Approved: May 2, 2003
Date

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

The meeting was called to order by Chairperson Senator Stan Clark at 4:30 p.m. after Senate adjournment on May 1, 2003 in Room 423-N of the Capitol.

All members were present except: Senator Lee, excused
Senator Feleciano, excused

Committee staff present: J. G. Scott, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee: None

Others attending: See attached sheet.

The committee members were provided a working draft of pages 4 through 21 from the President's Task Force on Medicaid Reform final report to the 2003 Legislature to make recommendations for further implementation of the proposed Strategies for Action in the following areas: (Attachment 1)

(1) Long Term Care Insurance
(2) Prescription Drugs
(3) Care Management and the Various Populations
(4) Internal Management
(5) Issues Beyond the State
(6) Public Health Issues
(7) Directions for the Future
(8) An Ongoing Medicaid Review Structure

Recommendations on where study and action on each topic set out in the report on the above areas were made as follows:

(1) Long Term Care Insurance (pages 4-7)

1. Statewide public education campaign - Governor Sebelius/Insurance Commmissioner Praeger but to delay the campaign until after the legislature adopts one of the following two items for the purchase of long-term care insurance.
2. Deductible long term care insurance premiums- Interim Tax Committee Sen. Corbin
3. Refundable tax credit of 25 per cent of long term care insurance premium - Interim Tax Committee - Senator Corbin
4. Spend-down - Revisor of Statutes Norman Furse; Dennis Priest, SRS; NCSL; National Governor's Association
5. Financial and disability requirements – Joann Corpstein, Chief Counsel, Dept.of Aging and SRS Dennis Priest
6. Identification of people who have transferred assets - Joann Corpstein, Chief Counsel, Dept.of Aging and SRS Schlansky & Priest
7. SRS proposed regulatory change - Joann Corpstein, Chief Counsel, Dept.of Aging and SRS Schlansky & Priest
8. Legislative Proposals regarding assets requirements – **SB 272** - Recovery of previous paid medical assistance
9. Public education – Janet Schlansky, SRS
10. Program Request - waivers -
Janet Schlansky, SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas

11. Legislative Follow up - Legislative Post Audit

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.

(2) Prescription Drugs (pages 8-11)

1. Purchasing and Negotiation - Check with Attorney General and Governor on which one would like to lead
2. Multi-state pharmaceutical program - Governor
3. Develop tracking system for prescription drugs similar to Alcohol Beverage Control - place on hold
4. Cooperation with Pharmacists
    a. Compensation for services - Bob Day, SRS
    b. Pilot projects - whole care integration - Bob Day, SRS
    c. Pharmacy inspectors - Kansas Board of Pharmacy
    d. Academic detailing - Bob Day, SRS
5. Medicaid Claims
    a. Review of exceptions – Bob Day, SRS, Laura Howard, Jerry Slaughter
    b. Over-prescribing - Bob Day, SRS, Laura Howard, Jerry Slaughter
    c. Review of claims information - Bob Day, SRS, Laura Howard, Jerry Slaughter
    d. Audits of pharmacy providers- Bob Day, SRS; Attorney General's Fraud Unit
    e. Eligibility for VA assistance - Dennis Priest, Candace Shively, Janet Schlansky
    f. Waiver programs -
        Janet Schlansky, SRS
        Gina McDonald, Kansas Assn. For Centers of Independent Living
        Shannon Jones, Statewide Independent Living Council of Kansas
6. Legislative follow up - LCC

(3) Care Management and the Various Populations (pages 12-14)

1. Community-based programs -
    Janet Schlansky, SRS
    Gina McDonald, Kansas Assn. For Centers of Independent Living
    Shannon Jones, Statewide Independent Living Council of Kansas
2. Long Term control of Health care costs -
    Janet Schlansky, SRS
    Gina McDonald, Kansas Assn. For Centers of Independent Living
    Shannon Jones, Statewide Independent Living Council of Kansas
    Roderick Bremby, Secy. KDHE
3. Health and well-being protocol - Roderick Bremby, Secy. KDHE; Richard Morrissey, Healthy Kansas 2010
4. Program of preventative care - Mark Bailey, Via Christi HOPE; cc: Richard Morrissey, Healthy Kansas 2010
5. Multi-discipline review – Roderick Bremby, Secy. KDHE; Richard Morrissey, Healthy Kansas 2010
6. Targeted care management
    Janet Schlansky, SRS; Bob Day, SRS
7. Financial incentives
    Janet Schlansky, SRS; Bob Day, SRS
8. Medicaid Physician Fee schedule
    Sen. Morris, Rep. Neufeld; cc: Duane Goossen; Jerry Slaughter
9. Hospital compensation - Kansas Hospital Assn., Don Wilson
10. PACE (Program of All Inclusive Care of the Elderly) - Pam Betts, Dept. of Aging
11. Use of Psychotropic drugs - Request a Post Audit
12. Primary care and MH services - Bob Day, SRS; Martha Kuhlmann, Barry Reynolds of Assn. Of Health; LCC
13. Legislative follow up - LCC

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MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on May 1, 2003 in Room 423-N of the Capitol.

(4) Internal Management (pages 15-16)

1. Reimbursement for service providers -Bob Day, Laura Howard, Janet Schlansky
2. More timely reimbursement - Bob Day, Laura Howard, Janet Schlansky
3. Other programs using Medicaid funding - Bob Day, Laura Howard, Janet Schlansky
4. Waiver caps -
   Janet Schlansky, SRS; Bob Day, SRS
   Gina McDonald, Kansas Assn. For Centers of Independent Living
   Shannon Jones, Statewide Independent Living Council of Kansas
5. Have $$ follow Long Term Care (LTC) to Independent living - in Governor's budget amendment, tracking by Secretary of Aging Betts
6. Durable medical equipment - retain and refurbish - Schlansky, SRS; Betts, Aging; Bob Day, SRS; Laura Howard, SRS; cc - Roger Werholtz, Dept. Of Corrections
7. Legislative follow up - LCC

(5) Issues Beyond the State (pages 16-17)

1. Purchasing cooperative with other states - Attorney General and Governor - recommend legislative leadership attend the National Legislative Assn. On Prescription Drug Prices meeting on June 27, 2003 in Concord, N.H. (Attachment 2)
2. Federal government assume responsibility for dually eligible - LCC letter to Congressional Delegation and Tommy Thompson, HHS Secretary; also work with MCSL and National Governor's Assn.
3. Same drug purchasing provisions as VA - Attorney General, Governor
4. Voucher programs -
   Janet Schlansky, SRS; Bob Day, SRS
   Gina McDonald, Kansas Assn. For Centers of Independent Living
   Shannon Jones, Statewide Independent Living Council of Kansas

(6) Public Health Issues (Pages 17-18)

