Approved: March 16, 2004
Date

MINUTES OF THE SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman Pete Brungardt at 10:30 a.m. on February 19, 2004 in Room 231-N of the Capitol.

All members were present except:
Senator Ruth Teichman- excused

Committee staff present:
Russell Mills, Legislative Research
John Beverlin, Committee Secretary

Conferees appearing before the committee:
Laura Howard, Deputy Secretary, Department of Social and Rehabilitation Services
Scott Brenner, Department of Social and Rehabilitation Services

Others attending:
See Attached List.

Chairperson Brungardt called the meeting to order. He informed the committee that minutes from the previous week had been passed out. Chairperson Brungardt then welcomed Laura Howard of the Department of Social and Rehabilitation Services to the podium.

Ms. Howard provided a follow up to the original visit by the Department of Social and Rehabilitation Services (Attachment 1).

Chairperson Brungardt asked the committee for questions.

Senator Clark asked whether SRS was creating an inventory list of all of their durable medical equipment.

Ms. Howard explained the inventory procedure and inventory labels. She explained that it was fairly easy to track the items and the cost savings that occurs.

Chairperson Brungardt asked whether the state receives money from Tri-Care.

Ms. Howard answered that the state does receive money from Tri-Care. She explained that Tri-Care has to pay first since Medicaid is the payer of last resort.

Senator Clark asked about prescription benefits through the VA. He wanted to know whether the state utilizes the prescription benefits through the VA hospital before Medicaid pays for them.

Ms. Howard explained that members of the military, military retirees, and their survivors have different options. She further explained that they are eligible for Tri-Care, which is a managed health plan. If persons are enrolled in the program, they are receiving their services from private providers. If individuals are enrolled in Tri-Care, Tri-Care is the payer of first resort, and Medicaid becomes the payer of last resort.

Senator Barnett explained that most veterans are not going to have Tri-Care. They would either have something else or nothing at all. He further explained that prescriptions at the VA hospital are seven dollars. If a veteran is on Medicaid, there is no incentive for them to receive their prescription drugs from the VA hospital, since they can receive them for free through medicaid.

Chairperson Brungardt stated that Senator Barnett makes a good point. He explained that it would be hard to come up with an incentive to get individuals to get their prescriptions through the VA, and save the state money.

Senator Barnett explained the prescription benefits at the VA hospital were still good. He explained that an individual who served in the military can get prescriptions cheap and thus save money, therefore, running out of money later in their life. This would also help save the state money in Medicaid costs.

Chairperson Brungardt asked about nurse managers. He wanted to know whether the nurse managers work in offices, or whether they worked in the field with the people.

Ms. Howard explained that the nurse managers would be out in the field working with the individuals. She further explained that the nurse managers would work in partnership with the physicians who are providing care to the individuals. She stated SRS felt like this was a community-based system of care.

Senator Barnett stated there would be limitations to case management. He explained that some individuals would be too sick to participate. The key, he explained, is having the medical community involved. The problem with the state is that reimbursements are so low, a physician is lucky to cover the cost of a procedure or service.

Chairperson Brungardt stated he hoped the program would make life easier for medical practitioners. He explained that the program gets better compliance from individuals who receive Medicaid. He used the example of diabetics and individuals who need to take medication.

Ms. Howard explained that it was the goal of the program to improve compliance of individuals in Medicaid.

Chairperson Brungardt asked what the common experience was on how long it takes to reimburse a practitioner both routinely and problematically.

Ms. Howard deferred the question to Scott Brenner.

Mr. Brenner answered that the average for a clean claim is about 20 days. But the average was not typical, because most claims are not clean. The reason why the claims are not clean is usually because of a defect with the provider eligibility or the beneficiary eligibility. He stated that it was also possible that the claim hits one of several internal edits. These delays move the claim into a suspense category where the claim has to be viewed by an individual. Mr. Brenner explained that the back log of claims in the suspense category, that are more than 30 days old, is 8000 to 9000 claims. He explained that a large part of those claims were dental claims.

Chairperson Brungardt asked whether the problem of claims that are not clean was a software problems or a problem with the company.

Mr. Brenner stated that the blame can be spread around. Though, he explained, getting some practitioners to use the electronic transaction format correctly has caused problems.

Senator Vratil asked why there was a 20 day delay with clean claims.

