Approved _____
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Senator Paul Hess at
Chairperson

11:00 a.m./p.m. on January 24, 1983, 19__ in room 123-S of the Capitol.

All members were present except:

Senators Bogina, Doyen and McCray

Committee staff present:

Research Department: Marlin Rein, Sherry Brown, Mary Galligan, Ray Hauke, Lyn Goering
Revisor's Office: Norman Furse
Committee Staff: Mark Skinner, Administrative Aide; Doris Fager, Secretary

Conferees appearing before the committee:

Motion was made by Senator Harder and seconded by Senator Werts to introduce a bill regarding certificates of indebtedness to meet state obligations. The motion carried by voice vote.

Budget Memo 83-2 - Medicaid

Staff presented a portion of Budget Memo 83-2 (See Attachment A). The Chairman announced that it would be completed at the next meeting of the committee.

The meeting was adjourned by the Chairman.

Budget Memo No. 83-2
Legislative Research Department

SUBJECT: Medicaid Cost Containment Options

Introduction

National data reflects that overall expenditures related to the Medicaid program have increased an average of 15.5 percent annually, during the years 1974 through 1979.* Kansas data for that period indicates a similar trend, as the average annual increase was 16.8 percent in the Kansas medical assistance program. That rate of increase has slowed in Kansas, as gross medical assistance program costs have increased only 8.4 percent annually, during the most recent 5 fiscal years (1977 through 1982). However, that decline in average rate of increase was largely due to programmatic reductions which occurred during FY 1978 and FY 1982.

Many governmental programs have increased at rates equalling or exceeding Medicaid, particularly those requiring high degrees of technology, such as involved in medical science. Nevertheless, Medical assistance programs receive considerable scrutiny at both the state and federal level. This scrutiny is largely due to the large overall outlay and to the general perception that medical assistance costs are uncontrolled. A recent survey of states reflects that the majority spend between 6 to 10 percent of the total state budget on medical assistance programs.** Kansas is in that range, with approximately 8.2 percent of the FY 1982 budget projected for medical assistance expenditures. The perception that medical assistance costs are uncontrolled results from the frequency with which states have been required to appropriate supplemental funds for the purpose of financing unbudgeted medical assistance expenditures. As most legislators are aware, Kansas has experienced such supplemental appropriations several times during recent years.

This memorandum reviews various components of the medical assistance program and details recent cost containment actions as well as those which are proposed for the upcoming fiscal year. Additionally, the memorandum mentions the limitations which impact each of the subject areas.

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* The Medicare and Medicaid Data Book, 1981 Health Care Financing Administration, U.S. Department of Health and Human Services.

** State Medicaid Budget Process, John E. Leuhrs, the Intergovernmental Health Policy Project.

Method of Analysis

Many volumes have been written concerning medical assistance. Given the fiscal condition of many states, many additional volumes are likely to be developed concerning methods of cost reduction. Consequently, the analytical techniques which may be employed are numerous. It is generally agreed that three basic factors control expenditures: persons eligible, services offered, and reimbursement for services. Each of those factors will be reviewed in this memorandum, although reimbursement procedures will generally be discussed as a part of services offered. The technique used in this memorandum will be analysis of the program relative to: (1) items mandated to occur by prevailing law and regulation; (2) items allowed to occur under prevailing law and regulation; (3) present SRS practice in program operations; and (4) proposals for change. Given this framework, it will be possible to review the operation of the program compared to its requirements and allowances. This form of comparison allows decisionmakers to more readily review potential program changes in light of what is both permitted and required.

All major categories of eligibility will be briefly mentioned. Only six major services will be reviewed; however, those six services comprise over 90 percent of the revised FY 1983 medical assistance budget, with the remaining 13 services comprising less than 10 percent of that budget. Overall federal requirements are contained in Title XIX of the Social Security Act, which governs conditions under which federal financial participation is available. State statutes governing this program are generally contained in Section 7 of Chapter 39 of Kansas Statutes Annotated.

Eligibility

Requirements. Participation in Title XIX requires states to extend medical assistance eligibility to a group known as the categorically needy. There are certain persons who must be included as categorically needy and states have certain options to define others as categorically needy. States must include all ADC recipients, SSI recipients, and individuals terminated from assistance due to increased earnings or hours of employment (for a period of up to four months). Further, states may include individuals who are between the ages of 18 and 21 and regularly attending school. Inasmuch as the unemployed parent component of ADC is optional coverage, then the medical services to those persons is also optional. Nevertheless, states cannot extend cash benefits to such persons but deny them medical assistance.

States may extend Title XIX financed services to another category known as the medically needy. These are persons meeting all other criteria for ADC or SSI but ineligible for cash benefits due to excess income. Title XIX provides that medical assistance may be provided to such persons having a monthly income up to 133 1/3 percent of the state's maximum assistance payment to similarly sized ADC families. Through spenddown provisions, incorporated in Title XIX, coverage may be extended to persons having income above the 133 1/3 percent level, who also have high medical expenses that reduce their net income below the medically needy maximum.