1. Public health environment - Richard Morrissey, Healthy Kansas 2010, Roderick Bremby, Sec., KDHE
2. Healthy living options - Richard Morrissey Healthy Kansas 2010; Secretary Bremby, Ks. Health and Environment
3. Living healthier live styles - Richard Morrissey Healthy Kansas 2010; Secretary Bremby, Ks. Health and Environment

(7) Directions for the Future (Pages 19-20)

1. Develop Medical Benefit Accounts - LCC Interim Tax and Insurance Committee Topic Recommendation
2. Restrict MBAs to health care - LCC Interim Tax and Insurance Committee Topic Recommendation
3. Working Healthy program - Gina McDonald and Shannon Jones
4. Solutions for health insurance - LCC Interim Tax and Insurance Committee Topic Recommendation

(8) An Ongoing Medicaid Review Structure (Pages 20-21)

Dr. Robert St. Peter, Kansas Health Institute

Adjournment at 5:30 p.m.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 2

President's Task Force on Medicaid Reform
GUEST LIST

DATE: **May 1, 2003**

Name	Representing
Ron Seeber	Hein Law Firm
Shannon Jones	SILCR
Bob Harder	UMC - KS
Tanya Dorf	SRS
Chris Collins	KMS
Robert Day	SRS
Bill Rey	KFC

services now being given. However, there were issues the Task Force thought should be explored.

Strategies for Action

Long-Term Care Insurance

- The Task Force recommends the Office of the Governor and the Office of the Insurance Commissioner launch a statewide public education campaign to educate the public as to the importance of buying long-term care insurance. Geared to persons in their 50s or early 60s, the campaign should encourage citizens to plan for their own long-term care.

- Long-term care insurance premiums should be deductible from Kansas Income Tax as part of Kansas Schedule S, Part A (Kansas Modifications to Federal Adjusted Gross Income).

- The state should allow a refundable tax credit of 25 percent of the long-term care insurance premium to be claimed on line 22 of K-40 Individual Income Tax.

- The state should protect an individual's estate by excluding from Medicaid spend-down, assets of value equal to the amount of the policy maximum benefit. Additionally, we should suggest a similar policy be adopted in the U.S. Congress.

Regulatory Changes Regarding Asset Requirements

- Social and Rehabilitation Services and the Department on Aging should jointly review financial and disability requirements to ensure a tight system, yet one that accounts for the particular needs of each person. Kansas Medicaid financial eligibility standards currently are more lenient than other states. They allow Kansans to shelter a large portion of their assets and become eligible sooner than they would in other states.

- Social and Rehabilitation Services should become more aggressive in identifying people who have transferred assets or created trusts by increasing the look-back period to 60 months from the current 36 months for non-trust property and apply any resulting penalty period to begin with the month of application for assistance rather than the month the property was transferred.

- The Task Force supports the Social and Rehabilitation Services-proposed regulatory change to adopt the current federal minimum limit on non-business property ($6,000 limit with 6 percent return requirement). Additionally, the agency should adopt the federal minimum limit on the

value of vehicles ($4,500) and replace the blanket exemption of all personal effects and furnishings with a limit of $15,000. In so doing, the Department may focus any recovery assets on extravagant purchases done for sheltering purposes.

Legislative Proposals Regarding Asset Requirements

SB 272

- We support legislation similar to SB 497 presented in the 2002 Session which permitted the agency to establish a lien on the real property of a Medicaid recipient who has been in a long-term care facility for a year or more. The lien would be enforced at the time of sale or upon the death of the individual for repayment of Medicaid expenditures.

SB 272

- We support legislation changing the definition of an estate, for estate recovery purposes, to include jointly owned property. Such property currently passes to a survivor upon the death of the other joint owner and is not available for estate recovery purposes. Each year, the Social and Rehabilitation Services Estate Recovery Unit closes out approximately 1,000 cases 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 were subject to estate recovery, it is estimated that recoveries could increase by at least $1 million.

SB 272

- The state should prohibit property owners applying for or receiving Medicaid from specifying a certain percentage of ownership of jointly owned property. Where such ownership already exists, the full value of the property would still be considered for Medicaid purposes and be subject to estate recovery. A recent Kansas Court of Appeals decision allowed a Medicaid recipient to add an additional owner to exempt property without penalty and avoid estate recovery. The new owner received only 1 percent ownership while the recipient retained 99 percent. This did not result in a penalizable transfer, but did remove the property from the recipient's estate and prohibit the agency from establishing a claim at the time of death.

SB 272

- We support legislation that requires discretionary trusts funded by people other than the consumer (or spouse) to be considered a countable resource for public assistance purposes based on the total value of assets contained in such trusts. Refusal to pay for necessary medical care from the trust would be considered a breach of fiduciary duty and contrary to public policy. This would overrule a longstanding District Court case that allowed such trusts to be exempted for Medicaid purposes.

SB 272

- We support legislation to limit the scope of contracts, written prior to Medicaid eligibility being established, between a Medicaid recipient and his or her family members to provide basic services in exchange for a large prepayment. These contracts established solely for socialization services such as visitation and transportation for appointments and errands would

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be considered as a transfer of assets solely to obtain Medicaid coverage and result in a penalty. The agency has seen an increase in such contracts whereby, for example, the recipient gives his or her family $50,000 or more to perform such duties instead of using the money for medical needs.

Public Education

Janet Schlansky

- As the above changes are adopted, Social and Rehabilitation Services and Aging should gather a multi-disciplined team of all interested parties, including consumers and consumer advocates to review the results.

- Social and Rehabilitation Services and Aging should educate the public on eligibility requirements and enforcement actions as it applies to recipients, parties that jointly own property with recipients, and potential heirs. The legal department of Social and Rehabilitation Services shall closely monitor Elder Law Seminars and report the latest impoverishment schemes to become eligible for Medicaid.

Program Request

Janet Schlansky

Gary McDonald, Ks Assn for Centers of Independent Living

Shannon Jones, Statewide Independent Living Council of Kansas

- The Task Force heard testimony on waivers referred to as "Cash and Counsel" or referred to as "Project Independence" by the Centers for Medicare and Medicaid Services, that recognize the importance of an individual or family member planning and purchasing his or her community-based long-term care services. This type of waiver is designed to delay more restrictive institutional or other high cost care by supporting the elderly or disabled individual in his or her own home. In the three states that have experience with such waivers, each individual in the waiver receives a cash allowance based on a calculation of service needs developed by each state. Individuals may, at any time, drop out of the project and return to more traditional waiver services. In one program, while enrolled, the participants are assigned a counselor who offers advice and recommendations about issues involved with self-directing care and assistance with management functions, particularly payroll and bookkeeping. Funds can be used for virtually any facet of the waiver, services or items; they are not exclusively for salary. The potential for fraud and abuse critics of these waivers feared has not materialized and consumer satisfaction has been nearly universal. The Task Force believes the objective of this type of waiver is for the individual to get the right amount of care, and recommends a Project Independence waiver be requested by Social and Rehabilitation Services or Department on Aging. The Task Force believes this approach could be beneficial in other parts of the Medicaid system.

