Approved:
Date 2-11-03

MINUTES OF THE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

The meeting was called to order by Chairperson Senator Ruth Teichman at 9:30 a.m. on February 4, 2003 in Room 234-N of the Capitol.

All members were present except:Senators Adkins and Corbin, excused

Committee staff present: Ken Wilke, Office of the Revisor of Statutes
Dr. Bill Wolff, Kansas Legislative Research Department
Marlene Putnam, Committee Secretary

Conferees appearing before the committee:Robert Day: Director of Medical Policy, SRS
Joy Wheeler, President FirstGuard Health Plan

Others attending: See attached list

Senator Barnett opened the meeting by introducing Robert Day, Director of Medical Policy/Medicaid in the Health Care Policy Division of SRS.

Mr. Day talked about what SRS does do to prevent fraud and abuse. The calim that 10% of all medical claims are fraudulent has no data to support this statement. The 10% figure relates to perhaps as much as 10% of all medical claims are inaccurate. Such as: Incorrect service codes, diagnosis, date of service, or even incorrect dollar charge.

Mr. Day reported the figures of claims processed (see attachment 1) reporting that 87% are submitted electronically, and never require human intervention.

He reported that Medicaid is the payor of last resort. If the claim can be paid from other sources, such as Medicare or other insurance, the audit will reveal this.

It was also revealed that a new system called FAD (Fraud Abuse Detection System) will be on line in October. It contains an excellent Fraud Abuse Detection System.

Senator Teichman introduced Joy Wheeler, President of FirstGuard Health Plan.
She reported that HealthWave now has a total membership of 90,000. This has been phenomenal growth and the program has been highly successful.
Ms Wheeler reviewed major aspects of the Kansas operations (See attachment 2)

A question and answer session followed.

Meeting adjourned.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST

DATE: _____

NAME	REPRESENTING
Lanie Ann Lower	KAHP
Joann Bentley	KID
Jamel Lebeda	KID
John Peterson	Ks Governmental Consultg
Jay Brock	KAHP
Robert Day	SRS
Mike Heim	First Guard
Jim Byrnes	Senator Salmans Office
L Murdie	Legislative Post Audit
Amber Kjellsmus	Sen. Pete Brungardt's Intern
Ernest Kutzley	AARP
Ernie Pogge	
Tom Bruno	EDS
Jennifer Crow	Governor's office
Shelly May	DD Council
Bill Sneed	HIAA
Kevin BARON	Hein Law firm
Kerie J Bacon	KCDC
Marika Gabehart	KCDC
Jennifer Bernardy	KACIL
Susan Mahoney	SSC
Robert Choromanski	KTLA
Tanya Daft	SRS
Brent Wideck	SRS
Stan Clarke	Senate
John L Patterson	KC
Barb Hinton	Post Audit
Carolyn McGinnis	Ks St Dr Assn

Kansas Department of Bob Day

Social and Rehabilitation Services

Janet Schalansky, Secretary

Senate Financial Institutions and Insurance Committee

February 4, 2003

Medicaid Fraud

Division of Health Care Policy

Robert Day, Director of Medical Policy/Medicaid

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Senate F I & I Committee
Meeting Date: 2-4-03
Attachment No.: 1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Financial Institutions and Insurance Committee
February 4, 2003

Medicaid Fraud

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 address payment accuracy in the Kansas Medicaid program.

Overview

First, I want to be clear that we do not take lightly the 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 other federally funded health care programs as well, including Medicare.

While the popular culture would tell us that up to 10% of all medical claims are fraudulent, there are, to the best of our knowledge, no real data to support such a statement. So let me put some numbers and facts to this story. The 10% figure often referred to relates to a theory that perhaps as much as 10% of all medical claims are inaccurate. Examples of inaccurate information are incorrect service codes or incorrect diagnosis, mistakes in date of service or even incorrect dollar charge. In a few cases, issues of fraud and abuse arise when a service was billed but not actually delivered.

SRS through the Fiscal Agent, processes claims for the Medical Assistance Program (which includes all Medicaid services). In FY 2002 the Medicaid Management Information System (MMIS) received almost 13.4 million claims from over 20,000 providers. These providers encompass physicians, pharmacists, hospitals, community service providers and a plethora of other provider types. In all, 10.7 million claims were adjudicated, resulting in payments totaling over $1.4 billion. The bulk of claims (87%) are submitted electronically and never require human intervention during the entire computer processing and payment cycle. These claims cover a vast array of services or supplies provided to thousands of eligible beneficiaries, including inpatient and outpatient hospital, skilled nursing facility, home health, hospice, physician, laboratory, and other services and supplies, durable medical equipment, designated therapy, and host of other medically necessary services.

