MINUTES

SPECIAL COMMITTEE ON MEDICAID REFORM

September 19, 2005
Room 519-S—Statehouse

Members Present

Senator Derek Schmidt, Chairperson
Representative Melvin Neufeld, Vice Chairperson
Senator Jay Emler
Senator Anthony Hensley
Senator Time Huelskamp
Senator Laura Kelly
Senator Dwayne Umbarger
Representative Bob Bethell
Representative Jerry Henry
Representative Mike Kiegerl
Representative Nancy Kirk
Representative Don Myers

Staff Present

Audrey Dunkel, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Norman Furse, Office of the Revisor of Statutes
Lisa Montgomery, Office of the Revisor of Statutes

Senator Derek Schmidt, Chairperson, called the initial meeting of the Special Committee on Medicaid Reform to order at 9:10 a.m. on Monday, September 19, 2005, in Room 519-S of the Statehouse.

Senator Schmidt welcomed all Committee members and stated that the charge of the Committee was to review the state Medicaid program with the goal of determining the efficiency and cost effectiveness of the services delivered, as well as the appropriateness of the populations served.

Representative Melvin Neufeld, Vice-Chairperson, commented that this Committee is looking for answers to a growing problem. He felt that there is a need to move toward a wellness culture and that long-term care issues must be addressed.

Audrey Dunkel, Kansas Legislative Research Department, reviewed the contents of the Committee notebooks, which include numerous handouts. Anyone requesting the handouts may sign up to receive them by e-mail.

Ms. Dunkel then presented an overview of Medicaid programs. A chart of the Kansas Health Policy Authority (HPA) was reviewed (Attachment 1). On July 1, 2006, Medicaid will come under HPA. She explained how the HPA would assume responsibility for health programs in the state.

Kansas Medicaid, A Primer, a booklet prepared by the Kansas Health Institute and the Kansas Legislative Research Department, was distributed (Attachment 2). Medicaid is a publicly financed program that provides health and long-term care coverage to three groups of low-income Kansans. It is a state/federal partnership that accounts for nearly one-fifth of the Kansas state budget. The federal government determines many aspects of Kansas' Medicaid program, but in one respect or another, most spending is a state option. The federal government contributes approximately $1.50 for every dollar of state Medicaid spending in Kansas, a 60 percent matching rate.

Medicaid differs from Medicare. Medicare is a federally-funded health insurance program for Americans 65 and older, and provides medical coverage, but very limited long-term care. Medicare requires U.S. citizenship or permanent residence for at least five continuous years. Medicaid does not cover single adults without children. Approximately 19 percent of all children in Kansas are under Medicaid.

Medicaid spending per low-income child in Kansas is projected to average $2,460 annually, compared to $11,460 per enrollee with disabilities and $7,310 per elderly enrollee. Medicaid covers a broad and comprehensive range of health, mental health, and long-term care services. Some of the services required by federal law include inpatient and outpatient hospital services, lab and x-ray services, nursing home, and home health services. Administrative costs totaled $126.4 million in FY 2005 and comprised about 5 percent of state Medicaid expenditures.

The average cost of long-term care services through a waiver is anywhere from 15 percent to 50 percent less than nursing facility services. There are six home- and community-based services waivers.

Federal statutes define more than 50 groups of individuals who may qualify for Medicaid coverage, in four broad categories: (1) seniors; (2) the disabled; (3) low-income children; and (4) low-income adults

Ms. Dunkel explained the "spend -down" procedure, which makes it possible for some people who may not have otherwise qualified to participate in the Medicaid programs.

Seniors and people with disabilities are the most expensive Medicaid clients. Since FY 2001, the number of low-income children and adults receiving Medicaid has increased at a steady rate. Over the ten-year period between 1997 and 2006, State General Fund revenues have increased 34.1 percent, while State General Fund Medicaid expenditures have increased by 142 percent. The growth in expenditures for seniors has closely followed the growth of seniors receiving Medicaid, while expenditures for people with disabilities have greatly exceeded the population growth. While the numbers of low-income children and adults served by Medicaid continue to increase, the cost of providing services has increased at a higher rate. When compared to other states, Kansas ranks relatively low or average in several measures of population health care needs.

