MINUTES

SPECIAL COMMITTEE ON WAYS AND MEANS/APPROPRIATIONS

August 28-29, 2001
Room 514-S—Statehouse

Members Present

Representative Kenny Wilk, Chairman
Senator Steve Morris, Vice Chairman
Representative Melvin Minor, Ranking Minority Member
Senator Paul Feleciano, Jr.
Senator Dave Jackson
Senator Nick Jordan
Senator Susan Wagle
Representative Bob Bethell
Representative Jerry Henry
Representative Nancy Kirk
Representative Melvin Neufeld
Representative Clark Shultz

Member Absent

Representative Larry Campbell

Staff

Alan Conroy, Kansas Legislative Research Department
Rae Anne Davis, Kansas Legislative Research Department
Leah Robinson, Kansas Legislative Research Department
Deb Hollon, Kansas Legislative Research Department
Becky Krahl, Kansas Legislative Research Department
Jim Wilson, Revisor of Statutes Office
Mike Corrigan, Revisor of Statutes Office
Nikki Feuerborn, Secretary

August 28, 2001
Morning Session

Chairman Wilk called the meeting to order at 10:00 a.m., reviewed the agenda (Attachment 1) and announced that the Legislative Coordinating Council had assigned a new topic to the Special Committee—Foster Care and Adoption Services-Oversight and Funding Accountability (Attachment 2).

Staff presented a review of the food service inspection program and related fee structure (Attachment 3).

Steve Paige, Director of the Bureau of Consumer Health, Department of Health and Environment (KDHE), explained the mission of their department in the area of inspection of food service establishments and other food protection issues (Attachment 4). The inspection program was established in 1913 and progressed with various boards and commissions until 1975 when the responsibility for licensing of food service establishments was assigned to the Department of Health and Environment. Currently there are approximately 12,000 food service establishments operating at any given time in Kansas. Last year the Department issued 13,889 licenses. They also inspect 800 lodging facilities which are subject to licensing. Approximately 30 vending machine companies which operate 3,000 food machines are licensed by the Department. Facilities which prepare meals to go are licensed as food service establishments. Beginning July 1, 2001, the Department began licensing the 3,500 retail food stores (a facility which sells packaged food for consumption off premises) which now fall under the food inspection program. Seven hundred food processing plants are also inspected under this program. The Department is also involved in transportation accidents and natural disasters. They responded to more than 100 accidents such as truck wrecks that carried food supplies, train accidents, tornadoes, and power failures which jeopardized the safety of the food. Inspections are conducted under Chapter 36, Article 5 of the *Kansas Statutes Annotated*, and retail food processing plants and other facilities are inspected under Chapter 65, Article 6. In addition to the regulatory position, the Department also provides a number of educational opportunities for persons who are operating businesses to allow them to understand the purpose and meaning of regulations and to assist them in finding ways to comply with regulations with the least amount of expense. The Department has 23 field inspectors which conduct inspections in non-contracting counties. They contract with local health departments in eight counties to establish food service establishment inspections. Those contracts comprise about 5,000 of the 12,000 facilities that the agency licenses annually.

Mr. Paige explained that they have 23 field staff for FY 2002, which is one inspector for every 534 food service establishments which must be licensed. Contracting agencies usually are required to have one inspector for every 350 establishments.

The agency also responds to consumer complaints. The number of complaints have increased through the years with the public becoming more aware of food safety issues. Twenty-two percent of all complaints received are individuals who feel they have become ill from the food they have eaten. Seventy-six percent of the complaints included concerns with cleanliness of the facilities and equipment, employees' hair and cleanliness,

temperature of the food, insects, or quality of the food. Last year they investigated and confirmed 11 food-borne disease outbreaks in Kansas.

Also presented was a fee chart for the inspection program. There is a public hearing scheduled for September 21, 2001, that will consider the regulations of $130 licensing fee and $130 application fee for food service establishments. Fee revenue generated from retail food stores will be approximately $200,000, annually. The food processing plant fee will generate approximately $80,000, annually. The food service license fee and application fee should generate approximately $1.8 million on an annual basis.

Last year the Department issued slightly less than 100 administrative orders, slightly more than 400 notices of non-compliance (letters asking for correction), and 48 embargoes on food.

Because the food industry has made many changes in the past 20 years, Mr. Paige said food protection was probably more important than ever before. Our food economy is much more global.

