Approved: 3-7-03
Date

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

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

All members were present except: Sen. Huelskamp, excused

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

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

Others attending: See attached sheet

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

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

Part I - The Medicaid Program - The Overview

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

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

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

an individual state.

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

The three pillars of the Medicaid Program - Eligibility, Reimbursement & Coverage. Federal law governs what a state must or must not include or has discretion to include or not in the State Plan. A State Plan must include the "Categorically Needy"; a State Plan may cover the "Medically Needy". Forty states have the spend-down provisions. Eligibility - the SSI Disabled are automatically entitled to Medicaid without any waiting period.. Mr. Muse reviewed the Medicaid eligibility of low income Medicare beneficiaries for payment of certain Medicare costs. He listed the items and services that the Medicaid program will pay and provide for the Categorically Needy and the Medically Needy and the requirements for prescription drugs and their limitations. Each state must have a Drug Utilization Review (DUR) Program.

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

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

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

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

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

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

service, medicaid enrollment, and eligibility groups by % consumer and % expenditures FY 2002.

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

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

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

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

Senator Kerr – is Kansas using the Rare and Expensive Disease Management (REM) program? It sounds like this could be used aggressively to address a wide range of problems and fix a lot of existing problems and how widely can it be used? Mr. Muse suggests that we profile people in this area based on clinicals; that a personal call and visit be made to those individuals and that we have targeted case management in this area. He states that Maryland is aggressively using this and would recommend that we look into the Maryland model. Kansas started the REM program about a year ago and it was administered out of the Governor's office but that person is no longer there. This program looks for people with certain clinic patterns and high expenditures but can't be aimed at a lower cost range as CMS would object.

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

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

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

PART IV - MSIS Data for Kansas

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

PART V - National Pharmaceutical Council (NPC) Data

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

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

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

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

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

In any case management you need to determine the amount of financial resources you want to commit and

pick a target of medical assistance you want to invest cash management in congestive heart failure. He suggested you target people just discharged from the hospital and the specific areas he mentioned were- HIV and Diabetes.

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

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

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

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

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 1