Medicaid Expenditures graphs were distributed (Attachment 3). Expenditures are expected to be $3.3 billion within five years. Total Medicaid Expenditures information also was presented (Attachment 4). Expenditures will increase 276 percent from all funds within 15 years.

Committee discussion followed Ms. Dunkel's presentation. Documented non-citizens means that students are not eligible, but those who have a green card or refugee status are eligible for Medicaid. Senator Huelskamp requested more information on what type of documentation is

required from non-citizens. It was noted that, in comparison with other states, Kansas has fewer people participating in Medicaid but tends to be more generous with its spending.

Emalene Correll, Kansas Legislative Research Department, reviewed the recommendations of the President's Task Force on Medicaid Reform and the Federal Medicaid Commission appointed by the Secretary of Health and Human Services (Attachment 5). The bipartisan Commission on Medicaid Reform was established by the Secretary of the Department of Health and Human Services and directed to report recommendations on options to achieve $10 billion in scorable Medicaid savings over five years.

The following is a partial list of recommendations from the Task Force.

- The Task Force recommended a statewide public education campaign to educate the public as to the importance of buying long-term care insurance, but this has not been implemented.

- The Task Force recommended that the Department of Social and Rehabilitation Services (SRS) 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 should 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 recommended support of establishing a lien on the real property of a Medicaid recipient who has been in a long-term care facility for a year or more and legislation changing the definition of an estate, for estate recovery purposes, to include jointly owned property. The state should prohibit property owners from applying for or receiving Medicaid by specifying a certain percentage of ownership of jointly owned property. The 2004 legislation set out circumstances in which a lien cannot be imposed which generally follow federal law and set out the conditions that will satisfy the lien.

- Purchase and negotiation of prescription drugs should be explored. An important factor in maximizing purchasing power is the ability to determine actual costs. SRS should consider reviewing the systematic approach used to track the cost of liquor at the manufacturer, wholesaler, and retailer levels to see if it is transferable to the pharmacy system.

- SRS should identify and counsel doctors who might be over-prescribing certain medications, as indicated in the Medicaid Management Information System (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, it is impossible to conduct a review of claims information to identify potential fraud or to efficiently pursue alleged fraud. Changes have been made in the pharmacy claims form to make it possible to track the prescriber. This is an area in which Committee members felt much improvement could be made.

Ms. Correll presented three additional reports to Committee members:

- Medicaid Reform, A Preliminary Report from the National Governors Association, June 15, 2005 (Attachment 6);

- Short-Run Medicaid Reform from the National Governors Association, August 29, 2005 (Attachment 7); and

- NCSL Principles for Medicaid Reform (Attachment 8).

Chairperson Schmidt asked Senator Vicki Schmidt for comments concerning the report. She said she was very disappointed to see that the report said that the SRS pharmacy benefits manager analyzed polypharmacy (the practice of concurrently prescribing multiple drugs, often for the same condition) in the Medicaid program. She said that is not true and should not have been in a report of this magnitude to a Committee of this importance. She said it is time to get moving on this problem, as there is a tremendous amount that could be done and there has to be a way to accomplish it. Over 60 percent of the prescriptions do not have the prescribing physician listed, according to Senator Huelskamp.

In response to Senator Vicki Schmidt's comments, Dr. Robert Day, Director of Division of Health Policy and Finance, admitted that there was a problem with the contractor in that respect. He said they would pursue changing this problem.

The Committee recessed from 11:45 a.m. to 1:40 p.m.

