Approved: 3-6-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting of the President's Task Force on Medicaid Reform was called to order by Chairperson Senator Stan Clark at 12:00 Noon on February 6, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research
Norman Furse, Revisor of Statutes
Ann McMorris, Secretary

Conferees appearing before the committee:

Others attending: See attached list

The following materials obtained by Legislative Research were supplied to each member of the committee for their study of the Medicaid issues.

1. Medicaid Survival Kit
2. Five - Medicaid Audits conducted by Legislative Post Audit
3. Recap of Post Audits on Medicaid (Attachment 1)
4. NCSL handout

Chairman Clark welcomed the members of the Task Force and the audience and indicated this would be informal discussion and he would be asking for participation from the audience as well as the committee for suggestions for future meetings. He noted the Task Force's goal will be to look at the big picture of Medicaid and have discussions on all issues of concern for the future recommendations by the task force.

Announcements on scheduled task force meetings -

Monday, February 10 – 9:30 a.m. to 10:30 a.m. Room 231-N
Monday, February 10 - 3:30 p.m. (or adjournment, if later) - 234-N
Thursday, February 13 - 3:30 p.m. Room 234-N - Prescription Drugs
Monday, February 17 - 3:00 p.m. Long Term Care
Tuesday, March 4 - 9:00 a.m. to 5:00 p.m. - 519-S

Chairman Clark announced that Donald Muse has been hired as a consultant and on Monday, February 10, at 3:30 p.m. in Room 234-N there will be a taped slide presentation by Mr. Muse on comparison of costs on prescriptions.

Other issues to be considered in the committee deliberations: nursing home administration, foster care, reimbursement of physicians and hospitals; health care laws; role of providers; and civil rights of Medicaid.

Chairman Clark noted a mandate has been handed down by the Governor to streamline the Medicaid process, make it cost effective, and provide better services.

The next meeting of the Task Force will be on Monday, February 10.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachment - 1

President's Task Force on Medicaid Reform

DATE: FEBRUARY 6, 2003

Noon Session

Name	Representing
Bob Harder	UMC - KS
Tom Bruno	EDS
Bob Addesso	KPSC
Bob Williams	KPHA
Ryan Schrink	"
Robert Day	SRS
Dawn Howard	SRS
Marianne Deagle	SRS
Trent Reday	Sen Pres Off
Barb Hinton	Post Audit
L Murdie	Post Audit
Michelle Peterson	Kansas Governmental Consulting
Jennifer Schwartz	ASSISTIVE TECH FOR KANSANS
Josie Tafoya	KACIL
Nancy Pierce	KHCA
Bill Speed	UKHA / Merck

President's Task Force on Medicaid Reform

DATE: FEBRUARY 6, 2003

Name	Representing
Patrick R Hubbell	Pfizer
Mike Hammond	Assoc. of CMHCs of KS
LINDA LUKENSKY	KS Home Care Assoc
~~Gary~~ Kansas Robbins	KS Optometric Assn
Cindy Kabeline	KS Area Agencies on Aging Assoc.
Kirk Lowry	TLRC tlrckl@tlrc.org
Shannon Jones	SILCK SHANOZ@aol.com
Joyce DeMott	Kansas Association for Medically Underserved
Jason Gallagher	Independent jason@ibelievedesign.com
S Therese Bangert	Ks. Catholic Conf.
Mary Ellen Conlee	Via Christi Regional Medical Center
Mike Hein	Hein Law Firm
Tom Bell	KHA
JERRY SLAUGHTER	KMS

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RECAP: Cost Savings Ideas Identified in Recent Medicaid Audits Conducted by the Legislative Division of Post Audit

August 2002 **Medicaid Cost Containment: Controlling Costs of Long-Term Care**

Contact person: Laurel Murdie, Audit Supervisor 296-5153

SRS and the Department on Aging could do more to limit the number of people eligible for long-term care services and could do more to limit what Kansas pays for such services. Cost containment options include:

Raise the minimum score needed to functionally qualify for Medicaid. (P. 17) The Department on Aging provided the 2002 legislature with estimates showing the impact of raising the eligibility score for the frail elderly waiver and nursing facility programs.

