Approved: 02/12/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on January 14, 2009, in Room 136-N of the Capitol. Senator Barnett introduced Lauren Leif, an intern from Emporia State University studying political science.

All members were present.

Committee staff present:
Jan Lunn, Committee Assistant
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes

Conferees appearing before the committee:
Levi Bowles, Kansas Department of Health
Dr. Andy Allison, Kansas Health Policy Authority
Jerry Slaughter, Kansas Medical Society

Others attending:
See attached list.

Sky Westerlund, representing the Kansas Chapter of National Social Workers, was recognized by Chairman Barnett. Ms. Westerlund requested the conceptual introduction of legislation that would add six hours of continuing education credit to social workers applying for licensure renewal. Upon a motion by Senator Brungardt to move introduction, and a second by Senator Schmidt; the motion carried.

Senator Schmidt moved introduction of a bill concerning the board of pharmacy; relating to fingerprinting and criminal history record checks; regulating pharmacy technicians; terms and membership of the board; and amending and repealing various sections of existing sections. Senator Kelsey seconded the motion; the motion carried.

Senator Barnett introduced a bill concerning expressions of apology, sympathy, compassion or benevolent acts by health care providers. Senator Barnett communicated that the bill was brought forward by Cynthia Smith, representing the Sisters of Charity of Leavenworth Health System. Senator Kelly moved introduction of the bill; Senator Brungardt seconded the motion. The motion passed.

Chairman Barnett introduced Mr. Levi Bowles, from the Legislative Post Audit Office, who distributed a handout relative to the audit of "Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse" (Attachment 1). Mr. Bowles described "data mining techniques" were used to identify potential Medicaid problems. Data mining involves using statistical and non-statistical data analysis techniques to identify unusual claims which could be problematic. The key findings of the audit included more than 10,000 clients whose income appeared to exceed program limits; 266 clients who provided no valid Social Security number received approximately $700,000 in claims; some doctors may have "up-coded" office and emergency room visits at a higher level of service than provided; almost $435,000 in non-hospital claims were paid for beneficiaries who were hospitalized at the time the service was provided; there were 31 instances when a beneficiary received 20 or more dental services in a single day; and 415 clients whose date of death had not been recorded in the system and were still eligible for services. Estimated savings potential resulting from the audit was $3.1 million per year. Recommendations included that the Health Policy Authority develop systems to compare Medicaid beneficiaries to income and death certificate data, work with contractors and other agencies to review and improve system edits, and review of systems for detecting suspicious claims.

Following Mr. Bowles testimony, Senator Brungardt inquired whether errors were reviewed for simple typographical/data keying errors. Mr. Bowles indicated that type of review had not been performed. Senator Schmidt questioned whether any in-depth review had been done relative to up-coding problems. She provided an example of a child going to the pediatrician for a well-check, and the physician being asked to evaluate a secondary medical condition which might have resulted in up-coding. Mr. Bowles

replied that no medical records were reviewed. Senator Colyer inquired relative to beneficiaries without a Social Security number and whether that problem was on the client or the provider side. Mr. Bowles indicated the problem appeared to be on the client side. Senator Colyer also asked Mr. Bowles whether the potential for "under-coding" had been examined. Mr. Bowles indicated nothing related to "under-coding" was examined. Senator Kelly asked how the $3.1 million in yearly savings was calculated; Mr. Bowles replied that other analyses were reviewed and consideration was given to how much could likely be recouped with some margin for error included. Senator Kelly inquired about the reasoning for selecting three specialties for the audit, and whether sub-specialists were audited. Mr. Bowles replied that general practitioners, internists, and pediatricians were selected because they comprise the greatest share of physicians, and that sub-specialists were not included in the audit.

Chairman Barnett recognized Dr. Andy Allison from the Kansas Health Policy Authority. Dr. Allison presented written testimony (Attachment 2) indicating the audit analyzed claims paid between October 1, 2005 and September 30, 2006, which included approximately $2 billion worth of paid claims. Dr. Allison concurred with the LPA office in that data mining processes are designed to identify unusual patterns in large data sets to increase the likelihood of finding fraud and abuse. The value of this process significantly narrows the search for fraud and abuse. Dr. Allison indicated the majority of the audit period was prior to the time the KHPA assumed responsibility for Medicaid. Dr. Allison reviewed those recommendations on which the KHPA concurred and on those recommendations on which the Kansas Health Policy disagreed. Dr. Allison provided detailed testimony relative to KHPA's actions on recommendations from the Legislative Post Audit Review.

Jerry Slaughter, Executive Director of the Kansas Medical Society, testified relative to the Legislative Post Audit Report. However, Mr. Slaughter strongly disagreed with the analysis, and his testimony is attached (Attachment 3). He urged legislators to view the audit critically; he indicated that the up-coding conclusions were not supported by the audit's findings and methodology. Without examining any medical records associated with the claims in their study and/or without examining underlying diagnoses, it is impossible to judge appropriateness of a billing code. Mr. Slaughter elaborated on the absence of any medical expertise on the audit staff.

Senator Barnett thanked all conferees for their testimony, and he adjourned the meeting at 2:22pm. The next meeting is scheduled for Tuesday, January 20, 2009.

Senate Public Health and Welfare
Guest List
Date: 1-14-09

Cynthia Smith	SCL Health System
Levi Banks	Post Audit
Patrick Vagelsberg	Kearney and Assoc.
Dave Rahney	KHI News Service
Berend Koops	Hein Law Firm
Robin Meyer	KHPA
Sky Westerlund	KNASW
Stephanie Buchanan	CMS
Connie Hancock	KAMC
Suzanne Cleveland	KHI
Rachel Katnic	SRS
Bobbi Mariani	SRS
Michelle Stevens	Capitol Strategies
Kelly DiRocco	Little Gov Relations
Travis Love	Pinegar, Smith, & Assoc.
Anne Nugent	KHI
Colin Thomasset	ACMHCK
Barb Conrad	KDOA
Marty Kennedy	KDOA
Scott Frank	Leg. Post Audit
Anne Spiess	American Cancer Society
Dave Heinz	NCS

Legislative Post Audit
Performance Audit
Report Highlights

Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse

Highlights

Report Highlights

December 2008 • 08CC02

Audit Concern

The Legislative Post Audit Committee has directed us to use "data mining" techniques to search for potential fraud, abuse, and non-compliance in various areas of State spending.

Key Facts & Findings

- *More than 10,000 clients whose income appeared to exceed program limits received more than $10 million in claims.*
- *266 clients who didn't provide a valid Social Security number received almost $700,000 in claims.*
- *Doctors may have "upcoded" some office and emergency room visits at a higher level of service than they provided, costing Medicaid almost $600,000.*
- *Almost $435,000 in non-hospital claims were paid for clients who were hospitalized at the time the service was provided.*

(Continued on other side)

Estimated Potential Cost Savings as a Result of This Audit:

$3.1 million per year

AUDIT QUESTION 1: Do There Appear To Be Significant Instances of Fraud, Abuse, or Non-Compliance Within the State's Medicaid Expenditures?

AUDIT ANSWER:

- We found a total of almost $13 million in suspicious Medicaid claims for federal fiscal year 2006.
- More than $11 million of the problematic claims involved clients whose income appeared to exceed program limits while they were receiving benefits, or who hadn't provided a valid Social Security number.
- We identified more than $1 million in suspicious claims submitted by providers, including potentially "upcoded" office and emergency room visits, and claims for non-hospital services when a client was hospitalized.
- We identified 519 clients who received more than $600,000 in prescriptions for controlled substances from five or more doctors in one year, which may be indicative of potential abuse.
- The potential savings to the State if these questionable claims were all found to be inappropriate would be about $3 million.

We Recommended

- The Health Policy Authority should develop systems to compare Medicaid clients to income and death certificate data to identify ineligible or deceased clients.
- The Authority should work with its contractors and other agencies to review and improve system edits.
- The Authority should review its systems for detecting suspicious claims, and consider if those systems could be enhanced by incorporating the techniques used in our analyses.

Agency Response: In general, the Authority agreed with the report and our final recommendations.

Public Health and Welfare
Date: 01/14/09
Attachment:

- *There were 31 instances where a client received 20 or more fillings, crowns, or root canals in a single day, resulting in more than $55,000 in claims.*

- *415 clients whose date of death hadn't been recorded in the system still were listed as eligible for benefits.*

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Barbara J. Hinton,
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DO YOU HAVE AN IDEA FOR IMPROVED GOVERNMENT EFFICIENCY OR COST SAVINGS?

If you have an idea to share with us, send it to ideas@lpa.ks.gov, or write to us at the address shown. We will pass along the best ones to the Legislative Post Audit Committee.