See CMS Independence plus website.

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Legislative Follow-Up

Post Audit

The Task Force understands that nationwide, states will be very active adopting and implementing many of these initiatives. We recommend and encourage the Legislative Post Audit Committee periodically to direct Legislative Post Audit to review Kansas compliance with changes related to the sheltering of assets and other relevant aspects of long-term care. The findings from those audits should be presented to the appropriate legislative committees.

PRESCRIPTION DRUGS

Statement of the Issue

Prescription drugs are an essential component of any Medicaid solution. Last year there were 7,500 less people receiving pharmacy assistance, but the prescriptions of those that did receive assistance cost $25 million more. During the first six months of FY 2003, the cost of prescription drugs was approximately $114 million, while the combined cost of inpatient and outpatient hospital services and physicians' fees was approximately $118 million. The Task Force recognizes prescription drugs have had a significant and beneficial effect on the lives of many Kansans. Many disabled and elderly Kansans are able to have productive lives through the stabilizing effect of medications.

However, the Task Force views with alarm the extreme growth in prescription drug costs. Without proper cost competition at the manufacturing level, further hardship will fall to the Kansas pharmacists whose dispensing fees have been reduced from $7.05 in the 1960s to $3.40 currently. However, any system changes require a close partnership with pharmacists, but little trust exists for efforts to reform this system.

According to figures provided by IMS Health (2001), 22.4 percent of an average prescription cost stays with the retailer. 3.4 percent for the wholesaler, and 74.2 percent makes its way back to the manufacturer. Further breakdown of the manufacturer's 74.2 percent portion indicates that only 29.3 percent goes to material cost: the rest is distributed 28.7 percent for advertising, 20.8 percent for research and development, 6.1 percent for taxes, and 15.1 percent for net profit. While nationally 92.5 percent of all prescription dollars are for brand names, in the Kansas Medicaid program, Social and Rehabilitation Services has reduced the brand name proportion to 85 percent.

Jim Cleland, pharmacist from WaKeeney, provided revealing information as to how complicated the pricing structure is for prescription drugs. As he went through a number of containers he had with him, it was hard to avoid the sense that the pharmacist who was the best bargainer was going to be the pharmacist who got the best price. There did not seem to be a lot of logic to the pricing. The Task Force was struck by the fact that, when Mr. Cleland suggested the state should get rid of the Average Wholesale Price (AWP), one of the drug company lobbyists indicated agreement with such a change.

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Interestingly, the Task Force reviewed information indicating that both the privately insured population and Medicaid beneficiaries have little incentive to manage their prescription costs. Prescription benefits, in both cases, are constructed with relatively low, fixed-dollar co-payments. In Medicaid, the maximum co-payment is $3.00 and is a voluntary payment.

Some medications can be obtained either in a higher dosage form with a doctor's prescription or a lower-dosage form across the counter. An example is Pepcid AC, a popular stomach acid controller, which can be obtained as a 20 mg. pill with a doctor's prescription or as a 10 mg. pill over the counter. A study of the average price from eight Kansas City area pharmacies found the 30 pill quantity 20 mg. Pepcid AC to be $67.94 and the price of a 60 pill quantity 10 mg. over the counter to be $21.33. Why the difference? The doctor prescribed form is covered by insurance and Medicaid; the over the counter dosage is not.

In the current system(s), the physician, the patient, or the pharmacist has no financial incentive to save money. Requiring beneficiaries to pay a percentage of the costs of brand name medicines at 20 percent, 30 percent, or even higher will create consumer discretion.

A positive side the Task Force saw was in the work of Steve Smith, pharmacist from Hiawatha. He knows his community and its facilities and has developed, in cooperation with medical staff in his community, a means to integrate the medical-pharmaceutical needs of persons receiving institutional care so the prescription drugs are geared to the needs of the patients, including a means for cross-checking to ensure there are not competing medications. Members of the Task Force have had the opportunity to talk about this system and are optimistic that a similar system would work in the Medicaid program.

We commend Social and Rehabilitation Services and the pharmacists of the state for all of the good work that has been done in a genuine effort to contain costs related to prescription drugs. A complete listing of these steps and possible savings has been incorporated into the Medicaid budget document, so we will not repeat that information. We do suggest a review of those steps to get a sense of the work that has been done.

Because of the potential for continued escalating costs in this area, it is imperative that new and innovative thinking go into new strategies in this area.

Strategies for Action

Purchasing and Negotiation

Attorney General negotiations

- Social and Rehabilitation Services legal and program staff, the Office of the Attorney General, the Office of the Governor, the President's Task Force and pharmacists should explore ways for the agency to make maximum use of its purchasing power to drive down the costs of drugs. The exploration should look at the possibility of Social and Rehabilitation Services securing a purchase price for the individual pharmacist which is as low as any place the drug can be purchased in the United States. This negotiation with wholesalers and drug manufacturers should be on behalf of all citizens and not just the Medicaid recipients. This would require a

change in federal law. The Task Force suggests the development of a multi-state purchasing cooperative. (Note: In FY 2002, the state spent $27.5 million for the top five drugs by expenditure and $41.6 million on the top ten. Any purchasing cooperative could focus on these drugs for bulk purchase.)

- On Friday, March 14, 2003, the Task Force was notified by the Governor's Office of a pending agreement to join the State of Michigan in a multi-state pharmaceutical program. Michigan took the lead in establishing an expansive preferred drug list and supplemental rebates with pharmaceutical manufacturers negotiated through First Health Services. While we appreciate the Governor's efforts and the direct rebate payments to the state, we believe it still allows manufacturers to raise their selling prices to all citizens to cover such rebates.

- An important factor in maximizing purchasing power is the ability to determine actual costs. Social and Rehabilitation Services should consider reviewing the systematic approach used to track the cost of liquor at the manufacturer, wholesaler, and retailer level to see if it is transferrable to the pharmacy system. Both systems have the same three tier industry structure and require permits or licenses at each tier. The pharmacy compensation fee will be implemented simultaneously with this strategy.

Cooperation With Pharmacists

- Participating pharmacists should receive adequate compensation for their services; we would recommend a pharmacy compensation fee of $10 for brand name prescriptions and $15 for generics. When tablets are prescribed, many times money can be saved if higher strength tablets are halved by the pharmacist. We recommend paying the pharmacist 50 cents for each dosage halved. Legislative Post Audit estimates $700,000 can be saved annually by halving tablets on one drug alone.

- Social and Rehabilitation Services and the Kansas Pharmacists Association. should work together to develop several pilot projects that duplicate the whole care integration of Mr. Smith in Hiawatha.

- The Task Force recommends the Kansas Board of Pharmacy beef up its inspectors. We would recommend hiring pharmacists that have many years of experience behind the counter and want a new challenge. We would like to raise the level of professionalism within the ranks and recommend inspections include spot checks comparing amounts of specific medicines ordered with medicines dispensed as well as Medicaid compliance checks.

