Approved: 3-24-03
Date

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

The meeting was called to order by Chairperson Senator Stan Clark after Senate adjournment - 10:30 a.m. on **March 14, 2003** in Room 234-N of the Capitol, recessed and continued on **March 16, 2003** at 1:30 p.m. in Room 449-N and recessed and continued on **March 17, 2003** at 3:30 p.m. in Room 234-N.

All members were present except: Senator Barnett, excused
Senator Brungardt, excused
Rep. Bob Bethell, excused

Committee staff present: Emalene Correll, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee:

Others attending: See attached list

Approval of Minutes
Moved by Senator Feleciano, seconded by Senator Lee, the minutes of the President's Task Force on Medicaid Reform for meetings held on March 5, 2003 at 9:30 a.m., March 5, 2003 at 3:30 p.m., March 6, 2003, March 7, 2003, March 10, 2003 and March 11, 2003 be approved. Motion carried..

Initial Draft of Medicaid Report
Chairman Clark had compiled a rough draft of the report which incorporated an introduction, sections on long term care, prescription drugs, legislative follow up, care management and the various populations, internal management, issues beyond the State, public health issues, and an ongoing medicaid review structure. An outline of the draft follows:

I. Introduction
   History
   Post Audit
   Waivers
   Expansion of Coverage

II. Long Term Care
   Statement of the Issue
   Strategies for Problem Solving, Possible Action Steps, Who is Responsible
   (a) Recommendations
      Statewide public Education Campaign on importance of Long Term Care Insurance
      Allow long term care insurance premiums as deductible on Kansas Income Tax
      Allow refundable tax credit of 25% of the long term care insurance premium
      Protect an individual's estate by exclusions
   (b) SRS and Aging review financial and disability requjirements
   ©) Legal Dept of SRS responsible for reviewing state lien laws
   (d) Frail elderly waiver score definition of eligibility issues
   (e) Multi-disciplined team review findings on above issues

III. Prescription Drugs
   Statement of the issue
   Strategies for Problem Solving, Possible Action Steps, Who is Responsible
   (a) Explore maximum use of SRS purchasing power on drugs
   (b) Effort made to contain costs related to prescription drugs
   ©) Incentives for medical doctor, patient and pharmacist
   (d) Clinical pharmacists - academic detailing to providers
   (e) Pilot project patterened after Hiawatha pharamist's program

IV. Legislative Follow up

V. Care Management and the Various Populations

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on March 14, 2003 in Room 234-N of the Capitol.

(a) Statement of the Issue
(b) Strategies for Problem Solving and Possible Action Steps and delegating of responsibility
©) Legislative follow up

VI. Internal Management
(a) Statement of the Issue
(b) Strategies for Problem Solving and Possible Action Steps and delegating of responsibility
©) Legislative follow up

VII. Issues beyond the State
(a) Statement of the Issue
(b) Strategies for Problem Solving and Possible Action Steps and delegating of responsibility
©) Legislative follow up

VIII. Public Health Issues

IX. An Ongoing Medicaid Review Structure

Senator Clark announced from the Senate Floor on March 14 that the meeting of the task force on March 14 after Senate adjournment would be recessed and continued on Sunday, March 16 starting at 1:30 p.m. in his office 449-N in the Statehouse to continue work on the final report.

The following information was handed out to the Task Force:
(1) Nurse practitioners of Wichita testimony (Attachment 1)
(2) Annual Report of AG & SRS Secretary (Attachment 2)
(3) SRS Follow-up Information to Task Force (Attachment 3)

March 16, 2003 Meeting
Those present at the March 16 session were Chairman Clark, Senators Lee, Feleciano and Huelskamp and guests Pat Hubbell and Martin Hawver. Work on the report continued. Chair recessed the meeting at 6:00 p.m. to be continued on March 17 at 3:30 p.m.

March 17, 2003 Meeting
The Task Force reconvened on March 17, 2003 at 3:30 p.m. in Room 234-N. Present were Chairman Clark, Senators Lee, Huelskamp, Barnett, Feleciano, Brungardt and Rep. Bethell. Legislative Research provided a written report compiled from the March 16 session and further discussion was held and changes, additions and corrections made to the report.