An example was given regarding licensing inspections. A person owns a small business which is a slaughter house that sells meat over the counter and has a small catering business. The custom meat processing plant would be under the regulations of the Kansas Department of Agriculture and would be under the state meat plant inspection program which is done in cooperation with the USDA. The catering operation would be licensed and inspected annually as a food service facility through KDHE. The retail sale portion of the business would be inspected and licensed by KDHE according to SB 100. Mr. Paige said he was interested in further investigating the option of the Department of Agriculture doing the inspections of that portion of the business which sold meat over the counter. (The Committee later elected to send a letter to the Department of Agriculture requesting cooperation with KDHE on such inspections.)

The temporary fee service as set up by KAR 28-36-30 increases the license fee and the application fee for food service establishments. The fee prior to July 1, 2001, was $100 per establishment and the application fee was a one-time fee of $100. Both of those fees were increased to $130 effective July 2, 2001. KAR 28-36-60 is a new fee regulation that applies to food processing plants. The application fee currently is $10. Anyone operating on June 30, 2001, would pay an application fee of $10. This fee regulation expires October 31, 2001, and after that point the application fee will be split into two categories—those facilities which have less than 1,000 square feet will pay an application fee of $50; those facilities that have more than 1,000 square feet will pay an application fee of $100. This is a one-time fee. The annual license fee will be structured similarly. A temporary regulation regarding licensure now in place establishes fees of $25 for food processing plants under 1,000 square feet and $75 for those facilities over 1,000 square feet. This six-month license regulation will expire December 31, 2001. The annual license fee under the permanent regulation for facilities that have more than 1,000 square feet will be $150; those under 1,000 square feet will pay $50.

Retail food stores also have a split structured fee. The initial application fee under the temporary regulations is $10. After that, the license fee for retail food stores with 5,000

square feet or less would be $50. Facilities which have 5,000 to 15,000 square feet will be charged a license fee of $100. Those facilities which have more than 15,000 square feet will pay a license fee of $150.

Mr. Paige explained that within lodging facilities, only those vending machines which sell food are required to be inspected. The lodging facilities which offer continental breakfasts *i.e.* toast, juice, coffee, cereal, etc. are required to have a license. If doughnuts are brought in from outside the facility and offered to the customers, a license is not required.

The Committee was concerned about the increased rate of fees for small businesses if they were involved with more than one facet of food inspection and licensure. They recommended a review of the proposed fee schedule even though the square footage designation was agreed to by the industry. The Committee questioned whether the fee increase would be fair to the smallest of facilities.

Ron Hein, representing the Kansas Restaurant and Hospitality Association, presented testimony in support of the proposed increases in fees and licensure requirements (Attachment 5). Twenty percent of the restaurants in Kansas belong to the association.

Dr. Moser, Director of Health, KDHE informed the Committee that none of the 60 reported cases of hepatitis A in Hutchinson have been traced to restaurants. Although it is not a standard requirement in such situations, most restaurants have asked that their employees be vaccinated at the restaurant's expense. The federal contract price plus an administrative cost has been offered to the owners for the vaccine which is available through the local health departments.

Frances Kastner, Director of Governmental Affairs for the Kansas Food Dealers Association, expressed her concern at the passage of HB 2500 and SB 100 (Attachment 6). In her opinion no formal hearings were held. She indicated that her association believes that the fee is a hidden tax because a portion of the sales tax charged on food was to be spent on inspection and licensure. The definition of "retail food store" was questioned as was the fact that farmer's markets are not subject to inspections as food service establishments are.

Barb Hinton, Legislative Post Auditor, appeared before the Committee to discuss Topic No. 8—Review Cost Factors of Medical Assistance, and to discuss factors driving up Medicaid costs. Although Legislative Post Audit (LPA) had not done any audits regarding Medicaid fraud, they have done some audits on cost containment. The Attorney General has a fraud investigation unit for Medicaid that is federally funded. The fiscal agent for Medicaid, Blue Cross/Blue Shield, also conducts some investigations. The Department of Social and Rehabilitation Services' (SRS) quality utilization review team may have some involvement with this.

Ms. Hinton stated that LPA could provide the following information in an audit:

- Identify what is Medicaid fraud and who are the participants or entities conducting investigations.

- Look at what the investigations are producing.