Barbara Hinton, Legislative Post Auditor, Legislative Division of Post Audit, reviewed the cost savings ideas identified in recent Medicaid audits conducted by the Legislative Division of Post Audit (Attachment 9).

Findings from the following Performance Audit Reports were presented:

- Medicaid Waivers: Reviewing Differences in Rates and Hours of Service for Self-Directed and Agency-Directed Care, July 2005 (Attachment 10);

- Medicaid: Reviewing Factors That Affect the Amount of Attendant Care Services Certain Medicaid Clients Receive, October 2004 (Attachment 11);

- Medicaid: Assessing the Cost-Effectiveness of Current Procedures for Transporting Medicaid Consumers to the Services They Need, April 2003 (Attachment 12); and

- Medicaid: Reviewing the Compensation of Payroll Agents for Home- and Community-Based Waiver Programs, April 2003 (Attachment 13).

The audit findings included:

- More could be done to control the costs of services for clients who self direct. If voluntary services are available, Medicaid should not pay for the service to providers. The number of hours family members can be paid to provide services could be limited. Family members could be reimbursed at a reduced pay rate. Make sure increases in service hours are based on objective criteria.

- Raise the minimum score needed to functionally qualify for Medicaid.

- Lower the amount of "protected income" so applicants would be required to use more of their own income to pay for long-term care services.

- Continue to use waiting lists for waiver services.
- Use spending caps per consumer.
- Reduce unnecessary services by systematically reviewing and analyzing claims data.
- Strengthen efforts to identify and recoup amounts paid in error.
- Increase the number of people who have long-term care insurance.
- Freeze nursing facility reimbursement rates or delay rate increases.
- Eliminate funding for people Kansas is not federally required to serve; serve only the most needy.
- Reduce the length of time people are eligible for services.
- Expand the use of copayments.

Ms. Hinton then gave an update on what has been done concerning the Post Audit recommendations. Cindy Lash, manager of the audits, answered Committee members' questions concerning the reports.

Historically, Medicaid has paid more for clients with self-directed care than for clients getting agency-directed care. Ms. Hinton said she did not know the reason for this.

Independent living centers and some home health agencies are in a position to benefit by authorizing more services for certain clients. This was a concern by the Committee. Post Audit found no evidence of conflict of interest, but did agree that it could happen.

Commercial providers provide most non-emergency medical transportation services in Kansas. Cost to provide such transportation has increased from $4.6 million in FY 2000 to $6.3 million in FY 2002, an increase of 37 percent in just two years. SRS has recently identified several instances of inappropriate payments that likely contributed to the increase in costs, and has made changes in how it reimburses transportation providers. Kansas' current transportation program is not structured to effectively control costs. The state has a number of options for setting up a more cost-effective Medicaid transportation program, but there are no simple solutions.

Agencies visited by Post Audit in Kansas kept an average of $2.14 for every hour of attendant care service billed to Medicaid.

Kansas spent $50 million on self-directed care, and if the state could reduce that by 1 percent, it would produce over $500,000 savings annually.

Scott Brunner, State Medicaid Director, answered questions from Committee members. He said that a car of any value and the fair market value of a business are exempt from being counted as assets when applying for Medicaid. It was agreed that many recommendations could be implemented by regulation; however, some would need to be made by the Legislature. A critical area that keeps reappearing as a recommendation is the need to have review of programs. The biggest optional payment is for pharmacy benefits.

Representative Kiegerl requested assistance from Mr. Brunner for a constituent who cannot seem to get help from any source. Mr. Brunner assured him that he would look into the matter.

Members concurred that Post Audit should audit the MMIS.

Andy Allison, PhD, Director of Health Care Finance and Organization, Kansas Health Institute, made a presentation entitled, "Medicaid Reform: Options for Kansas and Lessons from Other States" (Attachment 14). Dr. Allison stated Medicaid costs have increased because of increased spending per person, and Medicaid costs per person have grown substantially more slowly than in the private sector. Medicaid also has grown due to enrollment. Spending per Medicaid enrollee in Kansas for FY 2006 will be $2,460 for low-income children, $11,460 for disabled, and $7,310 for seniors.