Although coverage of the medically needy is optional, specific mandates govern that program if states elect to offer such coverage. Certain requirements must be met for extending eligibility to all qualified medically needy individuals (i.e., states

cannot serve those persons categorically related to SSI but exclude from coverage those persons related to ADC). Prior to federal FY 1982, medically needy programs were required to both serve all categories of the medically needy and to extend the same services to all categories of the medically needy. P.L. 97-35 modified this requirement to provide the following:

1. If a state provides services to any medically needy group, it must provide ambulatory services to children and prenatal and delivery services to pregnant women.

2. If a state provides institutional services to any medically needy group, it must provide ambulatory services for that group.

3. If a state provides coverage for medically needy persons in specialized facilities for the mentally retarded (known as ICF-MRs) it must offer to all groups in its medically needy program the same mix of services required under previous law. (Note: that mix of services is described elsewhere in the memorandum.)

States may develop virtually any medical program outside of that which is partially financed with Title XIX funds; however, such programs will be financed with all state funding.

Kansas statute is rather flexible regarding medical coverage and provides considerable authority to the administering agency. K.S.A. 39-702(f) defines medical assistance and directs the Secretary of SRS to develop a plan for medical care. K.S.A. 39-708c(b) provides that the Secretary shall not develop rules and regulations requiring partiality in the amount of medical assistance to be given to persons having approximately equal need. K.S.A. 39-709(e) provides for medical assistance to be given to persons whose resources and income do not exceed levels prescribed by the Secretary. This section also allows the Secretary to provide for income and resource exemptions and protected income and resource levels. Finally, K.S.A. 39-709(f) allows SRS to provide medical care to certain Kansas residents, outside the state, until such time as they are physically able to return to Kansas.

Present Kansas Eligibility. As Kansas participates in federal Medicaid it obviously provides medical coverage to ADC and SSI recipients. Kansas operates an unemployed parent component of ADC and therefore provides automatic medical coverage to such persons. Kansas no longer provides automatic medical eligibility to persons between the ages of 18 and 21 and attending school full-time. Medical services to the categorically needy are estimated to comprise approximately 46 percent of the revised FY 1983 medical assistance budget.

Kansas is one of approximately 31 states providing coverage to the medically needy. Kansas covers both those categorically related to SSI and categorically related to ADC. Kansas has not routinely increased its maximum income levels for the medically needy program but has routinely increased its ADC standards. Therefore, Kansas is not extending eligibility to the full 133 1/3 percent of maximum AFDC benefits, as Title XIX would permit. The following table shows maximum monthly income guidelines for persons in independent living and 133 1/3 percent of the maximum allowable monthly ADC standard. The maximum income levels are also known as protected income, levels for persons who must meet a spenddown requirement, prior to being eligible for medical assistance.

Family Size	Protected Income Level	133 1/3% of Maximum ADC Standard
1	$ 310	$ 323
2	410	410
3	420	485
4	430	548
5	453	604

Due to the spenddown provisions, individuals having income above the protected income level (PIL) may become eligible upon spending that portion of their income above the PIL for medical expenses. For example, an otherwise eligible individual having income of $500, could become eligible upon incurring medical expenses of $190.

Kansas provides automatic medical eligibility to General Assistance (GA) recipients, a program financed entirely with state funds. During FY 1983, medical assistance to GA clients will comprise approximately 13 percent of medical assistance expenditures. Kansas no longer operates a General Assistance - Medical Only program which formerly functioned in much the same fashion as the remainder of the medically needy program. Persons otherwise eligible for GA, except for excess income, could receive state financed medical assistance upon meeting spenddown requirements. This program was abolished at the beginning of FY 1982.

Proposed Eligibility Amendments. The FY 1984 SRS budget request proposed only one change in eligibility standards. That proposal was a reduction in the eligibility criteria for General Assistance, which has a concurrent reduction in medical assistance eligibles. As a further cost containment measure, the Governor's recommendation includes elimination of adult caretaker relatives from the ADC-Medical Only program.

Eligibility Options. As can be concluded from abovementioned percentages approximately half of medical assistance expenditures are optional as far as the state's participation. Even among the categorically needy, participation is optional related to the unemployed parent component of ADC. Nevertheless, as will be mentioned in the following discussion on services, total elimination of significant portions of the program would be difficult, despite those expenditures being, in fact, optional. Further, state participation in medical assistance for GA recipients is entirely optional. It is generally agreed that curtailing eligibility is one of the easier methods of reducing costs but one of the more difficult to enact, due to its impact upon individuals.

Services

Requirements. Title XIX of the Social Security Act provides federal financial participation for 16 basic services. Not all services are mandated by the act. To some degree services are intermingled with eligibility. The 16 basic services are as follows from Section 1905 of the Social Security Act:

1. Inpatient Hospital;
2. Outpatient Hospital;
3. Laboratory and X-Ray;
4. Skilled Nursing Facility Services;
5. Physicians Services;
6. Home Health Care;
7. Medical or Remedial Care recognized under state law;
8. Private Duty Nursing Services;
9. Clinic Services;
10. Dental Services;
11. Physical Therapy;
12. Prescribed Drugs, Dentures, and Prosthetic Devices;
13. Other diagnostic screening, and Rehabilitative services;
14. Hospital or Nursing Home services for persons 65 years of age or older and residing in an institution for tuberculosis or mental diseases;
15. Intermediate Care Services (other than such services in an institution for tuberculosis or mental disease); and
16. Inpatient psychiatric hospitalization for individuals under age 21.