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the Medicaid Program

Medicaid is a joint State and federal program that provides health care to the needy. *The Kansas Health Policy Authority is the primary State agency responsible for administering the Kansas' Medicaid program. In that role, the Authority also is responsible for overseeing two major contractors that process Medicaid eligibility and claims data. Two other State agencies also play significant roles in administering specific areas of the Medicaid program: the Department of Social and Rehabilitation Services (SRS) which is responsible for mental health and substance abuse services as well as several community-based long-term care programs, and the Department on Aging which is responsible for long-term care services for the elderly.*

..... page 3

The Kansas Medicaid Program spends more than $2 billion annually on healthcare for Kansans. *About 60% of Medicaid funding comes from the federal government and the remaining 40% from State dollars. The total expenditures for fiscal year 2008 were almost $2.4 billion including almost $1.0 billion in State dollars.*

..... page 3

Question: Do There Appear to be Significant Instances of Fraud, Abuse, or Non-Compliance Within the State's Medicaid Expenditures?

We used data-mining techniques to identify potential problems with Medicaid claims. *This data mining project uses statistical and non-statistical data analysis techniques to identify unusual claims that are more likely to be indicative of fraud or abuse. While data mining helps narrow our scope to claims that are more likely to be problematic, it doesn't allow us to draw any conclusions about claims that aren't in our analysis. That means we can't say whether the transactions we didn't look at do or don't have problems.*

..... page 5

Our analyses found almost $13 million in suspicious Medicaid claims for federal fiscal year 2006. *We analyzed Medicaid claims and client data that the Kansas Health Policy Authority submits annually to the federal Department of Health and Human Services. For this audit, we used data from federal fiscal year 2006 (October 1, 2005 to September 30, 2006), the most recent year available. Overall, we found almost $13 million in suspicious claims. The two largest categories of potential problems we found were income eligibility ($10 million) and invalid Social Security numbers ($679,000). Because about 60% of Medicaid dollars comes from federal funds, at most the State would only be able realize 40% of any potential savings.*

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This audit was conducted by Levi Bowles. Scott Frank was the audit manager. If you need any additional information about the audit's findings, please contact Levi Bowles 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.

Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse

The Kansas Health Policy Authority was created by the 2005 Legislature, and became a State agency on July 1, 2006. Its purpose was to develop and maintain a coordinated health policy agenda that combined effective purchasing and administration with health-promotion-oriented public health strategies. As part of that mission, the Authority is responsible for the administration of several large health care programs. For this audit we focused on one of those programs, the State's Medicaid program.

The Medicaid program specifically had $2.4 billion in expenditures in fiscal year 2008. The program is a federal/State matching-funds program for preventive, primary, and acute health services for low-income individuals, children, and families.

As part of the ongoing compliance and control audit work authorized by the Legislative Post Audit Committee to address the risk of fraud and abuse, Legislative Post Audit conducted audit work reviewing Medicaid claims, providers and clients for fraud, abuse, or non-compliance.

This performance audit answers the following question:

Do there appear to be significant instances of fraud, abuse, or non-compliance within the State's Medicaid expenditures?

As approved by the Legislative Post Audit Committee, we applied "data mining" audit techniques to this area. These techniques make use of modern technology—both hardware and software—to increase the likelihood of finding fraud and abuse if it exists. Compared to traditional audit approaches, data mining allows us to:

- Analyze entire groups of transactions, budget categories, etc., instead of just samples.
- Identify specific transactions or situations more likely to be fraudulent or abusive, and focus the audit effort on those items.
- Compare large data sets belonging to different agencies or divisions that normally wouldn't be compared.

While no audit approach can guarantee that existing fraud and abuse will be found, this audit approach increases that likelihood.

A copy of the scope statement for this audit is included in ***Appendix A.***

Government auditing standards set forth by the U.S. Government Accountability Office require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We conducted this performance audit in accordance with these standards with certain exceptions. Specifically, we didn't directly test the reliability of the Medicaid, income, or death certificate data used in this report.

Our primary evidence, the Medicaid data, have been reviewed for accuracy by the federal Department of Health and Human Services, as part of its auditing process. As a result, we feel that it's unlikely that the data are grossly or systematically wrong.

The income data are compiled by the Department of Labor. We conducted only preliminary testing to determine if these data are stable over time, but believe they generally are reliable for our purpose, which was to show that there are clients who earn more income than is allowed by program guidelines.

The death certificate data are compiled by the Department of Health and Environment. Based on our preliminary testing of these data, we found errors in the Social Security numbers for many records. As a result, we only used these data to identify clients where we could match results on three factors: Social Security number, first name, and last name. Because the probability of a false match on all three of these factors is extremely low, we feel that these data are reliable enough for the way in which we used them.

Overall, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our findings begin on page 5, following a brief overview.

Overview of the Medicaid Program

Medicaid Is a Joint State And Federal Program That Provides Health Care to the Needy

Created in 1965 under Title XIX of the Social Security Act, Medicaid is a joint state and federal program that provides long-term care and health care coverage for low-income families with children, the disabled, and the elderly. The program is administered at the State-level, with funding matched by the federal government. In Kansas, the matching rate is approximately 60%, which means the State pays 40% of all joint expenditures.

The Kansas Health Policy Authority is the primary agency responsible for administering the Medicaid program. The Authority was created by the 2005 Legislature to develop and maintain a coordinated health policy for the State. In addition to the Medicaid program, the Authority is responsible for several other State-funded health insurance programs, such as the State Employees Health Plan, the State Self Insurance Fund, Medikan, and the State Children's Health Insurance Program (SCHIP).

As the State Medicaid agency, the Authority oversees two major contractors that process Medicaid data—MAXIMUS and EDS. MAXIMUS processes and maintains most SCHIP eligibility applications and provides administrative support for Medicaid eligibility applications for low income families, pregnant women and children.

In addition to the Authority, two other State agencies play a secondary role in administering the Medicaid program. The Department of Social and Rehabilitation Services (SRS) oversees Medicaid mental health and substance abuse services as well as several Medicaid waiver programs for community-based long-term care, including programs for the developmentally disabled and the physically disabled. The Department on Aging administers long-term care services for the aged, including the frail elderly community-based waiver program and nursing home services.

The Kansas Medicaid Program Spends More Than $2 Billion Dollars Annually On Healthcare For Kansans

As mentioned above, about 60% of Medicaid funding comes from the federal government, and about 40% from the State. The total expenditures for fiscal year 2008 were about $2.4 billion including both State and federal dollars. The program's revenues and expenditures are summarized in the ***At-a-Glance*** box on page 4.

Kansas Medicaid Program
AT A GLANCE

Authority: Originally created by Title XIX of the 1965 Federal Social Security Act, Medicaid provides health benefits to eligible clients.

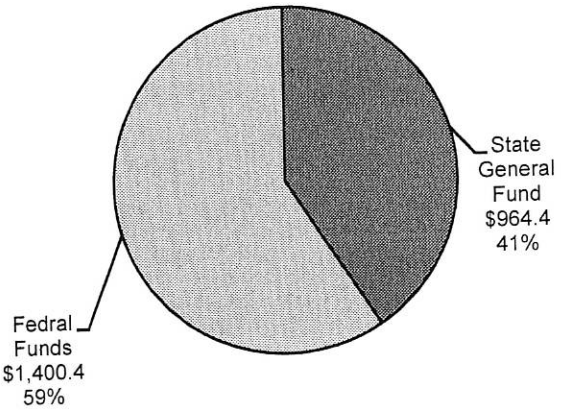
Staffing: The Medicaid/HealthWave Division is overseen by the Kansas Health Policy Authority. The Division manages Medicaid, SCHIP and other medical programs. The Division has 64 FTE, with an additional 38 FTE at its application processing clearinghouse, for a total of 102 FTE.

Budget: A joint Federal and State program, Medicaid's medical services are funded 40% with State funding and 60% federal funding.

FY 2008 Expenditures

Type		Amount	% of Total
Managed Care (Includes Pace, PAHP,PIHP, PCCM)	$	581,503,333	25%
Home & Community Based Services	$	460,253,719	19%
Adult Care Homes (Includes Nursing Facilities)	$	370,448,295	16%
Inpatient Hospital	$	330,978,818	14%
Pharmacy	$	160,431,377	7%
Non-Client Specific Dollars	$	109,526,311	5%
Other Medical Services	$	351,612,180	15%
Total Expenditures:	**$**	**2,364,754,033**	**100%**

Sources of Funding for Expenditures
(in millions)



Total Funding: $ 2,364,754,033

Source: Budget and expenditure data provided by the Kansas Health Policy Authority.

Do There Appear to be Significant Instances of Fraud, Abuse, or Non-Compliance Within the State's Medicaid Expenditures?

ANSWER IN BRIEF:	*Using data-mining techniques we found almost $13 million in suspicious Medicaid claims for federal fiscal year 2006 (the most recent year for which complete data were available to analyze). The suspicious claims included: more than $10 million in claims for more than 10,000 clients whose income appeared to exceed program limits; almost $700,000 in claims for clients who didn't provide a valid Social Security number, almost $600,000 in potential "upcoding" by doctors for office and emergency room visits, and almost $500,000 in other suspicious claims such as claims filed for deceased individuals and charges for non-hospital services when a client was hospitalized. In addition, we identified 519 clients who received prescriptions for controlled substances, such as heavy painkillers and powerful stimulants, from five or more doctors in one year, which may be indicative of potential abuse. These and other findings are discussed in more detail in the sections that follow.*

We Used Data Mining Techniques To Identify Potential Problems With Medicaid Claims

As part of Legislative Post Audit's ongoing compliance and control work, we reviewed State Medicaid data using data mining techniques. Using these techniques, we can efficiently analyze all of the State's Medicaid claims for a given time period.

