Approved: 3-7-03
Date

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

The meeting was called to order by Chairperson Senator Stan Clark at 9:00 a.m. on March 4, 2003 in Room 519-S of the Capitol.

All members were present except: Sen. Huelskamp, excused

Committee staff present: Emalene Correll, Legislative Research
Jim Wilson, Revisor of Statutes
Justin Butterfield, Intern
Ann McMorris, Secretary

Conferees appearing before the committee:
Donald Muse, Washington, DC

Others attending: See attached sheet

Donald Muse of Muse & Associates, Washington, D.C., presented a notebook (Attachment 1) to each committee member containing the following information:

1. The Medicaid Program: An Overview
2. The Financial and Statutory Interaction of Medicare and Medicaid
3. Kansas Medicaid Analysis
4. MSIS Dada
5. NPC Data
6. CNS Mental Health Drug Algorithms

Part I - The Medicaid Program - The Overview

Mr. Muse reviewed the information with a slide presentation. Medicaid was never intended to cover single people between ages 21-65 unless they were disabled.. Federal role includes administering the drug rebate program and directly and indirectly monitoring quality of care in nursing homes. State's role - one agency must be designated to sign the documents to go to the federal government. Each state has its own State Plan and has a great deal of discretion to design its own program. He noted that Plan Amendments are better than waivers and renewal of waivers should be avoided.

Funding of the Medicaid Program is a continual controversy but don't look for any major changes. Federal Medical Assistance Percentage (FMAP) is the distribution formula and Kansas match is 40%. There is a question on what is included in the cost covered by Federal match in the computerized eligibility determination systems. The Medicaid budget cost is larger than Medicare and increasing 9.5% per year and will be larger than Social Security within five years. Payment trends growth is 7% to 8% a year.

Mr. Muse stated that now is an excellent time for states to approach CMS for plan amendments or waivers. He suggests that plan amendments are preferable because waivers require a renewal at some future date. He says the current administration is open to ideas and said this is probably the most opportune time in the last twenty years to put together a proposal that would have the greatest benefit to an individual state.

Medicaid waivers were originally for temporary demonstrations with 5 year renewal. Congress has never intervened in a waiver. It was noted urban needs are different than rural needs and service delivery systems differ. 22% of all Medicaid expenditures are now in waivers. Some waivers can now be used for permanent State program reforms and this is being done by Arizona and Tennessee with the 1115 waiver. Waivers require a huge amount of agency time.

The three pillars of the Medicaid Program - Eligibility, Reimbursement & Coverage. Federal law governs what a state must or must not include or has discretion to include or not in the State Plan. A State Plan must include the "Categorically Needy"; a State Plan may cover the "Medically Needy". Forty states have the spend-down provisions. Eligibility - the SSI Disabled are automatically entitled to Medicaid without any waiting period.. Mr. Muse reviewed the Medicaid eligibility of low income Medicare beneficiaries for

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payment of certain Medicare costs. He listed the items and services that the Medicaid program will pay and provide for the Categorically Needy and the Medically Needy and the requirements for prescription drugs and their limitations. Each state must have a Drug Utilization Review (DUR) Program.

Reimbursement - The only basic requirement is that the State must have the methodology of reimbursement outlined and approved in the Medicaid State Plan. Medicaid cannot pay more than Medicare. Medicaid regulations provide for "upper limits" for the payment that can be allowed for drugs. Kansas has an aggressive Maximum Allowable Cost (MAC) program.

Mr. Muse explained the Drug Rebate Program and the participation by the manufacturers. The Medicaid law requires "covered outpatient drugs" be subject to price rebates. The State receives 43% of rebate and Federal government receives 57%. When a Medicaid recipient enters a managed care organization for which a capitated payment is made, rebates are no longer collected.

Part II - The Financial and Statutory Interaction of Medicare and Medicaid

Medicare drives certain aspects of the Medicaid Program - defining covered services; defining qualified providers and certain payment limitations. Medicaid law lists covered services while Medicaid regulations define covered services. Watch out for changes in Medicare law as it could adversely affect Medicaid. Mr. Muse commented on the overlap between Medicare and Medicaid eligibility, Medicaid responsibility for Medicare deductible and coinsurance. Fiscal truth about waivers, type of block grants for dual eligibles are things that affect who wins and who loses.

Part III - 2002 Medicaid Fee for Service Data - State of Kansas

In Kansas, Medicaid is 17% of the state budget. Around our nation, state revenues are projected to grow minus 4% this coming year and the Medicaid program is projected to grow 9.5%. 49 states are making Medicaid cost containment plans to have: more controls on pharmacy costs; increased co-pays; eligibility restrictions; benefit reductions. A map showed by state the Medicaid Studies done or in progress, contact made but no commitment, or no action. Various graphs showed by year -- Kansas Medicaid recipients by eligibility status, medical vendor payment by eligibility status, medical vendor payments by type of service, medicaid enrollment, and eligibility groups by % consumer and % expenditures FY 2002.

No nursing home care was included in the Kansas Medicaid Fee for service summary of Primary diagnosis data for selected conditions - asthma, diabetes, CHF/Heart Failure. After studying the distribution of Kansas Costs for these three selected conditions, the conclusion was that Disease Management should be targeted - and patients should see their doctor regularly and stay out of the Emergency Room.

Medicaid recipients with mental illness and selected chronic illness don't always have a primary physician so they go to the Emergency Room which drives the cost up. Questions to Mr. Muse concerned cost driven up by disabled and use of expensive drugs. He urged prudence in what is done in these areas. Restricted drugs may send more to the hospital. Providers need education on prescribing mental illness drugs . Mr. Muse referred the committee to Section 4, Table 3 Medicaid expenditures by type of service for Kansas FY2000 and reviewed how the money is spent and noted in particular $364 million is the largest single cost covering disabled.

At 12:30 p.m. the committee recessed till 1:45 p.m.

Questions – Senator Feleciano noted federal law takes precedence over state law. Any changes on Medicare will affect Medicaid. Mr. Muse responded - everything is waiverable and if federal makes a change and Kansas wants to do different, they can use waivers.

Senator Kerr – is Kansas using the Rare and Expensive Disease Management (REM) program? It sounds like this could be used aggressively to address a wide range of problems and fix a lot of existing problems and how widely can it be used? Mr. Muse suggests that we profile people in this area based on clinicals; that a personal call and visit be made to those individuals and that we have targeted case management in

this area. He states that Maryland is aggressively using this and would recommend that we look into the Maryland model. Kansas started the REM program about a year ago and it was administered out of the Governor's office but that person is no longer there. This program looks for people with certain clinic patterns and high expenditures but can't be aimed at a lower cost range as CMS would object.

Senator Brungardt - A high percentage of people with congestive heart failure after release will return to the hospital within six months. Muse had suggested a high tech method of checking their progress or a low tech way by case manager. Medicaid Management Information System (MMIS) can monitor and intervene and this works.

Senator Feleciano - If we can determine the three top cost areas would that allow us to capture a savings of the dollars spent. Muse - There is a data processing system which processes drug bills where a savings could be anticipated. This system could be used to pull out certain kinds of people. This would cost money and the state should decide how much to spend and prioritize their goals. Muse indicated he would be available to assist.

Senator Kerr thanked the SRS for their cooperation in getting the contract with Mr. Muse. More discussion on making sure people take their drugs and buying their prescribed medication.

PART IV - MSIS Data for Kansas

Mr. Muse reviewed Table 1 - Medicaid eligibles FY 2000 for Kansas by maintenance assistance status and basis of eligibility; Table 2 - Medicaid eligibles by age group; Table 3 - Medicaid expenditures by type of service for maintenance assistance status and basis of eligibility where he called attention to the expenditure for Children under physician and dental services, and capitated payment services; Table 4 - Medicaid beneficiaries by type of service for maintenance assistance status and basis of eligibility; Table 5 - Medicaid expenditures by type of service and age group where he noted capitated services for age 21-44 included parents of kids and pregnant moms; Table 6 - Medicaid beneficiaries by type of service and by age group; Table 7 Medicaid expenditures - program type by maintenance assistance status and basis of eligibility. Tables 3 thru 6 showed columns for 18 different services.

PART V - National Pharmaceutical Council (NPC) Data

This 2001 report by NPC covers pharmaceutical benefits under state medical assistance programs. There is information on Total Medicaid eligibles per 1000 population, 1999; State ranking based on drug expenditures; Maximum Allowable Cost (MAC) programs; Mandatory substitution; and details on the Kansas Senior Pharmacy Assistance Program 2001.

Much discussion on purchase of drugs, drug abusers and their control; provider education; lock in - restrict to one; case workers and gatekeepers. Managed care and where to go on the big three - asthma, diabetes and heart failure. Reimbursement of physicians, pharmacists and providers was a concern and the need to involve them in the process of managed care. Bob Day indicated SRS has done some work on case management which he would be glad to share with the committee.

Case manage congestive heart failure. Mr. Muse stated that there is a high probability of returning to the hospital. Indicators are weight gain, rate of unacceptable high blood pressure. This is a good area for case management and there are plenty of studies in both private managed care and the public sector and he recommended at least six months' case management for patients with congestive heart failure.

Prescription drug edits. You can place edits on those who have from 12 to 20 prescriptions over a 180 day period.. Basically you need to work with your current EDS who is your claims processor. Have EDS insert edits to identify the patient. When you have identified people who see multiple medical doctors or go to multiple medical pharmacies, send a letter to that patient to cease and desist that practice. This is an area for case management and probably a team approach of case management would involve medical doctors, pharmacists and nurses and he noted that SRS currently has lock-in provisions to specific persons because of abuse.

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on March 4, 2003 in Room 519-S of the Capitol.

Mental Health and prescription drugs. Mr. Muse stated there is a gulf between access to drugs and proper prescriptions. He recommends that all stakeholders be in the room when discussing this topic. He said this is an area for case management and that you need somebody performing as ombudsman/gatekeeper function.

In any case management you need to determine the amount of financial resources you want to commit and pick a target of medical assistance you want to invest cash management in congestive heart failure. He suggested you target people just discharged from the hospital and the specific areas he mentioned were- HIV and Diabetes.

Mr. Muse pointed out that many recipients of Medicaid coverage are also covered by Medicare. He said that as case management and other initiatives are proposed to CMS for their approval that the State of Kansas should negotiate not only how the savings would be split between the federal government and Kansas for Medicaid but also Kansas should negotiate for a portion of the savings that accrues for Medicare. He urged the committee to "make a deal" on these dually eligible Medicaid and Medicare recipients.

Jerry Slaughter of the Kansas Medical Association, voiced his concern over compensation in Kansas. He noted providers are giving services at less than cost and as reforms are implemented, the state has to make a commitment for sharing the savings with the providers..

Discussion on what issues needed to be considered and how these can save money. How do drugs get on a list for payment by Medicaid, how to control drug availability. A list of drugs being used by nursing homes in Kansas will be made available by Muse. SRS has a program that will provide nursing home prescribing patterns. Other areas of discussion were on services that could be limited, number of people receiving services and costs and where a savings could be made. SRS will provide some data on the top 200 Medicaid people.

The next meeting of the Task Force on Medicaid Reform will be March 5, 2003.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 1

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President's Task Force on Medicaid Reform

DATE: MARCH 4, 2003

Name	Representing
Linda Lubensky	KS Home Care Assoc
Josie Torrez	KACIL
Craig Kaberline	KS Area Agencies on Aging Assoc.
Randal Liebmann	Kansas Health Institute
Susan Kannarr	Kansas Health Institute
Tony Wellever	Kansas Health Institute
Nursing Division Barney Okruzo.	Washburn School of Nursing
B McCarley	Midland Adult Day Programs
Heidi Pickerell	Midland Adult Day Program
Martin Hawver	Hawver's Capitol Report
Chip Wheelen	Assn of Osteopathic Med.
Bill Snead	KAHA / MSCK
Kari Huston	KU Med
Chuck Conway	intern Velerans
Deb Kirmer	Midland Hospice - Topeka

President's Task Force on Medicaid Reform

DATE: MARCH 4, 2003

Name	Representing
Vicki Whitaker	Ks Health Care Assn.

Muse & Associates

Analysis of Kansas Medicaid Data FY 2002

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President's Task Force on
Medicaid Reform
March 4, 2003
Attachment 1-1

The Medicaid Program: An Overview

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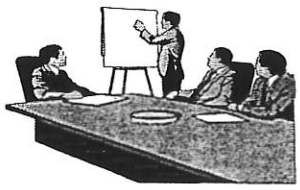
Purpose of the Presentation

- Outline of the Medicaid Program with a focus on prescription drugs;
- Designed for persons who need to understand the Medicaid Program but currently have limited knowledge; and
- Presentation will provide participants with a basic knowledge of the program particularly as it relates to prescription drugs.



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Organization Of The Presentation

WHAT IS MEDICAID?

Federal role; State's role; Traditional Medicaid State Plan; Who Pays for the Medicaid Program?: Cost of a State's Administration

MEDICAID WAIVERS

MEDICAID ELIGIBILITY, COVERAGE & REIMBURSEMENT

EPSDT

PRESCRIPTION DRUGS IN THE MEDICAID PROGRAM

Coverage; Limitations; Prior Authorization Programs; UR Programs: Formularies; Statutory Restrictions;

Payment; Drug Rebate Programs

What Is Medicaid?

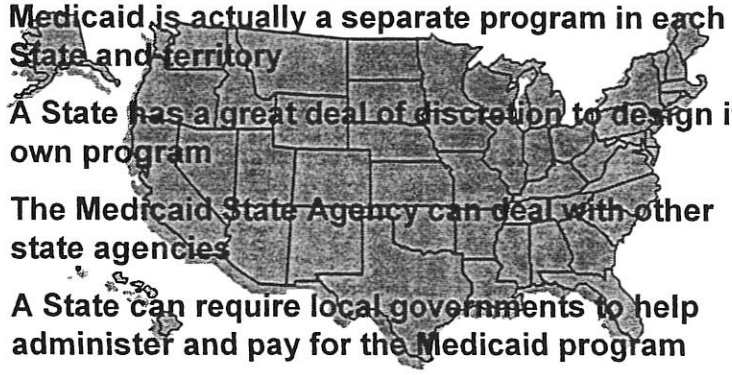
Medicaid is a joint Federal/State program that pays the medical bills for low-income people who can't afford the costs of medical care.

1-3

Federal Role

- Reviewing and approving State plans and subsequent State plan amendments
- Reviewing State quarterly expenditure reports and paying federal match
- Assuring continuing State compliance with State plan and Federal law and regulations
- Implementing new Federal legislation
- Issuing necessary regulations
- Administering the drug rebate program
- Collecting and disseminating data
- Directly and indirectly monitoring quality of care in nursing homes

State's Role



- Medicaid is actually a separate program in each State and territory
- A State has a great deal of discretion to design its own program
- The Medicaid State Agency can deal with other state agencies
- A State can require local governments to help administer and pay for the Medicaid program
- A State develops and revises State plan

1-4

The Traditional Medicaid State Plan

- Each State has its own Medicaid Plan which determines
  - who is eligible
  - what services it will pay for
  - how much it will pay for the services

- CMS must approve the State Plan and each amendment
- Some years, more than 1500 separate amendments are received and approved or disapproved by CMS
- Plan Amendments are better

Who Pays for the Medicaid Program?