Title XIX further specifies that the categorically needy must receive services enumerated in items 1 through 6 above. The medically needy must receive either services 1 through 5 or any seven of the abovementioned services. As previously mentioned, 1981 Congressional action amended the service mix mandated for medically needy programs. However, as Kansas provides specialized care for the retarded in ICF-MRs, the above provision continues to apply to services required for Kansas participation in its medically needy program.

In addition to the 16 basic services, 1981 amendments to Title XIX (contained in Section 2176 of P.L. 97-35) provide that the traditional list of Medicaid eligible services can be expanded under specified conditions to include selected social services. This provision requires a waiver of traditional requirements by the Secretary of Health and Human Services. Waivers are available for services that reduce or prevent placement in skilled nursing facilities or intermediate care facilities. Waivers can be granted only if: total costs of proposed state programs do not exceed the total costs of serving persons at risk of institutionalization under current programs; the state preserves the integrity of patient choice; written plans of care are developed for each person provided waivered services; and it can be demonstrated that the services are based upon an individual's needs and not short-term cost savings.

Prior to 1982, Title XIX allowed states to assess co-payments for all optional services. Co-payments could not be charged of the categorically needy for mandatory services. The co-payments are limited by the total cost of the service. Basically, a 50 cent co-payment can be charged for services which total $10 or less and a $1.00 co-payment can be charged for services which total between $11 and $25.

Amendments during 1982 increased flexibility for co-payments by allowing co-payments for all but the following:

1. services to children under 18;
2. services related to pregnancy;
3. services to inpatients of nursing homes;
4. services of HMO enrollees;
5. family planning services; and
6. emergency services.

Kansas statute does not specifically address services which are mandated or allowed. Kansas law does address reimbursement for services in K.S.A. 39-708c(x). That section specifies that

> "The Secretary of SRS shall establish payment schedules for each group of health care providers. Any payment schedule established by the Secretary shall be based, as appropriate, on either reasonable charges, reasonable costs or prospective rates and shall be subject to the federal social security act and state law and to rules and regulations adopted under said act and such law . . . "

Present Kansas Services. Kansas provides a full range of services, not limiting its program to the mandatory services. Additionally, Kansas makes the same range of services available to both the categorically needy and the medically needy. Further, Kansas provides the full range of services to its General Assistance clients. Nevertheless, within each of those services, states are given considerable flexibility to establish limitations in the quantity of services which will be financed. Consequently, few services are open-ended in the total quantity of services for which SRS will reimburse.

Several of the allowable Title XIX services actually include more than one service (i.e., item 6 would include chiropractic and podiatric, while item 12 includes a very wide range of actual services). For this reason SRS budgets for more than 16 services. The services separately budgeted by SRS include:

Inpatient Hospital
Outpatient Hospital
Psychiatric Hospital
Home Health Services
Rural Health Services
Laboratory Services
Prescription Drugs
Family Planning Services
Medical Transportation
Physician
Dental
Optometric
Mental Health Centers
Rehabilitation Services
Podiatry
Chiropractic Services
Audiology
Medical Supplies
Alternate Services

As can be noted from the above designation of Alternate Services, Kansas has received a waiver of traditional Title XIX services and provides alternate care as an option to nursing home care.

FY 1984 Proposal. The original SRS budget did not propose elimination of services. However, the Governor's recommendations propose expenditure reductions of $4.6 million due to reductions in optional services. Specifically mentioned are reductions in dental services, pharmaceuticals, podiatry services, and mental health services.

Service Considerations. The mandatory services (excluding those to GA clients) are estimated to comprise approximately 35 percent of the revised FY 1983 budget. Further, mandatory services to the categorically needy comprise only 29 percent of the revised FY 1983 budget. These statistics seemingly indicate a considerable majority of the program is voluntary, which legally is a correct assumption. The above statistics exclude Intermediate Care Facility expenditures, which comprise approximately 38 percent of medical assistance expenditures. Although optional, services in ICFs are purchased on behalf of approximately 12,000 persons. Realistically, it would be extremely difficult to eliminate services to such a large number. Additionally, ICF-MR reimbursements comprise an important funding mechanism for state hospitals. If one assumes that ICF care will not be eliminated, the percentage of the budget which is "nonoptional" increases to approximately 73 percent.

However, that computation excludes prescription drugs, another optional service. Nevertheless, if a state is seriously attempting to operate a medical assistance program, it is extremely difficult to do so without pharmaceuticals. Inclusion of that total increases the "nonoptional" aspects of the program to approximately 79 percent.

It is occasionally mentioned that Kansas operates a relatively generous program, which it does. Nevertheless, a number of the services offered could be eliminated without substantially reducing expenditures. As a result, discussion of cost containment frequently becomes a discussion of methods which can be employed to reduce expenditures in the major service (and consequently expenditure) categories.