Data mining involves using statistical and non-statistical data analysis techniques to identify unusual claims that may be more likely to be problematic. Data mining allows us to identify unusual patterns in large data sets that we could not identify with traditional audit methods. It also allows us to bring various State data sets together to check for irregularities or potential problems between the data sets. An example of data mining from a previous audit report is comparing the State's personnel database to State's accounting database to identify instances where State employees may have engaged in self dealing.

While data mining helps narrow our analysis to claims that are more likely to be problematic, it doesn't allow us to draw any conclusions about other claims. Auditors use two primary methods to select financial records for review. Each method has its own purpose, as described below:

- **Auditors select a <u>representative</u> sample when they want to use the sample records to draw conclusions about all records.** The records in a representative sample are selected randomly so they end up looking like a smaller version of the population. As a result, whatever the auditor finds for the sample—such as the amount of fraud or abuse—can be projected back to the entire population.

- **Auditors target specific records because they believe those records are more likely to represent something specific such as fraud, abuse, waste, or noncompliance.** The records in a targeted sample aren't selected randomly. Rather, they're more likely to be what the auditors are looking for. For example, if we are looking for self dealing in State financial transactions, we would look only at transactions that match certain data from State employees such as addresses and names. Because this targeting method only looks at things that are suspicious, the results aren't necessarily representative of the entire population and the auditors' findings can't be projected.

Because data mining is a technique used to look for transactions that are more likely to be problematic, we end up targeting transactions that don't look like the rest of the population. Therefore, what we found (or didn't find) in this audit doesn't necessarily represent the rest of what's out there.

Our Analyses Found Almost $13 Million In Suspicious Medicaid Claims In Federal Fiscal Year 2006

We analyzed Medicaid claims and client data that the Kansas Health Policy Authority submits annually to the federal Department of Health and Human Services. The Authority provided data from federal fiscal year 2006 (October 1, 2005 to September 30, 2006), which was the most recent year available at the time we began this audit. As shown in ***Figure 1-1***, there were more than $2 billion in Medicaid claims billed for more than 330,000 clients in federal fiscal year 2006.

Figure 1-1
Summary of Kansas Medicaid Statistics
Federal Fiscal Year 2006

Clients	
Clients who were eligible for services	360,126
Clients who received services	330,651
Claims	
Claims paid by Medicaid (##)	18,353,632
Claims paid by Medicaid ($$)	$ 2,004,962,807

Source: Medicaid eligiblity and claims data provided by the Kansas Health Policy Authority.

Using our data mining techniques, we looked for and found suspicious Medicaid claims in the following areas:

- clients whose income exceeded the program's eligibility requirements
- clients who didn't provide a valid Social Security number
- overlapping claims for services delivered in the community and in a hospital on the same day
- clients who received prescriptions for powerful painkillers and other controlled substances from five or more doctors

- providers who charged an excessive share of office or emergency room visits at more expensive levels of service (also known as "upcoding")
- claims that were paid for services rendered after the client died
- a number of other smaller issues, such as clients receiving more than 20 dental fillings in a single day

Figure 1-2 summarizes the total dollar amount of suspicious claims we found in each of these areas. It's important to keep two things in mind about these results:

- Some of the categories may overlap slightly. For example, some of the emergency room visits that were billed at more expensive levels of service may have been for clients whose income exceeded eligibility requirements. However, the two largest categories—income eligibility ($10 million) and invalid Social Security Number ($679,000)—are mutually exclusive, based on our review of the data.
- Approximately 60% of the amounts we found are federal funds. This means the State would only be able realize 40% of any potential savings.

Figure 1-2
Summary of Suspicious Medicaid Claims Identified by LPA
Federal Fiscal Year 2006

Problem Area	Total Amount Paid By Medicaid
Income exceeds eligibility requirements	$ 10,561,706
Invalid Social Security number	$ 679,280
Prescriptions for controlled substances from five or more physicians	$ 622,946
"Upcoding" office and emergency room visits	$ 598,689
Overlapping community and hospital services	$ 433,291
Other issues	$ 62,111
Total	$ 12,958,023

Source: LPA analysis of Medicaid eligibility and claims data provided by the Kansas Health Policy Authority and quarterly income data provided by the Kansas Department of Labor.

Our findings in each of these areas are discussed in detail in the sections that follow.

More Than 10,000 Clients Whose Income Appeared To Exceed Program Limits Received More Than $10 Million in Services

Because Medicaid is a program for people in poverty, clients must meet certain income guidelines to qualify. Focusing on low-income adults who receive services because they have children, we matched the list of Kansas Medicaid clients to quarterly income data from the Department of Labor, summarized the amount of income earned by each Medicaid household during the months the clients were receiving benefits, and compared those amounts to the program's

eligibility criteria. As ***Figure 1-3*** shows, we identified more than 10,000 clients whose estimated income exceeded the Authority's income eligibility guidelines, including 123 clients whose income was more than five times the program limit. In total, these clients received more than $10 million in services.

Figure 1-3
Clients Whose Estimated Household Income Exceeded Medicaid Program Guidelines
Federal Fiscal Year 2006

Household Income Was This Percent Above the Program Guidlines (a)	Total Number of Clients	Total Number of Claims	Total Dollar Amount of Claims
0%-100%	7,110	100,788	$ 6,159,378
100%-200%	2,353	43,957	$ 2,790,702
200%-300%	726	15,368	$ 1,034,807
300%-400%	227	4,666	$ 338,116
more than 400%	123	2,632	$ 238,703
Total	**10,539**	**167,411**	**$ 10,561,706**

(a) Clients are assigned to these categories based on their highest earning quarters when they were listed as eligible for Medicaid benefits.

Source: LPA analysis of Medicaid eligibility and claims data provided by the Kansas Health Policy Authority and quarterly income data provided by the Kansas Department of Labor.

Although these clients had more income than the program allows, most of them still were very poor, with incomes around or below the federal poverty level. However, we did find some more extreme examples of individuals with high incomes receiving benefits, such as:

- One family had a monthly income of $7,600 per month—more than five times the program limit of about $1,300 per month. The adults in the household received more than $6,000 in services for the year.
- One had a monthly income of $9,000 per month, primarily from the telecommunications industry (the program limit was about $1,100 per month). The adults in the household received more than $7,000 in services for the year.

Officials from the Authority told us they have access to the Department of Labor's quarterly income data, and use that data when a client initially applies for benefits and during a client's annual eligibility review. However, the Authority doesn't have a system in place to match all clients against the quarterly income data as soon as they become available. Although having such as system wouldn't completely prevent clients with too much income from getting services, it would allow the Authority to more quickly identify those clients and expedite the process of removing them from the program.

Another thing to note is that the Authority's eligibility policies exclude a share of the household's income from the eligibility calculation for established clients, as a way of reducing any incentives there may be for existing clients to avoid working because they fear they'll lose their benefits. While new clients have all their income count against the federal program guidelines ($543 a month for an adult from a family of three), established clients are allowed to exclude a little more than 40% of their income. This means an established client with a family of three could make up to $995 a month and still remain eligible. In our analysis we identified almost $7 million in claims for nearly 5,000 clients who made more than the federal guidelines, but were eligible under the State's policy.

Recommendations for Executive Action:	To help ensure that Medicaid clients' income is within the program's eligibility guidelines, the Health Policy Authority should develop systems to periodically compare a list of existing Medicaid clients to the Department's income data to identify anyone who no longer appears to be eligible, and have the appropriate staff follow up to make a final eligibility determination.

266 Clients Received Almost $700,000 In Services Without Providing a Valid Social Security Number

In general, a client must have a valid Social Security number to be eligible for Medicaid services, although there are a few exceptions for infants and other individuals who may not have been issued a number yet (they're required to apply for a Social Security number at the time they apply for Medicaid), children in foster care who many not know their Social Security number, and immigrants who only are eligible for limited emergency and childbirth services. Social Security numbers are important to the program because they serve as a form of identification, allowing case workers to match client information to other databases, and making it easier to verify a client's income. We analyzed the Medicaid client data looking for three specific types of invalid Social Security numbers:

- clients without a Social Security number
- clients with a Social Security number that will never be issued, such as those beginning with the numbers "666"
- clients with a Social Security number that hasn't been issued yet, according to data provided by the Social Security Administration

Our results are summarized in ***Figure 1-4*** on page 10 which shows that we found a total of 266 clients without valid Social Security numbers, who received almost $700,000 in Medicaid services. The vast majority of these clients had no Social Security number in the system, although many of them may actually have a valid

number. That's because the system used by the Authority and SRS to determine eligibility for the State's medical programs and other social services doesn't require a valid Social Security number for each client. Even though a valid number is required by the Medicaid program to receive benefits, nothing requires a case worker to enter a valid Social Security number into the system.

