Approved: 03-13-03
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on February 13, 2002 in Room 231-N, of the Capitol.

All members were present except: Senator Jordan (EA)
Senator Brungardt (EA)
Ms. Emalene Correll, Kansas Legislative Research Department (EA)

Committee staff present:
Ms. Lisa Montgomery, Revisor of Statute's Office
Ms. Margaret Cianciarulo, Administrative Assistant

Conferees appearing before the committee: Mr. Robert Day, Director of Medical Services/Medicaid for SRS

Others attending: See attached guest list

Response to Legislative Post Audit - Medicaid Fraud and Abuse Audit

Chairperson Wagle opened the meeting by announcing to the Committee that Mr. Robert Day, Director of Medical Services/Medicaid for SRS was here to respond to testimony provided by Mr. Riley on the Legislative Post Audit regarding medicaid fraud and abuse.

Mr. Day stated while popular culture would say that up to 10% of all medical claims are fraudulent, there is, to the best of his departments knowledge, no real data to support such a statement. He provided some statistics and facts, stating that their goal is to maintain an acceptable level of payment accuracy by developing cost avoidance and pay-and-chase. He stated that every claim filed with the program is sent through a series of over 800 pre-payment electronic edits meeting a minimum criteria of acceptability.

He spoke of the Surveillance and Utilization Reviews (SURS) staff contracted at Blue Cross and Blue Shield, and their review of claims and also a second review which determined an accuracy rate of 84%. When discounting errors due to absent documentation, the rate rose to 96%, which does not mean 4% fraud. He cited examples of errors that existed: a date discrepancy, incorrect or other insurance or inappropriate DRG.

He covered the process they use when they have reason to suspect that a provider may be billing in a fraudulent manner and provided a table comparing Kansas' recovery with neighboring states. Finally, he announced all of the changes they will be making with the new MMIS contract awarded to Electronic data Systems, replacing the current contract with state of the art information technology. A copy of his testimony is (Attachment 1) attached hereto and incorporated into the Minutes by reference.

Chairperson Wagle then asked for comments or questions from the Committee. A healthy discussion ensued with questions from Senators Brungardt, Praeger, Barnett, Salmans, and Jordan for Mr. Day ranging from if front loaded why is out recovery rate is so high, why isn't the claims process more user friendly, "store fronts", medicare beneficiaries to comments on change of contract with BCBS.

Adjournment

As there was no further business, the meeting was adjourned. The time was 2:15 p.m.

The next meeting is scheduled for February 14, 2002.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

37 in att.

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GUEST LIST

DATE: Wed. 2-13-02

NAME	REPRESENTING
Dale Blomquist	Kansas Care Inc. (Salina)
Linda Lubensky	KS Home Care Assoc.
Mary Lou Alison	CPAAA Harvey Co.
Kathy Hannemann	CPAAA Harvey Co.
Marvin H. Ewert	CPAAA - Harvey Co.
Scott Brunner	DOB
Brenda Career	Caring Hearts of Wichita
Jason Moore	KPhA - KU School of Pharmacy
Gina McDonald	KACIL
Jay J. Arnold	Coalition For Independence
Shannon Jones	SILCK
Matt Bergman	Pat Hubbell Assoc.
Stephanie Wood	PPA
[illegible]	[illegible]
Chip Wheelen	Osteopathic Association
Rick Gottlieb	Health Midwest
Julie Thein	Hein + Weir
Cheryl Dillard	Mid America Health
Denise Desch	Medicaid Fraud Control Unit
Jamie Ann Rowen	KAHP
Chris Collins	KMS
Tom Bell	KHA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: 2-13-02 cont'd

NAME	REPRESENTING
Natalie Bufkin	Via Christi
Mary Ellen Conlee	Via Christi

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
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Senate Public Health and Welfare Committee, Room 231-N
February 13, 2002 at 1:30 p.m.

Response to LPA - Medicaid Fraud and Abuse Audit

Health Care Policy
Robert Day, Director of Medical Services/Medicaid
785.296.3773

Senate Public Health & Welfare Committee
Date: February 13, 2002
Attachment 1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Public Health and Welfare Committee
February 13, 2002 at 1:30 p.m.

Response to LPA - Medicaid Fraud and Abuse Audit

Senator Wagle and members of the committee, I am Robert Day, Director of Medical Policy/Medicaid in the Health Care Policy Division of SRS. I appreciate this opportunity to respond to the testimony provided by Mr. Riley regarding fraud and abuse detection in the Kansas Medicaid program.

First I want to be clear that we do not take lightly the possible issue of providers fraudulently filing claims. Providers convicted of health care fraud suffer extreme consequences which can decimate their practice and take their livelihood. Termination from the Medicaid program generally results in exclusion from all federally funded health care programs, including Medicare.

However, I think a more balanced and fact-based assessment is in order. While the popular culture would tell us that up to 10 percent of all medical claims are fraudulent there is to the best of our knowledge no real data to support such a statement. The 10 percent figure cited by Mr. Riley is more myth than fact. So let's put some numbers and facts to this story.