Obviously most efforts attempt to adversely affect as few people as possible. Succeeding sections of this memorandum review the six services having the highest expenditure levels. Coincidentally, most proposals for expenditure reduction impact these services. Tabular displays accompany each service and detail expenditures, gross units of service, and average cost per unit. The six services in descending proportion of the revised FY 1983 medical assistance budget are as follows:

Service	Percentage
Adult Care Homes (includes: Skilled Nursing, ICF, and ICF-MR)	38.9%
Inpatient Hospital	29.0
Physician	9.5
Pharmaceuticals	6.5
Outpatient Hospital	4.2
Mental Health Centers	2.9

For purposes of discussion, Adult Care Homes are reviewed as a single service, although three separate types of adult care homes are reimbursed, as noted in the above listing. Expenditure and utilization data are from SRS Medical Assistance Category of Service Reports.

Adult Care Homes

Intermediate Care Facilities

	Expenditures	Average Recipients	Recipients Increase Over Prior Year	Average Expenditure Per Day	Average Expenditures Per Day Increase Over Prior Year
FY 1983 (6 mo.)	$ 36,889,737	11,285	(2.5)%	$ 17.59	2.2%
FY 1982	73,731,913	11,574	.1	17.21	4.7
FY 1981	69,912,154	11,563	3.9	16.43	7.3
FY 1980	62,981,928	11,128	(.8)	15.31	9.4
FY 1979	55,196,462	11,214	—	13.99	--

Intermediate Care Facilities — Mental Retardation

	Expenditures	Average Recipients	Recipients Increase Over Prior Year	Average Expenditure Per Day	Average Expenditures Per Day Increase Over Prior Year
FY 1983 (6 mo.)	$ 4,464,511	696	2.7	$ 34.56	6.4%
FY 1982	8,127,750	678	(19.6)	32.47	13.6
FY 1981	8,897,327	843	(12.6)	28.59	14.9
FY 1980	8,921,135	965	(24.8)	24.89	59.7
FY 1979	7,818,355	1,283	—	15.58	—

Skilled Nursing Facilities

	Expenditures	Average Recipients	Recipients Increase Over Prior Year	Average Expenditure Per Day	Average Expenditures Per Day Increase Over Prior Year
FY 1983 (6 mo.)	$ 885,516	297	2.1%	$ 23.19	3.3%
FY 1982	1,946,514	291	(19.8)	22.44	6.7
FY 1981	2,381,709	363	6.5	21.04	7.8
FY 1980	2,148,499	341	(11.2)	19.52	31.4
FY 1979	1,882,914	384	—	14.86	—

Alternate Care Services

	Expenditures	Average Recipients	Recipients Increase Over Prior Year	Average Expenditure Per Day	Average Expenditures Per Day Increase Over Prior Year
FY 1983 (6 mo.)	$ 620,251	2,406	27.0	$ 12.80	(8.2)%
FY 1982	1,158,089	1,894	(3.4)	13.94	(9.0)
FY 1981	1,032,510	1,961	32.5	15.32	(2.1)
FY 1980	975,774	1,480	15.7	15.65	(48.6)
FY 1979	911,688	1,279	—	30.45	—

(Note: Statistics include only home health care prior to FY 1983.)

Requirements. States are required to offer Skilled Nursing Facility (SNF) services. As previously mentioned, coverage in intermediate care facilities (ICF) and intermediate care facilities for the mentally retarded (ICF-MRs) is optional. Further, the definitions of intermediate care facilities specify that services may be offered to mentally retarded persons only if the facility specializes in such care. Consequently, ICF-MRs become a requirement if a state is serving mentally retarded persons at the ICF level of medical care. Facilities must be licensed by the state and must meet federal certification standards.

A physician must certify that ICF or SNF care is necessary. Additionally, prior to Medicaid payment an interdisciplinary team must review and evaluate the patients need for care, although this team typically consists of representatives of the facility to which the patient is being admitted. Further, a utilization review of continued stay must occur at least every six months. This utilization review cannot be conducted by anyone responsible for the patients care; employees of the nursing home; or persons having a financial interest in a nursing home.

Prior to federal fiscal year 1981, states were required to reimburse adult care homes on a reasonable cost related basis (Section 1902(a)(13)(E)). During 1980, Congressional action changed this provision to specify that states must reimburse at rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.

Kansas Program. Kansas reimburses for care in SNF, ICF, and ICF-MR facilities. The Kansas program has changed considerably during the last year. Consequently, the program, both in the immediate past and the present, will be briefly mentioned. Formerly, reimbursement was granted for any eligible person, having a valid physician's order specifying the need for ICF care. The need for continued care was (and still is) documented by purchased utilization review arrangmeents or certification by the SRS staff involved in Medical reviews.

In addition to the above, a screening process has been implemented, which is designed to assure the medical necessity of adult care home services and utilize alternative care whenever possible. Within 30 days of admission to an adult care

facility (and prior to admission whenever possible) the applicant/patient is screened by a team, typically consisting of an SRS Social Worker and a nurse. The nurse is usually an employee of a local health department. Local health departments are reimbursed at not more than $26.75 per screening. The team applies a numerical scaling technique, in which the client's mobility, mental ability, and personal care ability are quantified. The result of this scaling indicates the general need of the client for adult care home services; however, overall medical condition and not a simple test score is considered in making the final decision concerning the need for adult home care.

