Approved: _____
Date February 21, 2002

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 5, 2002 in Room 210 Memorial Hall

All members were present except: Representative Nancy Kirk, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
Renea Jefferies, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Dave Riley, Bland and Associates

Others attending: See Attached Sheet

Representative Showalter moved and Representative Lightner seconded introduction of an Emergency Medical Services scope of practice bill that replaces **HB 2664**. The motion carried.

Dave Riley, Bland and Associates, briefed the committee on a post audit report on medicaid cost containment: controlling fraud and abuse.

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

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

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

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

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

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

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

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

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

Audits examining cost containment in the Program would focus on five key areas:

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

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

Recommendations:

- appoint a strong advocate who would exercise "ownership" of meeting program goals.
- strengthen communications channels between SRS and the SURS
- establish clear and quantifiable performance expectations and measurements jointly agreed upon between the Contractor and SRS
- ensure positive oversight of contractor activities
- structure leadership involvement to clearly articulate the goals of the Kansas Medicaid program along with the associated customer benefits
- create and properly use incentives for the contractor to do more with less, suggest thoughtful and creative new processes, procedures, and customer
- create and properly use incentives for the contractor to do more with less, suggest thoughtful and creative new processes, procedures, and customer facing features.

Recommend post audit group be able to go in and see if there is improvement in 6 months or a year rather than waiting 21 years. Would give Kansas a C+ to C- and really should be a B+ or A-. There is a 3 year data base available and need to do a complete analysis to see how much fraud is going on by patients, physicians, hospitals, etc. Efforts are being made throughout the country to stop fraud and abuse but there are new schemes turning up all the time.

Blue Cross is being replaced as the fiscal agent in six months.

Barbara Hinton, Legislative Post Auditor, stated two questions were requested and the asked for an audit on one as if it were good there would be no need to follow up. Now we will go back to the Post Audit Committee to see if the second question can be addressed. It appears the SUR unit states they take direction for SRS and over and over people point fingers either way.

The meeting adjourned at 2:15 p.m. and the next meeting will be February 6.