Chairman Clark noted this has been a monumental task and he thanked the task force members for their participation.

Moved by Senator Huelskamp, seconded by Senator Feleciano, the President's Task Force on Medicaid Reform approves the Final Report of the Medicaid Reform Task Force and it will be presented to the President of the Senate. Motion carried.

Chairman thanked those in the audience who have attended the meetings and participated in the round table discussions for their information on all the areas discussed. He thanked the Representatives who joined the Task Force in this study and contributed their expertise.

The meeting was adjourned.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 3

President's Task Force on Medicaid Reform

DATE: MARCH 14, 2003

Name	Representing
Craig Kaberle	KAAAA
Josie Torrez	KACIL
Linda Whitaker	Ks Health Care Assn.
Barbara Belcher	Merck
Barb Hinton	Post Audit
Tanya Dorf	SRS

PRESIDENT'S TASK FORCE ON MEDICAID REFORM GUEST LIST

DATE: **MARCH 17, 2003**

Name	Representing
Bob Harder	UMC - KS
Jeff Bo Horberg	Merck
Pat Hubbell	Pharma
Bob Alderson	KS Pharmacists Assoc.
Barbara Belcher	Merck -
Janet Schalansky	SRS
Laura Howard	"
Christy Lane	KDOA
Vicki Whitaker	KS Health Care Assn.
Barb Hinton	Post Audit
Stuart Little	Assoc. of CMHCs

INITIATIVE: The utilization of nurse practitioners as providers in an integrated primary care and mental health practice ensures quality health services while reducing operating costs. This approach has allowed Associates in HealthCare L.L.C. to provide services for approximately five years to a patient base dominated by Medicaid and Medicare patients. Because we rely only on fee-for-service payments and do not receive grants or subsidies, we depend on maximum operational efficiency based on a full caseload of patients for each of our providers. As we serve more patients and thereby remove those people from the roster of the medically underserved, we reduce our marginal operating costs. This basic principle allows us as a free market provider to sustain high quality patient care while remaining financially viable.

STEPS: Because of our successful operational history in Wichita, we request that our present model be considered as a prototype or pilot example for statewide expansion. We are now evaluating the feasibility of expansion in other counties based on a critical need for Medicaid services in many areas. We discussed this specific area with state Medicaid officials and made our determination after evaluation of their recommendations. We will also pursue the pilot Medicaid project in Sedgwick County to mitigate frequent hospitalization for chronically ill patients. These projects represent our initial level of expansion. We welcome inspection of our Wichita facility and offer any information needed to support our observations regarding our operational success and excellent quality of care. We are ready to grow and expand our services to those that desperately need our help.

ESTIMATES OF IMPLEMENTATION TIMES: Expansion of services to other locations could be implemented within sixty days after completion of our feasibility evaluation. This determination depends on the level of community participation and the critical information that we will obtain from the Medicaid Director's office. We are unable to provide an estimate for implementation of the pilot Medicaid program in Sedgwick County until the final requirements for that program are known.

SOLUTIONS: Our integration of primary care and mental health services addresses two of the most dramatically underserved areas in Kansas. Because many physical problems are directly related to mental health issues, our effectiveness is greatly enhanced through this internal combination of services. We have demonstrated the tremendous value of this approach in our Wichita practice.

Our proactive health care model should be evaluated in direct comparison with the fragmented network of Medicaid services associated with the conventional mix of physicians, mental health professionals and non-profit clinics. In order to provide the same services that we provide internally, this disparate network must initially accept all Medicaid patients and provide a complete diagnosis of both physical and mental health issues at one location. As we know, the existing provider network combined with the non-profit "safety net" clinics experience significant challenges regarding basic accessibility for Medicaid patients and certainly does not provide integrated primary care and mental health services. As many physicians and mental health care professionals do not accept Medicaid patients, the initial obstacle to success is access itself. If the patient is seen, the primary care provider may not diagnose a related mental health issue at all and if diagnosed, they must then attempt to find another provider willing to accept the patient on referral. Certainly the patient is severely inconvenienced by this process and may not have access to transportation to multiple providers.