$ Medicaid is jointly funded by the Federal government and the States

$ The average Federal match for medical assistance is 57% and the States put up an average of 43%

$ The Federal share is determined by a statutory formula, called the Federal Medical Assistance Percentage or "FMAP"

$ The Federal match varies from no less than 50% to nearly 90%, depending on the State's per capita income

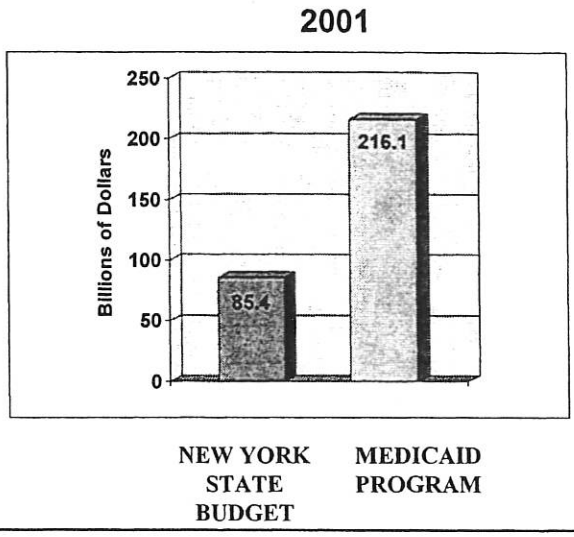
$ Kansas match is 40%

1-5

Cost of a State's Administration

- The Federal match for a State's administrative expenses is 50%
- Some administrative expenses receive "enhanced matching" to encourage the State to undertake the costs of a particular administrative activity such as
  - Computerized eligibility determination systems - 90%
  - Medical and utilization reviews - 75%
  - Medicaid Fraud Control Units - 75%
- Gray Areas

How Big is Medicaid?



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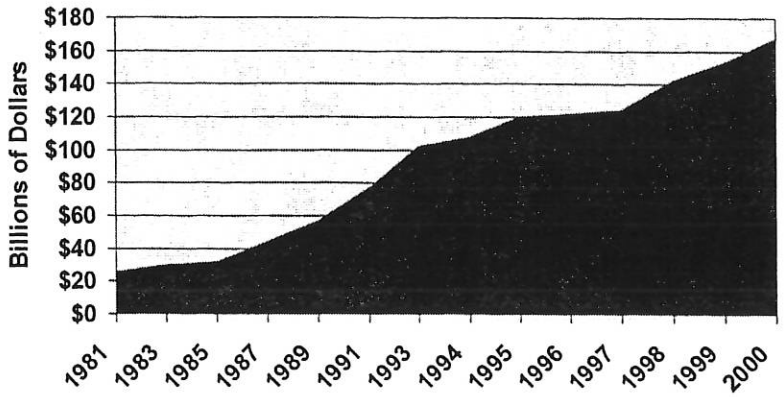
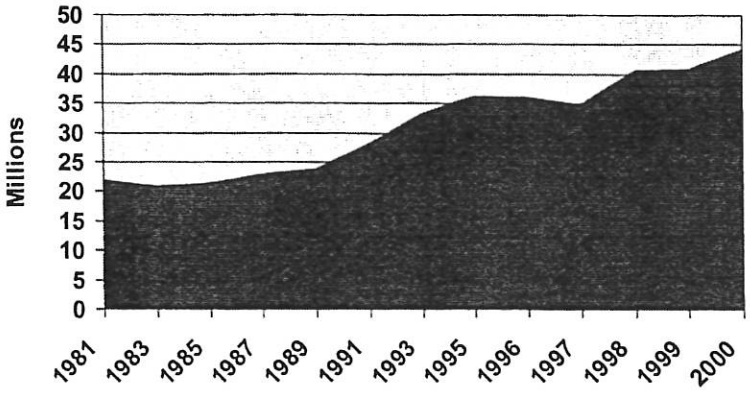
Payment Trends in Medicaid Program

FY 1981 - FY 2000



Recipient Trends in Medicaid Program

FY 1981 - FY 2000



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Medicaid Waivers

- Originally for temporary demonstrations (5 year renewal)
- Some waivers can now be used for permanent State program reforms
- Fifteen comprehensive waivers have been approved since 1992, as well as 31 sub-waivers
- Approximately 22 percent of all Medicaid expenditures are now in waivers
- What's Waived?
  - Federal Medicaid Law and implementing regulations
  - Amount, Duration, Scope
  - Comparability

Populations Covered By Waivers

Welfare Population (98.5%)

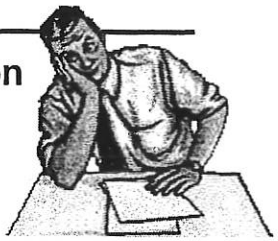
Aged and Disabled (1.5%)

Types of Waivers

- Section 1115(b) - Large scale Medicaid waivers
- Section 1919 - home & community-based waivers
- Section 402 - Medicare & Medicaid reimbursement, coverage and administration waivers
- Miscellaneous, specific waivers

1-8

Obtaining A Waiver



- A State sends in the application and Secretary approves within 90 days.
- Real Life
  - State Executive Branch initiates with or without legislative approval
  - CMS sends back at least once
  - Politicals visit White House, Congress, and OMB gets involved
  - A year later, state gets one-half of waiver
  - State legislature blocks implementation
  - Consultants make money

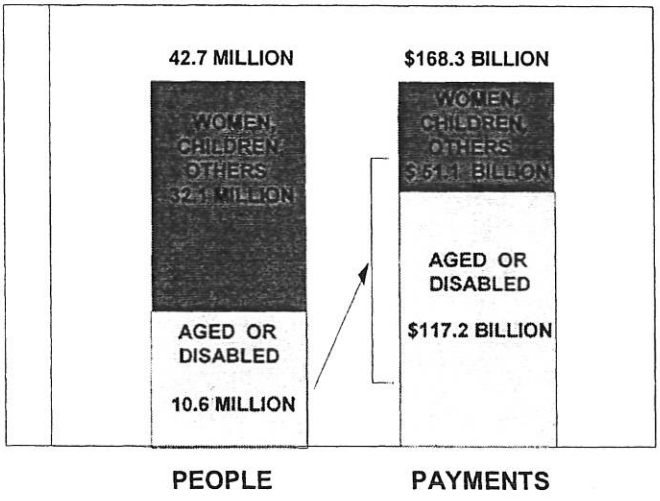
The Three Pillars of the Medicaid Program: Eligibility, Reimbursement, & Coverage

In each of these three areas, Federal law governs:

- what a State ***MUST*** include
- what a State ***MUST NOT*** include
- what a State has ***DISCRETION*** to include or not in the State Plan

1-9

About Medicaid in 2000



ELIGIBILITY, Reimbursement and Coverage

I-10

Medicaid Eligibility

- A State Plan ***MUST*** include the "Categorically Needy"
  - TANF standards
    - Income and resource standards are used to determine Medicaid eligibility for TANF - related families and poor children
  - SSI recipients
- A State Plan ***MAY*** cover the "Medically Needy"
- An individual may "spend down" monthly to qualify as "Medically Needy"

Medicaid Eligibility

- SSI covers the "disabled" among the adult categories of welfare
- The definition of "disability" is the same as in Social Security, except it also applies to children under age 18
- There is no 5 month waiting period (as in Social Security disability)
- There is no 24 month waiting period (as in Medicare for the disabled)
- The SSI Disabled are automatically entitled to Medicaid without any waiting period

I-11

Medicaid Eligibility - QMBs, SLMBs, QDWIs & QIs

- The State Medicaid program MUST help certain low income Medicare beneficiaries pay some of their Medicare costs:
- QMBs - Qualified Medicare Beneficiaries
- SLMBs - Specified Low Income Medicare Beneficiaries
- QDWIs - Qualified Disabled and Working Individuals
- QIs - Qualified Individuals

Medicaid Eligibility - QMBs

- The State ***MUST*** cover Qualified Medicare Beneficiaries (QMBs)
  - Medicaid pays only for Medicare premiums, deductibles, and coinsurance
  - Income and Resources:
    - Income does not exceed 100% of Federal poverty guideline
    - Resources do not exceed twice the SSI limit for resources
    - "Income" and "resources" determined according to the SSI rules

1-12

Medicaid Eligibility - SLMBs

The State ***MUST*** cover Specified Low Income Medicare Beneficiaries (SLMBs)

- Medicaid pays only for Medicare Part B premiums - $45.50/month in 1999
- Income and Resources
  - Income does not exceed 120% of Federal poverty guideline
  - Resources do not exceed twice the SSI limit for resources
  - "Income" and "resources" determined according to the SSI rules

Medicaid Eligibility - QDWIs

- The State ***MUST*** cover Qualified Disabled and Working Individuals (QDWIs)
  - Medicaid pays only for Medicare full cost premiums
  - Low Income former Social Security Disability Beneficiary
  - Disability continues but benefits ended because of return to work
  - Income and Resources
    - Income does not exceed 200 percent of Federal poverty guideline
    - Resources do not exceed twice the SSI limit for resources
    - "Income" and "resources" determined according to the SSI rules
  - Can continue Medicare entitlement based on disability, but must pay the full cost in monthly premiums (up to $309 monthly in 1999, plus Part B premiums)

1-13

Medicaid Eligibility - QIs (QI-1)

- The State ***MUST*** cover Qualified Individuals (QI-1s)
  - Medicaid pays only for Medicare Part B premiums
  - Income and Resources
    - Income exceeds State limit for QMBs
    - Income is at least 120% but less than 135% of Federal poverty guideline
    - Other requirements same as for QMBs

Medicaid Eligibility - QIs (QI-2)

- The State ***MUST*** cover Qualified Individuals (QI-2s)
  - Medicaid pays only for the part of the Part B premiums attributable to home health benefits
  - Income and Resources
    - Income exceeds State limit for QMBs
    - Income is at least 135% but less than 175% of Federal poverty guideline
    - Other requirements same as for QMBs

1-14

Medicaid Eligibility - QIs Funding Provisions

- FMAP = 100%
- Federal payment is capped at $250 million nationwide for FY 1999
- Increasing to $400 million nationwide for FY 2002
- Federal Payment from Medicare Part B Trust Fund

Medicaid Eligibility - Other Individuals

- States may elect to include other individuals in their Medicaid program, but the Federal Government will not match these costs
- These programs may be designed to include individuals from State general assistance programs

1-15

Eligibility, *COVERAGE* & Reimbursement

Coverage

- **What are the items and services that the Medicaid program will pay for?**
  - **Some items and services *MUST* be covered**
  - **Mandatory coverage packages vary, depending on the basis of the individual's Medicaid eligibility ("Categorically Needy," "Medically Needy," etc.)**
  - **The State *MAY* cover practically any additional services it wants to**

1-16

Medical Coverage for the Categorically Needy

- For the "Categorically Needy," the State ***MUST*** pay for:
  - Inpatient hospital services
  - Other laboratory and X-ray services
  - Physician services
  - Nurse-midwife services
  - Outpatient hospital services, rural health clinic services, federally qualified health center services
  - Nursing facility services; family planning services
  - Early and Periodic Screening, Diagnosis & Treatment (EPSDT") of physical and mental defects for individuals under age 21
  - Pediatric nurse practitioner services and family nurse practitioner services
  - Home health agency services

Medical Coverage - Additional Services for the Categorically Needy

- The State Plan ***MAY*** specify additional services as covered services. These services must be selected from a long list of authorized services.
- Additional services must be specified separately for the Categorically Needy, and for each group of the Medically Needy.
- Examples of additional services:
  - Home health services
  - Dental services
  - Physical and occupational therapy and speech language pathology services
  - Prescribed drugs

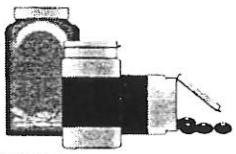
1-17

Medical Coverage for the Medically Needy

- If the State has a "Medically Needy" program, it ***MUST*** pay for:
  - Prenatal care and delivery services for pregnant women
  - Ambulatory services, as defined in the State plan, for
    - individuals under age 18
    - groups of individuals entitled to institutional services
  - Home health services to any individual entitled to Nursing Facility services

Prescription Drugs

- A State Medicaid Plan ***MAY*** include drugs (outpatient prescription drugs)
- All States and territories have a prescribed drug benefit
- All but 16 of them provide the prescribed drug benefit to BOTH Categorically and Medically Needy persons
- Prescribed drugs must be:
  - dispensed by licensed pharmacist
  - dispensed on written prescription
  - determined to be safe and effective
  - prescribed by physician or other licensed practitioner



- Does not include
  - drugs determined to be less than effective under Medicare
  - drugs furnished as part of Inpatient hospital services, hospice services, physician services, nursing facility services (separate payment for outpatient prescription drugs not made)

1-18

Limitations on Drug Coverage

- State may establish a prior authorization program
- State may exclude or restrict a drug if
  - not for a medically accepted indication
  - restricted by Medicaid law
  - restricted by rebate agreement
  - restricted by State formulary

- Other restrictions:
  - A State may impose limitations, with respect to all drugs in a therapeutic class, on minimum or maximum quantities per prescription and number of refills

Prior Authorization (Preferred Drug Program)

- State Plan may require approval of a drug before dispensed for any medically accepted indication only if:
  - system provides for response by telephone, etc. within 24 hours of request
  - in emergencies, provides for dispensing at least a 72-hour supply
- Approximately 38 states have prior authorization programs
- Many Flavors!