Claim data for FY 2002

Number of Claims Received	Number of Claims Paid
13,392,245	10,701,209

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 approach involves what is referred to as "pay and chase," trying to recover monies that have been inappropriately paid.

Cost Avoidance

Every claim that is filed with the program is sent through a series of over 800 prepayments electronic edits to assure that the claim meets a minimum criteria of acceptability. Examples of these edits are: checking to assure appropriate prior authorization for certain services is in place, 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. Approximately $14 million is saved by these system edits. Perhaps the most significant cost avoidance process is assuring that there is no other insurance payment source for that beneficiary. Medicaid is after all the payer of last resort. To put this in perspective, in FY 2002, Kansas netted a cost avoidance savings of over $337 million. This figure is including cost avoidance savings generated from Medicare being primary payer.

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 MMIS, to electronically review the information. This front end process allows us to cost avoid a number of potentially inappropriate claims.

Utilization Management

The Surveillance and Utilization Review (SURS) staff contracted at EDS, 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 from SRS staff, consumers, and providers have been the most productive and cost-effective method of assuring payment accuracy. Reviewing 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.

In 2002, Kansas conducted a second review of claims payment accuracy for the Medicaid program. When we discounted errors due to absent documentation, we determined an accuracy

rate of 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 Diagnosis Related Grouping (DRG). While the reliability of the payment accuracy review sample was statistically valid, the large variance presents significant avenues for interpretation. In addition to the SUR reviews Kansas contracts with Kansas Foundation for Medical Care (KFMC) to review inpatient hospital claims. KFMC reviewed over 61% of the nearly 36,000 hospital claims in the 2002 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) in the Kansas Attorney General's Office begins. This suspicion generally arises through the SURS review process, or through a consumer or provider complaint. SURS 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).

Utilization Management

SRS has utilization management oversight for the Medicaid program. These efforts include costs recovered (post-payment billing to insurers) and costs avoided (claims denial through the use of system edits/audits or prior authorization). SRS has continued to enhance efforts in this area, as evidenced by the totals for the following years:

Year	Costs Recovered	Costs Avoided	Grand Total
2000	$9,499,390	$6,518,373	$16,017,763
2001	$7,703,015	$9,488,786	$17,191,801
2002	$6,860,541	$14,710,512	$21,571,053

These figures do not include any Medicare cost avoidance, as a result of Medicare being primary coverage.

Other Prevention Efforts

We are in the process of replacing 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 in real time, abnormalities in claims history and to better profile providers and beneficiaries. We will be one of a handful of states to have this system. FADS and other efforts by SRS are important in developing the programs and systems that discourage and help prevent fraud.

State staff and Fiscal Agent staff have spent considerable time in design meetings to identify FADS requirements as well as requirements for the Decision Support System (DSS). While the specification of these requirements is nearly complete, this functionality will not be available until the new system goes into place in October 2003. The new FADS will allow greater levels of decision support and a more flexible approach to identifying any unusual patterns of utilization and/or billing. We expect to be able to provide a meaningful report on the impact of the new FADS or DSS systems by spring of 2004.

In the meantime, on October 22, we held a planning retreat with the SURS staff of the new fiscal agent (EDS) to refocus priorities and to target specific review billing methods that have already been identified as problematic. These reviews will be conducted between now and the new system implementation. The timing of the transfer of fiscal agent activities from Blue Cross to EDS - which took place July 1, 2002 - limited our ability to conduct this activity until this fall. As a result of this meeting we have focused our efforts on specific areas. For example, we have revised the policy for the medical transportation program to allow for a more effective means of providing services to beneficiaries. We will continue to focus reviews on those provider groups who have demonstrated a higher than average billing error rate.

To augment the new information system, we have assigned 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.

There are a number of initiatives that are underway, or planned in addition to the existing safeguards that SRS and MMIS have historically relied upon. These initiatives are scheduled for implementation in late 2003. (For examples, see Attachment A)

Additionally, SRS' Medicaid program was audited in December 2002 by Berberich Trahan & Co., P.A., a CPA firm contracted to perform this federally mandated audit. The result of the audit strongly suggests that SRS and EDS (the fiscal agent) are processing claims through the MMIS appropriately and accurately. This is evidenced by the fact that the only finding from the audit was the lack of a standard accounting report. As this report is unable to be produced by the current MMIS, this finding was to be expected. The RFP for the replacement MMIS (being designed and implemented by EDS) contains the requirement for this report to be compiled by the fiscal agent, and SRS will be compliant after October 2003.