- Due to the magnitude of Medicaid, it would be more efficient to focus on particular areas where there might be problems. Depending on the type of information systems Medicaid has available, LPA could look at doctors billing for more hours than there are in a day, double billing, complaints or reports that clients have originated, the reports generated by the Government Accounting Office and/or the Inspectors General, and procedures being used by other states. The agency would look at generalities rather than using a case-by-case system which would be very time consuming and costly.

Items which would not be available through the above described process would be such things as billing for goods or services which were not provided and identifying phantom patient business.

Ms. Hinton reminded the Committee that audits can always be done in sections, *e.g.* looking at some things in detail and others in a more general way. To identify the majority of the fraud occurring might require more time and depth of study and take longer than the Legislature would be willing to wait. The Committee requested copies of the cost containment audit which was completed in March of 2000.

The Chairman requested that LPA develop a scope statement for the Committee. The Committee will then prepare their request for presentation at the next LPA meeting.

Cindy Lash, Legislative Post Auditor, reported that the Attorney General's Medicaid Fraud and Abuse Division acts on complaints. By federal law the agency is prohibited from doing searches for fraud or other problems. Blue Cross/Blue Shield of Kansas is the Medicaid fiscal agent for SRS. Also the Utilization Management Review Team within SRS reviews the data from the Medicaid Management Information System. There is a component of that computer system that is called Surveillance and Utilization Review Subsystem. It pulls data on utilization and will do three-year comparisons and provider profiles. The team can choose certain areas to focus on, but not necessarily fraud. They may be looking at other types of overpayment. Ms. Lash said they would possibly go into the same type of data that the team uses, but with their interest really focused on areas where there might be more likelihood for fraud.

Ms. Hinton suggested that the Committee focus on fraud issues rather than inefficiencies or ineffectiveness as the outliers would be very different. She pointed out that it would be a very different audit if the focus is on efficiency. She suggested that if the Committee recommended a multi-prong approach audit, a scope statement could be developed which would have various parts *i.e.* efficiency which looks mostly at processes and use of resources as well as those of providers; cost containment in the delivery of medical services especially pharmaceutical costs; and fraud even though none has been noted in Kansas.

Chairman Wilk recessed the meeting for lunch at 11:45 a.m.

Afternoon Session

Chairman Wilk called the meeting back to order at 1:45 p.m. Staff presented a review of Topic No. 5—Community Clinic Model (Attachment 7). Also included in the testimony was a letter from Dave Kerr, Senate President requesting consideration of the topic which would deal with the considerable dissatisfaction with the current Medicaid model for delivery of primary health care for those who are poor, uninsured, and in need of care.

Richard Morrissey, Director of the Office of Local and Rural Health, KDHE, presented testimony on community-based primary care clinics (Attachment 8). He pointed out that community health centers that are funded by federal dollars are required to take all clients not matter their payment circumstance. Rural health clinics are not required to take patients who cannot pay either privately or through insurance.

Dr. Robert M. Day, Director of Medical Policy/Medicaid, SRS, gave a review of the community clinic model as a provider of Medicaid services (Attachment 9). He explained that a clinic cannot bill Medicaid for any in-patient services, so a physician who is on contract with the clinic and has a patient who needs acute care in a hospital setting has to bill Medicaid directly with a different provider number than the clinic. Physicians can follow the patient to the hospital and bill under the physician's provider number. If a clinic originally made the choice to become Medicaid certified, they are required to accept all Medicaid/-Medicare patients. Clinics which have opted not to become Medicaid certified have done so for various reasons including a mission to serve only the medically indigent without any access to medical care and a reluctance to compete with private physicians and others who are providing services to the Medicaid population. SRS served more than 42,000 Medicaid beneficiaries in rural health clinics or in federally qualified health clinics in the past year, paying out more than $8.2 million for their services. These are primarily physician visits which can have three or four procedures within the one visit but are reimbursed as a single encounter payment. There is no limit on the number of patients which can be seen or the number of encounters made. Physician service is the lowest outflow of money in the Medicaid program. The clinics receive a higher reimbursement rate than physicians because they have a cost-based settlement. They could receive more if their volume of business increases. The option of requesting additional federal grants for clinics is being used by some communities *i.e.* the United Methodist Clinic in Garden City and a clinic in Emporia have received community health center funding. President Bush has added $100 million for a five to six year phase-in to increase the funding for existing and new clinics. Kansas will have few new areas which can qualify based upon the requirements for shortage area designations and levels of poverty and health status that are tied to that funding. SRS is currently working with communities to encourage the existing clinics to accept the federal money and the associated requirements. Thus far church-related clinics have been uninterested in participating. Many of the rural areas will not qualify for this federal funding.

