

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #7
Waste, Fraud, and Abuse in Medicaid Reform**

Background

On July 9, 2008, the Legislative Coordinating Council, (LCC) approved a number of studies be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. Reporting on which Medicaid anti-fraud/waste/abuse policies have yielded the highest rate of cost benefit was one of the studies identified.

Introduction

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program in section 1936 of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program. One of the MIG's tasks is to support and assist states in the prevention, detection, and prosecution of Medicaid fraud, waste, and abuse. As one means to do this, the MIG contracted with the Department of Justice to establish the Medicaid Integrity Institute (MII). The MII is located on the campus of the University of South Carolina in Columbia, South Carolina. It focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, and case development. MII provides this training at no cost to the states, and KHPA is an active participant. A KHPA staff member was selected to participate on the workgroup tasked to identify states' needs and develop a course curriculum. Four KHPA staff attended the MII in federal fiscal year 2008. Four staff attended in October of 2008, one in December 2008, one in January 2009, and it is anticipated that more will attend as the federal fiscal year progresses.

Best Practice

The MII solicited best practices from each state, the District of Columbia, and Puerto Rico in May of 2008. The responses were distributed to attendees of the Program Integrity Directors Conference in June of 2008. Best practices were also a primary focus of the conference. The following were selected best practices for reducing fraud, waste, and abuse by providers of Medicaid services, followed by KHPA's actions toward implementing the practices. Engaging in best practices, Kansas has saved or avoided \$3,335,469.00 in State Fiscal Year 2008. And, in SFY 2008, the SURS Unit identified \$2,233,319 in overpayments from desk reviews and data mining activities and recouped \$3,730,842. The recouped amount is larger because it includes dollars identified in the current year and in previous years. More than \$5.5 million has been saved or recouped in SFY 2008.

Recommended Practice

1. Cooperative relationships with Program Integrity, Medicaid Fraud Control Units, Offices of Inspector General, United States Attorneys, and active participation in Health Care Fraud Task Forces.

KHPA Medicaid Program Integrity staff, representatives of the Managed Care Organizations (MCO's), and representatives of the fiscal agent meet regularly with the Medicaid Fraud Control Unit (MFCU) of the Kansas Attorney General's office and assists the MFCU and U.S. Attorney's office in case investigation and preparation. KHPA continually works with the MFCU on ways to improve our efforts and on cross-training between all organizations. KHPA representatives attend the quarterly Kansas City Metro

Health Care Fraud Working Group which includes representatives of the FBI, KBI, U.S. Attorney's office, MFCU, private insurance companies, and others from Kansas, Nebraska, Iowa, and Missouri. KHPA staff also participates in CMS sponsored Fraud and Abuse Technical Advisory Group, and Regional Program Integrity conference calls.

2. Update provider agreements to ensure they are consistent with changes in laws and regulations.

In June of 2008, KHPA began the process of renewing provider agreements with all providers enrolled in Medicaid. The new provider agreement updated all references of SRS to KHPA, strengthened the language that incorporated the provider manuals, reflected the transition from paper to electronic claims, and accurately portrayed the language of the record-keeping requirements of the Kansas Medicaid Fraud Control Act. During the same time period, a new Disclosure of Ownership and Control form was implemented. The form was designed to better screen applicants who may be excluded from participation in the program or otherwise sanctioned, and to deter applicants who owe money to the state under one provider number from obtaining a new provider number to avoid payment. To date, no providers have been denied payment due to owing money under another provider number. However, the process acts as a deterrent to those who may have previously been able to evade detection.

3. Pre-payment review monitoring in which new claims are suspended until they have been reviewed by an investigator.

KHPA utilizes pre-payment review in cases where questionable billing practices or poor documentation have been identified. Six providers were on a pre-payment review in fiscal year 2008. Costs avoided due to denied claims by these providers totaled \$6,447.46. This practice has also served as a deterrent to fraud and abuse as all of the providers placed on pre-payment review ceased billing Medicaid once the claims were denied. Based upon the amount these providers were paid in the twelve months prior to being placed on pre-payment review, \$3,089,252 was saved. Three of the providers have since had their provider agreement terminated by KHPA.

4. Use of advanced data analysis and identification of aberrant providers.

KHPA contracts with EDS to conduct post-payment reviews on claims that have already been paid. The program, Surveillance and Utilization Review (SURS), is federally mandated in order to safeguard against unnecessary or inappropriate use of services and against excess payments, and to assess the quality of services. Among other techniques, the SURS unit uses data mining to identify providers who may be billing inappropriately. In FFY 2007, the most recent time period for which this data is available, the SURS Unit identified \$592,604 in overpayments from data mining activities.

5. State review of contractor's audit findings prior to recoupment.

EDS' recoupment letters are thoroughly reviewed for accuracy by State Program Managers and Legal staff prior to being sent to the provider by EDS. This practice avoids correcting errors during the fair hearing process which is a cost saving to both providers and the State.