Cost savings if the eligibility score were raised from 26 to:	30	$ 493,149
	40	1,838,241
	50	4,571,209

Cost estimates weren't available for other waiver programs

Lower the amount of "protected income" so applicants would be required to use more of their own income to pay for long-term care services. (P. 19) In March 2002, SRS estimated that reducing the protected income level for 3 waiver programs by $50 could save the State $977,000 a year. Reducing it by $100 could save about $2.1 million annually.

Continue to use waiting lists for waiver services. (P. 21). Anyone who is eligible for services and is placed on a waiting list for community services can still choose to go to a nursing facility or other institution for those services. However, many people aren't willing to consider institutional care, so this solution would likely reduce costs in the short-run.

Use spending caps per consumer. (P. 22) Kansas has chosen not to refuse community-based services for individuals for whom institution-based care would cost Medicaid less. However in fiscal year 2001 more than 900 people who received waiver services in the community likely cost the Medicaid Program about $9 million more than they would have if they have received services in institutions.

Reduce unnecessary services by systematically reviewing and analyzing claims data. (P. 22) Agency officials need to analyze key information that is available to them. For example:

- determine which services are being used more often and why, and investigate less costly ways to provide those services
- determine whether consumer needs are increasing over time, by tracking assessment scores
- determine, over time, whether more or fewer needs are being met by unpaid caregivers

Strengthen efforts to identify and recoup amounts paid in error. (P. 23) In 1999 and 2001 SRS conducted payment accuracy studies to look at the appropriateness and accuracy of payments made to providers. In both years it found numerous errors in payments, although accuracy improved from 1999 to 2001. Further reductions in errors could produce additional savings.

Increase the number of people who have long-term care insurance. (P. 25) About half of Kansans rely on Medicaid to pay for their long-term care, whether in the community or in an institution. Increasing the number of people with long-term care insurance will, over the long run, reduce the amount the State pays. Ways to do that include:

- offering a tax credit or a special deduction for long-term care insurance premiums
- making long-term care insurance more attractive or affordable for low-income seniors.
- raising public awareness about the need for long-term care insurance

Freeze nursing facility reimbursement rates or delay rate increases. (P. 26) Reimbursement rate increases for 2003 were limited after the 2002 Legislature reduced the Medicaid nursing facility budget. Department on Aging officials estimate costs could have increased as much as $19 million without the limit.

March 2002

Medicaid Cost Containment: Controlling Costs of Medical Services

Contact person: Laurel Murdie, Audit Supervisor 296-5153

Options for controlling costs fell into 3 areas: reducing the number of people enrolled, reducing coverage, and paying less for services.

Eliminate funding for people Kansas is not federally required to serve. (P. 30) State General Fund expenditures (in millions) for these people in fiscal year 2001 totaled $73.4 million:

• people who are "medically needy" but whose income exceeds Medicaid guidelines	$ 58.3
• general assistance to adults awaiting federal SSI determination	12.6
• certain children receiving adoption support	2.4
• institutionalized children	.1

Serve only the most needy. (P. 32) Kansas' eligibility guidelines are already pretty restrictive, but the State could take 2 more steps:

- set limits on the value of assets (home, car, personal belongings, etc.) that aren't counted when determining whether a person meets the income limits for Medicaid.
- reduce the level of income that is "disregarded" or "protected" when determining whether a person meets the income guidelines for Medicaid

Reduce the length of time people are eligible for services. (P. 32) Federal rules require eligibility to last for a certain period of time after a person is determined eligible. Kansas exceeds those time periods in two areas: the State provides 12 months, rather than the required 6 months, of continuous eligibility for children and for people no longer eligible for Family Medical coverage because their earnings are too high.

Eliminate coverage for non-mandatory services. (P. 33) Kansas provides many optional services that aren't federally required. The State's cost of providing those services in fiscal year 2001 was $93.1 million. The highest cost optional services are broken out below.

• pharmacy	$ 71.6
• mental health centers	7.5
• behavior management	3.8
• supplies	3.6
• targeted case management for the frail elderly	2.6

Expand the use of co-payments. (P. 34) Although co-payments can't be required for certain services, such as pre-natal care, small co-payments for other services would reduce expenditures and could discourage unnecessary services. There is a $2 co-payment for most prescription drugs dispensed.