1-19

Drug Utilization Review (DUR) Program

- Each State ***MUST*** have a DUR program
- Assures that prescriptions are appropriate, medically necessary, and unlikely to cause adverse medical results
- State administrative costs are matched at 75%
- DUR program requirements:
  - Prospective review of drug therapy before each prescription is filled to assure appropriate usage
  - Retrospective review to identify patters of fraud, abuse and waste
  - Assessment whether usage complies with predetermined standards
  - Educate practitioners on common drug therapy problems
  - Establish State Drug Use Review Board of health professionals to help implement DUR program and report annually on savings

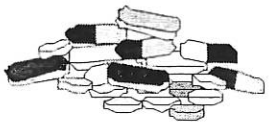
Drug Formularies

- Background
  - In 1987, five states had significant formularies as measured by a scale recently developed by PhRMA. In 1996, twenty-one states had a significant formulary as measured by the same scale
- A State ***MAY*** establish a formulary if:
  - Developed by State Drug Use Review Board, or by physicians pharmacists, and other appropriate individuals appointed by Governor
  - Includes the covered outpatient drugs of any manufacturer with a rebate agreement
  - An excluded drug may nevertheless be paid for under a prior authorization program (except drugs excluded by Medicaid law)
  - Meets other CMS requirements in order to achieve program savings consistent with protecting the health of program beneficiaries

1-20

Drugs Restricted by Medicaid Law

- Statute permits restriction of drugs used for the following:
  - Used for anorexia, weight loss, weight gain
  - Used to promote fertility
  - Used for cosmetic purposes or hair growth
  - Used for relief of cough and cold symptoms
  - Used to promote smoking cessation
  - Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
  - Nonprescription drugs
  - Linked to exclusive sale from manufacturer of related tests or monitoring services
  - Barbiturates
  - Benzodiazepines



EPSDT

Early and Periodic Screening, Detection, & Treatment Services

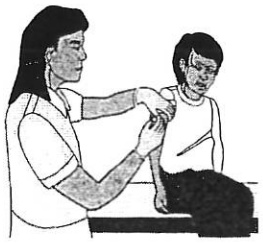
- To ascertain physical and mental defects and to correct or ameliorate any chronic conditions discovered
  - Includes screening, vision, dental, and hearing services at appropriate intervals
  - Includes appropriate immunizations
- ***MUST*** be furnished to Categorically Needy Individuals under age 21 (AFDC)
- ***MAY*** be furnished to Medically Needy under age 21
- Includes ANY service listed in the law, even organ transplants, whether or not covered under the Plan, if needed to correct or ameliorate defects discovered from the screening

1-21

EPSDT - Immunizations

- States ***MUST*** check for needed immunizations and boosters for:

diptheria	pertussis	tetanus	polio
measles	rubella	hemophilus	mumps
hepatitis B	influenza type b conjugate (Hib)		



The State must provide the needed immunization when medically necessary and appropriate

The State must provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP)

Eligibility, Coverage & Reimbursement

I-22

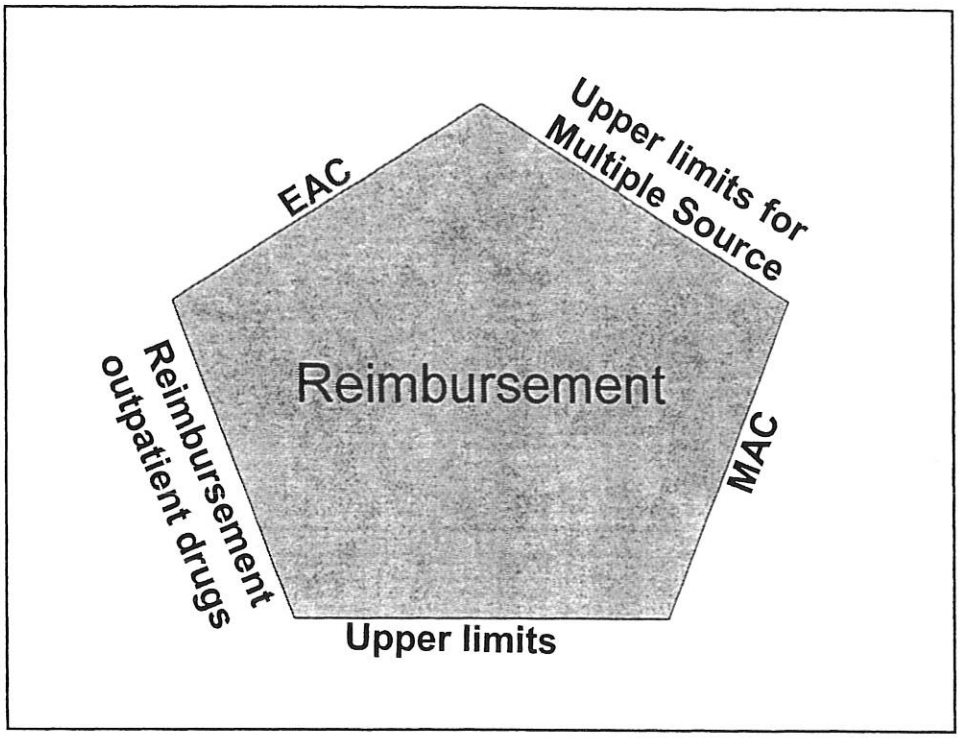
Medicaid Reimbursement

- States have huge flexibility in what reimbursement methodology they can use. The only basic requirement is that the State must have the methodology outlined and approved in the Medicaid State Plan
- To be approved, the Medicaid State Plan ***MUST***:
  - set payment rates that are consistent with efficiency, economy, and quality of care
  - describe the policy and the method used in setting payment rates for each type of services
  - assure appropriate audit of records if payment is based on cost of services
  - set payment rates at levels that are sufficient to enlist enough providers so that covered services are reasonably available

Medicaid Reimbursement After Repeal of Boren Amendment

- States required to implement a public process for determining NF rates
  - publish proposed and final rates
  - explain methodology
  - justify proposed rates
- Medicare rates are Medicaid upper limits
- State must consider DSH hospitals
- Repeal designed to
  - Give States maximum flexibility
  - Minimize CMS's role in establishing payment rates
  - Reduce Costs

I-23



Payment for Drugs "Upper Limits"

- The Medicaid law has always required that payments be consistent with efficiency, economy, and quality of care
- Based on this, the Medicaid regulations have long provided for "upper limits" on the amount that can be allowed for matching purposes
- The upper limits vary by type of covered item or service and by reimbursement method
- In the past, upper limits for prescription drugs included the "Maximum Allowable Cost" (MAC) regulations
- In 1987, the MAC upper limit was replaced with regulations establishing upper limits for multiple source drugs
- In 1990, congress augmented those regulations and established upper limits based on the drug rebate provisions

1-24

The "MAC"

Before 1987:

- Payment could not exceed the lower of (1) cost plus a dispensing fee, or (2) provider's usual and customary charge to the general public.
- For a multiple source drug, "cost" was the lower of (1) the MAC, the Maximum Allowable Cost designated by CMS's Pharmaceutical Reimbursement Board, or (2) the EAC, the Estimated Acquisition Cost, the State's best estimate of the price providers were generally paying for a drug in the package size most frequently bought by providers.
- The MAC was the upper limit used to determine costs that could be recognized for matching purposes.

Payment for Outpatient Prescription Drugs

- Payment method depends on whether drug is a "multiple source drug" or an "other drug"
- CMS publishes lists of "multiple source drugs" and payment upper limits if -
  - All FDA approved formulations of the drug have been found therapeutically equivalent in Approved Drug Products with Therapeutic Equivalence Evaluations
  - FDA lists the drug as Category A
  - At least 3 suppliers list the drug for sale nationally in published compendia of cost information (Red Book, Blue Book, Medispan)

I-25

Payment for Outpatient Prescription Drugs

- **Multiple Source Drugs**
  - State's aggregate payments may not exceed "upper limits" established by CMS
- **Other Drugs**
  - State's aggregate payments determined by applying the lower of
    - Estimated Acquisition Cost (EAC) plus dispensing fees set by State, or
    - Providers' usual and customary charges to the general public
- **Certification of Brand Name Drugs**
  - A physician may certify in own handwriting that a specific brand is medically necessary for a particular recipient
  - Payment is made as an "other drug," not as a multiple source drug

Estimated Acquisition Cost

- State's best estimate of price currently and generally paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.
- A published Average Wholesale Price (AWP) level is not acceptable as EAC unless significant discount (10%-20%) is applied.

1-26

Payment for Drugs

Upper Limits for Multiple Source Drugs

- For each drug entity, the upper limit is, in the aggregate:
  - 150% of published price for least costly therapeutic equivalent (using all available national compendia) that can be furnished by pharmacists in quantities of 100 tablets or capsules (or the commonly listed size), plus
  - reasonable dispensing fee established by State
- States have opportunity for more aggressive program!

Coverage & Limitations, Reimbursements, and REBATES

1-27

Overview of the Drug Rebate Program

- Manufacturers are literally forced to participate
- Although rebates are required for all drugs, rebates for single source drugs and innovator multiple source drugs are much higher than for multiple source drugs
- Single source and multiple source drugs that have price increases above inflation must pay a special rebate penalty

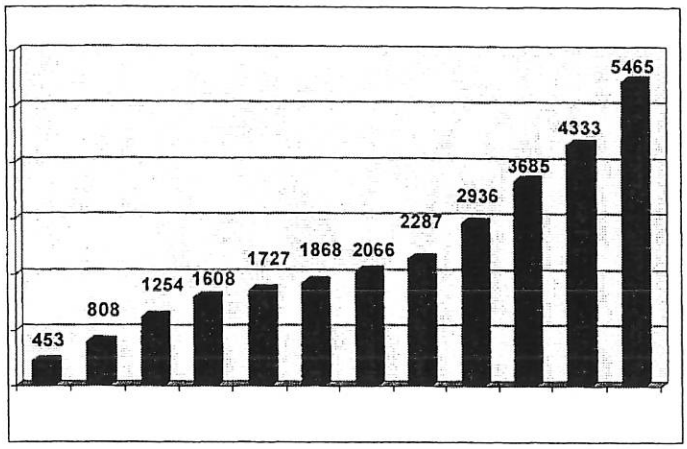
Drug Rebate Program

- **The Medicaid law requires "covered outpatient drugs" be subject to price rebates**
- **No FMAP for <u>any</u> drug of a manufacturer without rebate agreement**
- **The Manufacturer must**
  - **enter into an agreement to pay a rebate on each unit of its drug paid for by Medicaid**
  - **State receives 43% of rebate and Federal government receives 57%**
  - **agree to participate in the VA and PHS discount programs**

1-28

Prescription Drug Rebates

FY 1991 - FY 2002



Amount of Rebate

Single Source Drugs / Innovator Multiple Source Drugs

- **Rebate equals difference between Average Manufacturer Price (AMP) and Best Price**
- **Minimum rebate percentage is 15.1% of AMP**
  - **AMP determined by CMS based on required manufacturer's reports**
  - **Subject to verification, surveys, and penalties**
- **"Best Price" includes cash or volume discounts, rebates, free goods contingent on purchase**
  - **lowest price available to anyone, except:**
    - **Indian Health Service, Department of Veterans Affairs, U.S. Public Health Service, Federal Supply Schedule, among others**
- **Generics**
  - **Rebate percentage is 11% of AMP**

1-29

CPI Penalty Rebate on Single Source and Innovator Multiple Source Drugs

- Limit is based on July - September 1990, increased by the CPI (all urban) for periods after September 1990
- Rebate must be increased by the amount AMP in which any period exceeds AMP for base calendar quarter
- The rebate is cumulative and can result in large penalties being paid for individual drugs

State Supplemental Programs and Rebates

- **Nineteen (Twenty four) States have some form of public program that provides outpatient prescription drugs to persons not eligible for Medicaid.**
- **The States pay for 100% of these supplemental program expenditures (Sort of).**
- **The typical program covers elderly persons who are nearly poor with high drug expenditures.**
- **Almost all of these programs require that manufacturers pay Medicaid level rebates.**
- **A few large States, often led by California and Florida have attempted to get larger than Medicaid sized rebates for their supplemental and regular Medicaid program.**

1-30

Rebates and Managed Care

When a Medicaid recipient enters a managed care organization for which a capitated payment is made, rebates are no longer collected.

Certain types of managed care arrangements do not include outpatient prescription drugs in capitated payments.

Carve-in or Carve-out

I-31

Part II
The Financial and Statutory Interaction of Medicare and Medicaid

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The Interaction Between Medicare and Medicaid

- **Medicare Drives Certain Aspects of the Medicaid Program**
  - **Defining covered services**
  - **Defining qualified providers**
  - **Certain payment limitations**
- **Overlap Between Medicare and Medicaid Eligibility**
- **Waivers**
- **About Money**

1-32

Defining Covered Services

- The Medicaid law
  - lists covered services
  - but does not define them
- The Medicaid regulations define covered services by
  - repeating the Medicare definition, or
  - incorporating the Medicare definition by reference

Defining Qualified Providers

- The Medicaid law generally defines "services" - not "providers"
  - Example: *"Home health agency* means a public or private agency or organization . . . **that meets requirements for participation in Medicare** and any additional standards legally promulgated by the State that are not in conflict with Federal requirements." 42 C.F.R. §440.70(d), part of the Medicaid definition of covered "home health services."
- The Medicaid regulations often define "covered services" in terms of being furnished by a Medicare qualified entry
  - Example: *"Inpatient hospital services* means services that . . . (3) Are furnished in an institution that . . . (iii) **Meets the requirements for participation Medicare as a hospital**. . . ." 42 C.F.R. §440.10, part of the definition of Medicaid covered "inpatient hospital services."

1-33

Medicaid Payment Limitations Based on Medicare

Approved Medicaid Payment Systems

Before the BBA of 1997

- CMS had to approve each State payment system
- The State had to make various "assurances" that certain statutory requirement were met
- Medicare payment systems were presumptively approvable

Medicaid Payment Limitations Based on Medicare

APPROVED MEDICAID PAYMENT SYSTEMS

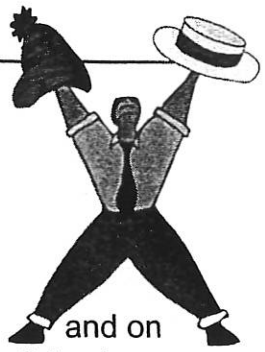
Now, almost any State payment system developed through a public notice and comment procedure meets Federal requirements

- As amended by the BBA of 1997, a Medicaid State Plan must provide–
  - "(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which–
  - "(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
  - "(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
  - "(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
  - "(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;"

Section 1902(a)(13)

1-34

Dual Eligibles



An individual who is both -

- Entitled to Medicare
  - based on age, disability, or ESRD
- Eligible for Medicaid
  - based on income & resources, and on age or disability (usually an SSI beneficiary)
    - includes many children
- Keep a watch out for Medicare Reform!

Medicaid Can Pay for Medicare Part B Premiums

- Cost effective for Medicaid
- Medicaid is the payer of last resort - most benefit costs shifted to Medicare
- CMS's FFP matches the State's costs for part B premiums
- There is no FFP for costs that could have been paid by Medicare Part B if the beneficiary was eligible for, but not enrolled in, Part B. This is an incentive for States to pay Part B premiums, under the buy-in or otherwise.
- Medicaid can also pay for the health insurance premiums of low income individuals and members of their families. The premium costs are "medical assistance" matchable by FFP.

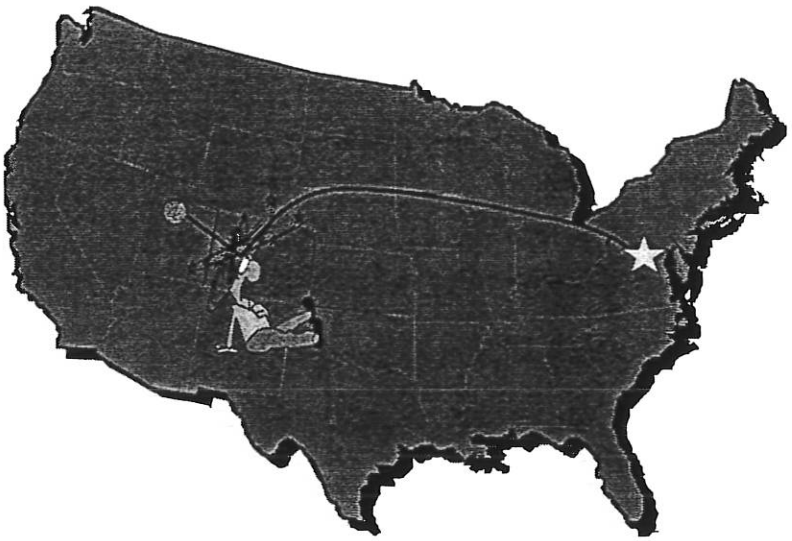
I-35

Medicare, Medicaid and Money

- Waivers
- Block Grants
- Medicare Reform

Waivers - Achieving Budget Neutrality

- Typical waiver is more people at lower price or
- Non-covered service replaces covered services



Types of Block Grants for Dual Eligibles

- Prescription drugs only (widely discussed)
- Disease specific grants
- Population specific (CHIPs)
- Once every ten years or so we briefly consider a total block grant

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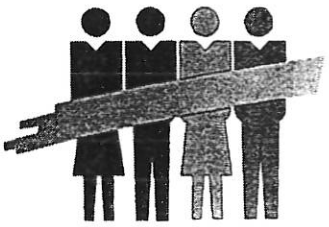
Other Questions to Ask

- Will you be reimbursed for administrative costs?
- When does funding run out?
- Can state programs for those affected by the block grant be covered by the grant?