Figure 1-4
Medicaid Clients Without a Valid Social Security Number
Federal Fiscal Year 2006

A Social Security number...	Total Number of Clients	Total Number of Claims	Total Dollar Amount of Claims
...wasn't provided	235	1,963	$ 504,293
...was provided, but it wasn't valid	9	143	$ 33,643
...was provided, but it hadn't been issued yet	22	849	$ 141,344
Total	**266**	**2,955**	**$ 679,280**

Source: LPA analysis of Medicaid eligibility and claims data provided by the Kansas Health Policy Authority.

Recommendations for Executive Action:

To help ensure that clients do not receive claims without a valid Social Security number, the Authority should work with SRS to review and improve the edits in the eligibility system that are designed to prevent new clients from being added to the system without a valid Social Security number, or other exception such as being an immigrant, a foster child, or having recently applied for a number.

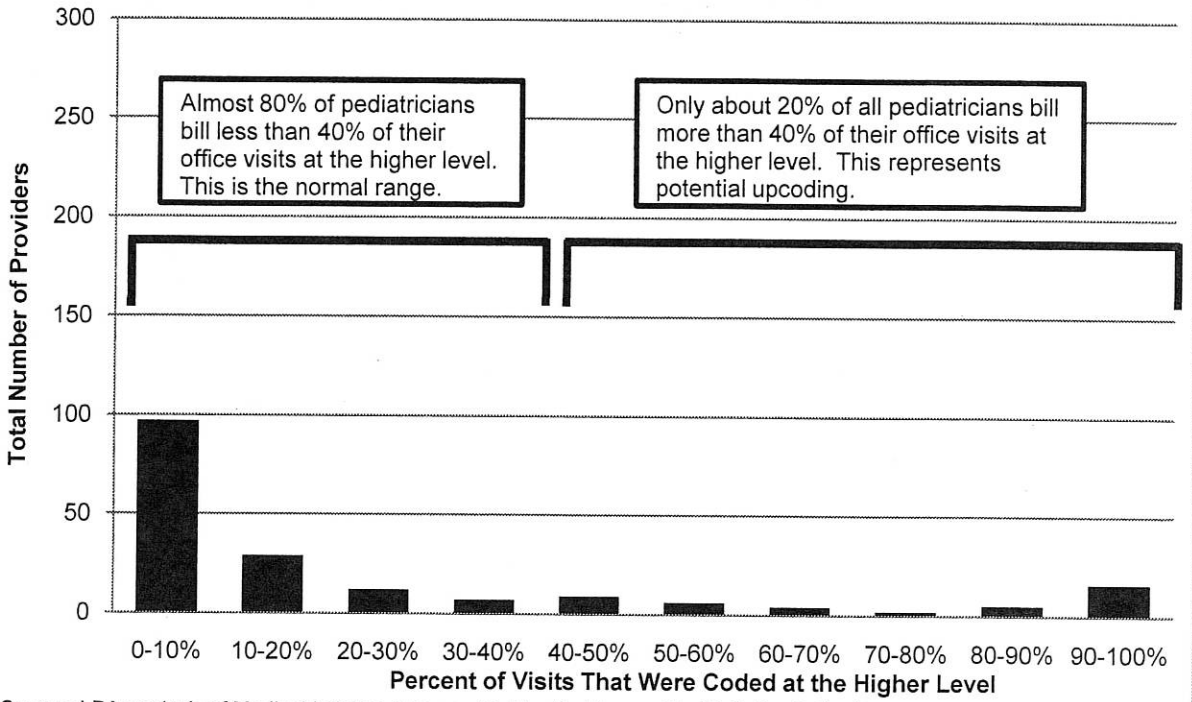
We Identified More Than $590,000 In Potential "Upcoding" By Doctors

"Upcoding" occurs when a doctor bills for a higher level of service than was actually provided to a client in order to get more money. It can be a very subtle way for doctors to take money from the system.

While it's impossible to tell if upcoding really has occurred just from looking at claims data, the pattern of claims for different doctors can be indicative of potential upcoding. For example, nearly all visits to a doctor's office are billed at one of two levels—a lower level of service for which Medicaid pays up to $40 per visit, and a higher level of service at $64 per visit. We assigned doctors to one of the following groups based the share of all office visits they billed at the higher level:

- Normal Range—This is where the overwhelming majority of doctors fall. For example, nearly 80% of all pediatricians bill between 0% and 40% of their office visits at the higher, more expensive level. The normal range will vary somewhat, depending on the type of doctor (for example, internists as a group tend to bill more office visits at the higher level than do pediatricians, so their normal range was between 0% and 50%).

Figure 1-5
Upcoding Example For Pediatrician Office Visits



Source: LPA analysis of Medicaid claims data provided by the Kansas Health Policy Authority

- Potential Upcoding—These are doctors whose share of visits billed at the higher level is greater than the normal range (in some cases, much greater). For example, about 20% of all pediatricians bill more than 40% of their office visits at the higher level. So a pediatrician who bills 60% of his or her visits at the higher level may be upcoding.

Figure 1-5 provides an example of potential upcoding among pediatricians in Kansas.

We looked for potential upcoding in two areas:

- Regular office visits—Because the level of service provided may vary based on the type of doctor, we looked at three separate types of doctors: general practitioners, pediatricians, and internists.
- Emergency room visits—This includes just the fee to see the doctor and doesn't include other services such as lab work, x-rays, and medications.

To estimate the potential cost to the system of upcoding, we calculated the amount that would be saved if the providers who may have upcoded visits billed at a rate more comparable to the other providers in the system. Our results are summarized in ***Figure 1-6*** on page 12.

As the figure shows, we identified 277 doctors who billed significantly more of their office visits at the higher level of service

Figure 1-6
Estimated Cost of Potential "Upcoding" of Office Visits and Emergency Room Visits
Federal Fiscal Year 2006

OFFICE VISITS

Percent of Office Visits That Were Coded at the Higher Level		Total Number of Doctors	Total Number of Claims	Estimated Excess Cost of Potential "Upcoding"(a)
General Practioners				
Normal	0-30%	440	74,665	$ -
Potential Upcoding	*30-50%*	*78*	*13,559*	*$ 12,452*
	50-70%	*20*	*2,825*	*$ 12,507*
	70-100%	*13*	*1,573*	*$ 16,805*
Upcoding Subtotal		***111***	***17,957***	***41,765***
Pediatricians				
Normal	0-40%	145	45,509	$ -
Potential Upcoding	*40-70%*	*19*	*8,424*	*$ 17,631*
	70-100%	*23*	*4,284*	*$ 35,877*
Upcoding Subtotal		**42**	**12,708**	**$ 53,508**
Internists				
Normal	0-50%	300	36,610	$ -
Potential Upcoding	*50-80%*	*81*	*8,259*	*$ 13,124*
	80-100%	*43*	*3,728*	*$ 28,904*
Upcoding Subtotal		**124**	**11,987**	**$ 42,027**
TOTAL OFFICE VISIT UPCODING		**277**	**42,652**	**$ 137,301**

EMERGENCY ROOM VISITS

Average Amount Billed Per Emergency Room Visit(b)		Total Number of Doctors	Total Number of Claims	Estimated Excess Cost of Potential "Upcoding"(a)
Normal	$0-$60	861	132,963	$ -
Potential Upcoding	*$60-$90*	*224*	*51,904*	*$ 445,111*
	$90-$120	*6*	*243*	*$ 10,803*
	$120+	*3*	*87*	*$ 5,474*
TOTAL ER VISIT UPCODING		**233**	**52,234**	**$ 461,388**
UPCODING GRAND TOTAL		**510**	**94,886**	**$ 598,689**

(a) The excess cost is based on how much could be saved if upcoding doctors billed at a rate more comparable to other doctors in the system.
(b) The average amount billed does not include dollars paid by other means (the patient, private insurance, Medicare) and does not include additional services rendered such as labwork, x-rays, and medication.

Source: LPA analysis of Medicaid claims data provided by the Kansas Health Policy Authority.

than appears to be normal, costing Medicaid about $137,000. Included in this group were 13 doctors who billed every office visit at the higher level. We also identified 233 doctors who billed emergency room visits at a significantly higher rate, costing Medicaid more than $460,000.

Authority officials told us they use their data systems to identify instances where providers appear to have upcoded office visits and other types of claims over a relatively short period of time. While these analyses have identified a number of doctors as possibly upcoding office visits, officials told us staff don't have enough

time to follow up on all the potential problems. They told us the Authority currently is developing a better system to track doctors who repeatedly are identified for upcoding claims and have their staff focus on those providers.

Recommendation for Executive Action:	To help identify instances where doctors are billing for a higher level of service than they provide to clients, the Authority should review its system for detecting upcoding and consider if it could be enhanced by incorporating the analyses used in this report.