This piece-meal system is clearly problematic and certainly does not provide the same level of service that we offer every day. Business efficiency requires consolidated services and economies of scale. We have proven that these same principles combined with our fundamental commitment to each patient also promote the best possible care for the Medicaid population. We contend that the free market is ultimately the best provider of any good or service. As we have established, medical care is not the exception to this rule as many others assert. We look forward to a very positive working relationship with the State of Kansas to provide medical care to the underserved.

ANNUAL REPORT OF
THE ATTORNEY GENERAL AND THE SECRETARY
DETAILING EXPENDITURES AND REVENUES
UNDER THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM
FOR FISCAL YEAR 2001

As Required by
Section 1817(k)(5) of the Social Security Act

STATUTORY BACKGROUND

The Social Security Act section 1128C(a), as established by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act), created the Health Care Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in health care, including both public and private health plans.

Under the joint direction of the Attorney General and the Secretary, the Program's goals are:

1. to coordinate Federal, state and local law enforcement efforts relating to health care fraud and abuse;
2. to conduct investigations, audits and evaluations relating to the delivery of and payment for health care in the United States;
3. to facilitate enforcement of all applicable remedies for such fraud;
4. to provide guidance to the health care industry regarding fraudulent practices; and
5. to establish a national data bank to receive and report final adverse actions against health care providers.

Here are some germane parts from this report related to pharmacy costs:

Medicaid-Pharmacy Acquisition Costs: Ongoing audits and evaluations have generated information that will be valuable to policymakers who are considering alternate reimbursement approaches. Following up on previous work, HHS/OIG conducted a nationwide review of pharmacy acquisition costs for brand name drugs reimbursed under Medicaid. Most states use average wholesale price (AWP) minus a percentage discount, which varies by state, as a basis for reimbursing pharmacies for drug prescriptions. This review sought to determine the size of the discount. Based on pricing information from 216 pharmacies in 8 States, HHS/OIG estimated that the national actual acquisition cost for brand-name drugs was an average of 21.8 percent below AWP. In most states, the average discount below AWP for reimbursement of estimated acquisition cost was only 10.3 percent in 1999. If this disparity were eliminated, HHS/OIG estimated that nearly $1.1 billion could have been saved for the 200 brand name drugs (accounting for the greatest amount of Medicaid reimbursement in 1999)

Medicare-inflated Payments for Prescription Drugs: In Medicare, HHS/OIG studies spanning the last 4 years have revealed that Medicare and its beneficiaries pay considerably more than do other Federal health care programs for prescription drugs. In January 2001, HHS/OIG released a

report comparing Medicare reimbursement to prices available to the physician/supplier community, the Department of Veterans Affairs (VA), and to Medicaid. The study focused on 24 drugs representing $3.1 billion of the $3.9 billion in Medicare drug expenditures in 1999. For every drug in the review, Medicare paid more than the wholesale price available to physicians and suppliers and the VA Federal Supply Schedule price. In fact, for half of the drugs, Medicare paid more than double the VA price. Medicare and its beneficiaries would have saved over $1.6 billion if it had paid the same amount as does the VA, or $761 million at actual wholesale prices. These comparisons were run again using more current drug pricing information -- the sometimes large discrepancies between Medicare and other reimbursement for the same drugs remained. The study also found that Medicare carriers are not establishing consistent drug reimbursement amounts for certain drugs. The HHS/OIG recommended that CMS continue to seek administrative and legislative remedies to reduce excessive drug reimbursement amounts and require all carriers to reimburse a uniform amount for each drug.

Pharmacy Payments from Third Parties: Millions of Medicaid beneficiaries have other pharmacy coverage through private health plans, employers, non-custodial parents, State programs such as workers' compensation, or Federal programs such as Medicare. Because Medicaid is usually considered the payer of last resort, other insurance sources may be liable for claims providers send to Medicaid. An HHS/OIG study found that States were at risk of losing 80 percent ($367 million) of the payments they tried to recover ($440 million) in 1999 through a "pay and chase" approach. On the other hand, States that did not make the unnecessary payments in the first place safeguarded $185 million against possible risk. Almost three-quarters of States surveyed reported that third parties refuse to process or pay Medicaid pharmacy claims. States say they have more problems with pharmacy benefit management companies than with all other types of third parties combined. The $367 million represents the universe of potentially recoverable claims. In those states where financial records were reviewed, the amount actually recoverable is somewhat less due to coverage and eligibility requirements of third party payers that are not known to States. The CMS concurred with HHS/OIG recommendations to review use of cost avoidance waivers (which authorize Medicaid to pay first and seek reimbursement from private insurers), improve claim formats, and educate third party payers