Reduce unnecessary services by systematically reviewing and analyzing claims data. (P. 35) As one of the largest providers of health care services in Kansas, SRS should do such things as

- monitor and compare actual service expenditure and usage information against expected outcomes
- coordinate care for people who aren't in managed care (very few elderly and only about half of disabled people - the most expensive Medicaid beneficiaries-are in managed care) SRS officials said they would begin using nurses to manage care for high-use consumers with chronic medical conditions in October 2002.
- ensure services are being provided by the most cost-effective providers. An SRS review of home health services found that 83% of skilled nursing visits could have been provided by a person with less formal training. The study concluded Medicaid could have saved $4 -5 million by having these services provided by the lowest level qualified provider.

January 2002 **Medicaid Cost Containment: Controlling Fraud and Abuse**

Contact person: Barb Hinton, Legislative Post Auditor 296-3792

This audit identified problems in the effectiveness of the State's effort to find and control potential Medicaid fraud, including:

- The Surveillance and Utilization Review (SUR) Unit staff generally didn't follow up on anomalies they saw in computerized data that could point to potentially fraudulent or abusive billing practices, much of the Unit's work didn't focus on the highest risk or most lucrative areas, and Unit staff didn't do much additional analysis outside the standard reports. (P. 20, 23)
- SRS hasn't done much with the information it has gotten from the SUR Unit that pointed to potential problems

March 2001 **Medicaid for Long-Term Care: Reviewing the Department of Social and Rehabilitation Services' Efforts to Identify Inappropriate Means of Sheltering Assets to Qualify for Medicaid**

Contact person: Laurel Murdie, Audit Supervisor 296-5153

Federal regulations provide basic guidelines for analyzing applicants' assets to determine whether they are eligible for Medicaid, but the regulations give states flexibility in determining which and how much of an asset is "countable".
Several of Kansas' requirements are more lenient than in surrounding states, which allows Kansas applicants to shelter more assets. (P. 11) For example, in Kansas:

- at least 1 car is considered non-countable, regardless of its value. Three other states only exempt the first $4,500 of value.
- the fair market value of income-producing property, such as a business or farm, is non-countable Four other states count the value of income-producing property in excess of $6,000.
- personal property, such as jewelry, antiques, and household goods are non-countable regardless of value. Four other states count the value of personal property in excess of $2,000.

SRS could do more to ensure applicants haven't made transfers or created trusts within 3 - 5 years of applying for Medicaid. (P. 14) For example, the agency could require applicants to provide residential addresses for the past 3 - 5 years, copies of income tax returns for the past 5 years, and copies of life insurance policies held in the past 3 years.

SRS could routinely perform computer cross-matching with other agencies' databases to determine whether applicants own additional real estate or motor vehicles. (P. 17)

March 2000 **Reviewing the Medicaid Program's Use of Generic Drugs**

Contact person: Jill Shelley, Audit Supervisor 296-5696

For a sample of high-expense or high-use drugs, Medicaid paid for the generic version of those drugs more than 80% of the time. Opportunities to reduce expenditures include:

- paying for brand-name drugs when they are less expensive than the generic version, either before or after rebates are taken into account (P. 9)
- using generic drugs when they are cheapest and appropriate for the patient (P. 10)
- expanding coverage of over-the-counter drugs as an alternative to more costly prescription drugs (P. 17)
- requiring prior authorization for more drugs, particularly high-cost drugs (P. 18)
- requiring the most cost-effective drug therapy to be prescribed first (P. 18)
- expanding educational efforts to encourage physicians to focus on cost-effective drug alternatives (P. 18)
- counseling patients with chronic conditions on how to manage those conditions (P. 19)
- requiring use of "starter doses" of new prescriptions to make sure medication is working (P. 19)
- splitting larger-dose tablets of certain prescription drugs (P. 19)
- reducing the amount paid to pharmacies for drugs (P. 20)

you need additional information, please call the contact person identified for each audit or call the Legislative Division of Post Audit at 96-3792.