Musings on Block Grants

- Devil is truly in the details

2002 Medicaid Fee for Service Data State of Kansas



March 2003

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The 20 - minus 4 – 9.5 Problem

- Medicaid is 20 percent of an average state's budget (17% in Kansas)
- State revenues are projected to grow minus 4 percent this coming year
- The Medicaid program is projected to grow 9.5 percent this coming year (up from 5 percent through most of the 1990's)

1-39

Survey of Current State Medicaid Trends

Survey Results:

- While state revenues have been falling for 5 quarters, Medicaid costs have continued to increase, leading to a shortfall in 40 states' Medicaid budgets
- 49 states are making Medicaid cost containment plans to:
  - More controls on pharmacy costs
  - Increased co-pays
  - Eligibility restrictions
  - Benefit reductions
- All states are seeking ways to increase federal share of Medicaid funding
- Outlook for 2004 is no better

Source: Survey of all 50 states and DC done for Kaiser Commission on Medicaid at beginning of FY 2003

Medicaid's Problem Periods in the Past

- Early 80's - Bottom falls out of economy, unemployed swell roles
  - Solution: Throw people off roles and cut provider rates
- Early 90's - Waxman mandatory groups kick in
  - Solution: Put children and mothers in managed care
- Early 00's – Medical costs increased overall, general rolls up as economy slows
  - Solution: ??

1-40

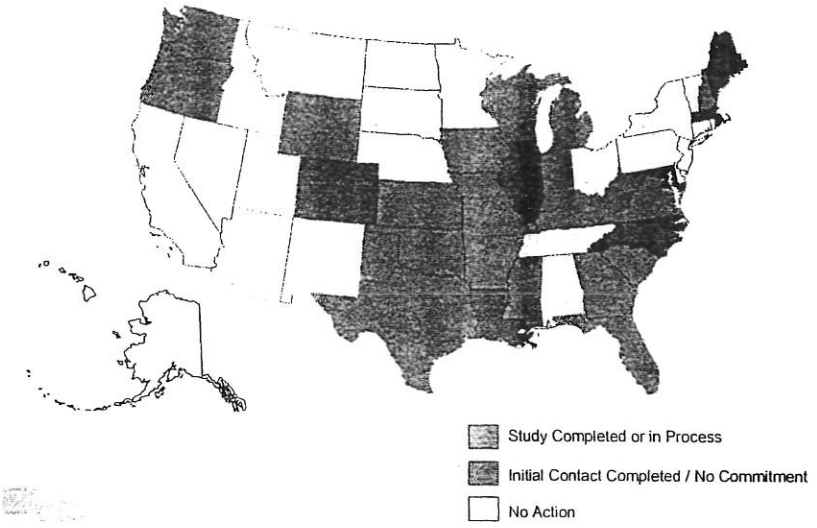
Finding Solutions to the Medicaid Program Problems

What We Do

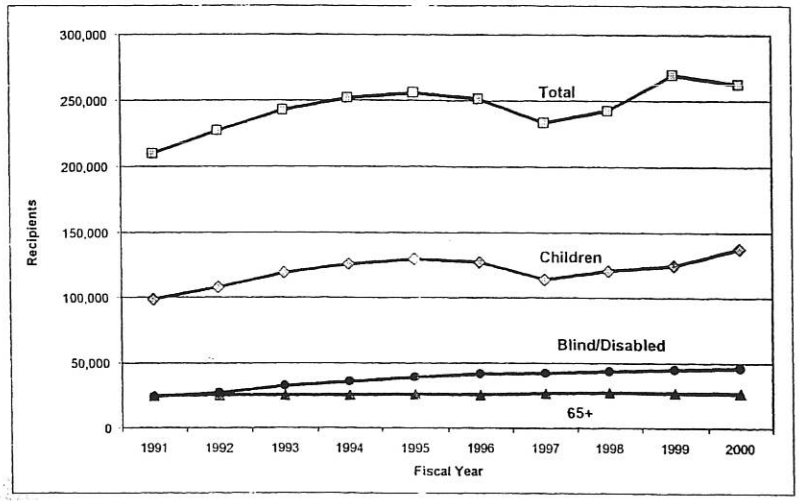
- Receive tapes submitted to the Centers for Medicare and Medicaid Services (CMS), deliver results and detailed backup in person in two weeks
- Goal is to identify what is driving the cost of the Medicaid program, and therefore, where are the greatest potential savings
- Outline the potential use of disease management and other policy options to improve patients' health outcomes and save money

State Medicaid Studies

November 1, 2000 through March 1, 2003

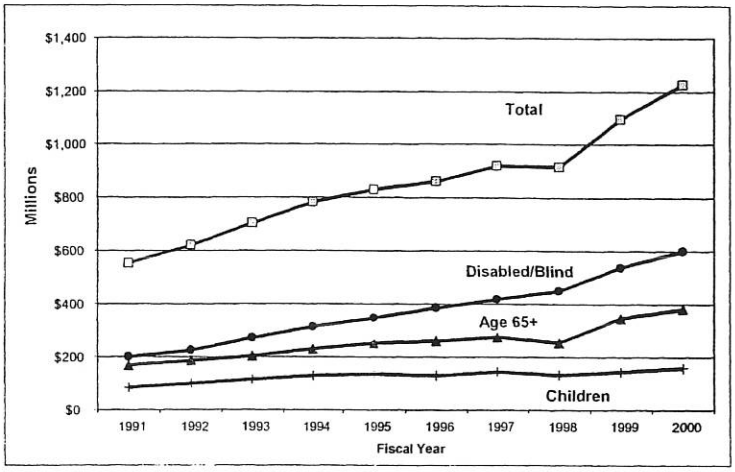


Kansas Medicaid Recipients by Eligibility Status by Year

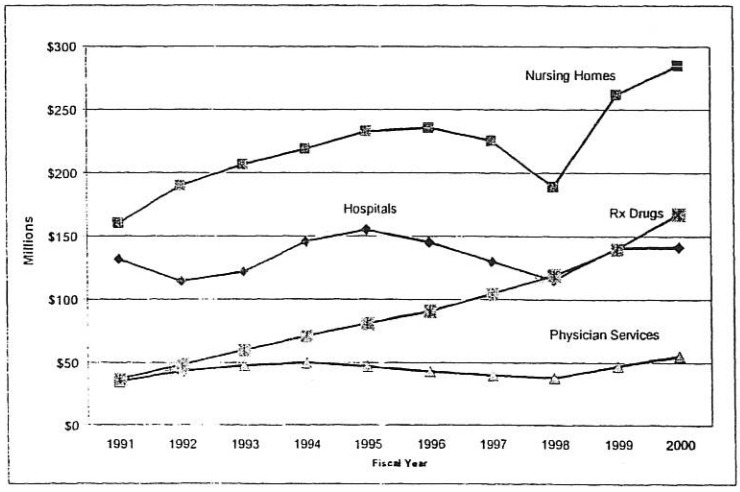


1-42

Kansas Medicaid Medical Vendor Payment by Eligibility Status by Year

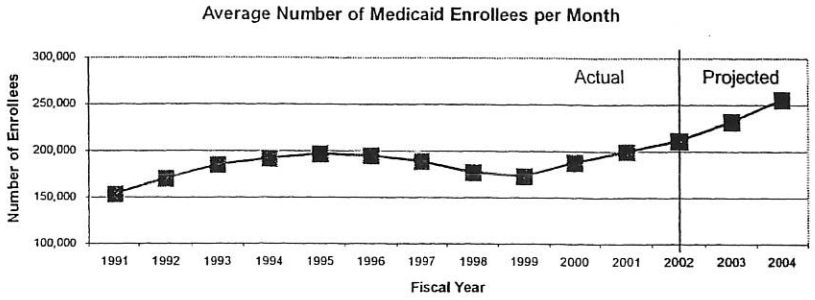


Kansas Medicaid Medical Vendor Payments by Type of Service by Year



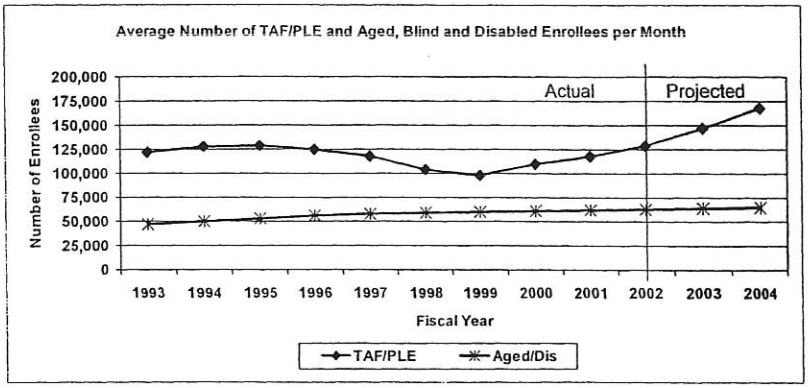
1-43

Average Number of Medicaid Enrollees per Month



Source: Dr. Robert Day, Health Care Policy Division, Kansas Dept. of SRS

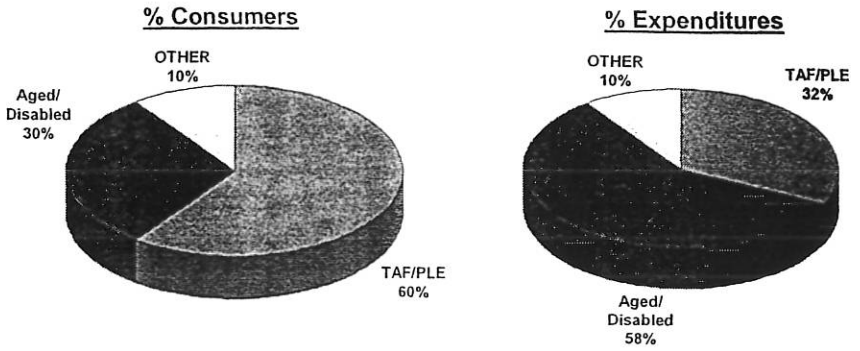
Average Number of Medicaid Enrollees per Month by Population



Source: Dr. Robert Day, Health Care Policy Division, Kansas Dept. of SRS

1-44

Eligibility Groups by % Consumers and % Expenditures FY 2002



Source: Dr. Robert Day, Health Care Policy Division, Kansas Dept. of SRS

Caveats about this Presentation

- Fee For Service (FFS) data only – (Just received new data with Capitated information)
- Drop in volume for Q4 (FFY 10/1/01-9/30/02) in all patient claims compared to other quarters, especially Inpatient Hospital claims
  - Due to transition from Blue Cross to EDS as processor for Kansas
- Primary Diagnosis codes in "Other" category missing in 39% of the time

1-45

Total Expenditures by 3 Digit Primary Diagnosis for All Datasets by Amount Paid

Diag Code	Description	Patients	Paid	Paid Per Patient
Y45	Homegrown Kansas Category	17,607	$253,628,957	$14,405
318	OTHER SPECIFIED MENTAL RETARDATION	1,722	$66,462,142	$38,596
295	SCHIZOPHRENIC DISORDERS	5,317	$37,711,668	$7,093
296	AFFECTIVE PSYCHOSES	11,227	$28,984,932	$2,582
250	DIABETES MELLITUS	10,341	$24,490,174	$2,368
783	SYMPTOMS CONCERNING NUTRITION	15,331	$20,056,886	$1,308
428	HEART FAILURE	5,686	$16,601,435	$2,920
331	OTHER CEREBRAL DEGENERATIONS	1,807	$14,969,315	$8,284
290	SENILE AND PRESENILE ORGANIC PSYCHOTIC	1,822	$14,592,100	$8,009
NOS	No Diagnosis Specified	117,354	$14,586,330	$124
317	MILD MENTAL RETARDATION	1,306	$14,054,212	$10,761
401	ESSENTIAL HYPERTENSION	11,946	$13,970,486	$1,169
V30	SINGLE LIVEBORN	5,837	$12,777,985	$2,189
312	DISTURBANCE OF CONDUCT	5,697	$12,579,298	$2,208
780	GENERAL SYMPTOMS	22,110	$12,559,809	$568
436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE	2,300	$11,984,071	$5,210

Big Three

1-46

Kansas Medicaid Fee for Service

2002 Summary of Primary Diagnosis Data for Selected Conditions**

	Patient Count	% Patient	Medicaid Paid	% Paid	Average Paid
Asthma	9,432	5.0%	$86,057,253	7.4%	$9,123.97
Diabetes	11,614	6.1%	$191,433,978	16.6%	$16,483.04
CHF/Heart Failure	6,950	3.7%	$137,074,274	11.9%	$19,722.92
Total 3 Diseases*	24,223	12.8%	$329,894,882	28.5%	$13,619.08
Total State	188,930		$1,155,566,753		

*Unduplicated

**Underestimates

Distribution of Kansas Costs for Those with Asthma, Diabetes, Heart Failure

- Top 10% of recipients (2,422) cost $137 million (12% of all dollars) and averaged $56,529 per recipient *(other states ranged from $31,956 to $56,345 per recipient)*
- Long term care patients were 22% of the top 10% expenditures
- Other 78% of patients had heavy use of inpatient hospital and physician services

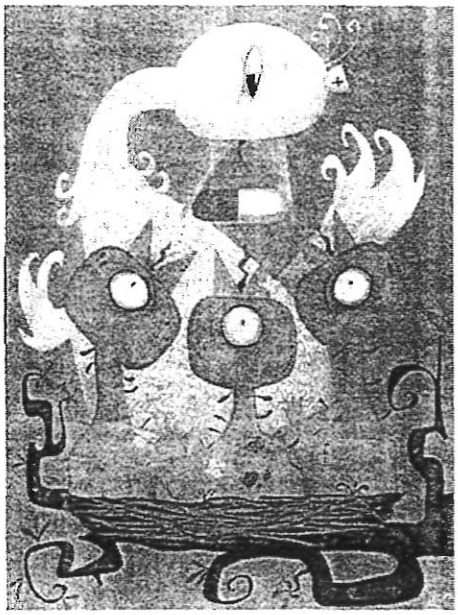
Examples of Controllable FFS Expenditures for Asthma: 2002

