Kansas.

This testimony is not intended to address the ultimate objective of the proposed legislation, which is to encourage the construction of research facilities. It is, however, intended to point out potential drawbacks to its methodology.

HB2690 exempts from Kansas statutes all current and future Board of Regents research building projects including new construction, remodeling and purchases. The reason given as justification for this exemption is that the statutes constitute a "decades old bureaucracy" that only serves to slow progress and add costs.

These statutes are laws passed by the Kansas Legislature and signed by a Governor with the intent of providing checks and balances to prevent the misappropriation of taxpayer dollars. These laws did and continue to serve a purpose. With these laws in place, the State of Kansas has had no scandals associated with building construction in the last 23 years.

The primary reason these statutes seem to be bureaucratic is that they were designed to facilitate the traditional method of construction used in the late 1970's: Design - Bid - Build. Since then other successful methods have been used to construct buildings: Design - Build and Construction Manager at Risk, which is currently being used on the Kansas Statehouse project. There are also many hybrids of the three methods. However, the statutes as written do not facilitate the use of any other method than Design - Bid - Build.

This shortcoming does not justify throwing out the statutes wholesale, but does justify updating the statutes to facilitate these new construction processes while ensuring taxpayer dollars are protected. Therefore, the Department of Administration would like to offer an amendment that provides a solution. This amendment is designed to provide a mechanism for streamlining the construction process while ensuring adequate checks and balances.

HOUSE APPROPRIATIONS
DATE 2/5/02
ATTACHMENT 3

However, before I offer the amendment, I would like to point out several portions of this bill that the committee may want to review.

Page 3. Lines 13 & 14. – The Board of Directors is chosen solely by the Board of Regents and there are no qualifications for appointment to the board.

Page 3. Lines 30 & 31; 42 & 43. – The Board of Regents is only required to advise and consult with the Joint Committee on State Building Construction, not receive its approval.

Page 7. Lines 16 to 26. – The current statute, K.S.A. 75-3741c which exempts state buildings from inspections by local governments, is not changed by this bill. Therefore, since the language under this bill exempts building inspections by the state, there is no requirement for code compliance or authority to enforce code compliance.

As I have testified before the Joint Committee on State Building Construction, when the state builds a building it owns the building forever. Because of this long-term commitment, a different model must be used when building a state facility than that used when building a strip mall or retail shopping center. With long-term ownership the costs of utilities and maintenance far outweigh the initial construction cost. Therefore, no shortcuts should be taken with design development, code compliance and life cycle costing.

Traditionally the Department of Administration has been tasked by the Kansas Legislature to oversee construction projects and to ensure these critical items are analyzed. A subsidiary corporation of the type proposed in this legislation may not provide the best oversight and accountability for the projects envisioned. We believe the legislature should take a careful look at the legal ramifications of creating a subsidiary corporation, responsible for making legal decisions for operations, maintenance and management oversight. Legal issues regarding liability and accountability remain unclear in the present bill draft. However, if you consider necessary the formation of a subsidiary corporation, we would offer adjusting the language with the following amendment:

Page 3. Line 14 to 17. Strike "shall be appointed by the Board of Regents. The board of directors of the subsidiary corporation shall be composed of not more than five members and shall not include more than two members who are members of the board of regents." and change to " *shall consist of five members. Two members shall be appointed by the Kansas Board of Regents. Two members shall be members of the Kansas Legislature with one appointed by the Senate President and one appointed by the Speaker of the House. One member shall be the Secretary of Administration or the Secretary's designee. All board members shall serve without compensation.*"

Page 7. Line 26. Add "*The Secretary of Administration when acting under the authority of this act has the authority to establish policies, procedures and requirements to ensure competitive bidding and to provide administrative oversight of building design,*

construction, and code compliance. All deviations from exempted statutes shall be presented to and approved by the Joint Committee on State Building Construction. The Secretary of Administration when acting under the authority of this act has the authority to recover the actual costs of services provided under this act."

The Department of Administration met yesterday with the Board of Regents' staff and believes that under this amendment, we can accommodate the Board's needs while preserving accountability to the taxpayer.

Mr. Chairman, I stand for questions.

thereto, in accordance with the procedures therein contained, to perform or to assist the board of regents in the performance of powers, duties and functions under this act. The subsidiary corporation shall be subject to the same restrictions and limitations as to the powers and purposes under this act to which the board of regents is subject. The board of regents may delegate any of its powers, obligations and duties under this act to the subsidiary corporation by inclusion of such powers, obligations and duties in the articles of incorporation of the subsidiary corporation. The subsidiary corporation so formed shall constitute a legal entity separate and distinct from the board of regents and the state. The board of regents shall not be liable for the debts or obligations or for any actions or inactions of its subsidiary corporation unless the board of regents expressly agrees otherwise in writing. The board of directors of the subsidiary corporation ~~shall be appointed by the board of regents. The board of directors of the subsidiary corporation shall be composed of not more than five members and shall not include more than two persons who are members of the board of regents~~ [inserted: shall consist of five members. Two members shall be appointed by the Kansas Board of Regents. Two members shall be members of the Kansas Legislature with one appointed by the Senate President and one appointed by the Speaker of the House. One member shall be the Secretary of Administration or the Secretary's designee. All board members shall serve without compensation.]. The state, any municipality or any state commission, public authority, agency, officer, department, board or division authorized and empowered to enter into agreements with, to grant, convey, lease or otherwise transfer any property to, or to otherwise transact business with the board of regents, shall have the same authorization and power to engage in these activities with the subsidiary corporation of the board of regents.