- Clinical pharmacists should be utilized to provide academic detailing to providers. The Task Force received an example of how a pharmacist worked with the physician and patient, without compromising the patient's

welfare, to reduce the number of prescriptions from 12 to 9 and the cost from $1,315.11 per month to $96.96 per month. Many drugs are tried and true. Generics, over-the-counter, and herbal supplements are available. Thousands of drugs have been approved for dispensing, but the average physician prescribes less than 25 different drugs. Knowledgeable academic detailing offers potential savings without compromising patient care.

Scrutiny of Medicaid Claims

- The prescription drug program lends itself to management by exception. Recipients taking more than nine unique medications per day should have their medications reviewed by their doctor and pharmacist. Edits in the new Medicaid claims system (MMIS) can identify these recipients on the basis of high usage, expensive medications, or multiple prescriptions from different pharmacies.

- Social and Rehabilitation Services should identify and counsel doctors who might be over-prescribing certain medications as indicated in the MMIS edits.

- Medicaid currently allows and pays pharmacy claims without requiring the pharmacist submitting the claim to include information identifying the prescribing physician. Without that information on the claim, it is impossible to conduct a review of claims information to identify potential fraud or efficiently pursue alleged fraud. We recommend the new Medicaid Management Information System require this information before payment authorization.

- Social and Rehabilitation Services should consider audits of pharmacy providers that include comparing claims to actual prescription documents.

- An initial check of all Medicaid eligible patients should include a review of eligibility for Veterans Administration assistance.

Program Request

- As noted previously, Independence Plus and Cash and Counseling are waiver programs currently operating in other states. These waiver programs allow the consumer to buy his or her own personal home and community based services and the consumer satisfaction rates are near 100 percent. One reason this is so successful is consumers move from a defined benefit program to a system where the money they save in one area can be utilized in others. Examples given include saving money to purchase a new wheelchair for the consumer. We recommend Social and Rehabilitation Services ask for a demonstration waiver or develop a pilot program to establish a voucher system that encourages consumers to

utilize over-the-counter or generic drugs instead of brand name prescriptions and allow the money they save to be utilized like a medical savings account in other areas.

Legislative Follow-Up

The items suggested above could have a significant impact on the way in which the state does business in the name of Social and Rehabilitation Services. For that reason, we are suggesting regular reports be made to the Office of the Governor and the Legislature.

CARE MANAGEMENT AND THE VARIOUS POPULATIONS

Statement of the Issue

One of the most important topics covered by the Task Force is care management which arose from a recommendation of the consultant, Don Muse, who pointed out certain high cost Medicaid clients whose care, if managed by a team of health professionals, could result in better quality care at lower cost. The Task Force also discussed capitated managed care with conferees as well as traditional case management.

In the 1980s and 90s, managed care became a buzz word denoting a number of ideas. For persons with long involvement in the health services area, it was taken as an idea for genuinely managing the care of individuals. Medicaid is widely thought of as protection for poor women and children. Indeed, they are 75 percent of the recipients, and Kansas covers uninsured kids and pays for over half the births through Medicaid, largely through capitated managed care providers. The costs represent about 32 percent of the money in the program.

For the aged, mentally ill, and disabled consumers, though much smaller in terms of numbers of recipients, capitated managed care has been more challenging. It was thought that managed care was a way to assure adequate and appropriate care. It did not take long to discover that managed care had too often become another mechanism for controlling cost by turning medical practice over to clerks. It became a different way of rationing care and met very few expectations of persons who were getting the service or purchasing the service.

Over time, the medical system, the consumers, and the advocates insisted there be some mechanism for making good decisions on behalf of one's medical care. In this context, care management began to emerge as a more descriptive term. It was a term that could be filled with new meaning and was not burdened with the same, faulty ideas encompassed in managed care. It began to emerge as a descriptive word to explain that there was going to be a trained person giving an assist to those who were needing additional guidance as to their own medical care. Medical care management moves away from the concept of capitated managed care guided by clerks to an understanding that a trained person, where

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necessary will interact with the medical professionals to arrange the proper and appropriate care.

The problem already being faced by Social and Rehabilitation Services is the question of who is to provide the care management. If the agency and the state are to be assured of the best possible use of budget dollars, then there has to be an evaluation as to whether the service is best provided by a professionally trained medical person or by an attendant. It would seem that if the care management system is to work in the best interest of the consumer, then the initial medical evaluation needs to be done by a medically trained professional. The implementing of the medically prescribed program, hopefully, could be done by an attendant. By the blending of these two functions, the hope is that there can be a medically sound program which is guided day-to-day by an attendant but under the watchful eye of the health professional.

As we begin to think about care management, it is important to note we have two large population groups that Social and Rehabilitation Services is working to serve. The first grouping would be that of persons qualified for some type of institutional care and care provided through the home and community based waiver programs. The second grouping would be those individuals who are a part of Temporary Assistance for Needy Families (TANF), Pregnant Women and Children, and other childrens' groupings. These two populations are similar in that they are dependent upon Medicaid for their medical services, but they are different in that the latter group would not necessarily be involved with a medical professional or making use of attendant care. For that reason, different strategies will need to come into play.

The issue of long-term care and home and community based services is probably the most important topic covered by the Task Force. Both the manner in which the programs are operated and the recommendations the Task Force can make will make a difference in the lives of many. The significant challenge faced by the Legislature and Governor is to structure and fund the programs in ways to ensure individuals continue to have a high degree of independence and living in the community.

Strategies for Action

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- Social and Rehabilitation Services should continue its good work with the consumers and consumer advocates to build even stronger community-based programs. In view of the substantial cuts made in home health skilled services last year, the Task Force is calling upon the agency to re-examine the extent of those cuts. The Task Force agrees with the turn to care management, but it should not be viewed as a new way to cut back on the quality of care for these vulnerable populations.

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KDHE

- The Task Force feels that to provide an opportunity for long-term control of health care costs, Social and Rehabilitation Services should complete an analysis of the major causes of illness and disability found in Medicaid recipients. Following that analysis, recommendations should be considered for development of appropriate public policy dealing with prevention and health promotion.

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- If it is not already available, the Task Force recommends that a health and well-being protocol be developed and agreed to by all parties to assure the citizens of Kansas that appropriate medical services and attendant care are being provided by our health care personnel. These vulnerable populations should not feel as if they are second-class citizens simply because they are making use of these state sponsored programs.

- We recommend that a program be devised that would assure the Medicaid consumer there is someone who cares about his or her health and well-being and that such professional is really working to keep the consumer healthy. This could be the beginning of an extensive program of preventative care and wellness maintenance, instead of over-utilization of emergency rooms and hospitalization. Wichita or Sedgwick County could be the site for a pilot program in light of past activities in the area.