- $17.7 million in Inpatient Hospital expenditures
- $2.7 million in Outpatient Hospital (ER, MRI centers, etc.) expenditures

Relative Costs of Medicaid Recipients with Mental Illness and Selected Chronic Illnesses: Total Annual Expenditures Per Person

	Mental Illness Diagnosis	No Mental Illness Diagnosis
Asthma	$15,172	$6,123
Diabetes	$23,861	$13,244
Heart Failure	$27,555	$16,690

1-48



HMOs are using targeted disease management for high cost cases

Illustration is from "Take Your Medicine: HMOs are using a new service to manage their sickest patients"

by Daniel Eisenberg

Time Magazine, *Your Business* section, August 2001

More on Distribution of FFS Costs for Top 200 Medicaid Recipients

- Top 200 recipients cost $38.4 million and averaged $191,848 per recipient *(other states ranged from $121,921 to $344,843)*
- Hospital complications and septicemia, diseases of the lung, and intestinal problems dominate these 200 patients
- Inpatient hospital expenditures are 49.7% of this group's cost

1-49

Neonate Case Management

- 1,082 Neonates
- 165 hospitalized in first year
- 40 had two or more hospitalizations
- Many hospitalizations can be prevented

Kansas - Top 10 of the Larger Hospitals with the Highest Proportion of Septicemia or Complications - 2002

Provider	Patient Count	Sept/Comp Patient Count	Percent Sept/Comp	Medicaid Paid	Average Paid Sept/Comp
A	3,593	417	11.6%	$4,782,840	$11,470
B	2,112	214	10.1%	$11,528,353	$53,871
C	828	83	10.0%	$707,657	$8,526
D	771	74	9.6%	$431,060	$5,825
E	1,510	140	9.3%	$826,234	$5,902
F	1,114	72	6.5%	$441,274	$6,129
G	3,226	178	5.5%	$3,522,287	$19,788
H	1,612	87	5.4%	$859,464	$9,879
I	559	29	5.2%	$103,005	$3,552
J	814	40	4.9%	$169,302	$4,233
Total All Hospitals	31,543	2,350	7.5%	$30,960,936	$13,175

1-50

Expenditures for Persons with 9 or More Prescriptions in 180 Days*

- 35,939 total persons with $656.6 million in total expenditures
  - $142.5 million in prescription drug expenditures
- 26,905 non-institutionalized persons used $477.1 million of total expenditures
  - Represent ***23%*** of all ambulatory patients receiving prescription drugs
  - These patients used ***55%*** of total expenditures for all ambulatory patients

* Since analysis confined to one year, these are ***underestimates***

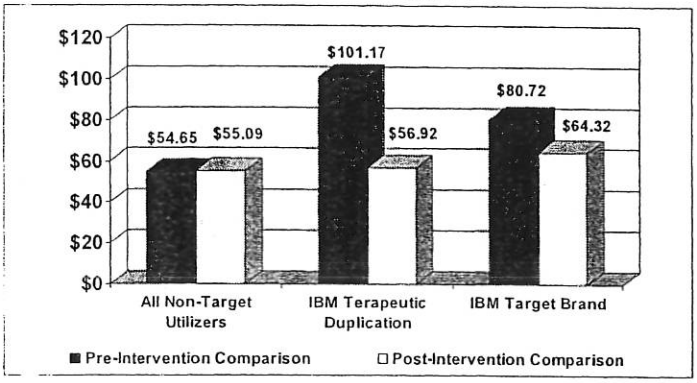
Expenditures for Persons with 20 or More Prescriptions in 180 Days*

- 7,272 total persons with $196 million in total expenditures
  - $51 million in prescription drug expenditures
- 4,822 non-institutionalized persons in this group used a total of $149 million or 13% of total Kansas Medicaid expenditures
  - These patients represent ***4.2%*** of all ambulatory patients receiving prescription drugs (other states range from ***0.3% to 5.2%***)

* Since analysis confined to one year, these are ***underestimates***

1-51

Florida Intensified Benefit Management (IBM) Program for Persons with 20 or more Prescriptions in 180 days



"The IBM program was able to produce cost savings for each intervention, including a 44% reduction in the PUPM (per user per month) for therapeutic duplication targeted recipients." *Medicaid Prescription Drug Spending Control Program Annual Report* , State of Florida Agency for Health Care Administration, Jan. 2002, p. 23.

Kansas - 2002 Prescription Drug Expenditures by American Hospital Formulary Service (AHFS) Classes by Amount Paid

AHFS Description	Patients	Paid	Percent of Total	Paid per Patient
ALL DRUGS	126,987	$196,479,381	100.0%	$1,547
CENTRAL NERVOUS SYSTEM DRUGS	75,934	$89,486,345	45.5%	$1,178
CARDIOVASCULAR DRUGS	31,619	$17,704,969	9.0%	$560
GASTROINTESTINAL DRUGS	27,855	$15,068,796	7.7%	$541
HORMONES AND SYNTHETIC SUBSTITUTES	41,923	$14,978,871	7.6%	$357
ANTI-INFECTIVE AGENTS	86,790	$14,421,734	7.3%	$166
AUTONOMIC DRUGS	37,246	$9,600,362	4.9%	$258
UNCLASSIFIED THERAPEUTIC AGENTS	11,910	$8,336,828	4.2%	$700
ANTIHISTAMINE DRUGS	30,692	$5,182,178	2.6%	$169
UNKNOWN - MISMATCH	25,728	$3,696,328	1.9%	$144
ELECTROLYTIC, CALORIC AND WATER BALANCE	22,806	$3,494,640	1.8%	$153

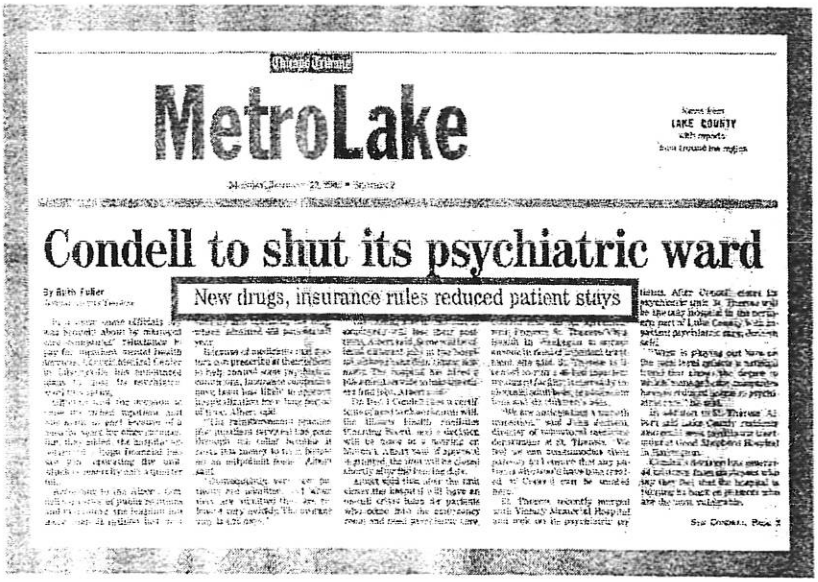
1-52

2002 FFS Prescription Drug Expenditures

(in millions of dollars)

Group	Dollars	Percent
Aged	$ 49	25.7%
Blind/Disabled	$112	***58.9%****
Children	$ 20	10.7%
Other Adults	$ 5	2.9%
Unknown	$ 3	1.7%
Total	$ 189	100.0%

* Other states ranged from 55.5% to 68.4%



Chicago Tribune

MetroLake

News from LAKE COUNTY with reports from around the region

Condell to shut its psychiatric ward

New drugs, insurance rules reduced patient stays

By Ruth Fuller

See also: "Use of Conventional Antipsychotics and the Cost of Treating Schizophrenia," by Ramon R. Lyu, Jeffrey S. McCombs, Bryan M. Johnstone, and Donald N. Muse. *Health Care Financing Review*, Winter 2001

1-53

2002 Expenditures for FFS Long Term Care Recipients

(in millions of dollars)

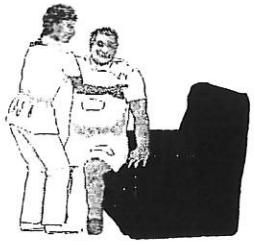
14,423 Residents (70% aged) Cost:

Type of Provider	*State*	*Percent*
Nursing Homes	$289.5	77.2%
Prescription Drugs	$ 44.3*	11.8%
Inpatient Hospital	$ 12.7	3.4%
Physicians	$ 14.3	3.8%
Hospital Outpatient	$ 1.1	0.3%
Clinic	$ 4.5	1.2%
Home Health Agency	$ 1.4	0.4%
Capitated Payments	$ 0.0	0.0%
Other	$ 7.2	1.9%
Total	$375.0	100%

* 23% of all prescription drug expenditures

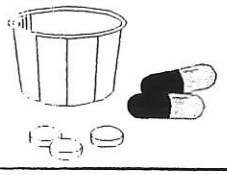
Research on Long Term Care (LTC) Facilities

- 14,423 Medicaid patients in LTC
- Approximately 428 facilities



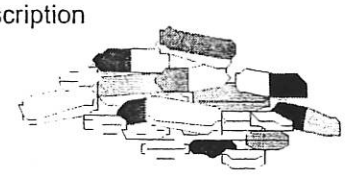
180 Days

- **Persons with 9 or more unique prescriptions in 180 days**
  - 9,134 (***63%***) of LTC patients had 9 or more prescriptions
  - These persons had $40.7 million in prescription drug expenditures
  - *78* facilities had more than ***75%*** of their patients with 9 or more prescriptions (excluding facilities with < 20 patients)
- **Persons with 20 or more unique prescriptions in 180 days**
  - 2,534 (***17.6%***) of LTC patients had 20 or more prescriptions (other states range from ***11% to 28%***)
  - These persons had $16.1 million in prescription drug expenditures



30 Days

- **Persons with 9 or more unique prescriptions in 30 days**
  - 7,407 (***51%***) of LTC patients had 9 or more prescriptions
  - These persons had $36 million in prescription drug expenditures
  - *37* facilities had more than ***70%*** of their patients with 9 or more prescriptions (excluding facilities with < 20 patients)
- **Persons with 20 or more unique prescriptions in 30 days**
  - 624 (***4.3%***) of LTC patients had 20 or more prescriptions (other states range from ***1.3% to 11%***)
  - These persons had $5 million in prescription drug expenditures



1-55

Indicators of Nursing Homes with Potential Problems

- Indicators developed in technical consultation with:
  - American Medical Directors Association
  - American Health Care Association
  - Long Term Care Pharmacy Alliances

General Indicators of Nursing Homes with Potential Problems

- What we look for:
  - High percentage of residents taking 20 or more prescriptions at the same time
  - High percentage of residents taking one or more of 19 modified Beer's list medications (always,rarely)*

*Zhan, C, et.al., JAMA 286, Dec. 12, 2001, p. 2823-9.

1-56

Indicators of Kansas Nursing Homes with Potential Problems

- 393 total homes of which 75 had 50 or more Medicaid patients:
- For the homes with 50 or more Medicaid patients:
  - 43 homes had more than 5 percent of residents taking 20 or more drugs at the same time
  - 11 homes had more than 25 percent of residents taking Beer's list medications (always,rarely)
  - 5 homes had both indicators

Drug Utilization in the Nursing Home Setting

- Study by researchers at the Landon Center on Aging and School of Pharmacy completed Feb. 03
- Using Beers criteria, found some short-term use (less than one month) of inappropriate meds, but very little chronic use (2-3%)
- Less than 2% of total drug expenditures were for drugs determined inappropriate for use in the elderly
- Future plans – use this information to target outlier providers and nursing homes for education

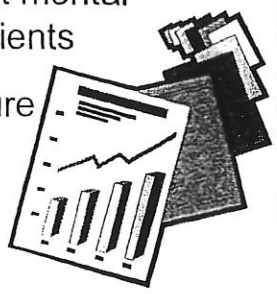
Source: Dr. Robert Day, Health Care Policy Division, Kansas Dept. of SRS

1-57

Potential Over / Under Utilization of Mental Health Medication

Overview of Analysis

- Mental health related protocols from Comprehensive NeuroScience, Inc. were applied to State XYZ's data
- Focus on medications used to treat mental health to identify mental health patients
- Based on published clinical literature



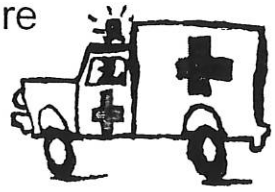
1-58

Key Finding 1
Potential Ineffective Dosage

- There were 5,487 (10.9 percent of those receiving mental health medication) patients that were prescribed an atypical at an ineffective strength. This represents 36 percent of patients who received an atypical medication. Industry experts indicate that this wastes money and is not helpful to treating recipients.

Key Finding 2
Potential Discontinued Usage

- There were 5,202 patients (10.4 percent) with severe mental illness that did not refill their prescription for their atypical anti-psychotic. This represents 34.1 percent of patients who received an atypical medication. Significant concern with respect to future hospitalizations, ER visits, etc. for these patients.



1-59

Key Finding 3
Potential Overlapping Medication

- There were 7,782 patients on 3 or more overlapping behavioral medications during 2002. This represents approximately 15.5 percent of recipients who received a prescription drug with a mental health indication.