519 Clients Received Prescriptions For Controlled Substances From Five or More Doctors In a Single Year, Indicating Potential Abuse

Certain prescription medications are specially regulated or "controlled" by the federal government's Drug Enforcement Agency because they are easily abused. These include heavy painkillers such as morphine, Vicodin, and oxycodone, as well as stimulants such as Ritalin and Adderall. To determine if Medicaid clients may be abusing any of these medications, we looked for patterns of "doctor shopping"—a situation where a client goes from one doctor to the next in order to receive multiple prescriptions for drugs. One important limitation of our analysis that we only looked at clients' prescription patterns, and couldn't account for the varying medical needs of some clients that may justify more prescribers for these clients.

More than 21,000 Medicaid clients received prescriptions for controlled substances in 2006. The number of clients obtaining prescriptions from one or more physician is summarized in ***Figure 1-7***. As the figure shows, 98% of all clients who were prescribed controlled substances had four or fewer prescribing physicians—almost 65% had only one prescribing physician. However, 519 clients (2%) received prescriptions in a single year from five or more doctors, totaling more than $600,000 in claims. Receiving prescriptions from this many doctors is highly unusual, and indicates the possibility of abuse by patients either overusing their medication or selling prescription drugs to others. Authority officials told us they already had identified 53 of the 519 clients as suspected abusers, but we weren't able to determine the outcome of their investigations.

Figure 1-7
Summary of Controlled Substance Prescriptions
Federal Fiscal Year 2006

Number of Prescribing Physicans	Total Number of Clients	Percent of Total Clients	Total Dollar Amount of Claims
1	13,790	64%	$ 3,827,707
2	4,570	21%	$ 2,975,775
3	1,877	9%	$ 1,672,285
4	742	3%	$ 774,366
4 or fewer	**20,979**	**98%**	**$ 9,250,133**
5	299	1%	$ 336,733
6	114	1%	$ 124,657
7	62	0%	$ 85,177
8	25	0%	$ 53,295
9	8	0%	$ 11,160
10+	11	0%	$ 11,924
5 or more	**519**	**2%**	**$ 622,946**
OVERALL TOTAL	**21,498**	**100%**	**$ 9,873,079**

Source: LPA analysis of Medicaid claims data provided by the Kansas Health Policy Authority.

Here are two of the more severe examples we found:

- One client was prescribed a number of controlled substances, including the painkillers oxycodone and Avinza from 13 different physicians over the course of one year. Medicaid paid almost $3,300 for these prescriptions, but they have an estimated street value of $34,000.
- Another client received controlled substances such as methadone and oxycodone from 12 different prescribers, with Medicaid paying just more than $1,200 for these prescriptions. The drugs have an estimated street value of $11,000.

Recommendation for Executive Action:	To help identify instances where clients might be abusing or inappropriately using controlled substances, the Authority should review its system for identifying abuse and consider if it could be enhanced by incorporating the analysis used in this report.

We Found Almost $500,000 In Other Suspicious Claims

As part of this audit we reviewed other state audits and Medicaid literature to determine common problems found in the Medicaid system. Based on this review we looked for additional problems in the State Medicaid system, and found the following:

- **We found almost $435,000 in non-hospital claims for clients who were hospitalized at the time the service was provided.** In these cases the Medicaid records showed that patients received services in another setting, such as their home, while they were in the hospital. Authority officials said they don't regularly review these types of claims, but had begun developing analysis techniques to identify and track down these types of issues.
- **We found 31 instances where a client received 20 or more restorative dental procedures such as crowns, fillings and root canals in a single day, resulting in more than $55,000 in claims.** Recent investigations in California and New York have looked at instances where dentists claimed more than 20 restorative procedures in a single day and found many of those billings to be fraudulent.

  Authority officials said that the contractor that previously processed dental claims allowed many problematic billing practices. More recently, EDS has taken over this contract and is currently working to tighten the controls that handle dental claims.
- **We identified 415 clients whose date of death hadn't been recorded in the system and were still listed as eligible for benefits.** We compared death certificate data from the Department of Health and Environment to Medicaid eligibility records. Claims had only been filed for two of these clients after death for a total of $5,000. Officials from the Authority told us they have access to the Department's death certificate data, but the Authority doesn't have a system in place to use that data to look for clients who have died.

We also looked for situations where claims were paid for services that make no sense. In one case, $941 was paid to a provider for a Cesarean section on an eight-year-old boy. Authority officials said this claim was caught by four different system controls but a data entry clerk improperly overode each of these controls. Officials told us the clerk has been counseled about these actions.

Recommendation for Executive Action:	To help ensure that only appropriate claims are processed, the Authority should: a. work with its contractors to review its system edits and other control procedures, with particular emphasis on overlapping claims and client deaths. b. develop a system to periodically compare a list of existing Medicaid clients to the death certificate data from the Kansas Department of Health and environment to identify clients who may have died, and have the appropriate staff follow up to as necessary.

APPENDIX A

Scope Statement

This appendix contains the scope statement for this audit of the State's Medicaid Program. This audit was conducted as part of the expanded ongoing compliance and control audit work authorized by the Legislative Post Audit Committee to better address the risk of fraud and abuse.

Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse

The Kansas Health Policy Authority was created by the 2005 Legislature, and became a State agency on July 1, 2006. Its purpose was to develop and maintain a coordinated health policy agenda that combined effective purchasing and administration with health-promotion-oriented public health strategies. As part of that mission, the Authority is responsible for the administration of several large health care programs:

- **Medicaid** ($2.2 billion in fiscal year 2007)—A federal/State matching-funds program for preventive, primary, and acute health services for low-income individuals, children, and families.
- **Healthwave** ($62 million in fiscal year 2007)—Another federal/State matching-funds program that is intended to expand health insurance access to children whose family income exceeds Medicaid guidelines.
- **State Employee Health Plan** ($370 million in fiscal year 2007)—Through this plan, health insurance services are provided to active, retired, and disabled State employees and their dependents, people on leave without pay, elected officials, blind vending facility operators, students at higher education institutions, and employees of school districts, community colleges, and other educational entities.

As part of the ongoing compliance and control audit work authorized by the Legislative Post Audit committee to address the risks of fraud, abuse, and non-compliance, Legislative Post Audit uses "data mining" techniques—methods that can be used to search for potential problems based on how they would appear in available data. This compliance and control audit would answer the following question related to the State's medical expenditures:

1. **Do there appear to be significant instances of fraud, abuse, or non-compliance within the State's Medicaid expenditures?** To answer this question, we will use data-mining techniques to search for different types of possible inappropriate medical expenditures. We will search for such things as payments for services that have been categorized incorrectly by providers to obtain a higher rate (also known as "up-coding"), for services that weren't actually provided, and for fictitious patients. The specific analyses and tests we will do will depend on the data available, the level of risk of various types of potential problems, and the financial impact of those problems.

APPENDIX B

Agency Response

On December 2nd, 2008 we provided copies of the draft audit report to the Kansas Health Policy Authority. Its response is included as this Appendix. Authority officials expressed concerns about some of the findings and recommendations, and based on their concerns we've incorporated several changes in the final report:

- **Clients whose income exceeded the program's eligibility requirements**—While agreeing to implement our recommendation in this area, Authority officials expressed concerns about how we used the Department of Labor's income data to identify clients who may be ineligible based on income. We've added language to page 7 of the report to clarify that our analysis only considered the income clients made during the months they were receiving Medicaid benefits.

- **Clients who didn't provide a valid Social Security number**—Authority officials contend that several of the clients we identified that hadn't provided a Social Security number had their cases closed properly after they failed to produce one within a reasonable amount of time—typically three months. Based on this, we took another look at the eligibility data for the 235 clients we identified that hadn't provided a Social Security number. Just more than half of these clients (123) were eligible for services for less than three months, meaning the remaining 112 clients remained eligible for services for more than three months, including 41 who remained eligible for a year or more.

  In addition, officials disagreed with our recommendation on page 10 to create system edits that prevent new clients from being added to the system without a valid Social Security number, because client eligibility is handled by a different system that is shared with SRS. We've changed this recommendation to have the Authority work with SRS to review and improve the edits in this eligibility system, and Authority officials told us they intend to follow the revised recommendation.

- **Providers who charged an excessive share of office or emergency room visits at more expensive levels of service ("upcoding")**—Officials disagreed with our recommendation on page 13 that they develop a system to review doctors' billing patterns on a regular basis and have the appropriate staff follow up on suspicious cases as necessary, because they already have a system in place to monitor this. We"ve changed this recommendation to have the Authority to review its system for detecting upcoding, and consider if it could be enhanced by incorporating the types of analyses we've used in this report. Officials told us they intend to follow the revised recommendation.

- **Clients who received prescriptions for powerful painkillers and other controlled substances from five or more doctors**—Officials disagreed with our recommendation on page 14 that they should develop a system to review clients' prescription patterns on a regular basis and have the appropriate staff follow up on suspicious cases as necessary, because they already had a system in place to monitor prescription drug abuse. We've changed this recommendation to have the Authority to review its system for identifying abuse, and consider if it could be enhanced by incorporating the analysis used in this report. Officials told us they intend to follow the revised recommendation.