6. On-site visits before enrollment of certain provider types.

Nationally, states, including Kansas have identified ongoing problems with providers of Durable Medical Equipment (DME). As a result of past problems, Provider Representatives from EDS now conduct site visits on all Durable Medical Equipment

providers prior to enrollment. Providers who do not meet program requirements are not enrolled. KHPA denied enrollment of three DME providers in SFY 2008 for not meeting program requirements. Based upon the average yearly amount paid to this provider type, this resulted in costs saving in the amount of \$50,713.

7. Review of selected provider enrollment applications to prevent questionable providers from enrolling in the program.

The KHPA Program Manager for Transportation Services reviews and verifies all applications for transportation providers prior to enrollment. Issues related to overpayment of providers, and enrollments of non-qualified providers were identified as ongoing problems in this Medicaid program. KHPA denied the enrollment of nine transportation providers in SFY 08. Based upon the average yearly amount paid to this provider type, this resulted in cost saving in the amount of \$195,504. Adjustments have also been made to the provider enrollment application which limits the ability of providers to re-enroll as a new provider without reimbursing the state for prior overpayments.

8. Legislation to form a computerized central database tracking system to track prescribing, dispensing and consumption of schedule II, III and IV controlled substances.

SB 491 requires the Board of Pharmacy to create a Prescription Monitoring Program (PMP) for Kansas and created a PMP Advisory Committee to develop and oversee the program. KHPA has a staff member on the committee.

9. Notification to various Boards (Healing Arts, Pharmacy, Nursing) when patterns of inappropriate activities are identified

KHPA and EDS staff routinely notify the appropriate Board when patterns of inappropriate activities are identified. Notices to Boards generally pertain to quality of care concerns and are based upon the Board's standards. Seven providers were referred to the State licensing boards in FFY 2007.

10. Conduct on-site visits to review provider records, meet with providers, and observe some of the services being provided.

The SURS unit has the authority to conduct on-site visits as necessary. However, SURS staff has found other options that are more productive, less costly and time consuming to review services, and exercise those options. For example, focused reviews are conducted. Focused reviews identify a single, questionable practice exhibited over multiple providers, occurring frequently enough to be investigated. Desk reviews are also conducted. In this instance, provider records are sent to KHPA for staff to review and compare with information contained in the MMIS. Desk reviews are more efficient as they do not require staff to go off-site, and, because they are conducted in office, staff may access MMIS records which would not occur in an on-site visit.

11. Time-line analysis of provider billings

In addition to a time-line analysis of Medicaid provider billings, this analysis is being explored in conjunction with the State Employee Health Insurance Program and the Kansas Insurance Commission data bases through the Data Analytic Interface. This option will allow KHPA to compare providers across all three groups to determine total number of hours billed per day or other specified time period by providers.

12. Receive referrals alleging fraud or abuse via Recipient Explanation of Medicaid Benefits (REOMB).

KHPA is currently in the process of improving the REOMBs to target specific provider types or beneficiary populations to reach populations more vulnerable to fraud and abuse without raising the cost. The current process selects beneficiaries randomly from all populations. One state reported initiating from two to four investigations per month from targeting REOMBs.

13. Use of a standardized form for referrals of suspected fraud to the MFCU.

MFCU and KHPA are currently working on a standardized form and process to refer all cases of suspected fraud to the MFCU. The form and the standardized information it will contain will be used by KHPA, SRS, KDOA, MCOs, and any other agency or contractor to make a referral to the MFCU. The form will also meet the Best Practices identified by CMS for Medicaid fraud referrals.

Future Practice

The following are best practices that KHPA does not currently have in place but are exploring for possible future use:

- **Random Pre-Pay Reviews:** This process is an anti-fraud control strategy that puts providers on notice that all claims submitted for payment is at risk for review prior to payment. A pre-determined number of claims would be selected for review on a weekly basis. Providers would be required to submit documentation to support the payment before the claim is approved. Any claim that cannot be supported is denied for payment.
- **Provider Self Audits:** This is a review of providers for deficiencies in their billing and request that the providers audit their own records. Providers repay the state if they identify an overpayment. One state claimed to have had over \$2 million in collections in Federal Fiscal Year 2007 from this process.

Although the MII's focus is currently on preventing, detecting, and prosecuting provider fraud, waste, and abuse, some states offered their best practices in the area of beneficiary fraud and abuse. All involved a program in which beneficiaries are limited to one physician, pharmacy, or hospital when patterns of abuse are identified. KHPA and the MCOs also employ this program, entitled Lock-In, to control the costs associated with beneficiaries' abuse of Medicaid benefits.

None of the states offered any best practices regarding beneficiary eligibility fraud at the MII. KHPA has discussed pursuing beneficiary fraud with the Medicaid Fraud and Control Unit in the Attorney General's office. More resources would be required to implement a beneficiary fraud program, and it does not appear that this is a widespread problem in the Kansas Medicaid Program.