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Attempts to Reduce Excess Expenses, Fraud, and Abuse in Medicaid Programs Through EVV, FMS, and KanCare

Madame Chairwoman and Members of the Committee:

During the past year the Kansas Department on Aging, along with SRS, has worked towards reducing fraud and abuse within our Medicaid Home and Community Based Service (HCBS) waivers. Electronic Visit Verification (EVV/ KS AuthentiCare), Financial Management Services (FMS), and KanCare are being implemented to improve health outcomes, better coordinate care and bend the cost curve of Medicaid down over time. Moreover, they are being implemented to reduce patterns of Medicaid fraud and abuse such as those explained to this Committee by the Attorney General's Office and also by SRS staff who have completed audits on all Centers for Independent Living (CILs).

These efforts have been made to ensure that the current resources of the waiver programs are being utilized appropriately. It is important to mention that although Kansas has the 6th highest utilization of nursing homes, we also have the 4th highest utilization of HCBS services; no other state has comparable statistics. This suggests that our current system is broken and needs significant reform.

My understanding is that you would like us to respond to the allegation of whether the implementation of EVV, FMS and certain provisions within KanCare is the result of retaliation for 600 *Olmstead* complaints filed with the federal government by advocates in conjunction with the statewide network of Centers for Independent Living.

I appreciate the opportunity to address these allegations. Until recently, I had no idea that programs such as EVV, FMS, and KanCare were being referred to as acts of retaliation against Centers for Independent Living- or any other participants in the Kansas Medicaid program.

While SRS has explained its audits of Centers for Independent Living during this hearing, I can assure you that EVV, FMS, and KanCare have been pursued completely independent of those audits. I was not aware of the audits when plans for EVV, FMS, and KanCare were being developed. The audit time-line for SRS goes back to at least 2008 and I was not aware of the audit findings until recently.

Quite simply, it is wrong to state that EVV, FMS, KanCare, and SRS audits are parts of a conspiracy to retaliate against the statewide network of Centers for Independent Living.

Having said that, I recognize that many aspects of providing supports and services for persons with disabilities is undergoing change. KanCare, EVV, and FMS are part of that change. Change is often challenging. Therefore, the reasons for change must be stated, and restated, many times. I have spent much of my time as Secretary explaining why EVV, FMS, and KanCare are needed. I am happy to do so again today.

I will start with FMS. FMS is only needed when a state allows self-directed care. Kansas supports self-directed care. However, CMS does not allow customers to pay their self-directed caregivers. Nor may the administrative costs of financial management be charged to attendant care services as was once the case in Kansas. Since Kansas believes that those receiving services should retain as much control as possible over how those services are provided, some form of financial management is necessary.

Kansas spent over two years determining what expenses FMS providers would incur and the proper rate at which those expenses should be paid. A consultant was chosen, a *Myers and Stauffer* study was completed, rates from other states were obtained, and input from stakeholders was solicited. With information from the *Myers and Stauffer* study we determined providers needed $100 per member per month to cover administrative expenses, and the national average rate for FMS providers is $98.10 per member per month.

While an updated calculation of financial service rates is necessary to ensure that Medicaid resources are being properly managed, no one has shown that FMS rates are unfair. In fact, there is no shortage of FMS providers under the current system.

With respect to EVV, the goal is simple. EVV will make accountability much more sure, and payment much more efficient, than the old paper system of keeping time sheets. EVV will not be difficult for direct service workers to use and it produces digital time records. The State of Kansas must do what it can to ensure that those receiving payment actually spend their time assisting customers. EVV makes it more difficult to take advantage of customers who may not want to challenge time claimed by direct care workers. Thus, EVV both strengthens and eases accountability for everyone.

EVV was initiated by an RFP. The program was discussed with providers beginning in May, 2011. It was advertised on an agency website. An email address for questions and comments was established. Providers were contacted about the program by telephone and in writing. Training seminars were conducted throughout the state. On-going support from SRS, KDOA, and the EVV contractor, First Data, will continue to be available. EVV has helped other states combat fraud and it can do the same for Kansas. Implementation of this system has not been perfect; there have been problems with third party liability integrating properly into the system. There has been a delay on implementation for those with physical disabilities because there was a disparity between how the PD waiver counted units of time compared to the other waivers. However, this system will be fully implemented March 16, 2012.

Obviously, KanCare has far more components than either FMS or EVV. However, its goals are the same. The KanCare RFP requires quality care, coordinated care, and accountability through credentialing, quality assurance, grievance programs, and a comprehensive network of providers. These are the elements of reducing cost while improving customer outcomes.

KanCare also requires all HCBS providers, except mental health and developmental disability providers, to provide conflict-free case management and service provision. It is a conflict of interest for the case management entity, who helps a consumer choose a service provider, to also be a service provider in that provider network. KanCare establishes that providers are not able to provide both case management and services to the same consumer. KanCare also establishes the use of Aging and Disability Resource Connections (ADRCs) to determine if a consumer is functionally eligible to receive HCBS, and which HCBS services they qualify for. Currently the same entity can determine whether a person is functionally eligible for HCBS, develop the care plan that determines how many services a person will receive,, help them choose which service provider to use, and act as the service provider. This inherent conflict of interest will not be allowed within the KanCare system.

Conclusion

The programs I have been discussing are meant to involve substantive changes; and substantive changes always require fresh attitudes and significant effort to achieve. However, the goals of FMS, EVV, and KanCare have everything to do with creating a better Medicaid system, which improves the health outcomes of Kansans and nothing to do with retaliation for *Olmstead* complaints.

Members of this Committee may agree or disagree with the need for change in the state's Medicaid program. Reasonable people differ on goals and the way to achieve them. There is no fault with debate. It is certainly no time for claims of retaliation when the evidence is available to prove otherwise.

Thank you and I will be happy to stand for any questions.