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KANSAS HEALTH POLICY AUTHORITY

December 12, 2008

Ms. Barbara J. Hinton
Legislative Post Auditor
800 SW Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

The Kansas Health Policy Authority (KHPA) has received the Legislative Division of Post Audit's (LPA) report regarding its audit of statewide medical expenditures in the Medicaid program. I appreciate the opportunity to respond to the findings and recommendations included in the report.

According to Appendix A of the report, the audit was requested as part of ongoing compliance and control audits authorized by the Legislative Post Audit Committee to better address the risk of fraud and abuse. The audit applies a technique described as "data mining" to analyze the entire universe of Medicaid claims paid between October 1, 2005 and September 30, 2006, which includes approximately $2 billion worth of paid claims. The data mining techniques used in the audit are intended to identify unusual patterns in large data sets in order to increase the likelihood of finding fraud and abuse. As described by the LPA, the process is designed to increase the likelihood that fraud and abuse will be found. We agree. The value of this process is that it can significantly narrow the search for fraud and abuse in known areas of vulnerability so that auditors and program staff can make better use of the time required to follow-up and confirm each finding.

Our assessment of LPA's findings suggest that this initial data-mining exercise identified less than one-half of one percent of Medicaid spending in federal fiscal year 2006 as "suspicious," e.g., "unusual" and "more likely to be problematic." We are pleased that the audit revealed no systemic problems warranting significant and immediate action, and welcome the recommendations to help improve payment accuracy. Although most of the audit period occurs prior to the time that the KHPA assumed responsibility for managing the Medicaid program – July 1, 2006 – we recognize the value of LPA's efforts and agree that many of the claims deserve a second look to determine whether a pattern of fraud or abuse exists. In responding to this audit, KHPA staff did have an opportunity to take a look at a small fraction of the suspicious claims identified by LPA's initial screens and found a mixture of results. Some suspicious claims were found to represent erroneous payments or directly indicated abusive billing practices, while

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Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

others were found to be in full compliance with Medicaid payment and eligibility rules. These findings are consistent with KHPA program experience and confirm the value of a multi-stage process to identify fraud, abuse, and erroneous payments.

KHPA Comments on LPA Conclusions and Recommendations

The audit examined whether there appears to be significant instances of fraud, abuse, or non-compliance within the State's Medicaid expenditures. The report indicates that the data mining techniques found suspicious Medicaid claims in the following areas:

Clients whose income exceeded the program's eligibility requirements. LPA matched beneficiary eligibility data from the Medicaid Management Information System (MMIS) to Department of Labor quarterly income data. The audit identified 10,000 beneficiaries whose income appeared to exceed program limits. Further investigation by KHPA indicates that only 20% of the sampled cases should be suspected of having incomes that exceed the income guidelines. The analysis in the audit relied on calculating a family's monthly income using the Department of Labor's data and dividing it by three. However, eligibility must be determined based on the applicant's income information at the time of application, not on an average of what past earnings had been.

The audit recommends that KHPA develop systems to periodically compare a list of existing Medicaid clients to the Department's income data to identify anyone who no longer appears to be eligible and have the appropriate staff follow up to make a final eligibility determination.

KHPA agrees with the recommendation and will explore the costs of developing or acquiring tools to perform the periodic matches. To make such a data-matching exercise cost-effective, KHPA would need to develop additional filters to narrow the suspected number of families with higher than allowed incomes to a reasonable number that could feasibly be investigated.

Clients who didn't provide a valid Social Security number: LPA identified 266 clients who received services without providing a valid Social Security number.

The audit recommended that KHPA should work with its contractors to create system edits that prevent new clients from being added to the system without a valid Social Security number.

KHPA disagrees with the recommendation. The federal requirement is for all persons who apply for Medicaid to provide a Social Security number or proof of application for a number to receive Medicaid benefits. Further investigation of some of the 266 clients revealed several cases where an individual was given a chance to apply for a Social Security number, but the case was closed after they failed to produce one. The medical coverage received during the short period the case was open is a legitimate Medicaid expenditure under the federal rules and does not constitute an overpayment.

In addition, the State eligibility system, KAECSES, already has a number of edits to prevent the entering of an invalid Social Security number. KAECSES is the eligibility system of record and it

would be inappropriate for the claims processing system (MMIS) to edit the eligibility file submitted by the eligibility system of record.

Providers who charged an excessive share of office or emergency room visits at more expensive levels of service (also known as "upcoding"). The audit reviewed claims data to identify "upcoding" without considering all of the relevant factors that make claims for the same type of providers similar or different. When payments to providers for comparable procedure codes are compared without considering the medical needs of the consumer, there can be many false positive results for excessive charges. For instance, a 24 year old male with a cold will take less of a physician's time than a 24 year old male with a heart defect. If the diagnosis, or illness level, of the consumer is not considered, the claim for the consumer with the heart defect could be interpreted as "upcoded" even for the same type for procedure.

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KHPA contracts with Electronic Data Systems (EDS) to provide Surveillance and Utilization reviews services (SURS) and a Fraud and Abuse Detection system (FAD). EDS uses a provider profiling tool that is used throughout the insurance industry. This approach provides a multi-dimensional analysis rather than the one-dimensional analysis used in LPA's data mining exercise. The profiling tool considers age, sex, and illness to compare the average cost for a consumer within a group of similar consumers to develop provider billing profiles. Nurses, using their clinical expertise, can then take these results and compare physicians to one another based on the expected cost of that consumer's care. Findings of overpayments are pursued via recoupment of the overpayment. Cases of suspected fraud are referred to the Attorney General's office for further handling. KHPA believes the existing system and process of profiling providers meets the intent of the audit recommendation..

Clients who received prescriptions for powerful painkillers and other controlled substances from five or more doctors. The audit recommends that KHPA should develop a system to review clients' prescription patterns on a regular basis and have the appropriate staff follow up on suspicious cases as necessary.

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Overlapping services, services rendered after death, and excessive amount of services rendered in a single visit. The audit recommends that KHPA work with its contractors to review its system edits and other control procedures, with particular emphasis on overlapping claims and client deaths. In addition, KHPA should develop a system to periodically compare a list of existing Medicaid clients to the death certificate data from the Kansas Department of Health and Environment (KDHE) to identify clients who may have died, and have the appropriate staff follow up to as necessary.

KHPA agrees with the recommendation. KHPA is in the process of refining the current death data match process we have in place with KDHE.

We appreciate the effort of Levi Bowles and Scott Frank in conducting the audit and being willing to discuss early drafts of the audit. They were responsive in responding to our concerns. Thank you for the opportunity to respond to the draft audit report.

Sincerely,

Andy Allison

Dr. Andrew Allison, Deputy Director
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KANSAS HEALTH POLICY AUTHORITY

Testimony on:
Response to LPA Audit

Presented to:
Senate Public Health and Welfare Committee

By
Andy Allison, Ph.D
Deputy Director
Kansas Health Policy Authority

January 14, 2009

For additional information contact:

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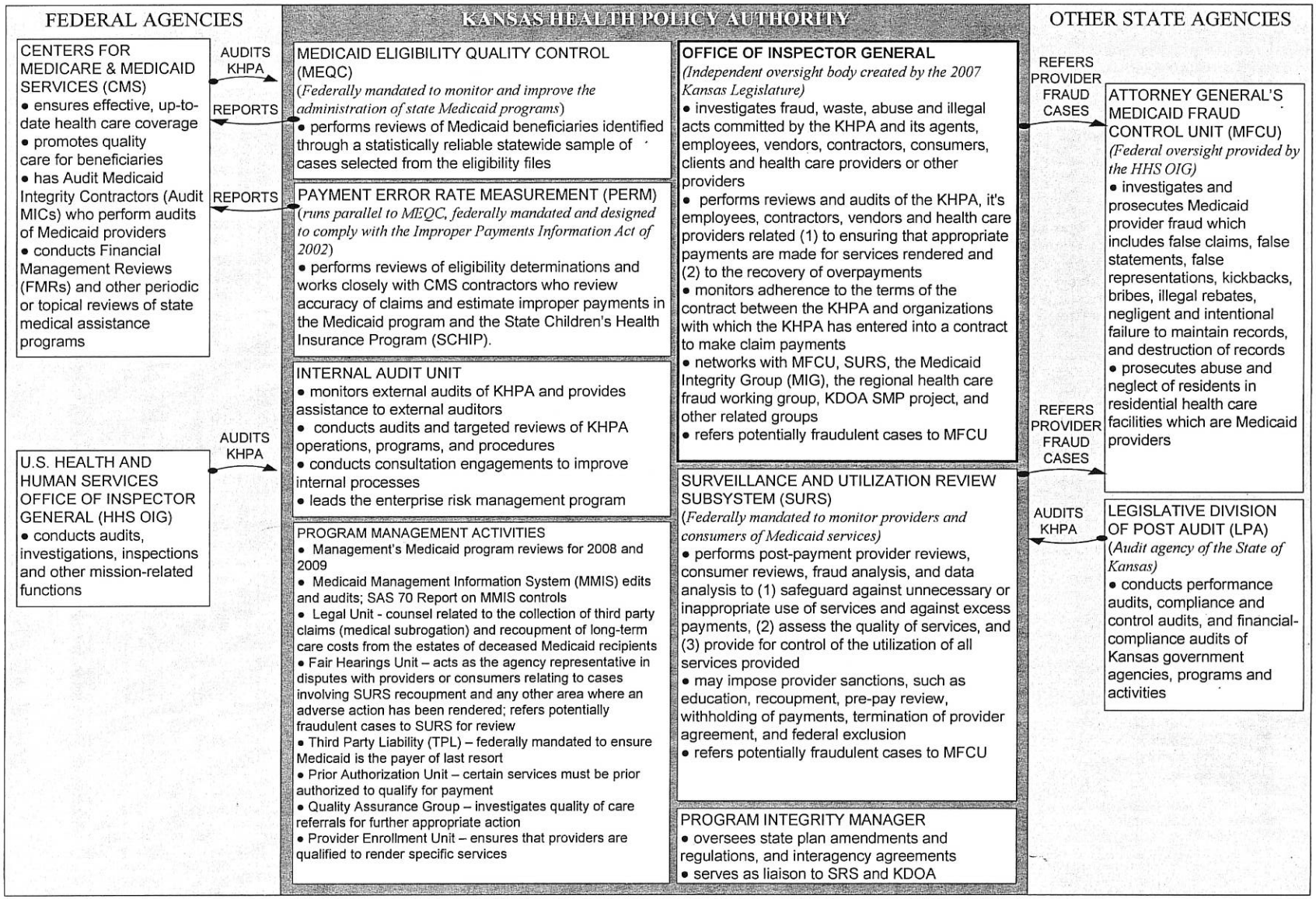
Dr. Andrew Allison, Deputy Director
Medicaid Director