- In reviewing these recommendations, the Task Force recognizes there are likely existing multi-discipline committees already functioning. If so, such committees could do some of this review. The Task Force asks only that the committees be multi-discipline and they include consumers and consumer advocates.

- Target care management, identify the amount of financial resources we can commit, strategically analyze and select a specific area for care management, make the investment, learn from mistakes and expand the program. We suggest that we start with patients with congestive heart failure just as they are discharged from a hospital and those that have any major chronic disease such as diabetes or asthma combined with mental illness, *i.e.*, a dual diagnosis.

- There have to be financial incentives for the individuals involved in care management, not flat fees, but rewards for doing great work. It cannot be on the "low-hanging fruit" legislative budget list. Care management is a long-term commitment, and the Legislature has to be a trustworthy partner.

- The State of Kansas should make a commitment to increasing the Medicaid physician fee schedule so it is equivalent to the Medicare fee schedule. This should be phased in over a three or four year period.

- The state should pursue all options available under federal rules to maximize how hospitals are compensated for their services. The state should re-examine the methodologies and rational it uses for establishing payment rates and work collaboratively with providers to ensure that state resources are being spent appropriately.

- In urban areas specifically, and other areas where practical, the Task Force recommends the expansion of the Program of All-Inclusive Care for the Elderly (PACE). This is a unique capitated frail elderly management care idea that utilizes a multidisciplinary team approach in an adult day

health center supplemented by in-home and referral service based on the participants' needs.

- Quietly whispered, though not substantiated, is the insinuation that psychotropic drugs are being used as a restraint in nursing homes and in schools. Drugs developed for schizophrenic disorders and other mental illnesses are being prescribed in disturbing amounts to people who do not have these clinical diagnoses. Therefore, the Task Force recommends a study involving six nursing homes that have received no citizen complaints or any citations by the Department of Health and Environment for violations of rules and regulations within the last two years to be compared with six nursing homes that have been cited with substantial complaints and violations. The study should analyze the prescribing practices between the two groups; render an opinion on the appropriateness of the prescribed drugs; compare the interaction of multiple drugs of each resident of the nursing home; and compare each nursing home's emphasis on resident participation in social activities and wellness activities. With these study results, the state will have the tools to assess the effective level of psychotropic drug use in Kansas, and provide the appropriate education to the nursing home provider.

- The Task Force is aware of a pilot program in Wichita that integrates primary care and mental health services through the utilization of advanced registered nurse practitioners. Research has shown that such nurse practitioner providers are particularly well suited to manage the primary care patient, including the medically complex patient with demanding chronic health issues. By integrating family practice and psychiatric health care specialities under the "same roof" and using advanced registered nurse practitioner providers, this model meets the three critical standards for today's health care delivery systems of effectiveness, efficacy, and efficiency, and patient satisfaction. The Task Force recommends this pilot project be expanded beyond Wichita and be used as a model of treatment for those with a combined diagnosis of mental illness and chronic health issues.

Legislative Follow-Up

As noted, the Task Force thinks the provision of long-term care and home and community-based care, as well as covering the balance of populations in the Medicaid program, is very essential and sets the tone for how we respond to vulnerable populations. As a result, the Task Force requests an assessment by Social and Rehabilitation and others as to the feasibility of the action items above and a report to the Task Force during the Veto Session.

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INTERNAL MANAGEMENT

Statement of the Issue

The members of the Task Force are firmly convinced the management of the Medical Assistance Program within Social and Rehabilitation Services is a monumental task. We have been pleased with our interactions with the appropriate agency staff in their information and insights. We recognize the dispensing of money for services rendered has the potential to generate ill will. However, it appears that hard work by both Social and Rehabilitation Services and the various service providers has resulted in a reasonably good working relationship. Nevertheless, with that said, there are some areas that need critical attention.

Strategies for Action

- In administration of the Medicaid program, the level of reimbursement for service providers has not changed in many years. With that in mind, the Task Force suggests a determined effort to reduce the hassle factor for providers. In light of the flexibility offered by the federal Department of Health and Human Services, we suggest Social and Rehabilitation Services and the Kansas Medical Society develop a plan to incorporate best management practices (BMP) into a payment plan. As a result, any provider operating within these BMPs would be cleared for payment. To assure program integrity, a sample audit of claims would remain.

- It would appear the state and the Department of Social and Rehabilitation Services will continue to operate with scarce funds. At the same time, the agency has moved to do even more purchasing of services from individual providers or small operations. This means they have limited cash flow capability. For that reason, Social and Rehabilitation Services must further refine its reporting systems in order to make timely reimbursement adjustments so local providers may avoid cash flow problems.

- Over time the Medicaid Program has loosened up in such a way that it is possible for a variety of non-SRS programs to make use of favorable funding available through Medicaid. The Task Force requests a report on these arrangements; a location of such funding, how the non-federal match is handled, and other similar programs that might qualify under Medicaid.

- In certain circumstances, waiver services for individuals are costing more than if the individual were in a long-term care facility. As such, the Task Force recommends placing appropriate caps on waivers so others on the waiting list can utilize waivered services. We fully recognize the restraints imposed by the Olmstead case and recommend sensible parameters for determinations.

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- Persons qualifying for the frail elderly or physically disabled waivers that currently are served in a long-term care facility should have the appropriate dollars follow them into independent living. A mechanism needs to be adopted where there is a transfer of budgeted dollars from Social and Rehabilitation Services to the Department on Aging. As an example, a person who falls and breaks a hip, following successful rehabilitation in a nursing home, may need to utilize some waivered services in order to return home. The transition plan approved by a care management team should provide that financial resources will follow the person until the waivered services become more expensive in the community than in a long-term care facility.

- The Task Force recommends that Social and Rehabilitation Services and the Department on Aging, along with their contractors, provide for the payment of durable medical equipment when an individual is transferred between programs instead of equipment being retained by the agency. We also recommend that the equipment be recouped at the time the equipment is no longer needed or at the death of the client. We suggest any equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles.

Legislative Follow-Up

Testimony from Social and Rehabilitation Services indicated there were a certain number of provider claims exceeding the expected number of claims in process. Hence, the Task Force would like to have a current report on the claims processing during the Veto Session.

Additionally, the Task Force requests a progress report on each of the above recommendations. After receiving these reports, the Task Force will determine when and where there might be additional reporting to the Legislature.

ISSUES BEYOND THE STATE

Statement of the Issue

The Task Force recognizes we are a small state, and for that reason we think attention should be given to see if there are ways to enhance the power of our state. Large numbers and expenditures are persuasive. The current federal administration has given every indication of wanting to reach out to the states. Any case that Kansas wanted to make would be enhanced if other states joined with it. Through the various associations in which Kansas has membership as well as Health and Human Services, every effort should be made to secure greater flexibility in funding and programs.