Mr. Brenner explained that it was the time from when the claim was originally received by EDS to when the claim was paid. He further explained that the payment cycle takes about a week.

Senator Vratil asked why it takes a week to cut a check.

Mr. Brenner explained the financial cycle ends on a Friday and the check is issued the next week.

Senator Vratil asked why it takes 20 days to approve a clean claim. He also wanted to know why the claim could not be approved in 24 hours.

Mr. Brenner stated that the 20 days is an average, that there are claims that are approved in 24 hours.

Senator Vratil wanted to know why the average was 20 days.

Mr. Brenner explained that the claim is claimed to be clean, but there may have to have prior authorization. If the authorization is not there, the process can be slowed.

Senator Vratil stated it then was not a clean claim.

Mr. Brenner explained that from the writer's point-of-view, the claim is clean. But there is some other piece that holds the claim back.

Senator Vratil stated he did not feel like he was getting an answerer to his question. He asked Mr. Brenner if SRS was understaffed.

Ms. Howard stated she would try to break the process down more. She explained that the claims go through hundreds of edits.

Senator Vratil asked whether games were played to make money off of the float by delaying claims.

Ms. Howard stated that such games absolutely did not occur.

Senator Vratil stated that he felt like he had not received an adequate answer to his question. He stated he wanted a written explanation as to why clean claims are not processed and paid within 24 hours. He explained that sometimes through practice, we come to accept delay in the processing of materials.

Senator Gilstrap asked if a clean claim goes through a process of auditing or if somebody just gets the clean claim and writes a check for the claim.

Mr. Brenner explained that there are hundreds of edits a claim has to go through. A clean claim, he explained, by definition would have navigated all of the edits.

Senator O' Connor asked who benefitted from the interest on the float.

Mr. Brenner explained the payment to the providers actually comes out of the state general fund. He further explained that EDS does not actually pay. Any benefit from the float goes to the state.

Senator Clark asked for the amount of time it took to process Blue Cross Blue Shield claims.

Mr. Brenner stated he would have to look that up.

Senator Clark stated the goals should be to beat the time claims are processed by Blue Cross Blue Shield.

Senator Barnett asked how much fraud SRS had detected.

Ms. Howard stated that she did not have the data with her today, but she would look into it for the committee.

Senator Barnett explained that the legislature had a post-audit showing a large amount of fraud and that he would appreciate the information.

Senator Barnett asked how much money had been saved in pharmacy costs through the preferred drug lists. He also wanted to know if there was an increase in the number of drugs on the preferred drug list that are required to go through competitive bidding.

Ms. Howard explained the curve in pharmacy costs had flattened a bit. She explained that in the first year of operation of the preferred drug list, there was a savings of eight million dollars. She further explained that at the current time, there were 13 classes on the preferred drug list.

Senator Brungardt asked about waivers before the federal government. He asked Ms. Howard what she thought the current presidential administration was doing regarding waivers.

Ms. Howard explained that there is a lot of speculation that the delays and increased questioning of states about the waiver applications were the result of an advocacy effort to get states to accept the block granting.

She further explained that there was a whole new series of questions states have to answer. Ms. Howard stated that she believes it has gone beyond what one may think of as scams, but they do not know the precise reason.

Chairperson Brungardt asked whether Kansas has some initiatives that might be judged aggressive or out -of-line compared to other states.

Ms. Howard explained the issue of intergovernmental transfer is probably the only issue that could have been considered aggressive. She further explained that the state was no longer receiving revenue from that program. She stated that she did not think there were any programs currently that could be considered aggressive.

Senator Clark asked if there were any details about being able to pass the value of long term care insurance to heirs.

Ms. Howard stated that she had seen some details but they were at a very high level at this point. She further stated that SRS would be watching for that.

Chairperson Brungardt asked the committee for additional questions. None were asked.

The meeting was adjourned at 11:45 a.m. The next meeting is scheduled for February 24, 2004, at 10:30 a.m. in room 231-N.

Senate Federal and State Affairs Committee

Date: ~~FEBRUARY~~ 19, 2004

Name:	Representing:
Laura Howard	SRS
Scott Brunner	SRS
Charlie Kelly	Hein Law Firm
Joyce Jackson	TILRC
Joe Seaton	JJA
DAVID OWEN	HOMELESS COME HOME

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

Senate Federal and State Affairs Committee
February 19, 2004

Follow up to President's Task Force on Medicaid Reform

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Senate Federal and State Affairs Com.
Date: FEBRUARY 19, 2004
Attachment: # 1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Federal and State Affairs Committee
February 19, 2004

Followup to President's Task Force on Medicaid Reform

Good morning, Mr. Chairman and members of the Committee. Thank you for the opportunity to appear before you and present some information regarding SRS follow-up activities concerning recommendations from the President's Task Force on Medicaid Reform.