Cost-saving strategies that would yield immediate savings would be reduction in reimbursement, eligibility restrictions, and cutting optional services. Longer–term strategies would include program reforms that facilitate future savings and changes that facilitate future decision making. Other states are making significant eligibility cuts.

Dr. Allison said that the top recommendation regarding making changes is: "Do It – Review It." The enhancement of governance and oversight could be accomplished with the creation of the KHPA, addressing myopic budget processes, and by fully accounting for costs of health care policies and ending balances.

Medicaid spending is driven primarily—but not exclusively—by growth in spending per person, especially among seniors and the disabled. There are both long-term and short-term options. Some sources of savings entail a focus on the population as a whole, and on the larger health economy. Elements of Kansas' budget process impede informed decision making for the long run.

Committee discussion followed Dr. Allison's presentation. He said that the use and collection of data can be helpful in planning the future, but the data needs to be used.

Scott Brunner, Division of Health Policy and Finance, testified on Medicare Part D and Kansas Medicaid (Attachment 15). The Medicare Modernization Act of 2003 will make a prescription drug benefit available to every Medicare beneficiary beginning January 1, 2006. At that time, dual eligibles will not be able to continue Medicaid coverage for any prescription drugs covered by Medicare Part D; they must choose a Part D plan or lose the coverage.

States are expected to continue to contribute to the cost of this coverage through a phased-down state contribution, commonly referred to as the "clawback." This is a payment each state will make monthly to the federal government. Committee discussion was held concerning the "clawback" issue.

Chairperson Schmidt said that this is a huge topic for the Committee to study. His preference would be to identify some areas in which the Committee has the ability to come to agreement, and to make recommendations to the Legislature. He would prefer to have a few things to suggest, rather than looking at too broad of a picture to be effective. At future Committee meetings, the formal presentations will be scheduled for morning and early afternoon, leaving the remainder of the afternoon open for Committee discussion and action. The Committee concurred with this plan.

The consensus of the Committee was to focus on the fraud and abuse issues. Another area of interest relates to long-term care. An incentive to folks to invest in long-term care insurance is an area to pursue. The states of Oregon and Washington have implemented creative things in their health care systems, so the Committee would like to review what they are doing. Preventive health care for children, *i.e.,* dental care and eye examinations, seems to be a priority. Wellness of Medicaid recipients should be addressed. Another area of concern is a Medicaid recipient failing to show up for scheduled medical appointments. It was suggested that county health associations could follow up and make arrangements for transportation, if needed.

A major issue of concern is tracking prescription drugs. It was felt that the state should be getting more for its money in this area. It was questioned how much latitude and flexibility the Committee had to build in good health behavior incentives. It was suggested that the Committee look at the State of Pennsylvania model. A medical doctor from Johnson County had excellent incentive ideas and the Committee would like for him to attend a meeting. Legislative Research will research his name and make the appropriate invitation.

Another area of concern was that personal property was not counted as an asset, a car of any value was not counted as an asset, and business value was not counted as an asset. These areas will be reviewed. Payroll agents will be looked at to see if they are effectively used. Family member reimbursement abuse will be reviewed, along with transportation issues. It was generally felt that transportation dollars could be used more effectively. More information from SRS regarding MMIS was requested.

Chairperson Schmidt thanked everyone for their participation. Additional attachments to these minutes are:

- Letter from AARP of Kansas (Attachment 16);
- Letter from Prisca Krehbiel, Contracted Case Manager, South Central Kansas Area Agency on Aging (Attachment 17); and
- Letter from Kingman County Council on Aging (Attachment 18).

The meeting adjourned at 4:35 p.m.

Edited by Audrey Dunkel

Approved by Committee on:

October 3, 2005
(date)