The Kansas Medicaid Program processes nearly 12,000,000 claims annually. It has over 19,000 providers. These providers encompass physicians, pharmacists, hospitals, community service providers and a plethora of other provider types. Our goal is to assure that claims are paid appropriately and in a timely fashion. By appropriately, I mean that we maintain an acceptable level of payment accuracy of which detecting fraud and abuse is but part. There are two approaches to this, the first is to develop methods that avoid unnecessary payments, referred to as cost avoidance, the second and more time consuming involves what is referred to as pay and chase, trying to recover monies that have been inappropriately paid.

Every claim that is filed with the program is sent through a series of over 800 pre-payment electronic edits to assure that the claim meets a minimum criteria of acceptability. Examples of these edits are: assuring the beneficiary and provider are enrolled in the program, checking to make sure the claim is not a duplicate already filed, that the codes for services are acceptable and relate to diagnosis, and perhaps most importantly that there is no other insurance payment source since Medicaid is a payor of last resort. These edits guarantee that the claim meets a minimal standard of acceptability.

Approximately 20% of all claims are rejected and returned to the provider as not meeting the appropriate standard. The vast majority of these returned claims simply lack correct information

to allow for the Medicaid Management Information System, MMIS, to electronically review the information. This front end process allows us to cost avoid a number of potentially inappropriate claims.

The Surveillance and Utilization Review (SURS) staff contracted at Blue Cross and Blue Shield, our current fiscal agent, review claims on both a random basis and on the basis of specific referrals. It has been their experience that reviews based on referrals have been the most productive and cost effective method of assuring payment accuracy. Reviews of claims is by and large a labor intensive process requiring staff to pour over the actual medical records to assure the appropriateness of the claims.

Kansas recently conducted a second review of claims payment accuracy and determined an accuracy rate of 84%. When we discounted errors due to absent documentation, the rate rose to 96%. This does not mean that 4% of the claims were fraudulent. Rather, it means that there existed some problem such as units of service differing from what was billed, a date discrepancy, incorrect other insurance or inappropriate DRG. In addition to the SUR reviews Kansas contracts with Kansas Foundation for Medical Care (KFMC) to review inpatient hospital claims. KFMC reviewed over 50% of the nearly 40,000 hospital claims in the last fiscal year.

When we have reason to suspect that a provider may be billing in a fraudulent manner, the referral process to the Medicaid Fraud Control Unit (MFCU) begins. This suspicion generally arises through the SURS review process, or through a consumer or provider complaint. Staff then attempt to gather documentation to support this suspicion and forward this in a referral to the MFCU. We may obtain further verification through medical professional consulting services or through a presentation to our Peer Education and Resource Council (PERC - a group of practitioners which serves in an advisory capacity to the Medicaid program).

Mr. Riley noted that if he were to grade the efforts of the Kansas medicaid program he would give it a D+. I would suggest that if he were to grade us on a curve, comparing us to similar states, we would receive a much higher grade. The table below compares Kansas' recovery with the neighboring states of Nebraska, Iowa, Missouri and also Oregon, a state known for inventive approaches to health care cost containment. As you can see our recovery rate totaled over seven million dollars during the most recent fiscal year.

State Recoveries *

	Kansas	**Iowa**	**Missouri**	**Nebraska**	**Oregon**
SURS	$7.7 mill.**	$500,000	N/R	$420,000	$1.2 mill.
MFCU	$1.1 mill***	374,000	$845,311	7,322****	$530,000

* Measurement time period is the most recently completed state fiscal year for SURS and the federal reporting year for Medicaid Fraud Control Units (MFCU).
** Includes recoveries from hospital in-patient reviews by KFMC - $6.4 mill.
*** This number is an annual average based on total recoveries since the unit began in October, 1995.
**** Nebraska has no MFCU but investigates Medicaid fraud through a state task force involving FBI, Nebraska Bureau of Investigation, U. S. Dept. of Health and Human Services Office of Inspector General, and county prosecutors.
N/R - No report as of the date this was prepared.

I do not want to leave the committee with the impression that we do not intend to do even more to improve our payment accuracy including improving our fraud and abuse detection. We have recently announced the awarding of a new MMIS contract to Electronic Data Systems, EDS. This contract will replace our current MMIS with state of the art information technology. A key component of this system is the acquisition of a Fraud and Abuse Detection System or FADS which will replace our current system. The FADS is a dynamic and adaptive system which can create its own algorithms based on claims history. This fuzzy logic model means that the FADS will be able to detect abnormalities in claims history and to better profile providers and beneficiaries. We will be one of a handful of states to have this system.

In addition to the new information system we are assigning an additional staff to assist the claims manager in assuring payment accuracy. Finally, the Senior Manager of Contracts and Fiscal Agent Operations will be applying a rigorous Contract Administration Plan approach to the new fiscal agent as well as working with the claims review staff to set specific targets designed to improve payment accuracy. These actions are part of a continuing focus we are placing on strengthening our approach to contract monitoring and developing more meaningful management tools. We believe we have taken many of the appropriate steps to recognizing and addressing the issue of Medicaid fraud and abuse in Kansas.