Key Finding 3
Potential Overlapping Medication
(cont'd)

- 824 patients (1.6 percent of those receiving mental health medication) were concurrently on more than one SSRI during the year. Patients should not generally be on more than 1 SSRI at a time
- About 7.2 percent of patients taking atypicals received two or more of this type of drug at the same time during the year. Patients should not generally be on more than 1 atypical at the same time

1-60

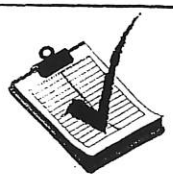
Third Generation Abuse Investigative Tools

- Applied Correct Coding Initiative(CCI) developed by CMS to database
- Two Areas
  - Compound Code Violations
  - Incompatible Code Violations

Examples of Compound Code Violations Upper GI Endoscopy, Biopsy

- CPT 43239, Upper GI Endoscopy, Biopsy and CPT 00740, Anesthesia, Upper GI Visualize should not be billed separately and should be bundled as part of the endoscopy procedure. Approximately $2,051 was paid for these codes in 2002 .
- Hundreds of pairs of codes
- In Kansas possible compound code violations were 0.043% of total expenditures for physician services

Incompatible Code Violations



- The CCI identifies CPT codes that should not be billed together on the same day.
- For example, CPT 73630, X-ray exam of foot and CPT 73610, X-ray exam of ankle should not be billed together on the same day. However, $4,430 was paid for this type of violation during 2002.
- In Kansas possible incompatible code violations were 0.042% of total expenditures for physician services

Analysis of Federal Medicare Prescription Drug Benefit

- Medicare is the primary payer to Medicaid
- Modeled our analysis of an Rx benefit on the Thomas bill
- Total Kansas prescription drug expenditures: $189.3 million
- Approximately 42% of Kansas prescription drug expenditures are for dual eligibles ($79.4 million)

Other Options

- 23 other options available through requests by the state

1-63

TABLE 1. MEDICAID ELIGIBLES - FISCAL YEAR 2000
BY MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	ELIGIBLES
RECV CASH-AGED	5,050
BLIND/DISABLED	35,071
CHILD	26,738
ADULT	17,371
MED NEEDY-AGED	6,950
BLIND/DISABLED	5,367
CHILD	566
ADULT	306
POV RELTD-AGED	4,184
BLIND/DISABLED	3,890
CHILD	100,131
ADULT	12,023
OTHER-AGED	16,610
BLIND/DISABLED	6,751
CHILD	8,434
ADULT	7,328
FOSTER CARE CHILD	11,042
1115 DEMO-AGED	0
BLIND/DISABLED	0
CHILD	0
ADULT	0
UNKNOWN	0
TOTAL	267,812

TABLE 2. MEDICAID ELIGIBLES - FISCAL YEAR 2000
BY AGE GROUP
STATE: KANSAS

AGE GROUP	ELIGIBLES
UNDER 1	13,662
AGE 1-5	55,176
AGE 6-14	63,730
AGE 15-18	22,387
AGE 19-20	7,740
AGE 21-44	48,165
AGE 45-64	21,762
AGE 65-74	11,427
AGE 75-84	11,742
AGE 85 >	12,021
UNKNOWN	0
TOTAL	267,812

TABLE 3. MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	TOTAL	INPATIENT HOSPITAL SERVICES	MENTAL HEALTH FACILITY SERVICES	ICF/MR SERVICES	NURSING FACLITY SERVICES	PHYSICIAN SERVICES	DENTAL SERVICES	OTHER PRACTITIONER SERVICES
RECV CASH-AGED	39,552,114	2,371,644	783,149	157,374	9,678,974	508,741	7,638	62,361
BLIND/DISABLED	364,663,612	52,428,890	2,476,107	21,180,615	11,700,626	16,046,710	726,474	1,101,430
CHILD	24,740,760	6,183,729	22,234	0	0	3,045,812	1,653,374	356,813
ADULT	30,104,031	9,869,259	12,740	0	9	5,423,393	234,096	344,378
MED NEEDY-AGED	24,515,150	848,710	51,110	13,634	13,169,798	481,282	1,311	29,001
BLIND/DISABLED	35,876,553	10,126,784	75,320	175,360	793,802	2,419,945	27,087	97,344
CHILD	3,065,674	390,479	1,860,024	291,221	0	58,663	8,531	3,578
ADULT	252,758	116,784	0	0	0	56,488	1,207	4,258
POV RELTD-AGED	2,165,685	349,608	82,873	0	443,033	179,670	179	12,396
BLIND/DISABLED	3,938,821	835,595	7,936	55,762	80,718	286,423	8,012	20,211
CHILD	82,869,452	21,804,170	479,060	0	0	10,293,299	5,619,798	1,039,174
ADULT	26,040,752	9,289,136	6,334	0	0	6,453,384	125,045	225,282
OTHER-AGED	315,762,376	2,073,296	3,635,670	1,779,089	226,267,328	608,429	23,225	114,679
BLIND/DISABLED	194,524,665	7,373,944	561,503	42,131,170	22,217,169	1,612,492	129,520	154,390
CHILD	8,946,213	1,979,718	90,498	0	0	1,000,292	491,307	106,706
ADULT	11,209,958	3,596,615	0	0	19,304	1,821,202	98,312	131,281
FOSTER CARE CHILD	38,440,146	5,125,338	1,493,572	600,982	0	2,104,762	1,447,629	528,373
1115 DEMO-AGED	0	0	0	0	0	0	0	0
BLIND/DISABLED	0	0	0	0	0	0	0	0
CHILD	0	0	0	0	0	0	0	0
ADULT	0	0	0	0	0	0	0	0
UNKNOWN	19,541,839	6,540,858	162,131	35,146	177,906	2,352,011	57,518	130,509
TOTAL	1,226,210,559	141,304,557	11,800,261	66,420,353	284,548,667	54,752,998	10,660,263	4,462,164

TABLE 3. (CONTINUED). MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	OUTPATIENT HOSPITAL SERVICES	CLINIC SERVICES	HOME HEALTH SERVICES	LAB & XRAY SERVICES	PRESCRIBED DRUGS	CAPITATED PAYMENT SERVICES	OTHER CARE SERVICES	PCCM SERVICES
RECV CASH-AGED	236,203	172,531	1,640,972	52,955	8,192,697	160	574,245	3,956
BLIND/DISABLED	6,957,106	15,708,200	8,449,235	1,581,692	61,896,472	171,237	15,535,234	367,072
CHILD	870,693	2,420,761	74,008	140,798	2,367,507	4,590,572	2,513,092	281,898
ADULT	1,681,112	1,025,355	135,585	482,272	3,292,035	5,579,188	304,975	93,250
MED NEEDY-AGED	133,346	95,693	650,408	37,322	4,876,847	0	384,628	66
BLIND/DISABLED	956,962	3,075,107	1,227,865	202,200	7,987,152	11,496	963,103	2,512
CHILD	24,007	79,723	0	3,545	53,732	2,480	45,324	564
ADULT	12,225	3,775	0	3,314	17,542	31,423	1,267	212
POV RELTD-AGED	85,161	49,701	34,207	16,971	553,577	120	50,502	122
BLIND/DISABLED	159,152	577,531	107,502	27,393	1,225,234	3,751	86,366	606
CHILD	2,753,632	6,764,765	227,221	466,524	7,271,974	17,330,777	7,027,091	893,746
ADULT	1,145,837	509,477	44,492	460,049	819,320	6,222,525	96,455	46,510
OTHER-AGED	310,596	312,052	2,636,328	76,549	40,131,532	230	2,033,733	22
BLIND/DISABLED	697,336	1,545,146	3,931,606	142,590	19,592,312	2,915	2,826,310	1,218
CHILD	299,237	1,621,632	40,246	48,091	723,856	1,484,725	733,324	82,848
ADULT	544,984	420,924	4,212	149,711	1,501,603	2,413,227	56,275	53,978
FOSTER CARE CHILD	696,286	11,854,668	79,464	149,616	4,961,556	127,146	3,684,574	12,052
1115 DEMO-AGED	0	0	0	0	0	0	0	0
BLIND/DISABLED	0	0	0	0	0	0	0	0
CHILD	0	0	0	0	0	0	0	0
ADULT	0	0	0	0	0	0	0	0
UNKNOWN	837,805	1,511,889	60,999	216,284	1,751,540	4,539,658	299,761	32,444
TOTAL	18,401,680	47,748,930	19,344,350	4,257,876	167,216,488	42,511,630	37,216,259	1,873,076

TABLE 3. (CONTINUED). MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	STERILIZATION SERVICES	PERSONAL SUPPORT SERVICES	UNKNOWN
RECV CASH-AGED	2,042	15,106,472	0
BLIND/DISABLED	107,619	148,229,210	-317
CHILD	19,343	221,560	-21,434
ADULT	330,318	1,291,122	4,944
MED NEEDY-AGED	0	3,741,994	0
BLIND/DISABLED	3,118	7,731,396	0
CHILD	110	243,693	0
ADULT	2,123	2,140	0
POV RELTD-AGED	650	306,915	0
BLIND/DISABLED	339	456,290	0
CHILD	59,632	913,294	-74,705
ADULT	365,919	227,288	3,699
OTHER-AGED	0	35,759,618	0
BLIND/DISABLED	3,265	91,601,758	21
CHILD	5,088	244,244	-5,599
ADULT	154,230	243,469	631
FOSTER CARE CHILD	35,742	5,537,747	639
1115 DEMO-AGED	0	0	0
BLIND/DISABLED	0	0	0
CHILD	0	0	0
ADULT	0	0	0
UNKNOWN	103,643	804,777	-73,040
TOTAL	1,193,181	312,662,987	-165,161

TABLE 4. MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	UNDUPLICATED TOTAL	INPATIENT HOSPITAL SERVICES	MENTAL HEALTH FACILITY SERVICES	ICF/MR SERVICES	NURSING FACLITY SERVICES	PHYSICIAN SERVICES	DENTAL SERVICES	OTHER PRACTITIONER SERVICES
RECV CASH-AGED	4,628	872	29	4	479	3,329	31	923
BLIND/DISABLED	33,815	6,189	77	271	629	26,099	2,813	7,030
CHILD	24,886	2,490	2	0	0	14,002	6,308	2,752
ADULT	14,431	2,881	4	0	1	8,794	729	2,117
MED NEEDY-AGED	4,183	573	17	1	2,129	1,643	11	428
BLIND/DISABLED	3,687	1,056	8	8	144	2,576	105	686
CHILD	363	66	80	3	0	178	50	33
ADULT	188	44	0	0	0	134	3	27
POV RELTD-AGED	1,742	256	2	0	57	1,237	2	237
BLIND/DISABLED	2,057	297	1	1	16	1,435	19	232
CHILD	93,672	9,038	28	0	0	48,020	22,049	9,093
ADULT	10,906	4,157	2	0	1	7,921	431	1,300
OTHER-AGED	16,020	1,814	222	36	11,770	6,239	118	1,793
BLIND/DISABLED	6,509	1,103	30	568	1,265	4,417	501	1,402
CHILD	8,087	659	5	0	0	4,694	1,999	886
ADULT	6,982	1,375	0	0	1	4,080	233	893
FOSTER CARE CHILD	10,023	617	64	7	0	7,769	5,164	3,301
1115 DEMO-AGED	0	0	0	0	0	0	0	0
BLIND/DISABLED	0	0	0	0	0	0	0	0
CHILD	0	0	0	0	0	0	0	0
ADULT	0	0	0	0	0	0	0	0
UNKNOWN	20,378	1,812	36	6	1,503	6,995	429	666
TOTAL	262,557	35,299	607	905	17,995	149,562	40,995	33,799

1-10

TABLE 4. (CONTINUED). MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	OUTPATIENT HOSPITAL SERVICES	CLINIC SERVICES	HOME HEALTH SERVICES	LAB & XRAY SERVICES	PRESCRIBED DRUGS	CAPITATED PAYMENT SERVICES	OTHER CARE SERVICES	PCCM SERVICES
RECV CASH-AGED	1,701	956	361	1,996	4,381	2	938	237
BLIND/DISABLED	18,690	13,831	1,697	15,996	29,392	434	11,453	19,642
CHILD	7,712	7,151	227	4,652	13,048	8,240	3,169	17,091
ADULT	6,724	4,081	107	5,736	9,752	4,948	1,106	8,393
MED NEEDY-AGED	748	476	159	1,208	3,850	0	687	10
BLIND/DISABLED	1,711	1,471	206	1,748	3,102	21	958	341
CHILD	100	112	0	66	166	9	54	49
ADULT	83	57	0	58	89	14	10	20
POV RELTD-AGED	599	371	15	695	569	1	202	16
BLIND/DISABLED	844	796	26	813	772	5	268	68
CHILD	24,699	26,312	558	15,719	44,984	31,944	8,446	60,492
ADULT	6,009	2,739	112	6,005	7,256	3,882	466	5,783
OTHER-AGED	2,575	2,000	761	3,763	15,437	2	2,534	4
BLIND/DISABLED	2,409	2,036	506	2,285	5,722	25	2,215	149
CHILD	2,617	2,483	52	1,553	4,444	2,697	890	5,098
ADULT	2,641	1,806	15	2,194	4,148	2,306	298	3,958
FOSTER CARE CHILD	4,268	5,230	78	2,870	7,725	439	3,093	1,345
1115 DEMO-AGED	0	0	0	0	0	0	0	0
BLIND/DISABLED	0	0	0	0	0	0	0	0
CHILD	0	0	0	0	0	0	0	0
ADULT	0	0	0	0	0	0	0	0
UNKNOWN	3,936	2,983	125	3,011	3,497	1,741	1,259	3,132
TOTAL	88,066	74,891	5,005	70,368	158,334	56,710	38,046	125,828

TABLE 4. (CONTINUED). MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE FOR MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	STERILIZATION SERVICES	PERSONAL SUPPORT SERVICES	UNKNOWN
RECV CASH-AGED	2	1,672	2
BLIND/DISABLED	668	9,105	376
CHILD	208	517	2,158
ADULT	1,770	929	120
MED NEEDY-AGED	0	1,055	0
BLIND/DISABLED	18	798	7
CHILD	2	115	4
ADULT	12	3	0
POV RELTD-AGED	1	118	0
BLIND/DISABLED	1	125	3
CHILD	692	1,865	9,491
ADULT	1,574	247	56
OTHER-AGED	0	5,285	0
BLIND/DISABLED	28	4,811	7
CHILD	58	284	736
ADULT	759	251	50
FOSTER CARE CHILD	385	1,590	295
1115 DEMO-AGED	0	0	0
BLIND/DISABLED	0	0	0
CHILD	0	0	0
ADULT	0	0	0
UNKNOWN	460	1,001	3,378
TOTAL	6,638	29,771	16,683

TABLE 5. MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND AGE GROUP
STATE: KANSAS

AGE GROUP	TOTAL	INPATIENT HOSPITAL SERVICES	MENTAL HEALTH FACILITY SERVICES	ICF/MR SERVICES	NURSING FACLITY SERVICES	PHYSICIAN SERVICES	DENTAL SERVICES	OTHER PRACTITIONER SERVICES
UNDER 1	34,848,504	21,364,505	0	0	0	3,980,117	603	4,880
AGE 1-5	55,285,076	14,595,785	0	0	0	7,658,792	2,049,662	216,204
AGE 6-14	77,846,768	5,651,835	1,986,168	262,240	0	4,806,013	5,483,059	1,334,989
AGE 15-18	56,885,254	6,351,552	2,838,957	935,580	6,653	3,352,352	2,194,644	738,779
AGE 19-20	28,065,955	5,461,670	1,250,772	1,928,311	81,090	3,025,302	420,076	184,572
AGE 21-44	307,602,555	40,595,037	556,185	40,536,443	5,791,432	16,718,237	311,242	990,367
AGE 45-64	243,377,749	33,060,926	0	20,245,864	26,564,262	10,423,849	105,787	606,257
AGE 65-74	92,100,481	4,161,335	2,884,360	2,086,679	32,555,147	1,640,788	18,320	128,546
AGE 75-84	131,522,519	2,040,179	1,620,282	390,090	81,419,748	551,196	10,070	83,893
AGE 85 >	179,133,859	1,480,875	501,406	0	137,952,429	244,341	9,282	43,168
UNKNOWN	19,541,839	6,540,858	162,131	35,146	177,906	2,352,011	57,518	130,509
TOTAL	1,226,210,559	141,304,557	11,800,261	66,420,353	284,548,667	54,752,998	10,660,263	4,462,164