Thank you, again, for your time and interest in this matter.

Attachment A

Payment accuracy in context

Paying claims accurately at first seems to be a relatively straightforward concept. Providers should receive payment appropriate to the service they provide. It is in the examination of what is appropriate that a highly complex set of checks and balances is necessary. Verification is needed to ensure such things as: the eligibility of the beneficiary; that the provider is enrolled in Medicaid and is willing to accept our payment terms and conditions; whether the required prior authorization has been obtained for certain procedures to substantiate their medical necessity; and that the supporting documentation is proper and complete, to name only a few of the checkpoints a claim must pass through to be paid. All of the correct documentation should be presented in the claim. Even when the claim adjudicates for full payment, recoveries may still be warranted, if third parties share liability for payment, or if a prior agreement for drug rebates apply. So payment accuracy becomes a much more complex concept than it first appears.

System Edits

The claims pricing and adjudication function edits, audits, and processes claims in accordance with the policies, procedures and benefit limitations of the Kansas Medical Assistance Program. This function includes the clerical, electronic and computerized operations necessary to receive, approve or deny, and pay Medicaid claims. The claims verification process performs functions such as input conversion, beneficiary editing, provider and reference file editing, medical policy auditing, control series, and history updating. There is a daily-generated report identifying by claims status codes, claims to be paid, denied, or suspended. The claims pricing and adjudication procedures are batch oriented processes centered around a multi-step claims processing cycle.

Managing the Medical Assistance Program is a continuous balancing act, in which the demands for increased program integrity must be carefully weighed against the medical needs of the consumer. To accomplish the processing and payment of Medicaid claims, SRS uses the MMIS, which is operated and maintained by the Fiscal Agent. The system is one of the country's largest automated claims payment systems, and has hundreds of pre-payment edits and safeguards. It also monitors providers and consumers alike in a post-payment mode to detect unusual patterns of billing or utilization. SRS has historically relied on a variety of pre- and post-payment claims review activities to protect the Medical Assistance Program from abuse. These activities include:

1. Pre-payment claims editing (both automated and manual review) - A wide range of automated edits and audits are employed to identify and reject inappropriate billings or to reduce payments for upcoding, billing errors, or payment policy violations. While a precise estimate of the savings resulting from these edits/audits is not available, they are believed to prevent hundreds of millions of dollars per year in payment for inappropriate services. In addition, up to 20 percent of services are suspended each week and reviewed manually by fiscal agent staff.

2. Pre- and Post-payment medical necessity review of certain high-cost hospital stays -

Savings in excess of $2 million result annually from the Department's effort to ensure that payments are made for only medically necessary inpatient hospital admissions and days of care, inpatient and outpatient observation services. Specifically, SRS and its fiscal agent medical review staff, and other contracted staff examine the following: (1) all inpatient psychiatric care provided to children, adolescents and adults; (2) inpatient care billed with diagnosis codes, which on post-pay review, have historically exhibited high nurse referral rates, indicating questionable admissions or lengths of stay; and (3) a random sample of paid inpatient and outpatient services.

3. Prior Authorization for many pharmaceuticals, medical equipment items, and medical supplies - Prior Authorization (PA) reduces the utilization of unnecessary or inappropriate medications, supplies, equipment or services. Through the use of professional medical staff, PA requests are reviewed, evaluated, and approved. The PA process was established in the early 1990's to require a mandatory advance approval for the use of expensive medications, medical equipment, supplies and care provided by Home Health Agencies. These requests are to be used in lieu of hospitalization to maintain a patient on an outpatient basis or to prevent a higher level of care.

4. Prospective (pre-payment) and Retrospective (post-payment) Drug Utilization Review (DUR) - SRS designed and implemented an electronic, point-of-sale (POS) system for submitting prescription drug claims in November 1996. POS processing allowed for the implementation of prospective drug use review (Kansas has had retroDUR in place since 1970). ProDUR edits prevent inappropriate drug utilization and screen clients for potential drug therapy problems such as therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect dosage or duration problems and possible clinical abuse/misuse.