Durable Medical Equipment

An area of focus regarding efficiency centers on the management of durable medical equipment (DME). DME includes an array of medically related commodities, both durable and disposable. In addition to the traditional equipment categorized as DME (e.g., wheelchairs, beds, and walkers), items such as dietary supplements, special feedings, as well as many standard pharmaceutical items also fall under DME.

When Kansas Medicaid purchases a piece of equipment that can be used again, the Kansas Equipment Exchange (KEE), located at the Kansas University Center on Disabilities at Parsons, receives notice. Staff at this program work with the DME providers to place a sticker with the toll-free number of KEE and a reminder about the re-use program on the equipment. SRS requires compliance of all enrolled DME providers with the re-use program. For certain expensive pieces of equipment, SRS notifies beneficiaries upon approval of purchase that the equipment must be returned for re-use once it is no longer needed by the beneficiary for whom it was purchased. KEE staff also call beneficiaries periodically to determine if the equipment is still in use.

The following case serves as an example of the savings the KEE program provides Medicaid. Kansas Medicaid purchased a significant amount of equipment for this person, who recently died, and all of the equipment was taken into the re-use program. The recycling of this one person's DME saved the State $21,000.

Payor of last resort

The Federal government requires that Medicaid be the "payer of last resort" for medical services so that other resources available to beneficiaries are utilized first. This allows SRS to stretch Medicaid dollars. SRS investigated beneficiaries who are entitled to Veteran's Administration (VA) benefits to determine if VA benefits were used first. SRS encountered some difficulties with this.

SRS can easily identify consumers who receive some type of monthly payment from the Veteran's Administration through the income codes used when making the eligibility determination. This includes Aid and Attendance, Unusual Medical Expense, Homebound Allowances, and other types of VA payments. SRS receives a cross-match report annually to assist in identifying cases in which a VA payment may be received, but is not coded on the system. Identifying the VA income, however, does not determine if the person receives VA health benefits. Additionally, other qualified household members may receive VA income payments instead of the veteran.

A veteran can qualify for health services through the VA while being ineligible for any type of monthly payment. No mechanism currently exists to identify persons who qualify for health services from the VA. A person may disclose this as an available service on the application for assistance, but it is not required. Medicaid cannot treat the services provided through the VA as it does other kinds of Third Party Liability. The beneficiary can choose to receive services from the VA, in which case, Medicaid would not be billed, or they can obtain services from a Medicaid provider from which to receive the services. Because of limitations on VA medical benefits, challenges regarding access to services exist.

If a veteran receives Tri-Care for Life insurance benefits, he or she must report this on the application for assistance; SRS then treats that coverage as a Third Party Liability on the fiscal agent's system.

Care Management

The Task Force recommendations centered on using limited resources wisely and ensuring that services and care are not duplicated or provided unnecessarily. SRS can use a care management program for persons with chronic diseases such as asthma, congestive heart failure, and diabetes to accomplish these recommendations.

After reviewing options and analyzing the data, SRS will present an opportunity to providers in Sedgwick County to craft a pilot care management program. This partnership project promotes community-based systems of care and implements disease management and case management as support tools. SRS modeled the proposed program after one in North Carolina exhibiting success in coordinating care between acute care centers, primary care physicians, beneficiaries, and their support systems.

SRS selected Sedgwick County for the demonstration site because:

- Population density: The county serves the most densely populated clientele in Kansas with more than 24,000 Medicaid enrollees;
- Medical professional network: Sedgwick County boasts a well-developed,

well-organized group of medical professionals; and,
- Sophisticated Acute Care Centers: The county possesses acute care centers with state-of-the-art services.

SRS staff will meet with Sedgwick County providers in the next few weeks to learn of their interest in the project. SRS will prepare a State Plan Amendment for submission to CMS upon reaching agreement with the providers.

By implementing this pilot program, SRS can measure effectiveness more easily and minimize limitations prior to implementation throughout the state.