Sec. 6. (a) The board of regents is authorized to acquire, construct and equip scientific research and development facilities on state-owned property of the board of regents or any state educational institution for purposes of scientific research from any moneys of the board of regents available therefor, except that no such scientific research and development facilities shall be acquired, constructed or equipped and no moneys shall be expended therefor unless the board of regents has first advised and consulted with the joint committee on state building construction regarding the proposed scientific research and development facilities and on each capital improvement project proposed therefor. The scientific research and development facilities shall become the property of the state upon completion and acceptance by the board of regents.

(b) The board of regents is authorized to initiate and complete capital improvement projects to repair, remodel or renovate state buildings and facilities of the state educational institutions for use as scientific research and development facilities from any moneys of the board of regents, except that no such capital improvement project for such repair, remodeling or renovation shall be initiated unless the board of regents has first advised and consulted with the joint committee on state building construction regarding the proposed scientific research and development facilities

1 Sec. 8. Purchases by the board of regents relating to scientific re-
2 search and development facilities shall not be subject to sales tax under
3 K.S.A. 79-3601 et seq., and amendments thereto, or use tax under K.S.A.
4 79-3701 et seq., and amendments thereto.
5 Sec. 9. This act shall be liberally construed. Except as otherwise ex-
6 pressly provided, nothing contained in this act is or shall be construed as
7 a restriction or limitation upon any powers which the board of regents or
8 the Kansas development finance authority might otherwise have under
9 other law of this state, and the provisions of this act are cumulative to
10 such powers. The provisions of this act do and shall be construed to
11 provide a complete, additional and alternative method for the doing of
12 the things authorized and shall be regarded as supplemental and addi-
13 tional to any other laws. Insofar as the provisions of this act are inconsis-
14 tent with the provisions of any other law, general, specific or local, the
15 provisions of this act shall be controlling.
16 Sec. 10. The board of regents is exempt from the provisions of K.S.A.
17 75-430a, 75-1250 through 75-1270, 75-3738 through 75-3741b, 75-3742
18 through 75-3744, 75-3776 through 75-3789, 75-3799 through 75-37,104,
19 75-4101 through 75-4114, and 75-5801 through 75-5807 and amend-
20 ments thereto, and K.S.A. 2001 Supp. 75-37,130 through 75-37,132, and
21 amendments thereto, when acting under authority of this act. No contract
22 entered into by the board of regents under authority of this act shall be
23 subject to approval under any other statute. No bidding, notice, award,
24 negotiation or other procurement procedures under any other statute
25 shall apply to any contracts or negotiations entered into by the board of
26 regents under authority of this act.
27 Sec. 11. If any provision of this act or any application thereof is held
28 invalid, the invalidity shall not affect other provisions or applications of
29 the act which can be given effect without the invalid provision or appli-
30 cation, and to this end the provisions of this act are severable.
31 Sec. 12. This act shall take effect and be in force from and after its
32 publication in the Kansas register.

The Secretary of Administration when acting under the authority of this act has the authority to establish policies, procedures and requirements to ensure competitive bidding and to provide administrative oversight of building design, construction, and code compliance. All deviations from exempted statutes shall be presented to and approved by the Joint Committee on State Building Construction. The Secretary of Administration when acting under the authority of this act has the authority to recover the actual costs of services provided under this act.

3-5

BILL GRAVES
Governor

JOYCE H. GLASSCOCK
Acting Secretary of Administration
1000 SW Jackson, Suite 500
Topeka, KS 66612-1300
(785) 296-3011
FAX (785) 296-2702

DEPARTMENT OF ADMINISTRATION

January 29, 2002

Representative Kenny Wilk
Chairman, House Committee on Appropriations
State Capitol, Room 514-S
Topeka, KS 66612

RE: *HB 2690 – a bill concerning R&D facilities at regents institutions*

Dear Chairman Wilk:

Tomorrow afternoon I am scheduled to meet with Eric King and Warren Corman to discuss some middle ground on a variety of issues regarding architectural services provided to the Regents by the Department of Administration (DofA).

A primary subject of that discussion will be Section 10 of HB 2690. As you know, Section 10 removes the construction of these R&D facilities from statutes pertaining to code compliance. These statutes constitute a history of law approved by both the legislative and executive branches and were enacted to prevent misappropriation of taxpayer dollars and ensure building safety. However, under this legislation, meeting these life and safety code requirements is not mandated.

I'd like to offer the Regents staff some options that may help resolve some of the stated concerns about Section 10 put forth today by the engineers, architects and contractor organizations.

My hope would be to return from that meeting with the Regents and be able to help construct an amendment that would address some of these issues. If possible, we would try to have something to you by Friday morning.

Let me know if you have any questions of DofA regarding these issues. Thanks for your help!

Sincerely,

Joyce

Joyce H. Glasscock
Acting Secretary