   RetroDUR review examines all patient services (hospital, physician, clinic, etc., as well as drugs) over time using predetermined medical standards and reports on potentially inappropriate health outcomes for follow-up. Some providers might receive educational interventions as part of this follow-up. While specific savings for RetroDUR are not available, a wide body of literature suggests that these programs significantly reduce health care utilization.

5. Consumer Monitoring and Restriction for Overutilization and Fraudulent Behavior (Lock-in) - The Lock-In program restricts consumers to a physician and pharmacy case managers and in some case also an outpatient hospital to provide appropriate utilization of medical services. A consumer may be a candidate for Lock-In when his or her profile identifies multiple physician visits, excessive pharmaceutical services, excessive emergency room services or fraudulent behavior which may constitute abuse or be a quality of care issue. Fraudulent behavior is also referred to the SRS Legal Department for further action. Many consumers correct their abusive behavior after education. When they do not and overutilization has been determined, restriction is warranted. The

consumer is placed in the Lock-In program for an initial two-year period. After the first year in the program, the consumer may request to have one or all of their case managers changed. This requested assignment would last for the remaining of their initial period.

Toward the end of the two-year period, a review is conducted and the consumer can be removed from the Lock-In program or placed on extended Lock-In. Extended Lock-In lasts as long as the consumer receives a medical card. Consumers removed from the Lock-In program are reviewed in six to twelve months later to determine if the abusive behavior revived. Consumers can only receive medical care from their case managers unless they have received a referral, the services are emergencies or the consumer is admitted to an inpatient hospital. The program not only improves the quality of care our consumers receive but also saves the State through cost avoidance for the 241 restricted consumers.

SAS 70 Report

The American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards No. 70, *Service Organizations* (SAS 70) contains the professional standards for auditors to report on the controls of a service organization. As this report is unable to be produced by the current MMIS, this finding was to be expected.

Joy Wheeler

Testimony Presented Tuesday, February 4, 2003,
to the Senate Financial Institution and Insurance Committee
for the State of Kansas

Madam Chair and Members of the committee my name is Joy Wheeler. I am the President of FirstGuard Health Plan and am pleased to provide this testimony.

FirstGuard Health Plan is a seven year old managed health care company with an HMO license in both Missouri and Kansas. FirstGuard was established in 1995 by Swope Parkway Health Center when Missouri began to privatize its Medicaid health care system. Swope Parkway is a Federally Qualified Community Health Center serving the underserved of greater Kansas City for over thirty years. As of this date, FirstGuard serves a total of 138,000 members in its two companies. FirstGuard Health Plan in Missouri serves 48,000 members in a nine county service area.

FirstGuard Health Plan established a Kansas licensed HMO and took over management of Horizon Health Plan in May 1999. An asset purchase agreement was completed the following year. When FirstGuard took over Horizon Health Plan, membership in Title 19, (Primecare) was 22,400 and Title 21 (HealthWave) was 6,900 for a total of 29,300 members. Today, membership in the blended Title 19 and Title 21 product called HealthWave is at a total membership of 90,000; Title 19 has 60,000 members and Title 21 is at 30,000 members. FirstGuard's membership over three years has increased 168% in Title 19 and 334% in Title 21, for a total of 201%

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increase in the combined HealthWave program. This has been phenomenal growth and the program has been highly successful. I am particularly proud of the positive relationships that have been developed between FirstGuard Health Plan and committed parties including; Kansas Medical Society, the Governor and Legislators, SRS and the Kansas Department of Insurance.

I will now review major aspects of our Kansas operations.

FirstGuard has continued to pursue expansion of the provider network throughout the State of Kansas. Our primary goal continues to be a seamless network for Title 19 and Title 21 and we are almost there. Today, we have 1,352 Title 19 and 1,409 Title 21 Primary Care Physicians. Specialist physicians are 2,710 in Title 19 and 2,691 in Title 21. Hospitals are at 154 for Title 19 and 154 for Title 21.

We continue to diligently serve our provider network; fifty-seven meetings were conducted in forty-one locations during the last quarter of 2002. This is the fourth year we conducted these provider education meetings we refer to as "Roadshows". A total of 1165 practice managers, office managers, and physician office employees attended one of these meetings. We are pleased with the growing usage of our Web-site, which allows the providers to readily access helpful information. In many instances, this easy access prevents the need to make a telephone call to our office. Web-site log-ins have steadily increased and as of year-end 2002,

provider log-ins averaged nearly 14,000 per month (an increase of 17% in the last six months of the year). FirstGuard has continued to meet its claims payment service standard and pays paper claims within 24 days. Electronic claims are paid within 5 days, for an overall average of 21 days.