Strategies for Action

- The Task Force underlines again the exploration of the possibility of establishing a purchasing cooperative with other states to drive down the costs related to medical supplies, durable medical equipment, and assistive technology.

- The Task Force should work with the leadership of the Legislature and their counterparts in other states to make the case for the federal government to assume full responsibility for those individuals who are dually eligible for both Medicare and Medicaid. This could be a win-win situation all of the way around. It would financially benefit the state, and it would simplify the administration of both programs. If federal funding is unsuccessful, we would then advocate that any realized cost savings to Medicare as a result of successful care management be reimbursed to Kansas at the current Medicaid reimbursement rate.

- The Medicaid program should be subject to the same provisions of the Veterans Administration Federal Supply Schedule prices for purchasing prescriptions. According to the annual report of the U.S. Attorney General, Medicare paid more than double the Veterans Administration price for name brand prescriptions. We assume Medicaid and Medicare prescription costs are similar. Working with the National Conference of State Legislatures, the American Legislative Exchange Council, the Council of State Governments, and the National Governers Association, we advocate seeking immediate administrative and legislative remedies.

- State and federal policy makers know the current growth of the costs of providing Medicaid services is unsustainable. A primary Task Force goal is care management, not managed money. In order to work, Medicaid must be structured to place more decision making authority in consumers. "Independence Plus" and "Cash and Counsel" waivers are steps in the right direction, but voucher programs have to be authorized for consumers, and risk-based contracting that rewards providers must be adopted. This Task Force is committed to an investigation of the reform of Medicaid and the opportunity to work with President Bush and Governor Sebelius.

PUBLIC HEALTH ISSUES

Statement of the Issue

When the work of the Task Force began, we did not anticipate significant discussion of public health issues. However, a representative of Social and Rehabilitation Services articulated that before the state makes any significant improvement in the health conditions of many Medicaid recipients, it will have to give attention to the environment in which we all

live. While we imagine the scope and needs in the area of public health, the Task Force did not spend enough time on this topic to make an extended statement. Just the suggestion of the topic with some amplification suggested that we should not let it drop. It is on that basis we make some observations.

We would like to see special attention given to encouraging more healthy living options for Medicaid recipients and the general public. There is a considerable body of literature that outlines some broad social health risks: We don't eat in a healthy way. We don't take good care of our bodies. We don't exercise properly. The list is extensive. An extensive public education campaign on healthy living may be necessary to address these societal problems.

The Task Force recognizes everyone is functioning on an overload basis. Yet we wanted to recognize that work in the area of changing the health environment, living healthier lifestyles, and making greater use of existing research has the potential for changing the well-being of many. We suggest inter-agency discussion and joint development of a coordinated public education campaigns on this subject.

DIRECTION FOR THE FUTURE

Statement of the Issue

Does more health care mean better health? What is this assumption is wrong? According to the Center for Evaluative Clinical Sciences at Dartmouth Medical School, 20 to 30 percent of health care spending pays for procedures, office visits, drugs, hospitalization, and treatments that do absolutely nothing to improve the quality or increase the length of our lives. At the same time, the type of treatment that offers clear benefits is not reaching many Americans, even those who are insured.

It is a sobering thought, but perhaps legislators, insurers, and the health-care industry might be able to save money by concentrating on improving the quality of medicine rather than controlling costs. Statistical patterns of Medicare spending nationwide are enlightening. A 65-year old in Miami will typically spend $50,000 more in Medicare expenses over the rest of his life than a 65-year old in Minneapolis. During the last six months of life, a Miamian spends twice as many days in the hospital and is twice as likely to see the inside of an intensive care unit.

This regional variation would make perfect sense if the regions where citizens were the sickest were the ones that used the most medical services. If this were true, the region around Provo, Utah , one of the healthiest in the country, would get fourteen percent fewer Medicare dollars than the national average. Instead it receives seven percent more. In contrast, the elderly around Richmond, Virginia tend to be sicker than the average American and should be receiving eleven percent more–than 21 percent less–than the national average. And these regional differences are not as a result of the cost of health care.

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Rather, much of the variation among regions–about 41 percent–is driven by hospital resources and the number of doctors. In other words, it is the supply of medical services, rather than the demand for them, that determines the amount of care delivered. The national average for expensive MRI technology is said to be 7.6 machines per one million patients. By this standard, Kansas should have 19. We have 47! Nearly the same as Michigan (48) which has four times the population. Medicare beneficiaries in Miami see, on average, 25 specialists in the last year of their life versus two in Mason City, Iowa, largely because Miami is home to a lot more specialists.

Recent studies show that excess spending in high cost regions does not buy the citizens better health. Patients in high-cost areas are no more likely to receive preventive care such as flu shots or careful monitoring of their diabetes, and they do not live longer. In fact their lives may be slightly shorter. The most likely explanation for the increased mortality in high-cost regions is they spend more time in the hospital. (Shannon Brownlee, "The Overtreated American," *Atlantic Monthly*, January-February 2003).

In the private sector, Blue Cross-Blue Shield of Kansas reported there were 201,000 more physician office visits in 2001 than in 2000. This is an increase of 14 percent, even though their membership grew only 5 percent. Hospital charges were 20.6 percent higher, diagnostic imaging 25.3 percent higher, clinical lab work was 29.2 percent higher, and speech, occupational, and physical therapy charges were 26.9 percent higher. If you are paying $1,000 or more a month for your family health insurance policy, you expect to get your money's worth. However, the incentive is in the wrong place and thus utilization rates continue to increase!

As noted previously, the runaway health costs of recent years have led many Medicaid programs and private insurance companies to impose Managed Care. And all too often, managed care consisted of an impersonal bureaucracy with a focus on managing dollars, instead of providing needed care. As an alternative, employers (and a few states with specific Medicaid waivers) across the country are empowering employees instead—by giving them the opportunity to manage some of their own health care dollars and experience the costs and benefits of prudent consumer behavior in the medical marketplace.

Additionally, a new ruling from the Internal Revenue Service allows the creation of a new kind of policy, called a Health Reimbursement Arrangement (HRA), which resembles a Medical Savings Account (MSA). HRAs, used with high deductible health insurance, can be funded by the employer and offer the employer an excellent vehicle to provide health insurance benefits. Individuals utilize the money in their HRA to pay out of pocket medical expenses. Money from the accounts can be rolled over year to year and the money travels with the employee in the event that the employee leaves the job. These accounts, instead of being drivers of medical inflation, now become inhibitors of inflation.

Strategies for Action

- Kansas Medicaid needs to follow the example of the private-sector HRAs. Accordingly, Social and Rehabilitation Services should explore the possibility of developing a Medicaid Benefit Account (MBA) to include patient cost-sharing and a health care savings account.