Medicaid Management Information System (MMIS) Claims Payment

Because of the large and complex nature of this system, implementation has presented some problems. SRS continually makes progress in identifying, isolating and resolving known system defects affecting claims payment. During the past two weeks, SRS significantly reduced the number of system defects. Since October 16, 2003 SRS has processed nearly 5.4 million claims paying more than $663 million to providers. These numbers compare with claims processed and paid prior to the implementation of MMIS.

SRS continues to work toward speedy resolution of any systems issues. In the meantime, SRS and its contractors have made a number of enhancements to accommodate customer service needs of providers. These changes will make customer service agents more accessible, and provide additional avenues for providers to make inquiries, such as by e-mail, fax-back, and an improved capacity for automated voice response to queries. Customer service agents work overtime to research provider queries after regular business hours. While it is impractical to project a date when all systems issues will be resolved entirely, SRS believes that providers should see an appreciable difference in their ability to receive prompt payments within the next few weeks .

Recent changes to address MMIS concerns

SRS understands that Medicaid providers make the program possible and know the agency must continually simplify administrative requirements for providers. Steps taken toward this goal include:

- Streamlining provider enrollment application forms and processes;
- Implementing the national claims billing formats and code sets required by the Health Insurance Portability and Accountability Act (HIPAA);
- Developing free billing software that is HIPAA compliant;
- Permitting greater use of a six-month period for Prior Authorization (PA) to reduce the need for frequent re-submission of PA's;

- Using the Kansas Board of Healing Arts information to verify provider credentials electronically, eliminating the need for providers to submit paper verification;
- Beginning a series of consultations with providers to make the Remittance Advice easier;
- Creating a website giving providers immediate access to a variety of services such as eligibility inquiry, claim inquiry, claim submission and on-line adjudication, claim correction, access to provider manuals and other pertinent literature; and,
- Providing toll-free numbers for telephone inquiries.

Medicaid Eligibility and Estate Recovery

SRS recently testified to the House Social Service Budget Committee in support of SB 272, which makes changes related to availability of trust assets and places restrictions on "life care" contracts. The same bill contains provisions to help increase the effectiveness of the estate recovery program. SRS continues to prepare the request for a waiver from the Centers for Medicare and Medicaid Services (CMS) to allow Kansas to extend the look-back period for transfers of non-trust property to sixty months. SRS anticipates submitting the waiver request in early April.

Fraud & Abuse Detection

The Task Force recommended SRS use the new Medicaid Management Information System (MMIS) to analyze data to help ensure effective and efficient use of medical services and to form the foundation to manage the care for persons with multiple chronic diseases. The Fraud & Abuse Detection System (FADS), which provides SRS the capability to identify potential fraud and/or abuse candidates, is operational. The Fraud and Abuse system addresses four key components:

- Targeted Queries - complex queries from the Decision Support System (DSS). The benefit of this targeted approach allows analysts to focus on known fraud schemes for fast case building.
- DSS Profiler - establishing benchmark patterns of utilization against which comparisons are made for the purposes of identifying aberrant behavior
- WebStation - used to modify the profiler and identify new patterns of unusual behavior as they emerge. This is the area where multiple beneficiary/provider relationships can be examined
- Ad Hoc Reporting - fully customizable report capabilities, such as drug costs, etc.

SRS uses the Physician and Pharmacy provider models to detect unusual patterns of utilization. Beginning this month, SRS will utilize this system to assist with ongoing

reviews. Starting April 2004, all reviews of physicians and pharmacies will use the reports generated by the FADS system. SRS currently can identify beneficiaries who are served by multiple providers, or to identify other targeted queries. SRS also uses this subsystem for cost recovery and re-pricing purposes, as is done for hospital inpatient claims by diagnostic related groupings.

Pharmacy costs

SRS continues to take steps to control Medicaid pharmacy costs. Two of these involve prevention of polypharmacy and the use of academic detailing. Polypharmacy – the prescribing of multiple drugs concurrently, often for the same condition – is not only costly, but in many cases not best practice.

SRS works with Heritage Information Systems, the pharmacy benefit manager for the state of Kansas through a subcontract with EDS, the fiscal agent. Heritage recently analyzed polypharmacy in the State Medicaid program. Beneficiaries with 10 or more unique prescriptions within a calendar month were reviewed and educational letters sent to their physicians. This intervention affected approximately 6,000 beneficiaries. SRS contractors will continue this educational intervention on a monthly basis. Professionally licensed staff will conduct reviews of pharmacy, medical and professional claims to determine the appropriateness of care once a beneficiary has been flagged as exceeding the monthly prescription threshold.