If the screening team determines that the client is in medical need of adult care home services, the client can be given the choice of alternate care services, provided such services can be offered at less cost than adult care home placement. If the screening team determines that there is not a medical necessity, no reimbursement can be made for adult care home services. Alternate care generally consists of such in home services as homemaker, home health, attendant care, and wellness monitoring.

SRS pays adult care homes according to a plan approved under the previous federal standard of reasonable cost related reimbursement. Separate rates are set for each of the major service categories (SNF, ICF, and ICF-MR). The rate setting mechanism is prospective. Each provider submits a cost statement, which details allowable costs during the most recent facility fiscal year. Costs are divided into four cost centers (administration, property, health care, and room/board). Limits are placed upon each cost center, utilizing a rank ordering of facility costs by cost center. Those limits are established according to percentiles, presently: 75th for administration; 85th for property; and 90th for health care and room and board. Further, an overall cost center, presently limited to the 75th percentile, controls total facility costs. Providers having overall costs below the 75th percentile essentially receive a rate that is their cost of operation, provided their costs do not exceed the limits within individual cost centers. Providers having costs above the 75th percentile receive the overall limit. During FY 1983, the overall daily limit per patient is $28.16 for ICFs; $42.83 for SNFs; and $41.24 for ICF-MRs.

Allowable daily rates are based upon costs assuming the facility is at least 85 percent occupied. Additionally, an efficiency factor (between 10 cents to 50 cents per patient day) is allowed for facilities having costs below specified percentiles in the administration and property cost centers.

FY 1984 Proposals. The FY 1984 request presumes no change in reimbursement methodologies or eligibility for services. Nevertheless, the FY 1984 request at budget levels A and B assumes a reduction of approximately 500 persons being served in adult care facilities and therefore assumes reductions of $3,481,819, in adult care home expenditures. Of this amount, it is assumed that expenditures will be reduced by $1,516,165 due to diverting approximately 200 persons from adult care home placement at the time of admission through the screening process. Additionally, expenditures will be reduced by $1,965,654, due to transferring 300 persons presently in ICFs to alternate care. Those reductions are partially offset by an increase of $1,965,654 in budgeted expenditures for alternate care.

Further, proposed expenditure reductions are partially offset by a request to develop specialized nursing facilities for the mentally ill that would serve approximately 300 persons. This proposal is based upon an anticipated federal audit exception. There is no legal basis for federal financial participation in the care of mentally ill persons under age 65 in ICFs. Kansas has such persons located in ICFs. The U.S. Department of Health and Human Services has taken audit exceptions on several states

having similar care. This proposal would develop specialized ICFs for such persons and the care would be financed entirely with state funds.

As can be seen from the tables preceding this section, the average number of persons in ICFs has declined by approximately 300 during the first six months of FY 1983 when compared to the average number served during FY 1982. Conversely, alternate care services are being rendered to an average of 600 more persons than during FY 1983. The average cost per service in alternate care appears to be declining; however, this is likely due to increasing purchase of less specialized care. During previous years home health services were generally limited to specific types of more intensive medical care.

In Patient Hospital

	Expenditures	Hospital Days	Days Increase Over Prior Year	Average Expenditure Per Day	Average Expenditures Per Day Increase Over Prior Year
FY 1983 (6 mo.)	$ 36,581,657	131,810	(5.2)%	$ 277.53	15.9%
FY 1982	66,578,001	278,140	(9.7)	239.37	23.8
FY 1981	59,579,386	308,116	2.5	193.37	13.4
FY 1980	51,247,137	300,592	(6.8)	170.49	14.9
FY 1979	47,888,806	322,638	—	148.43	—

* Based upon average monthly services to date.

Requirements. Inpatient hospitalization is a required service for categorically needy persons. Facilities must be licensed and have a utilization review plan applicable to Medicaid patients. Additionally, facilities must meet all requirements for participation in Medicare. Although states were allowed to place limits on the days of hospitalization for which they would pay, the medical necessity of the hospitalization itself must be demonstrated, typically through utilization review.

Prior to federal fiscal year 1982, Title XIX (Section 1902(a)(13)(D)) specified that hospitals must pay for the reasonable cost of providing the service. Facilities can be reimbursed their charges, if their charges are less than their costs. Reasonable costs have traditionally been measured using allowable cost standards for the Medicare program.

P.L. 97-35 changed the above requirement during 1981 and it now specifies that states must reimburse at rates that are reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility.

Kansas Program. Kansas provides inpatient hospitalization to all persons covered by its Medical Assistance plan, including the medically needy and General Assistance clients. Presently, Kansas is reimbursing hospitals at the former requirement of the lesser of costs or charges; however, an FY 1984 proposal would change this dramatically.

For several years, utilization review has been under direction of the Kansas Foundation for Medical Care (KFMC), which is the Professional Standards Review Organization (PSRO) in Kansas. Kansas has paid for most hospital services in which medical necessity has been demonstrated by the PSRO. At various times it has been threatened that SRS would limit days of coverage to specific percentiles contained in regional norms. However, this policy has not been implemented. The agency generally will not pay for nonemergency weekend admissions; psychiatric stays of more than 21 days; or substance abuse stays of more than 8 days. Additionally payment will not be made for inpatient services that could be performed on an outpatient basis, unless accompanied by specific documentation of medical necessity.