- Since these MBA's would be funded with taxpayer dollars, they should be restricted to the payment of medical bills and insurance premiums. This means that beneficiaries who consume health care wisely and see their account balances grow through time would not be able to withdraw these balances for non-health care spending. Instead, they would be able to use the funds for medical services not covered by their health plan. And in the future, they would be able to use unspent balances to pay insurance premiums and buy medical care directly after they have left the Medicaid rolls.

- We commend Social and Rehabilitation Services for the development of the Working Healthy program and encourage its continuation and expansion to allow individuals to retain health care coverage as they transition from welfare to the workforce.

- Challenges to the Medicaid system will persist until solutions are found for health insurance. Medicaid has to exist as a safety net. Market initiatives have to be adopted in both areas with individuals making and paying for the medical services that they choose to access.

AN ONGOING MEDICAID REVIEW STRUCTURE

Statement of the Issue

When President Kerr established his Task Force on Medicaid Reform, we had no idea of the level of interest which has been shown by interested parties. For Task Force members, it has been an eye-opening experience as we developed a deeper understanding of the work of Medicaid.

We have been pleased to learn of the many instances of positive activities taking place among consumers, consumer advocates, providers, Social and Rehabilitation Services and Aging. We commend all of them for their hard work. With a program as massive as the Medicaid program and involving so many people, it is not by accident that good things are happening. Good things are happening because of cross-discipline activity and the desire to serve the consumers. While there have been some instances where communication may have broken down, our general sense is that there has been good discussion. We have been pleased that the work of this Task Force has provided further opportunities for interaction between all parties. There are serious minded people working to make a system out of an unsystem.

In that context we recognize the merit of ongoing meetings of a multi-discipline group representing all aspects of the Medicaid program. While the Task Force is not interested in pointless busy work, an ongoing committee with the task of looking at the big picture would have merit. Such a committee of this type, including agencies, consumers, and providers,

would have the task of visualizing the grand design of a Medicaid Program in Kansas. Instead of simply looking at the mechanics of the program, this committee should focus on how to make the system professionally sound, fiscally sound, user friendly, and responsive to the Governor and the Legislature.

The Task Force believes the work started here allows us an opportunity to begin adopting and implementing many of the initiatives discussed during the last seventeen meetings. To that end the Task Force highly recommends that an ongoing review continue to take place and recommends that a proposal be put together to solicit a health grant from Kansas foundations. We would recommend the following possibilities:

- Kansas Health Foundation
- Sunflower Foundation
- United Methodist Health Ministry Fund
- Wyandotte Health Foundation (see also Appendix B)

Dr Robert St. Peter
Ks Health Institute.

Additionally, Social and Rehabilitation Services has just received a three-year grant of $1,385,000 funded from the Centers for Medicare and Medicaid Services. This grant, the Real Choice Systems Change Grant for Long-Term Care in Kansas, will be used to help make community based services as accessible as institutional services. As Task Force members we are interested in further pursuing this issue. To that end, if asked, we will pursue the outline of a plan before the end of the Veto Session. See also Appendix C.

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Recommendations from the Medicaid Report Task Force Report

#	Recommended action	Legis-lature	SRS Aging	Other agencies	Indus-try	Fed govt
	LONG-TERM CARE					
1	Statewide public education campaign on LTC insurance			X		
2	Make LTC premiums deductible	X--law				
3	Allow refundable tax credit of 25% for LTC premiums	X--law				
4	Exclude LTC premiums from Medicaid spend-down reqs	X--law				
5	Review financial and disability requirements to tighten up		X			
6	Increase look-back period to 60 months		X			
7	Adopt fed. minimums--non-business prop., vehicles, & blanket exemption	X--regs	X			
8	Establish a lien on recipient's real property	X--law				
9	Change definition of an estate (include jointly owned property)	X--law				
10	Prohibit prop. owners from specifying % of ownership for joint property	?	X			
11	Require discretionary trusts to be countable resources	X--law				
12	Limit scope of contracts to provide basic services in exchange for large $$	X--law				
13	Gather multi-disciplined team to review results of above		X		X	
14	Educate public on eligibility reqs/enforce. actions; monitor seminars		X			
15	Request waiver for cash and counsel programs		X			X
16	Encourage LPAC to request periodic audits of asset sheltering	X				
	PRESCRIPTION DRUGS					
17	Maximize drug purchasing power (i.e., lowest price anywhere, co-ops)		X	X	X	
18	Mention of Governor's agreement re: Michigan multi-state drug program					
19	Try to identify actual drug costs (then pay actual + higher fee shown in #20)		X			
20	Pay pharmacists $10 dispense fee for brand names, $15 for generics		X			
21	Develop pilot projects re: whole care integration (like Hiawatha)	$	X		X	
22	Beef up Board of Pharmacy inspectors	$-?			X	
23	Use clinical pharmacists to provide academic detailing to providers		X			
24	Put edits in MMIS re: > 9 drug users		X			
25	Identify and counsel overprescribing doctors		X			
26	Require prescribing physicia's name on pharmacy claims		X			
27	Audit pharmacy providers		X			
28	See if Medicaid recipients are eligible for VA benefits		X			
29	Estab. voucher system for generics; clients use $ saved on other medical	$	X			
30	Report regularly to Legislature and Governor on the above recs		X		X	
	CARE MANAGEMENT					
31	Re-examine cuts in home health skilled services	$	X			
32	Analyze major causes of illness/disability; rec. needed public policies		X			

#	Recommendation	Legis-lature	SRS Aging	Other agencies	Indus-try	Fed govt
33	Develop health and well-being protocol		X			
34	Devise program re: preventive care and wellness maintenance		X		X	
35	Have multi-disciplinary teams review recommendations		X		X	
36	Adopt / refine targeted care mgmt for chronically ill and dually diagnosed	$	X		X	
37	Adopt financial incentives for individuals involved in care mgmt	$	X			
38	Increase Medicaid physician fees to Medicare levels	$	X			
39	Maximize how hospitals are compensatived for services	$	X			
40	Expand PACE program	$-?	X			
41	Study nursing homes re: use of phychotropic drugs as restraints		X	X-?		
42	Expand pilot project in Wichita re: integrating primary care and MH services	$	X			
43	Assess feasibilty of above actions and report during veto session		X		X	
	INTERNAL MANAGEMENT					
44	Pay providers who follow BMPs without question; continue sample audits		X		X	
45	Refine reporting systems to reimburse providers more timely		X			
46	Report on arrangements re: other programs using Medicaid funding		X			
47	Cap waivers when cost under waiver more than institutional care		X			
48	Have $$ follow FE and PD clients from nursing homes to community	$	X			?
49	Pay for DME for people transferred from NH to community, but recoup	$	X			
50	Report on claims processing during veto session		X			
51	Provide progress report on above recommendations		X		X	
	ISSUES BEYOND THE STATE					
52	Establish purchasing co-op re: medical supplies, DME, asst. technology		X			
53	Have federal government assume $$ responsibility for dual eligibles	X				X
54	Give Medicaid Program same drug purchasing provisions as VA	X				X
55	Adopt voucher programs and risk-based contracting that rewards providers	X				X
	DIRECTION FOR THE FUTURE					
56	Develop MBAs to include patient cost-sharing and health savings accounts	?	X			
57	Restrict MBAs to payment of medical bills and insurance premiums		X			
58	Continue expansion of Working Healthy Program	$	X			
59	Adopt market initiatives; individuals decide and pay for med svcs they need		X		X	
	ON-GOING REVIEW OF MEDICAID STRUCTURE					
60	Continue ongoing review of Medicaid structure and solicit grant $$		X		X	