"Addendum: The final version of the LPA audit includes changes in their recommendation for executive action to address potential eligibility issues associated with Medicaid enrollees that do not have a valid Social Security Number recorded in KHPA's administrative records. KHPA agrees with LPA's modified recommendation, which addresses concerns that KHPA had raised in our original response to the version of the recommendation LPA shared with us prior to the Legislative Post Audit Committee's December 19, 2008 hearing on the subject. KHPA acknowledges LPA's responsiveness in addressing our concerns with earlier drafts of their audit, and looks forward to working with LPA to address remaining issues identified in the audit."

KHPA PROGRAM INTEGRITY ACTIVITIES

The chart below shows the KHPA programs and units performing program integrity functions. It also shows how these programs and units relate to federal agencies which provide oversight of KHPA medical assistance programs, as well as other State agencies which perform related program integrity functions.



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KANSAS HEALTH POLICY AUTHORITY

KHPA PROGRAM INTEGRITY ACTIVITY

Executive Summary

KHPA engages in a number of activities aimed toward program integrity. A summary of major KHPA Program Integrity totals with costs avoided, cost recovered, contractor costs and estimated State costs are summarized here for State Fiscal Years 2007 and 2008.

State Fiscal Year	Est. Costs Avoided	Actual Recoveries*	Est. Contract Costs	Est. State Costs	Est Cost of Recovery/avoidance %	Net avoidance/recovery
2007	173,593,198	95,315,408	24,895,270	1,240,099	9.7	242,773,237
2008	206,327,059	107,117,762	23,641,707	1,240,099	8.0	288,563,015

These activities are described below.

Surveillance and Utilization Review Subsystem (SURS) - Federally mandated to monitor providers and consumer of Medicaid services

SURS performs post-payment provider review, consumer reviews and data analysis to safeguard against unnecessary or inappropriate use of services and against excess payments, assess the quality of services and provide for control of the utilization of all services provided. The SURS unit may impose provider sanctions, such as education, recoupment, pre-pay review, withholding of payments, termination of provider agreement, and federal exclusion and refers potentially fraudulent cases to the Medicaid Fraud Unit of the Attorney General.

State Fiscal Year	# Provider Reviews	# Consumer Reviews	# MFCU Referrals (KHPA & EDS)	# Lock-In Clients	Identified Overpayments	Actual Recoveries*	Estimated Costs Avoided	Est. Contract Costs	Est. state costs**	Cost of Recovery/ avoidance %
2007	91	188	33	362	3,200,405	2,226,101	229,357	2,667,613	70,000	111.0
2008	66	191	15	362	2,233,319	3,343,842	1,430,824	2,757,606	70,000	59.0

Note: for FY07 recovery data are available for only 3 quarters of the year.

Hospital Utilization Reviews —KHPA contracts with Kansas Foundation for Medical Care (KFMC)

KFMC reviews inpatient hospital claims for overpayments and medical necessity.

State Fiscal Year	# Claims Reviewed	$ Identified for Overpayment	Actual Recoveries*	Est. Contract Costs	Cost of Recovery %
2007	26,383	8,510,651	8,510,651	1,408,882	16.5
2008	15,281	12,749,381	12,749,381	911,256	7.1

Prior Authorization

The primary purpose of prior authorization (PA) is to facilitate cost containment by ensuring medical services provided to beneficiaries in the Kansas Medical Assistance Program (KMAP) are medically necessary and cost effective.

State fiscal year	PA's Reviewed	Est. Costs Avoided	Est. Contract costs	Est. State costs **	Est Cost of Avoidance %
2007	82,267	6,352,904	2,004,495	16,539	31.8
2008	91,326	6,566,498	2,092,825	16,539	32.1

Quality Assurance Group

The primary purpose of the Quality Assurance Group(QAG) is to monitor beneficiary and provider grievances. This is accomplished through utilization reviews for established patterns; creation of corrective action plans (CAPs); evaluating special studies, and interaction with the Peer Education and Resource Council (PERC). If the QAG identifies issues which appear suspicious and warrant additional examination, they are referred to other units. The recoveries that occur from these referrals are reported by the other units.

FY	Est. Contract Costs
2007	1,769,378
2008	1,839,911

Third Party Liability

The Third Party Liability (TPL) programs enhance Medicaid's position as payer of last resort. When medical assistance has been paid and a third party becomes legally liable for the payment of those same medical expenses, the Medicaid program may recover the amount of medical expenses it paid to the provider.

State Fiscal Year	Medicare A B Actual Recoveries*	Champus Actual Recoveries*	Commercial Ins Actual Recoveries*	Post Pay Actual Recoveries*	Est. TPL Avoidance	Est. Contract Costs	Est. State Costs**	Est. Cost %
2007	1,172,054	506,166	10,466,300	9,027,199	134,977,860	1,735,239	70,000	1.0
2008	1,551,294	105,353	9,170,843	10,444,995	164,130,325	1,775,667	70,000	1.0

Estate Recovery

This is a federally mandated collections program aimed at the resources of Medicaid recipients who have been an inpatient in a nursing facility or have received Medicaid benefits from age 55 onwards. There are statutory protections from collections for surviving spouses, surviving minor children or surviving children who are disabled. In FY 2008, the program used a private contractor for some of the collections.

State Fiscal Year	Actual Recoveries*	Est. Contract Costs	Est. State Costs **	Cost of Recovery %
2007	8,449,111		137,364	1.6
2008	7,207,618	170,247	137,364	1.9

Subrogation

This is a federally mandated collections program aimed at recovering costs from 3rd party tortfeasors, their insurers and other parties deemed liable for medical care to Medicaid recipients. As part of the application for Medicaid, recipients assigned their rights in these matters to the state.

State Fiscal Year	Actual Recoveries*	Est. State Costs**	Cost of Recovery %
2007	1,325,087	131,596	9.9
2008	2,422,477	131,596	5.4

Drug Rebates and Supplemental Drug Rebates

Drug Rebate agreements are contracted by the Center for Medicare and Medicaid Service (CMS) with manufacturers requiring the manufacturers to repay part of the drug expense back to CMS and the State. The State also contracts with the manufacturers to receive an additional supplemental drug rebates.

	Actual Recoveries*	Est. Contractor Cost	Est. State Cost**	Cost of Recovery %
2007	53,632,739	884,796	253,000	2.1
2008	60,121,959	909,755	253,000	1.9

Provider Enrollment

The enrollment processes ensures that providers are qualified to render specific services by screening applicants for State licensure and/or certification upon initial enrollment and on a continuing basis, federal participation requirements, and specialty board certification.

State Fiscal Year	New Providers	Est. Contract Costs	Est. State Costs**
2007	1,726	247,985	61,600
2008	3,077	257,945	61,600

Other Related Activities

KHPA operates a certified Medicaid Management Information System (MMIS) – The claim processing sub-system has extensive built-in edits and audits to insure appropriate claim payments.

State Fiscal Year	Claims Processed	Est. MMIS Edits & Audits Costs Avoided	Est. contract costs (processing)	Estimated State costs**	Cost of avoidance %
2007	19,850,016	32,033,077	14,176,882	500,000	60.0
2008	18,076,487	34,199,412	12,926,495	500,000	52.0

* **Recoveries are all funds. The State must return the Federal Financing Participation (60%) to CMS.**

** **These estimated costs do not include all related costs.**

Notes: The estimated cost avoidances are based on the estimated Medicaid allowed amount.