In FY 1983, Kansas implemented procedures, which modified the utilization review process. The revised procedures involve contracts with the Sedgwick County Foundation for Medical Care (SFMC) and the Kansas Foundation for Medical Care. Under these contracts, hospital admissions are screened within the first day of admission for the medical necessity of hospitalization. If medical necessity is demonstrated, SRS reimburses for the stay. Although the former utilization review process included admission screening, this screening is considered different in two ways.

The first concerns whether the review is delegated to the admitting hospital. KFMCs operation of the PSRO was almost entirely based upon delegating to each hospital the actual review. The new contracts include review by KFMC or SFMC staff in the counties of Sedgwick, Shawnee, and Douglas, although the hospital delegated model continues to be used in several areas of the state.

Secondly, under these contracts, a standardized evaluation criteria is used through a review manual specified by SRS. Formerly, each delegated hospital could develop their own system as a statewide criteria was not in place.

The screening program has not been in place for a sufficient time to allow evaluation of it. Preliminary statistics indicate a reduction of 5.9 percent in the average monthly days of hospitalization, during the first six months of FY 1983. Nevertheless, SRS days of hospitalization have been decreasing during three of the last four years.

FY 1984 Proposal. The FY 1984 budget proposes no reductions in hospital services covered, although the budget includes expenditure reductions of $10.8 million, due to continued savings associated with the admission screening process and implementation of prospective reimbursement systems.

The major proposal associated with hospitals is FY 1984 implementation of a prospective reimbursement system. The procedure has been negotiated between SRS and the Kansas Hospital Association. During FY 1984, the rate setting mechanism will use 1981 as a base year. Each hospitals Medicaid related costs (including ancillary services costs) and days of Medicaid service will be compiled and utilized to produce an average cost per Medicaid day. Additionally, a statewide average cost per Medicaid day will be computed. To both individual and statewide averages will be applied a negotiated annual inflation rate of between 7 and 10 percent. Seven percent annual inflation has been negotiated for both FY 1982 and 1983.

The statewide average cost per Medicaid day was approximately $240 in FY 1981 and the inflated FY 1984 statewide average will be approximately $276. Those hospitals having an average rate below the statewide average will be reimbursed at their average rate. Hospitals having a rate above the statewide average will be reimbursed at their individual rate for those days of Medicaid service to a limit of 78 percent of the Medicaid days they rendered during FY 1981. For days above 78 percent of 1981 Medicaid days those hospitals will receive a rate which is the average for hospitals having rates below the statewide average (or approximately $220 per day). This limitation will impact approximately 30 hospitals.

An example will clarify the above narrative. The example assumes a hospital provided 100 Medicaid days during 1981 and had an FY 1984 rate of $300. Seventy-eight percent of 100, is obviously 78 days. Consequently, during FY 1984 that hospital would receive $300 per day for the first 78 Medicaid days and would receive $220 per day for days of service above 78 days.

The agreement between SRS and the hospital association provides for annual negotiation of the following: the annual inflation rate (within a range between 7 and 10 percent); the base year; and the limitation on number of days.

The abovementioned rates will be increased by a hospital's teaching costs (if any), which are excluded from the average computations and related limitations. Additionally, hospitals may appeal their limitation on days and that limitation will be adjusted if the number of Medicaid clients in the hospital's jurisdiction has increased disproportionately.

Review of Proposed Procedure. The SRS/KHA agreement appears to have several factors relevant for legislative consideration and analysis. Those factors are delineated in the items which follows:

1. The procedure is simple, when compared to the hospital rate setting procedures of several states. The SRS proposal requires no largescale increase in data gathering or processing by hospitals.

2. The negotiated inflationary factors have certain advantages for both hospitals and the state budget. Hospitals are guaranteed an inflation rate between seven and ten percent. This may become an important guarantee given forecasts of several years of reduced inflation; continued federal scrutiny over both the Medicare and Medicaid systems; continued scrutiny over expenditures by private insurors; economic conditions resulting in increased numbers of Medicaid recipients, and economic conditions resulting in decreased numbers of individuals having private insurance. The biggest advantage to the state is a limit on cost increases. As can be seen from the table preceding this narrative, the inflation rate in hospitals has repeatedly been above the maximums negotiated in this agreement.

3. Hospitals would be restricted by the limit on days. Nevertheless, they are not required to serve patients above those limited days and could direct patients to lower cost hospitals not constrained by reimbursement day limitations. Further, overall Medicaid hospital days are generally decreasing. Consequently, a hospital may be able to serve all Medicaid clients and receive full reimbursement for such, without reaching the limitation of 78 percent of 1981 Medicaid days.

4. Appeal of the days limitation is based upon an increase in total assistance eligibility rolls, not upon increase in hospitalized eligibles. Consequently, many hospitals would have relatively little difficulty demonstrating increased assistance eligibles in their jurisdiction, given the state of the economy, and thereby receiving an increase in that number of days which is without limitation.

5. Seemingly both the hospitals and the state incur the potential for risk in an arrangement where reimbursement is based upon averages. This obviously assumes that the service mix will remain equivalent to that which occurred during the base year. Nevertheless, both sides have the opportunity to renegotiate this base year.