National Legislative Association on Prescription Drug Prices
133 State Street, Room 313
Montpelier, Vt. 05602

Cheryl Rivers, Executive Director
Cheryl.rivers@state.vt.us

The Honorable Lana Oleen, Senate Majority Leader
State Capitol, Room 356-E
Topeka, Kansas 66612

April 23, 2003

Dear Senator Oleen:

We write to invite the participation of your state in the National Legislative Association on Prescription Drug Prices, a nonpartisan Legislative Association whose mission is to increase the accessibility and affordability of prescription drugs for all Americans. The Association was founded in 1999 by state legislators from the Northeast and provides an important forum for sharing ideas and information, as well as for exploring ways to cooperate to the mutual benefit of our constituents.

Our Association has an impressive track record of results, including the passage of important legislation in several states that has helped to save taxpayers many millions of dollars. Much important work remains. We have a plan to help states maximize their individual bargaining power and to facilitate joint state negotiations to leverage deeper discounts for states, businesses, and individuals. Our work is strictly constituent oriented and has been funded by public-interest entities, including direct state appropriations. Our bylaws specify that we will not accept funding from the pharmaceutical industry and that our Directors cannot have personal financial interests in the pharmaceutical industry.

In August our Directors voted to amend our bylaws and expand our membership beyond the Northeast and to change our name from Northeast to National. Our membership now includes nine states as well as the District of Columbia. We have representation from at least one Legislative chamber in the states of Maine, Vermont, New Hampshire, New York, Connecticut, Rhode Island, Massachusetts, Pennsylvania, and Hawaii. You can learn more about us by visiting our website at www.nlarx.org.

Our next meeting will be held Friday June 27 in Concord New Hampshire. We would encourage you to send a delegation to the meeting and to consider joining our effort. Our meetings feature presentations by national experts on the latest efforts in the struggle to win fair prescription drug prices and provide great tools for improving the effectiveness of legislative action. Our June meeting should include an update on the Association's effort to create a nonprofit pharmacy benefits administrator and presentations from existing organizations that may assist in this market participation approach to better deals for pharmacy services.

Phone: 802 828 0659

President's Task Force on
Medicaid Reform
Attachment 2
May 1, 2003

Please contact our Executive Director, Cheryl Rivers, former State Senator of Vermont, at the Association's office at 802-828 0659 or e-mail her at cheryl.rivers@state.vt.us for more information about the benefits of participating in this historic and vitally important effort, or to make plans for a delegation from your state to attend a meeting. There is no registration fee. States who decide to become members are asked to contribute from $25,000-$50,000 toward the expense of running the Association. However, we recognize these are difficult fiscal times for states, and would not wish to have this cost deter your participation. The only real prerequisite for participation is a commitment to the goals and vision of the Association.

As you know, legislators understand the need for and value of collective action. Its how we get things done inside our respective chambers. Please join us now in bringing this same collegial approach to the multi state issue fair prescription drug prices, so that your constituents and ours may benefit from this work.

Respectfully,

Representative David Lemoine, Chair
National Legislative Association on Prescription Drug Prices

***Phone:* 802 828 0659** **Fax : 802 828 0660**

JANET SCHALANSKY, SECRETARY

KANSAS

SOCIAL AND REHABILITATION SERVICES

KATHLEEN SEBELIUS, GOVERNOR

"Dispense as Written"
April 2003

SRS is opposed to any actions which would limit the state's ability to contain the pharmaceutical costs within the Kansas Medicaid program. Medicaid expenditures are one of the fastest growing parts of the state budget in Kansas and in nearly every other state. According to a 2001 "Medicaid Survival Kit" produced by the National Conference of State Legislatures, "Unfortunately, there are no easy answers and no 'quick fixes' to the problem of health care financing for the poor." Numerous cost containment efforts have been implemented in the Kansas Medicaid pharmacy program over the last several years, and in these economic times, it is important that the state continue to have as many tools as possible available to limit state spending, while still providing the services and supports vulnerable Kansans need.

The current Dispense as Written provision expires at the end of fiscal year 2003. SRS does not support the continuation of this provision for the following important reasons:

1. The 2002 Legislature required SRS to create a Preferred Drug List (PDL) in order to ensure Medicaid beneficiaries can receive the pharmaceuticals they need, but at the lowest prices possible. The PDL was implemented in December 2002. Continuing the DAW provision would greatly limit the projected savings which can be achieved as a result of the PDL.

   SRS projects $3.4 million ($1.3 million SGF) will be saved through the PDL in state FY 2003 and $5 million ($1.975 million SGF) in state FY 2004. An additional $10.0 million $4.0 million SGF) is reduced in the Omnibus bill based on projected savings from further expansion of the Preferred Drug List. The projected savings in FY 2004 is predicated on discontinuation of the DAW provision.

   Since the implementation of the PDL the number of claims for preferred drugs has been increasing, while the number of claims for non-preferred drug has been decreasing. However, among the non-preferred drugs, claims written as "Dispense as Written" are increasing. Since the PDL was implemented, of the claims that would have required prior authorization, about 70% have been overridden with DAW from the prescriber. This has limited the savings which could be realized from the PDL.

   The Preferred Drug List was developed with the assistance of an independent clinical advisory committee of practicing physicians and pharmacists who reviewed clinical evidence and determined if drugs within specific therapeutic drug classes are equivalent

in terms of safety, efficacy and clinical outcomes. The advisory committee was not provided individual drug pricing information. Their recommendations were clinical in nature only. For the drugs determined by the advisory committee to be clinically equivalent, SRS then considered the net cost to the Medicaid program when establishing the PDL . The average cost for preferred drugs is significantly less than the average cost for non-preferred drugs.

Medicaid beneficiaries continue to have access to non-preferred drugs through the prior authorization (PA) process. That is, through the PA process, any beneficiary can receive any non-preferred drug if it is medically necessary. A PA can be for an extended period of time. Typically, a PA is granted for a 6 or 12-month period of time.

The Dispense as Written provision impairs the clinical review process conducted by the independent PDL advisory committee and creates the potential for unnecessary and preventable over-utilization of more costly non-preferred drugs.

2. Continuing and/or expanding the Dispense as Written (DAW) provision would hinder the state's ability to participate in any multi-state agreement designed to combine the buying power of multiple states and further control Medicaid spending.