TABLE 5. (CONTINUED). MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND AGE GROUP
STATE: KANSAS

AGE GROUP	OUTPATIENT HOSPITAL SERVICES	CLINIC SERVICES	HOME HEALTH SERVICES	LAB & XRAY SERVICES	PRESCRIBED DRUGS	CAPITATED PAYMENT SERVICES	OTHER CARE SERVICES	PCCM SERVICES
UNDER 1	278,168	686,974	137,062	128,511	422,678	7,037,811	456,769	48,724
AGE 1-5	2,262,493	3,013,312	330,493	273,678	4,476,045	10,268,519	4,732,829	532,174
AGE 6-14	1,852,642	9,140,960	151,192	277,798	11,061,074	3,852,357	14,457,892	612,938
AGE 15-18	1,269,571	12,831,957	70,492	305,952	5,809,926	2,592,677	5,252,392	178,288
AGE 19-20	822,834	1,049,172	79,140	231,764	1,808,665	2,793,229	1,142,351	42,442
AGE 21-44	5,685,404	11,543,068	4,805,828	1,527,487	38,008,322	11,148,364	3,257,282	281,674
AGE 45-64	4,386,048	7,054,944	7,687,855	1,047,703	45,078,261	277,347	4,091,075	133,122
AGE 65-74	624,292	625,214	2,790,801	153,995	18,898,980	1,468	1,420,498	9,652
AGE 75-84	261,718	192,198	2,126,331	61,599	20,809,619	200	1,102,844	1,314
AGE 85 >	120,705	99,242	1,104,157	33,105	19,091,378	0	1,002,566	304
UNKNOWN	837,805	1,511,889	60,999	216,284	1,751,540	4,539,658	299,761	32,444
TOTAL	18,401,680	47,748,930	19,344,350	4,257,876	167,216,488	42,511,630	37,216,259	1,873,076

TABLE 5. (CONTINUED). MEDICAID EXPENDITURES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND AGE GROUP
STATE: KANSAS

AGE GROUP	STERILIZATION SERVICES	PERSONAL SUPPORT SERVICES	UNKNOWN
UNDER 1	89	302,013	-400
AGE 1-5	780	5,015,862	-141,552
AGE 6-14	14,670	16,900,970	-29
AGE 15-18	116,788	11,997,865	40,829
AGE 19-20	64,293	7,671,001	9,271
AGE 21-44	879,748	124,966,649	-214
AGE 45-64	10,478	82,603,997	-26
AGE 65-74	1,005	24,099,401	0
AGE 75-84	1,687	20,849,551	0
AGE 85 >	0	17,450,901	0
UNKNOWN	103,643	804,777	-73,040
TOTAL	1,193,181	312,662,987	-165,161

TABLE 6. MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND BY AGE GROUP
STATE: KANSAS

AGE GROUP	UNDUPLICATED TOTAL	INPATIENT HOSPITAL SERVICES	MENTAL HEALTH FACILITY SERVICES	ICF/MR SERVICES	NURSING FACLITY SERVICES	PHYSICIAN SERVICES	DENTAL SERVICES	OTHER PRACTITIONER SERVICES
UNDER 1	11,859	7,370	0	0	0	8,066	12	35
AGE 1-5	52,395	3,870	0	0	0	31,240	8,583	1,915
AGE 6-14	59,720	1,168	89	5	0	29,391	22,348	10,781
AGE 15-18	20,864	1,485	108	12	1	11,723	6,824	5,052
AGE 19-20	7,036	1,888	51	24	3	4,679	1,182	1,168
AGE 21-44	42,560	9,408	31	493	374	28,616	1,035	6,252
AGE 45-64	18,883	4,289	0	316	1,559	14,550	401	4,090
AGE 65-74	8,829	1,618	164	40	1,922	6,061	83	1,650
AGE 75-84	9,661	1,390	100	9	4,696	4,901	54	1,383
AGE 85 >	10,372	1,001	28	0	7,937	3,340	44	807
UNKNOWN	20,378	1,812	36	6	1,503	6,995	429	666
TOTAL	262,557	35,299	607	905	17,995	149,562	40,995	33,799

TABLE 6. (CONTINUED). MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND BY AGE GROUP
STATE: KANSAS

AGE GROUP	OUTPATIENT HOSPITAL SERVICES	CLINIC SERVICES	HOME HEALTH SERVICES	LAB & XRAY SERVICES	PRESCRIBED DRUGS	CAPITATED PAYMENT SERVICES	OTHER CARE SERVICES	PCCM SERVICES
UNDER 1	3,081	3,956	484	3,648	5,060	4,678	895	6,017
AGE 1-5	18,073	15,983	472	10,416	28,677	17,706	5,001	34,137
AGE 6-14	14,667	16,434	114	7,620	30,426	16,625	10,657	38,010
AGE 15-18	7,262	8,022	76	5,507	12,479	4,674	4,236	11,515
AGE 19-20	3,516	2,136	82	3,085	4,597	2,170	909	3,801
AGE 21-44	20,653	14,216	852	18,122	30,823	8,657	5,288	21,219
AGE 45-64	10,150	6,845	1,311	10,137	16,276	449	4,811	7,329
AGE 65-74	3,397	1,874	620	3,842	7,722	8	2,006	580
AGE 75-84	2,166	1,391	539	2,949	8,861	2	1,622	70
AGE 85 >	1,165	1,051	330	2,031	9,916	0	1,362	18
UNKNOWN	3,936	2,983	125	3,011	3,497	1,741	1,259	3,132
TOTAL	88,066	74,891	5,005	70,368	158,334	56,710	38,046	125,828

TABLE 6. (CONTINUED). MEDICAID BENEFICIARIES - FISCAL YEAR 2000
BY TYPE OF SERVICE AND BY AGE GROUP
STATE: KANSAS

AGE GROUP	STERILIZATION SERVICES	PERSONAL SUPPORT SERVICES	UNKNOWN
UNDER 1	3	317	0
AGE 1-5	9	1,790	5,680
AGE 6-14	163	2,532	5,816
AGE 15-18	1,335	2,443	1,354
AGE 19-20	756	701	149
AGE 21-44	3,860	7,012	179
AGE 45-64	49	5,138	116
AGE 65-74	2	2,885	11
AGE 75-84	1	3,305	0
AGE 85 >	0	2,647	0
UNKNOWN	460	1,001	3,378
TOTAL	6,638	29,771	16,683

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TABLE 7. MEDICAID EXPENDITURES - FISCAL YEAR 2000
PROGRAM TYPE BY MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	TOTAL	NO SPECIAL PROGRAM	EPSDT	FAMILY PLANNING	RURAL HEALTH CLINIC	FQHC
RECV CASH-AGED	39,552,114	25,890,603	29,952	2,817	64,841	9,003
BLIND/DISABLED	364,663,612	229,238,055	1,175,516	385,328	1,364,881	315,877
CHILD	24,740,760	22,942,249	1,055,766	55,017	536,602	114,347
ADULT	30,104,031	26,695,409	2,040,950	961,641	293,665	104,676
MED NEEDY-AGED	24,515,150	21,739,371	12,118	127	29,366	2,790
BLIND/DISABLED	35,876,553	29,171,056	101,606	18,242	65,648	16,678
CHILD	3,065,674	2,834,291	12,287	543	3,826	395
ADULT	252,758	225,431	19,008	6,417	1,373	529
POV RELTD-AGED	2,165,685	1,910,654	7,682	893	18,788	558
BLIND/DISABLED	3,938,821	3,514,018	8,724	3,810	24,695	4,580
CHILD	82,869,452	76,062,302	3,706,867	211,937	2,280,766	362,526
ADULT	26,040,752	20,882,478	3,793,209	1,176,796	120,299	64,004
OTHER-AGED	315,762,376	284,955,359	26,611	3,406	146,913	1,795
BLIND/DISABLED	194,524,665	108,954,974	106,578	54,659	132,949	4,739
CHILD	8,946,213	8,349,859	312,791	16,895	212,537	30,456
ADULT	11,209,958	10,141,520	408,379	425,052	182,773	43,538
FOSTER CARE CHILD	38,440,146	35,052,360	621,164	111,089	307,040	37,476
1115 DEMO-AGED	0	0	0	0	0	0
BLIND/DISABLED	0	0	0	0	0	0
CHILD	0	0	0	0	0	0
ADULT	0	0	0	0	0	0
UNKNOWN	19,541,839	18,386,767	350,713	191,194	137,563	75,402
TOTAL	1,226,210,559	926,946,756	13,789,921	3,625,863	5,924,525	1,189,369

TABLE 7. (CONTINUED). MEDICAID EXPENDITURES - FISCAL YEAR 2000
PROGRAM TYPE BY MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY
STATE: KANSAS

MAS/BOE	INDIAN HEALTH SERVICES	HCBC DISAB ELDERLY	HCBW SERVICES	UNKNOWN
RECV CASH-AGED	860	10,822,214	2,731,824	0
BLIND/DISABLED	5,848	3,147,586	129,030,521	0
CHILD	1,204	0	35,575	0
ADULT	4,816	0	2,874	0
MED NEEDY-AGED	0	2,579,855	151,523	0
BLIND/DISABLED	0	0	6,503,323	0
CHILD	0	0	214,332	0
ADULT	0	0	0	0
POV RELTD-AGED	0	196,418	30,692	0
BLIND/DISABLED	860	0	382,134	0
CHILD	5,848	0	239,206	0
ADULT	1,376	0	2,590	0
OTHER-AGED	172	27,118,138	3,509,982	0
BLIND/DISABLED	0	-4,886	85,275,652	0
CHILD	344	0	23,331	0
ADULT	344	0	8,352	0
FOSTER CARE CHILD	0	0	2,311,017	0
1115 DEMO-AGED	0	0	0	0
BLIND/DISABLED	0	0	0	0
CHILD	0	0	0	0
ADULT	0	0	0	0
UNKNOWN	688	123,384	276,128	0
TOTAL	22,360	43,982,709	230,729,056	0

Pharmaceutical Benefits under State Medical Assistance Programs

2001

Published by the
National Pharmaceutical Council, Inc.
1894 Preston White Drive
Reston, VA 20191-5433

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This compilation of data on State Medical Assistance Programs (Title XIX) presents a general overview of the characteristics of State programs, together with detailed information on the pharmaceutical benefits provided. The data collection effort covers all States with Medicaid programs and the District of Columbia.

Information for this compilation was acquired from multiple sources, including a survey of Medicaid prescription drug programs, administered for the National Pharmaceutical Council by Muse & Associates, Washington, DC with assistance from Buck Consultants, New York, NY. While we have checked all secondary data in the book for consistency relative to the original source, we have not validated the original data reported by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), and other organizations.

The data were compiled and the book prepared for publication by Donald Muse, Ph.D., David Goldenberg, Ph.D., Edward Steinhouse, J.D., Greg Portner, Anne Marie Hummel, Steven Heath, Stanley Weintraub, C.P.A, Errica Philpott, Liz Segall, and Monique White of Muse & Associates. Paul Gavejian, Kenneth Whitford, and Yolanda Obando of Buck Consultants prepared and conducted the 2001 survey. Gary Persinger and Kimberly Dietrich of the National Pharmaceutical Council provided valuable input and support.

Total Medicaid Eligibles Per 1000 Population, 1999

State	Total State Population	Total Eligibles	Eligibles per 1000 Populations
National Total	***281,421,906***	***41,078,120***	***146.0***
Alabama	4,447,100	649,501	146.1
Alaska	626,932	99,177	158.2
Arizona	5,130,632	644,376	125.6
Arkansas	2,673,400	483,257	180.8
California	33,871,648	6,216,756	183.5
Colorado	4,301,261	352,475	81.9
Connecticut	3,405,565	409,554	120.3
Delaware	783,600	113,253	144.5
District of Columbia	572,059	144,785	253.1
Florida	15,982,378	2,116,270	132.4
Georgia	8,186,453	1,236,782	151.1
Hawaii	1,211,537	203,159	167.7
Idaho	1,293,953	93,983	72.6
Illinois	12,419,293	1,698,504	136.8
Indiana	6,080,485	668,491	109.9
Iowa	2,926,324	313,328	107.1
Kansas	2,688,418	260,382	96.9
Kentucky	4,041,769	663,856	164.2
Louisiana	4,468,976	774,796	173.4
Maine	1,274,923	200,129	157.0
Maryland	5,296,486	628,454	118.7
Massachusetts	6,349,097	1,049,262	165.3
Michigan	9,938,444	1,335,050	134.3
Minnesota	4,919,479	585,449	119.0
Mississippi	2,844,658	544,553	191.4
Missouri	5,595,211	877,354	156.8
Montana	902,195	95,942	106.3
Nebraska	1,711,263	222,654	130.1
Nevada	1,998,257	143,001	71.6
New Hampshire	1,235,786	105,483	85.4
New Jersey	8,414,350	843,793	100.3
New Mexico	1,819,046	369,861	203.3
New York	18,976,457	3,326,637	175.3
North Carolina	8,049,313	1,205,499	149.8
North Dakota	642,200	61,883	96.4
Ohio	11,353,140	1,389,740	122.4
Oklahoma	3,450,654	524,766	152.1
Oregon	3,421,399	544,427	159.1
Pennsylvania	12,281,054	1,772,839	144.4
Rhode Island	1,048,319	154,535	147.4
South Carolina	4,012,012	724,555	180.6
South Dakota	754,844	91,979	121.9
Tennessee	5,689,283	1,532,638	269.4
Texas	20,851,820	2,676,056	128.3
Utah	2,233,169	202,028	90.5
Vermont	608,827	140,286	230.4
Virginia	7,078,515	699,005	98.8
Washington	5,894,121	895,148	151.9
West Virginia	1,808,344	377,490	208.8
Wisconsin	5,363,675	563,104	105.0
Wyoming	493,782	51,835	105.0

Source: U.S. Department of Commerce, Bureau of the Census, Census 2000; CMS, HCFA-2082 Report, FY 1999.