6. The potential for success of this procedure is greatly enhanced due to its endorsement by the Hospital Association

Physicians

	Expenditures	Units of Service	Units Increase Over Prior Year	Average Expenditure Per Service	Average Expenditures Per Service Increase Over Prior Year
FY 1983 (6 mo.)	$ 11,366,291	1,043,682	14.2%*	$ 10.89	3.2%
FY 1982	19,292,269	1,828,333	(5.3)	10.55	3.5
FY 1981	19,677,018	1,931,514	8.1	10.19	8.5
FY 1980	16,778,614	1,787,161	3.1	9.39	3.8
FY 1979	15,679,197	1,733,171	—	9.05	—

* Based upon average monthly services to date.

Requirements. Physicians services are required in the Medicaid program. The scope and duration of services are under general requirements for all services which specify: (1) that states must specify the procedures they will cover and for which eligibility groups those services are covered; (2) each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; (3) states may not arbitrarily deny or reduce services to an otherwise eligible person solely due to diagnosis or condition; and (4) limitations may be applied based upon medical necessity or utilization control.

Additionally, 1981 amendments to Title XIX (contained in P.L. 97-35) authorized "lock-in" procedures, which are designed to lock individuals who overutilize services into a specified provider. Those lock in procedures override general freedom of provider choice provisions which underlie the Title XIX act, but stipulate that individuals must have reasonable access to services.

P.L. 97-35 also contained authority for the Secretary of HHS to waive freedom of choice provisions for purposes of implementing primary care manager systems. These systems are generally designed to allow one practitioner to serve as a "broker" of all services for a client (typically a client who overutilizes services). Clients may not obtain services unless authorized by the case manager.

Physicians are reimbursed under general Title XIX provisions which require: (1) that agencies maintain documentation of payment rates; (2) an estimate of the percentile of the range of customary charges to which payment structures equate; and (3) that payment structures be sufficient to enlist sufficient providers so that Medicaid services are available to recipients at least to the extent that those services are available to the general population.

Kansas Program. Kansas provides physician services to all Medicaid eligibles and provides the same scope of procedures to all eligibles. Generally, physician services are covered subject to the following limitations:

1. one hospital visit per day;

2. no more than three office visits per month without documentation of medical necessity;

3. no more than one nursing home visit per month without documentation of medical necessity;

4. one physical examination per year;

5. multiple office visits on the same day to the same physician; and

6. only one physician will be paid for a patient with a single diagnosis, unless medical necessity is documented.

Formerly Kansas reimbursed all physician services to a limit of the 50th percentile of charges from the most recent Medicare survey. As a cost containment measure, the annual increase associated with this procedure was discontinued. Consequently, the majority of procedures are paid at the 50th percentile of 1976 Medicare charges. An exception exists for 139 procedures, basically those procedures which are performed in physician offices. The provision of those 139 procedures is designed to reduce unnecessary hospitalization and encourage outpatient service. Those 139 procedures are reimbursed at the 75th percentile of FY 1982 charges in the Medicaid program. Kansas has implemented a procedure in which clients having a pattern of unjustified utilization are locked into a particular physician. Presently, no co-payment is assessed for physician services.

FY 1984 Proposals. The FY 1984 budget contains proposals for amendment to physician services.

1. Introduce a $1.00 co-payment for applicable services, as permitted by 1982 Title XIX amendments. This proposal is designed to reduce expenditures by $550,000.

2. Obtain a federal waiver to introduce the primary care manager concept in certain areas of the state, a proposal which is budgeted to reduce expenditures by $872,639.

3. Increase by 5 percent the reimbursement for those procedures designed to discourage inpatient hospitalization. This proposal increases expenditures by $1,600,009.

Prescription Drugs

	Expenditures	Prescriptions	Service Increase Over Prior Year	Average Expenditure Per Service	Average Expenditures Per Service Increase Over Prior Year
FY 1983 (6 mo.)	$ 9,290,256	955,916	3.5%*	$ 9.72	10.8%
FY 1982	16,206,484	1,847,105	(9.3)	8.77	12.6
FY 1981	15,860,554	2,035,826	13.8	7.79	10.8
FY 1980	12,567,318	1,788,866	(6.7)	7.03	14.9
FY 1979	11,743,821	1,918,157	—	6.12	—

* Based upon average monthly services to date.

Requirements. Coverage of prescription drugs is an optional service. The scope of services is under the general requirements for all services, which are enumerated as a part of Physician requirements.

Federal regulations specify that an agency may not pay more than the lower of: (a) ingredient costs plus a reasonable dispensing fee; or (b) the provider's usual and customary charge to the general public. Additionally, the federal government has set maximum allowable drug costs for certain multiple source drugs.

Co-payments have traditionally been allowed on prescription drugs, as they are an optional service. Additionally, 1981 amendments (P.L. 97-35) provide for certain waiver authority for HHS to waive freedom of choice provisions related to pharmaceuticals. This provision allows for introduction of limited competition, provided it is under a plan approved by HHS.

Kansas Program. Kansas has a specific listing of covered pharmaceuticals. Only those drugs are covered when prescribed by a licensed practitioner and dispensed by licensed pharmacies, approved dispensing physicians, or approved hospitals. A 50 cent co-payment is charged for all prescriptions. Certain pharmaceuticals are allowed only when prior authorization is granted.