Heritage Information Systems also provides academic detailing by sending a clinical pharmacist to visit fifteen physician practice sites per quarter. Heritage selects sites because the physician prescribing patterns deviated from the norm. The clinical pharmacist presents detailed, educational information to the prescribing physician. This process assists in the establishment of best practice guidelines and provides documentation to the physician that depicts the physician's prescribing data compared to his or her peers. Heritage also uses academic detailing to help educate providers on the Kansas Medicaid Preferred Drug List.

Cash and Counseling Models

The President's Task Force made the recommendation that SRS look at other states and consult with the Center for Medicaid and Medicare Services (CMS) to see what is being done in regard to the cash and counseling model and how that might apply to Kansas. The concept of cash and counseling has been a growing method of providing individuals with disabilities services which allows increased control over the services provided. This ranges from training staff, setting hourly wages for those staff, and obtaining services from a wider range of providers. In the cash and counseling programs, the individual in need of services has a budgeted amount of funding with which they can purchase the necessary services. The amount of funding available to

that individual is based on the level of need as determined by an assessment. When the amount of funding is determined the individual can then purchase the necessary services. Medicaid rules do not allow for funding to go directly to an individual, therefore fiscal intermediaries are used as a means to reimburse for services. States that have implemented cash and counseling waivers have found a high rate of consumer satisfaction, health and welfare needs are being met, and individuals live within budgets. States have not necessarily found this to be a cost saving method of providing services.

SRS is in the process of preparing for submission to CMS a waiver request that would implement the cash and counseling concept for persons currently in the Working Healthy program who require personal attendant services to maintain employment. The attendants would assist with activities of daily living outside the work place, i.e. assisting with dressing for work and meal preparation. The projected implementation date for this waiver is July 1, 2004.

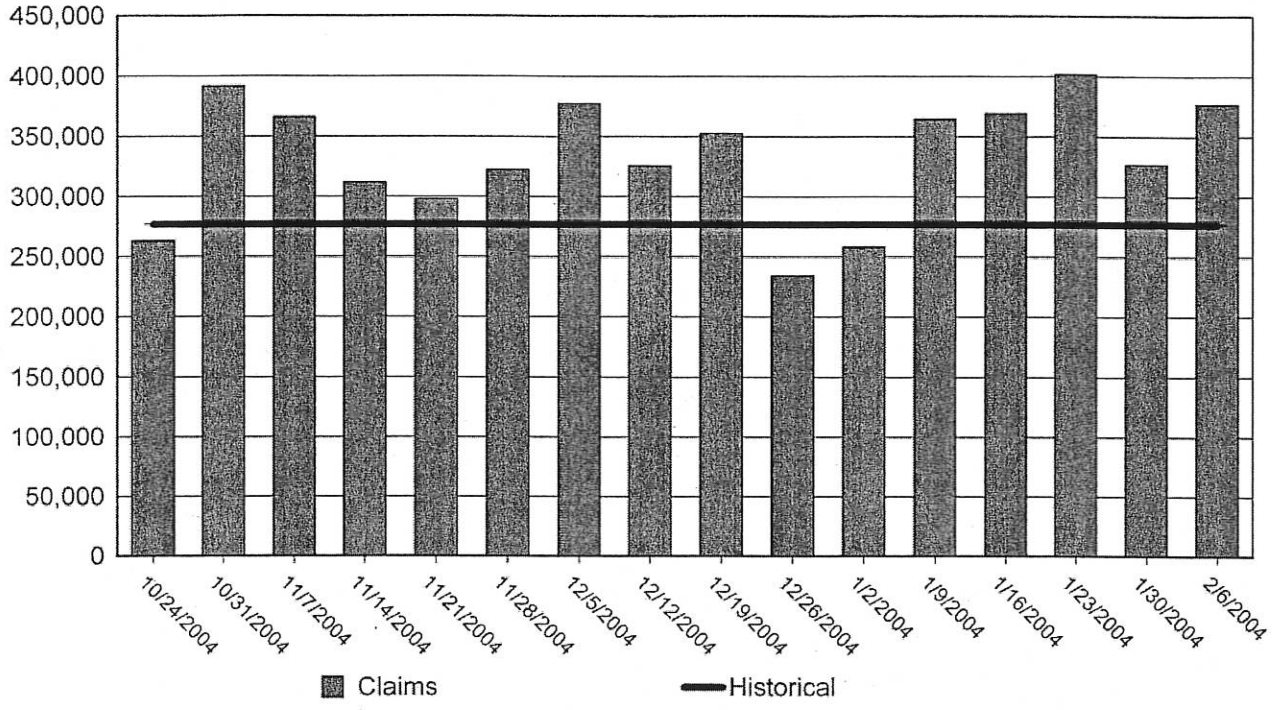
SRS is also researching the option of a cash and counseling waiver for individuals with mental retardation or developmental disabilities. This would follow the concept of a budgeted amount of money with which the individual or their family could purchase the necessary services for the individual to remain in the home and community based setting. We do not have an implementation date for this project at this time.