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

FOLLOW-UP INFORMATION FOR MEDICAID TASK FORCE

I. Resource Issues Highlighted in LPA Report

- Income producing property:
  SRS has proposed a July Kansas Administrative Regulation (KAR) change to adopt a current federal minimum limit on non-business property ($6,000 limit with 6% return requirement).

- Vehicles:
  SRS will pursue adoption of a KAR change to the limit value of a vehicle to federal the minimum of $4,500 for certain persons including those in institutions who cannot drive and whose transportation needs are met by the institution.

- Personnel effects and furnishing:
  SRS will pursue adoption of a KAR change to place a limit on these items to deter obvious abuses. May potentially use a $10,000 or $15,000 limit which would avoid considering most regular effects and furnishings in use and truly focus on extravagant purchases done for sheltering purposes.

II. Transfer of Property

SRS will propose a Medicaid waiver to extend the look back period for transfers of non-trust property to 5 years and apply any resulting penalty period to begin with the month of application for assistance rather than the month the property was transferred.

III. Legislation to Expand Definition of Estate to Include Joint Tenancy Property

Currently the SRS Estate Recovery Unit closes out approximately 1,000 cases each year due to property which cannot be collected because of joint tenancy ownership. The property passes to other survivors and does not go to probate. If such property was subject to estate recovery, it is estimated that recoveries could increase by at least $1 million.

Three recent cases highlight this impact.

- A claim of over $10,000 went unrecovered even though joint tenancy farm property worth over $400,000 existed.

- A claim of almost $37,000 went unrecovered even though joint tenancy real property worth $129,000 existed.

- A claim of $44,000 could not be recovered as the only asset was real property in joint tenancy that was worth over $144,000.

IV. Coverage of Non-Citizens

See attachment.

President's Task Force
on Medicaid Reform
March 14-17, 2003
Attachments 3-1

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

COVERAGE OF NON-CITIZENS IN KANSAS

Based on federal laws, coverage of non-citizens in Kansas is limited to the follows:

I. Legal Non-Citizens in U.S.

Eligibility - Cash, medical, food, and child care assistance is available for:

- Refugees
- Asylum Seekers
- Non-citizens whose deportation has been withheld
- Cuban/Haitian entrants
- Amerasians
- Non-citizens granted parole or conditional entry status (not applicable to food assistance)
- Lawful permanent residents who arrived on or before August 22, 1996 (further restricted for food assistance)
- Certain battered spouses and children
- Non-citizens who are veterans or on active duty (includes spouses and dependent children)
- Victims of trafficking

In addition, for food assistance, the following non-citizens can qualify:

- Lawful permanent residents who have been in the U.S. for 5 years or longer
- Non-citizens and legal permanent residents (in U.S. less than 5 years) who are either:
  - receiving blindness/disability benefits
  - 65 years of age or older
  - under age 18
- Non-citizens granted parole or conditional entry status who have been in the U.S. for 5 years or longer

Benefits - Same benefits as citizens with no restriction.

II. Other Legal Non-citizens

Eligibility and Benefits - The is no eligibility for any assistance programs for non-citizens who do not qualify based on above criteria except for emergency medical coverage as explained below.

III. Illegal and Certain Legal Non-citizens

Eligibility and Benefits - There is no eligibility for any assistance except in the case of medical coverage for emergency services. To receive emergency medical services, the individual must meet Medicaid eligibility criteria, except for their status. Emergency

services are defined as services required because of a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate medical attention could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

In the case of a pregnancy, labor and delivery are defined as emergency services. Coverage is only for care sufficient to care for the emergency.

IV. Documentation

All non-citizens must provide documentation of status. This status must be verified through an automated system established with Immigration and Naturalization Services (INS).