SRS reimburses pharmacies according to the published price of the drug (subject to abovementioned federal maximums) plus a dispensing fee. The dispensing fee, based upon pharmacy costs, is limited to the 85th percentile of costs and includes a 30 cent profit factor. The present 85th percentile maximum dispensing fee is $4.23. The average is $3.41.

FY 1984 Proposals. The FY 1984 budget request proposes expenditure savings resulting from changes to pharmacy procedures as follows:

1. increase of co-payments to $1.00, resulting in savings of $914,000;

2. alternate reimbursement mechanisms, savings of $125,000; and

3. increasing the number of drugs subject to maximum allowable cost limitations, savings of $100,000.

Initial savings due to alternate reimbursement mechanisms were based upon a waiver to allow certain competitive bidding in various areas of the state. It now appears that these savings would be achieved by increased utilization review and a regulation specifying that if the pharmacy accepts a lesser filling fee from another organization, they must also extend that filling fee to SRS. In addition to the above, proposals contained in the Governor's recommendation mention savings due to reductions in pharmacy services.

Outpatient Hospital

	Expenditures	Service Units	Units Increase Over Prior Year	Average Expenditure Per Service	Average Expenditures Per Service Increase Over Prior Year
FY 1983 (6 mo.)	$ 5,910,640	172,925	17.0*	$ 34.18	14.7%
FY 1982	8,813,654	295,648	(2.9)	29.81	22.7
FY 1981	7,401,485	304,566	26.9	24.30	10.2
FY 1980	5,292,309	240,060	8.8	22.05	(1.5)
FY 1979	4,945,104	220,720	—	22.40	—

* Based upon average monthly services to date.

Requirements. Outpatient hospital services are a requirement of the Medicaid program. General provisions related to scope and duration of service apply to the outpatient hospital program. Federal regulations specify that states may not pay more for outpatient hospitalization than prevailing charges for comparable services in the locality.

Kansas Program. SRS encourages outpatient procedures whenever such would reduce the necessity for inpatient hospitalization. Emergency room services are covered only as the result of an emergency situation. Certain emergency conditions require documentation.

Kansas reimburses outpatient services the lesser of audited costs or charges. No specific proposals underlie the outpatient hospital proposal for FY 1984.

Mental Health Centers

	Expenditures	Claims	Claims Increase Over Prior Year	Average Expenditure Per Claim	Average Expenditures Per Claim Increase Over Prior Year
FY 1983 (6 mo.)	$ 3,031,766	21,327	17.0%*	$ 142.16	(1.4)%
FY 1982	5,256,048	36,472	3.5	144.11	7.4
FY 1981	4,728,613	35,250	26.1	134.15	7.8
FY 1980	3,479,037	27,956	14.6	124.45	(6.6)
FY 1979	3,250,923	24,388	—	133.30	—

* Based upon average monthly services to date.

Requirements. Most services in mental health centers are reimbursed under the federally allowed services of clinic visits and are optional services. General requirements for scope and duration of services apply to this program as do general requirements for reimbursement.

Kansas Program. SRS covers the following services in mental health centers:

1. outpatient therapy, limited to 300 units per calendar quarter; (Note: Individual therapy equals 20 units per hour and group therapy equals 4 units per hour. Consequently, a client could receive 15 hours of individual therapy per quarter or 75 hours of outpatient therapy.)
2. psychological testing, limited to 6 hours per year;
3. admission evaluation, limited to 4 hours per year;
4. inpatient services, limited to 21 days;
5. case conferences, billed as inpatient therapy; and
6. day treatment programs.

Mental health facilities are reimbursed the lesser of audited costs or charges as demonstrated by 1980 cost statements. A limitation of $76 per day exists on day treatment programs. The FY 1984 Governor's recommendation proposes reductions in expenditures for community mental health services.

Conclusions

Principally due to the large expenditure involved in medical assistance programs, coupled with the fiscal crisis experienced by most states, medical assistance is an area for continuing scrutiny. This scrutiny is leading to a variety of proposals for cost containment. Those proposals range from simple curtailment of eligibility or services to highly complex alterations of reimbursement mechanisms. Additionally, some states are experimenting with approaches that introduce competition into a program, which has traditionally not been so constrained.

The preceding pages summarize previous attempts and proposed attempts to reduce expenditures in Kansas. With the exception of abolishing GA-Medical Only, most of these previous attempts have not eliminated overall eligibility or service availability for large groups of individuals. Most have focused upon changing reimbursement policies or mandating enhanced standards of medical necessity. It can be argued that restricting reimbursement and increasing standards of medical necessity shifts a burden to service providers, an allegation which has some validity. Nevertheless, curtailing eligibility frequently contains a similar burden for service providers, as they often provide those services without reimbursement. Selective abolition of services typically has a disadvantage of penalizing only certain clients or providers. Although wholesale service elimination is occasionally utilized as a cost containment measure, it must be applied with considerable thought. In some instances, elimination of specific services increases utilization of others, frequently at higher cost.

This memorandum has summarized the basic Medical Assistance program, showing that a considerable portion of it is voluntary from a strictly legal perspective. The memorandum summarizes program requirements and Kansas policies in an effort to assist Legislators in reviewing potential changes to this highly complex program.