Summary

These efforts help SRS work continually to provide appropriate medical services, pay providers promptly and appropriately and utilize resources efficiently to meet the needs of eligible Kansans.

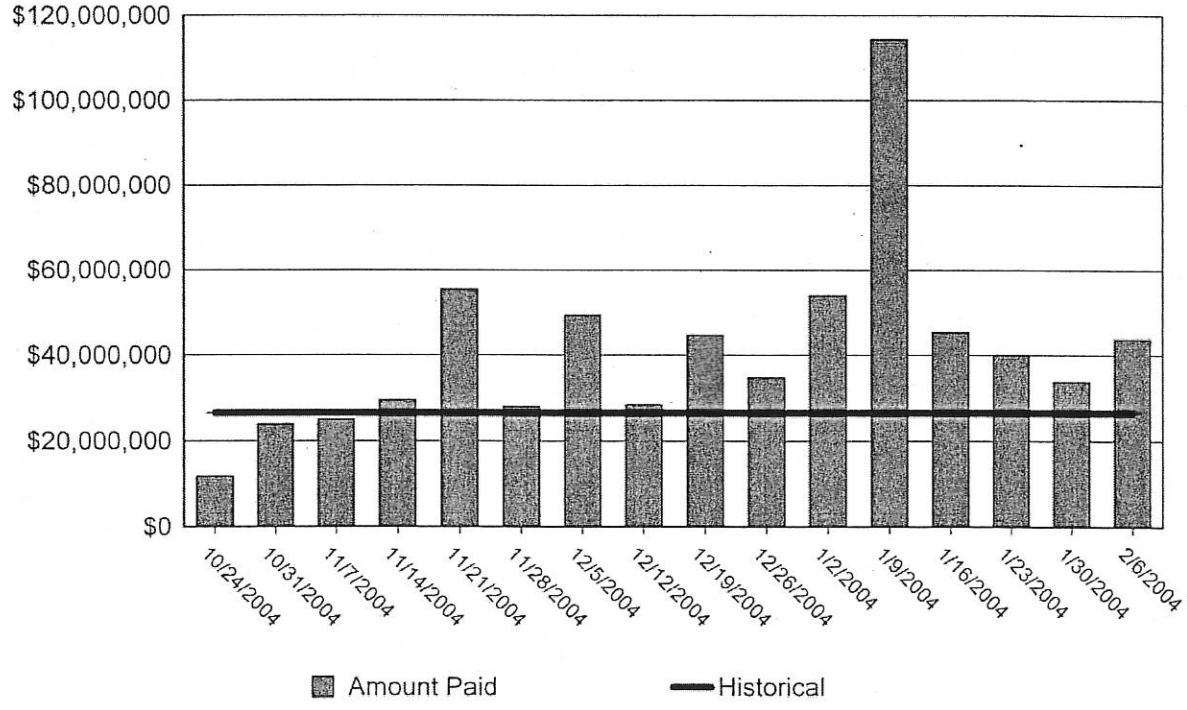
That concludes my testimony; I am happy to answer any questions you may have.

Claims Volume
October 24, 2003 through February 6, 2004



Total claims processed: 5,383,439

Amount Paid
October 24, 2003 through February 6, 2004



Total disbursed: $663,483,417

Note: The jump in disbursement in payment for 01/09/04 cycle is due to a large number of adjustments made by KDOA. The adjustments account for $72,454,770 of the $114,463,357 total disbursements made this cycle.