Ranking Based on Drug Expenditures

State	2000 Payments	2000 Ranking	% of 2000 National Medicaid Drug Payments	1999 Payments	1999 Ranking
New York	$2,540,602,423	1	12.4%	$2,088,576,625	1
California	$2,472,137,448	2	12.0%	$2,032,662,106	2
Florida	$1,359,073,656	3	6.6%	$1,071,411,418	3
Texas	$1,121,832,241	4	5.5%	$949,401,423	4
Ohio	$879,595,616	5	4.3%	$756,270,324	5
Illinois	$805,790,014	6	3.9%	$659,006,317	7
North Carolina	$803,739,171	7	3.9%	$620,874,547	8
Massachusetts	$698,428,250	8	3.4%	$598,422,405	9
New Jersey	$598,193,627	9	2.9%	$503,467,976	10
Missouri	$596,733,995	10	2.9%	$480,456,062	11
Pennsylvania	$594,222,924	11	2.9%	$701,110,270	6
Georgia	$578,085,759	12	2.8%	$467,000,844	12
Louisiana	$508,229,794	13	2.5%	$426,635,061	13
Kentucky	$463,275,891	14	2.3%	$362,414,242	15
Indiana	$462,862,435	15	2.3%	$375,536,860	14
Michigan	$396,533,784	16	1.9%	$322,059,815	17
Washington	$394,782,642	17	1.9%	$300,829,923	18
Virginia	$387,722,448	18	1.9%	$332,697,520	16
Mississippi	$368,769,294	19	1.8%	$273,504,800	22
South Carolina	$350,270,353	20	1.7%	$286,512,220	19
Wisconsin	$347,245,591	21	1.7%	$276,799,465	20
Alabama	$333,069,288	22	1.6%	$273,619,269	21
Tennessee	$273,537,047	23	1.3%	$158,651,249	30
Connecticut	$265,685,933	24	1.3%	$220,626,381	23
Minnesota	$231,735,404	25	1.1%	$193,808,976	25
West Virginia	$215,222,053	26	1.0%	$196,823,679	24
Arkansas	$206,168,873	27	1.0%	$176,967,929	27
Maryland	$204,698,146	28	1.0%	$175,293,688	28
Iowa	$197,279,041	29	1.0%	$170,725,015	29
Maine	$170,901,428	30	0.8%	$143,912,147	31
Oregon	$168,325,265	31	0.8%	$127,564,792	33
Kansas	$165,290,804	32	0.8%	$138,219,289	32
Oklahoma	$164,022,317	33	0.8%	$179,640,268	26
Colorado	$143,925,427	34	0.7%	$125,412,858	34
Nebraska	$143,192,600	35	0.7%	$119,869,151	35
Utah	$100,910,520	36	0.5%	$83,846,922	37
Rhode Island	$89,490,129	37	0.4%	$77,328,349	38
Vermont	$85,889,049	38	0.4%	$59,101,805	41
Idaho	$82,041,976	39	0.4%	$67,661,438	39
New Hampshire	$81,721,512	40	0.4%	$65,580,129	40
Delaware	$66,226,440	41	0.3%	$53,431,292	42
Hawaii	$61,762,044	42	0.3%	$46,485,988	43
Montana	$60,174,213	43	0.3%	$119,786,471	36
Dist. of Columbia	$55,739,551	44	0.3%	$42,568,093	44
Nevada	$50,370,705	45	0.2%	$38,809,443	47
New Mexico	$48,486,325	46	0.2%	$38,983,306	46
Alaska	$44,910,326	47	0.2%	$39,916,402	45
South Dakota	$44,180,275	48	0.2%	$36,772,125	48
North Dakota	$39,031,804	49	0.2%	$32,467,772	49
Wyoming	$27,472,115	50	0.1%	$22,165,867	50
Arizona	$1,627,485	51	0.0%	$1,248,581	51

Source: CMS, HCFA-64 Report, FY 1999 and FY 2000.

Maximum Allowable Cost (MAC) Programs

State	Federal Upper Limits	State-Specific Upper Limits	MAC Override Provisions
Alabama	Yes	Yes	Dispense as written, brand medically necessary
Alaska	Yes	No	Brand medically necessary and reason for medical necessity
Arizona*	Yes	No	Brand necessary
Arkansas	Yes	Yes	Brand medically necessary, prior authorization
California	Yes	Yes	Medically necessary and other products unavailable at MAC rate
Colorado	Yes	Yes	Prior authorization
Connecticut	Yes	No	Brand medically necessary
Delaware	Yes	Yes	Brand medically necessary
District of Columbia	Yes	No	Brand medically necessary plus an explanation
Florida	Yes	Yes	If drug is on Florida Negative Formulary
Georgia	Yes	Yes	Prior authorization
Hawaii	No	No	-
Idaho	Yes	Yes	Brand medically necessary, handwritten by M.D., prior authorization
Illinois	Yes	Yes	Prior authorization request by M.D. or R.Ph.
Indiana	Yes	No	Brand medically necessary, prior authorization
Iowa	Yes	No	Brand medically necessary, prior authorization for drugs on FUL list
Kansas	Yes	Yes	N/A
Kentucky	Yes	No	Brand necessary, brand medically necessary, PA on some drugs
Louisiana	Yes	Yes	Medically necessary, brand medically necessary
Maine	Yes	Yes	Brand medically necessary, prior authorization on some drugs
Maryland	Yes	Yes	Brand medically necessary and reason for medical necessity
Massachusetts	Yes	Yes	Dispense as written, medically necessary,brand necessary and/or brand medically necessary, prior authorization
Michigan	Yes	Yes	Dispense as written and prior authorization
Minnesota	Yes	Yes	Brand medically necessary or dispense as written. Brand medically necessary must be handwritten on the prescription by the prescriber, no pre-printed DAW allowed.
Mississippi	Yes	No	Brand medically necessary
Missouri	Yes	Yes	Prior authorization
Montana	Yes	No	Dispense as written, brand necessary, prior authorization
Nebraska	Yes	Yes	Brand medically necessary and MC-6 form signed by M.D.
Nevada	Yes	No	Brand medically necessary
New Hampshire	Yes	Yes	Brand medically necessary, MedWatch form for PA
New Jersey	Yes	No	Brand medically necessary
New Mexico	Yes	Yes	Brand necessary, brand medically necessary
New York	Yes	No	Dispense as written, brand necessary, or brand medically necessary
North Carolina	Yes	No	Brand medically necessary
North Dakota	Yes	No	Dispense as written
Ohio	Yes	Yes	Prior authorization
Oklahoma	Yes	Yes	Brand medically necessary
Oregon	Yes	No	Dispense as written, brand medically necessary
Pennsylvania	Yes	Yes	Brand necessary, brand medically necessary, or prior authorization
Rhode Island	Yes	No	Brand medically necessary with medical justification
South Carolina	Yes	Yes	Brand medically necessary w/ certification of generics treatment failure
South Dakota	Yes	No	Brand medically necessary
Tennessee*	-	-	-
Texas	Yes	Yes	Brand necessary, brand medically necessary
Utah	Yes	Yes	Brand medically necessary plus justification
Vermont	Yes	Yes	Dispense as written
Virginia	Yes	Yes	Brand necessary
Washington	No	Yes	Brand medically necessary
West Virginia	Yes	No	Brand medically necessary
Wisconsin	No	Yes	Brand medically necessary
Wyoming	No	No	-

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.
Source: As reported by State drug program administrators in the 2001 NPC Survey.

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Mandatory Substitution

State	Incentive Fee for Generic Substitution	Dispensing of Generic Multi-Source Required	Dispensing of Lowest Cost Multi-Source Required
Alabama	No	No	No
Alaska	No	Yes	No
Arizona*	-	-	-
Arkansas	No	Yes	No
California	No	No	Yes
Colorado	No	No	No
Connecticut	$0.50	No	No
Delaware	No	-	-
District of Columbia	No	No	Yes
Florida	No	Yes	No
Georgia	$0.50	Yes (brand PA required)	No
Hawaii	No	Yes (if AB rated & not against State law/regs)	No
Idaho	No	Yes	No
Illinois	No	No	Yes
Indiana	No	Yes	No
Iowa	No	Yes	Yes
Kansas	No	No	No
Kentucky	No	Yes	Yes
Louisiana	No	No	No
Maine	No	Yes	No
Maryland	No	Yes	Yes
Massachusetts	No	Yes	No
Michigan	No	No	No
Minnesota	No	Yes	No
Mississippi	No	Yes	Yes
Missouri	No	No	No
Montana	No	Yes	No
Nebraska	No	No	Yes
Nevada	No	Yes	Yes
New Hampshire	No	Yes	No
New Jersey	No	Yes	No
New Mexico	No	Yes	No
New York	No	Yes (if prescriber allows substitution)	No
North Carolina	No	Yes	No
North Dakota	No	No	No
Ohio	No	No	No
Oklahoma	No	Yes	No
Oregon	No	Yes	No
Pennsylvania	No	Yes	No
Rhode Island	No	Yes	No
South Carolina	No	Yes	No
South Dakota	No	No	No
Tennessee*	-	-	-
Texas	No	Yes	No
Utah	No	Yes	No
Vermont	No	Yes	No
Virginia	No	No	No
Washington	No	Yes	No
West Virginia	No	Yes	No
Wisconsin	No	No	No
Wyoming	No	Yes	No

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.
Source: As reported by State drug program administrators in the 2001 NPC Survey.

Kansas
Kansas Senior Pharmacy Assistance Program

Program Type: Direct Assistance
Year Operational: 2001
Number of Recipients (FY 01): 1,083

ELIGIBILITY CRITERIA

Eligibility Age (Elderly):	67+	**Eligibility Age (Disabled):**	
Eligible Income Level (Single):	$12,525 (in '01)	**Eligible Income Level (Married):**	$16,875 (in '01)
Other Eligibility Notes:	Must be Kansas resident; not covered under a private prescription reimbursement plan; not eligible for or enrolled in any other local, state, or Federal prescription program; not have voluntarily cancelled a local, State, Federal, or private prescription drug program within six months of application to the program. Must be current recipient of benefits through QMB or SLMB programs.		

FUNDING AND REIMBURSEMENT

Funding Source:	State General Revenue Fund
Budget (FY 02):	$1.2 million
Cost per Participant (FY 02):	$374.00
# of Rx's Per Participant:	N/A
Manufacturer Rebate Type:	None
Ingredient Cost Calculation:	None
Enrollment Fee:	None
Deductible Amount:	None
Copayment Amount:	30% of pharmaceutical cost
Dispensing Fee:	None
Notes:	Maximum annual benefit is $1,200 per enrollee.

DRUGS COVERAGE

Formulary:	State Medicaid formulary
Drugs Covered:	Legend drugs, diabetic supplies not covered by Medicare, and prescription drugs that treat chronic illness
Drug Coverage Restrictions:	Over-the-counter drugs, lifestyle drugs, and prescriptions for acute illnesses not covered

PROGRAM CONTACT

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Topeka, KS 66603-3404

Phone: 785/368-7327
Email: gailes@aging.state.ks.us

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C. ADMINISTRATION

State Department of Social and Rehabilitation Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; and total parenteral nutrition. Products covered with restriction: interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; DESI drugs; and drugs not rebated by the manufacturer.

Over-the-Counter Product Coverage: Products covered: analgesics (for adults); digestive products (H2 antagonist); and antifungals. Products covered with restrictions: cough and cold preparations. Products not covered: allergy, asthma and sinus products; digestive products (non-H2 antagonists); feminine products; topical products and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics (for children), antipyretics (for children), NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; anti-psychotics antilipemic agents; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathominetics (adrenergic); and thyroid agents. Prior authorization required for: anxiolytics, sedatives, and hypnotics; anorectics; and growth hormones. Products not covered: prescribed smoking deterrents.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, extended care facilities, and through physician payment program when used in physician offices.

Vaccines: Vaccines reimbursed as part of the Children Health Insurance Program and the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary.

Prior Authorization: State currently has a formal prior authorization procedure. The individual appealing may request an administrative hearing to appeal a prior authorization hearing by sending a request in writing to:

Administrative Hearing Office
610 S. W. 10th Ave, 2nd Floor
Topeka, KS 66612-1616

Prescribing or Dispensing Limitations

Prescription Refill Limit: As authorized by the prescriber and allowed by statute up to a one-year period from the date of issuance of the prescription for non-controlled drugs. No early refills (<75% Rx utilized).

Monthly Quantity Limit: 34-day supply.

Other: Narcotics, Viagra, and Relenza have other specific limits.

Drug Utilization Review

PRODUR system implemented in November 1996. State currently has a DUR Board with review every two months.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: $4.50, effective 1/95.

Ingredient Reimbursement Basis: EAC = AWP - 10%. IV fluids, AWP - 50%. Blood fraction products, AWP - 30%.

Prescription Charge Formula: Pharmacies are reimbursed the lesser of usual and customary, MAC, FUL, or acquisition cost (EAC) plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific maximum allowable cost (MAC) limits on generic drugs.

Incentive Fee: None.

Patient Cost Sharing: A recipient copay charge of $2.00 (effective 7/1/94) applies to each new and refill prescription not specifically exempted under Federal regulations.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 95,000 Medicaid Recipients were enrolled in MCOs in FY 2000. Recipients receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

First Guard
3801 Blue Pkwy
Kansas City, MO 64130

F. STATE CONTACTS

State Drug Program Administrator

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Health Care Policy Division
Department of Social and Rehabilitation Services
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E-mail: mho@srskansas.org
Agency Internet Address: www.ink.org/public/srs/

Prior Authorization Contact

Mary H. Obley, 785/296-8406

DUR Contact

Karen Braman, R.Ph., M.S.
DUR Program Director
KU School of Pharmacy
6052 Malott Hall
Lawrence, KS 66045-2500
T: 785/864-3264
F: 785/864-5849

DUR Board

Michael Burke, M.D., Ph.D.
Lawrence Davidow, Ph.D., R.Ph.
Stanley Edlavitch, Ph.D., M.A.
John Lowdermilk, R.Ph.
Linda McAnarney, R.N.
Janette McMillan, R.Ph.
Kathy Miller-Lemke, R.Ph.
Brenda Shewe, M.D.
John Whitehead, D.O.

Prescription Price Updating

Mary H.Obley, 785/296-8406

Medicaid Drug Rebate Contacts

Policy: Mary H. Obley, 785/296-8406

Technical: Cindy LaClair, Rebate Specialist
BCBS of Kansas
3640 SW Topeka, Suite 200
T: 785/291-4886
E-mail: Cindy.LaClair@BCBSKS.com

Claims Submission Contact

Blue Cross Blue Shield of Kansas
P.O. Box 3571
Topeka, KS 66611
800/933-6593

Medicaid Managed Care Contact

Debra Bachmann
Health Wave
Health Care Policy Division, Kansas Dept. of SRS
Topeka, KS 66612-1570
T: 785/296-3667

Mail Order Pharmacy Program

None

Social and Rehabilitation Services Department Officials

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Medical Care Advisory Committee Contact

Robert Day, Ph.D.
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Executive Officers of State Medical and Pharmaceutical Societies

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Summary of Findings for Kansas FFY2002 CNS Mental Health Drug Algorithms February 27, 2003		
#	Metric Description	Result
1	Total number of patients receiving two or more atypicals at the same time in past 12 months	1,095
2	Total number of patients on 3 or more behavioral medications at any time (concurrent)	7,782
3	Number of patients that did not refill an atypical prescription within 15 days of expiration	5,202
4	Number of patients on more than one SSRI at any time (concurrent)	824
5	Number of patients on sedative/hypnotic for more than 30 days	751
6	Number of patients switched from one atypical antipsychotic to another atypical	3,148
7	Number of patients switched from conventional to atypical in past 12 month by month	2,035
8	Number of patients switched from any antipsychotic more than 3 times during past 12 months	1,206
9	Number of patients being prescribed atypical at a strength higher than recommended	499
10	Number of patients being prescribed atypical at an ineffective strength	5,487
11	Number of patients receiving Zyprexa as initial atypical prescription	4,714
12	Monthly cost for conventional and for atypicals for each month	Report 12
13	Number of patients receiving prescriptions from 3 or more physicians within last 12 months	7,806
14	Number of patients receiving a prescription for an atypical from more than one physician at the same time (concurrent)	356
15	Number of patients being prescribed 2 or more Zyprexa pills per day	1,975
16	Number of patients being prescribed more than 20 MG of Zyperxa per day	374
17	Number of patients being prescribed more than 6 MG of Risperdial per day	190
18	Number of patients being prescribed depokote and zyprexa at the same time (concurrent)	742
19	Unduplicated count of patients receiving any prescription during 12 month period	50,206
20	Unduplicated count of patients receiving atypical during 12 month period	15,239