FirstGuard Health Plan conducted an extensive RFP process in the Spring 2002 to pursue one PBM (Pharmacy Benefits Manager) to serve all FirstGuard membership. This resulted in the transition of Kansas membership from Merck-Medco to Express Scripts. This transition occurred on July 1, 2002.

FirstGuard Health Plan has a participating retail pharmacy in all 100 Kansas counties that have a retail pharmacy. The other 5 counties in Kansas do not have a pharmacy. Some independent rural pharmacies have been able to negotiate higher than traditional reimbursement rates, if their exclusion would significantly impact member access, exceeding 20 miles one way. Currently, there are no significant issues regarding pharmacy access. Additionally, to our knowledge there are no major issues with access to services delivered by Doral Dental or the Mental Health Consortium, which are the carve-out vendors.

FirstGuard Health Plan continues to provide all new members with a welcome call. This call gives us an opportunity to determine that members have received their ID cards and packets and we review basic information on how the program works. During this call a

simple health assessment is conducted and any information gathered regarding a medical condition or pregnancy is forwarded to a case management nurse. We educate the member on how to reach us for assistance. FirstGuard has a Customer Care representative on call for 24-hour coverage seven days a week. Our Customer Care staff is provided tools to assist members and providers and is empowered to make decisions. When needed, this staff is also supported for medically related issues by a Care Management Nurse and by FirstGuard's Medical Director. We provide health-related education to our members via the health topic of the month. Additionally, a member newsletter is mailed twice each year. Customer Care representatives access an extensive network of transportation providers throughout the state to arrange transportation to and from providers and even for prescription pick-up.

FirstGuard's care management team coordinates members' medical and health care needs. Prior notification is required for a specific list of services. FirstGuard is committed to a care management model focusing on the appropriate management of chronic diseases, cancer, and pregnancy. High-risk pregnancy and low birth weight babies are a significant issue in the Healthwave population. The Guardian Angel program provides extensive oversight throughout the course of pregnancy. The EPSDT, well child, and immunization outreach program begins at birth with reminder letters sent to members and providers at all EPSDT periodicity points.

Asthma is a major medical issue throughout the state and FirstGuard's Asthma Disease Management program provides members with a proactive, patient focused program utilizing clinical guidelines from the National Heart Lung Blood Institute. We continue to administer the Asthma Disease Management Program but will be modifying its quality initiative this year to increase use of inhaled steroids consistent with most recent clinical research data findings and national recommendations.

FirstGuard coordinates with the state in providing appropriate care to special needs kids when referrals to in-network specialists are required. There are occasions when care is arranged by our care management team for out-of-network, to include out of state providers. When necessary, FirstGuard utilizes PPO networks that are available through its reinsurance carrier. FirstGuard is working collaboratively with SRS and the KDHE on several quality and cost containment initiatives including the Preferred Drug Formulary, Special Needs Children Program and the Childhood Lead Program.

FirstGuard Health Plan has continued coverage of additional over the counter drugs when the States were required to reduce that benefit significantly. We believe continued access to many of these medications is important to avoid the cost of inappropriate and unnecessary ER visits for minor illnesses and conditions, particularly in children. Some examples include; cough, cold and

fever medicines, vitamins including pre-natal, Claritin, and electrolyte replacement.

FirstGuard's patient satisfaction survey results for 2002 exceeded the national average. The results for HealthWave 19 are as follows and these numbers reflect the percentage of members who rated the Plan as excellent or very good: children population 78.7%, adult population 64% and Children with Special Needs population 76.2%. The results for HealthWave 21 are as follows: children population 79.8% and Children with Special Needs 79.2%. The satisfaction survey is conducted annually.

I am very pleased to represent FirstGuard Health Plan and provide this report to you. It is rewarding to look back and see how far we have come. There are no major operational challenges at this time but rather concern for the state budgets as the eligible population increases and health care cost trends continue to rise. I must express great appreciation for Kansas physicians and hospitals who continue to serve the HealthWave membership despite extremely low reimbursement rates. I commit to you that FirstGuard Health Plan will continue to work with you to meet the needs of the underserved.

Thank You.

I am happy to respond to any questions.