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To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: January 14, 2009

Subject: Post Audit Report on Fraud and Abuse in Medicaid, December 2008

The Kansas Medical Society appreciates the opportunity to appear today in order to express our concerns about the performance audit recently conducted and reported by the Legislative Division of Post Audit, *Statewide Medical Expenditures: Reviewing Medicaid Expenditures for Fraud and Abuse*. The specific question Post Audit sought to answer with this audit was: **"Do there appear to be significant instances of fraud, abuse, or non-compliance within the State's Medicaid expenditures?"**

First, let us be clear that we have great respect for Post Audit and their work on behalf of the legislature, and the public. We also expect and understand that there must be proper oversight and audits of expenditures of public money within the Medicaid program. We support reasonable and fair efforts to identify and eliminate fraud, waste and abuse within the public programs that make up Medicaid. Having said that, we strongly disagree with some of Post Audit's analysis about their findings in the report just released.

Our comments are confined principally to one area of the report in particular, that portion which relates to the issue of "upcoding" by physicians (pages 10-13 of the report). "Upcoding" is a term which is used to describe situations where physicians are alleged to submit a bill for a higher (and therefore, more costly) level of service than that which was actually provided to the patient. Post Audit reported that it found *suspicious* claims which included "almost $600,000 in *potential* upcoding by doctors for office and emergency room visits...." (Emphasis added).

Because the topic of fraud in the Medicaid program creates such significant interest in the press and with the public, it is instructive to examine Post Audit's words and characterizations throughout the report. While they stop just short of calling the "potential" for upcoding as fraud, there can't be any question that they are strongly inferring that the alleged upcoding ***is*** fraud, and that any physician who has a profile of billing for higher levels of service codes than their colleagues is committing fraud. The following excerpts are worth noting:

We looked for upcoding in Kansas Medicaid data and identified 277 doctors who may have been upcoding a significant number of their office visits, costing Medicaid about $137,000. We also identified 233 doctors who billed emergency room visits at a significantly higher rate than normal, costing Medicaid more than $460,000. (page ii of the Executive Summary, and pages 11 & 12 of the Report)

...we feel that it's unlikely that the data are grossly or systematically wrong." (page 2 of the Report)

Overall, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. (page 2 of the Report)

The suspicious claims included:...almost $600,000 in potential "upcoding" by doctors for office and emergency room visits... (page 5 of the Report)

Using our data mining techniques, we looked for and found suspicious Medicaid claims in the following areas:...providers who charged an excessive share of office or emergency room visits at more expensive levels of service (pages 6 & 7 of the Report)

Upcoding...can be a very subtle way for doctors to take money from the system (page 10 of the Report)

While it's impossible to tell if upcoding really has occurred just from looking at claims data, the pattern of claims for different doctors can be indicative of potential upcoding (page 10 of the Report)

Only about 20% of all pediatricians bill more than 40% of their office visits at the higher level. This represents potential upcoding. (Figure 1-5, page 11 of the Report)

...a pediatrician who bills 60% of his or her visits at the higher level may be upcoding. (page 11 of the Report)

In order to better understand the Post Audit findings, we met with the principal auditor who conducted the audit. In particular, we wanted to learn more about their research methods and the process by which they tested their conclusions. What we found was extremely troubling.

Their study covered a one-year sample of claims from the period October 2006 through September 2007 (the federal 2007 fiscal year). It covered only a portion of Medicaid recipients, those in "regular" Medicaid, which includes the aged, blind and disabled, and many who have multiple health issues and chronic conditions. It excluded the relatively younger and healthier, ambulatory population covered by the two managed care plans. In other words, it covered a subset of the Medicaid population that one would expect to see a greater number procedure codes for more intensive, higher complexity services performed by physicians.

Moreover, based on the information they shared with us, Post Audit confined their research to *paid* claims only. In other words, **they did not examine any medical records associated with the claims in their study**. Interestingly, Post Audit rather candidly admits in the report that *"it's impossible to tell if upcoding really has occurred just from looking at claims data...."* (page ii of the Executive Summary; emphasis added). In spite of that admission, which happens to be true, they nevertheless made findings which inferred widespread fraud, when their study methodology couldn't possibly have supported such a finding.

In addition, by their own admission, they have no medical expertise on their audit staff, nor did they seek the opinion of a physician consultant to help them construct a meaningful analysis of the value of the raw claims data they looked at. They describe their process as "data-mining", which in their terms "uses statistical data analysis techniques to identify unusual claims that are more likely to be indicative of fraud or abuse." Their conclusions are based on purely statistical assumptions about the relative proportion of 99213 vs. 99214 billing codes that family physicians, pediatricians and internists □primary care physicians - would be ***expected*** to perform and bill for in the Medicaid program.

We expressed strong concerns about their findings to the auditor because they made conclusions about the potential for fraud without looking at the underlying diagnosis, or without looking at one single medical record to see if the higher billing code was justified by the health status of the patient, and the time and intensity of services rendered by the physician. Post Audit used the same methodology and assumptions to analyze the ER visits as well. Any clinician will tell you that it is simply impossible to make any judgment about the appropriateness of a billing code without examining the underlying medical record to see what the health status of the patient was, and what was done by the physician during the office or emergency room visit.

Would you expect a physician to make a diagnosis without ever examining the patient or the patient's medical record? Then why would we expect an audit that didn't examine one single medical record out of the thousands it included in its study to be able to make any reliable judgment about whether the services rendered did in fact justify the bill submitted?

Post Audit's findings (Figure 1-6, page 12 of the Report) suggest that nearly 1 out of 4 claims for physician office and emergency room visits (94,886 out of 384,633 claims in their study, or 24.6%) represents "suspicious" or "potential" fraudulent upcoding. That inference is simply not credible, and it does a disservice to the hardworking primary care physicians of this state who serve the Medicaid population.

Moreover, the reality of public programs such as Medicaid is that the billing rules are voluminous and hideously complex. Experience has shown in most cases of improper codes being applied to a patient visit, that it often is just a simple clerical error, or a legitimate difference of opinion on the time, intensity and level of services provided. The opportunity to inadvertently violate these rules with simple clerical errors or policy

misunderstandings and have such errors labeled as "potential fraud" is enormous. In the normal course of taking care of patients and trying to follow the rules of this program, billing errors are routinely addressed and corrected without anyone labeling them as "fraud". If a physician was suspected of "potential" fraud every time his or her office submitted a 99214 instead of a 99213 billing code, nobody would participate in Medicaid. In fact, the penalties and consequences for committing fraud in public programs are so severe (being dropped from private insurance programs as well as Medicaid and Medicare, substantial financial penalties, and potential loss of license to practice), that the tendency for most physicians is to *downcode*, not upcode.

At a minimum, if Post Audit is going to continue "data mining" experiments such as this, we strongly recommend that they contract with a physician consultant to help them understand the limitations of the data they are looking at. We would also suggest that that Post Audit use greater care to be fair in its commentary when communicating its findings. In this instance, while they admitted they couldn't tell if fraud had actually occurred (*"it's impossible to tell if upcoding really has occurred just from looking at claims data.... "*), the clear message conveyed to legislators, the press and the public, is that there is widespread upcoding by primary care physicians that constitutes fraud. For example, consider just one press account of the Post Audit report, which appeared in the Topeka Capital-Journal on December 20: *"A new audit of the state's Medicaid program raised red flags Friday as analysts pointed to $13 million in suspicious claims, 500 doctors who may have falsely inflated bills...."* If Post Audit's goal was simply to generate headlines that unjustifiably impugn physicians, they succeeded. If their goal was to uncover fraud in Medicaid, they failed.

Furthermore, we seriously doubt that there is any more carefully scrutinized expenditure of public money than that which occurs in Medicaid. There already exist numerous programs and agencies, many of them overlapping in responsibility, which are singularly focused on identifying fraudulent activities in Medicaid and its related programs. The Surveillance and Utilization Review Subsystem (SURS), which is mandated by federal rules, does continuous and thorough analyses of provider billing practices and utilization of services in Medicaid. The Office of Inspector General also investigates fraud in the programs, and works with the Medicaid Fraud Control Unit (MFCU) at the Kansas Attorney General's office to prosecute fraud and false claims. The Centers for Medicare and Medicaid Services (CMS) supervises Medicaid Integrity Contractors (MICs), who perform audits of contracting health care providers. Inpatient hospital claims are also reviewed by the Kansas Foundation for Medical Care (KFMC) for medical necessity and appropriateness of payment. In addition, the Quality Assurance programs, the Prior Authorization programs, and the extensive audits/edits contained in the Medicaid Management Information System, are all dedicated to maintaining program integrity by identifying and eliminating fraud. Even the harshest critics of the agency and its programs would be hard pressed to suggest that there is inadequate attention paid to fraud and abuse oversight of the Medicaid agency and the providers who serve this population.

In summary, we would urge legislators to read this report with a critical eye. The agency's conclusions on the upcoding issue are simply not supported by the audit's

findings and methodology, and as such are meaningless from the standpoint of truly identifying fraud within the Medicaid program. We appreciate the opportunity to offer these comments, and would be happy to respond to any questions.