Laura Howard, Assistant Secretary for Health Care Policy, SRS, provided an update on the agency's services for the physically disabled 65 years of age and older (Attachment 10). Individuals on the Home and Community Based Services/Physically Disabled (HCBS/PD) waiver will be allowed to make a one-time choice of whether to remain on that waiver or move to the Home and Community Based Services/Frail Elderly (HCBS/FE) waiver. An educational program would be developed to teach and advise clients of their options and availability of service. Clients may be reluctant to choose to move to the Frail Elderly services as there would probably be a change in case managers even though the level of service would remain the same. The possibility of combining all three waivers (Frail Elderly, Developmentally Disabled, and Physically Disabled) for those attaining their 65th birthday in order to provide continuity of services was discussed and ultimately dismissed due to the difficulty in developing a service package which would service all their needs, especially the developmentally disabled. Also addressed was the time period the developmentally disabled were forced to wait for services after their application for the waiver. Additional funding of $5 million will allow for the treatment of more individuals.

Janis DeBoer, Deputy Secretary, Department on Aging, presented an overview of providing services to physically disabled individuals over the age of 65 under the HCBS/FE waiver program (Attachment 11). Her department supports the option of allowing individuals on the HCBS/PD waiver to stay on the waiver rather than being forced to move to the HCBS/FE waiver. The agency also supports this being a one-time choice with no option of transferring back and forth. Clients remaining on the HCBS/PD waiver would cost $150.70 per month more per client than those moving to the HCBS/FE waiver due to the type of services required for the physically disabled who wish to remain active in the community. It was pointed out that most of the clients on the HCBS/FE waiver are retired. Ms. DeBoer acknowledged that changing case managers is usually one of the big concerns regarding moving from one waiver to another.

Gina McDonald, President and CEO, Kansas Association for Centers for Independent Living, spoke in support of the option for the physically disabled to continue receiving the same services on the same waiver when they turn 65 years of age (Attachment 12).

Jim Beckwith, President, Kansas Area Agencies on Aging Association, provided testimony in support of the retention of the current program which requires the physically disabled to move to the frail elderly waiver upon reaching their 65th birthday (Attachment 13).

Janet Schalansky, Secretary, SRS, explained no legislative action would be required to make the option available for the physically and developmentally disabled upon reaching their 65th birthday to move to the HCBS/FE waiver or to remain in their current status. This could be done through amendments to the existing waivers.

Staff presented testimony on the Kansas Bureau of Investigation (KBI) as the agency for pilot building of a zero-based budget (Attachment 14).

Larry Welch, Director, KBI, explained that the agency has 200 FTE positions. The budget is comprised of 19 percent federal grants and 14 percent other fees. Mr. Welch described how the budget is division-driven. Marsha Pappon, Budget Director, KBI, explained the development of the budget that usually starts with the last fiscal year's

expenditures with adjustments regarding existing programs, program enhancements, federal and state grants, anticipated needs, and cost increases or decreases. The budget is then sent to the Division of the Budget. The Committee asked the agency to use their FY 2002 budget as a template and develop a zero-based budget for FY 2003.

Committee members requested copies of the agency's latest FY budget prior to the next meeting. Also requested was a list of statutes under which the KBI operates.

Ms. Hinton returned to the Committee with a scope statement, supporting documents on a performance audit regarding the use of generic drugs in the Medicaid program, and copies of the executive summary of a performance audit report on whether Kansas' Medicaid program makes maximum use of third-party insurers (Attachments 15, 16, and 17). The Committee discussed and prioritized the proposed audit as follows:

- 1A. Controlling the types and costs of covered medical services (including mental health and substance abuse treatment);
- 1B. Controlling fraud and abuse;
- 2. Controlling growth in case loads; and
- 3. Controlling the provision of residential services (including nursing homes, hospitals, and group homes).

Senator Feleciano moved that the scope statements as determined by the Committee be submitted to the Legislative Post Audit Committee for consideration. Motion was seconded by Representative Bethell. Motion carried.

Chairman Wilk, Representative Minor, and Senator Morris will make the presentation to the Legislative Post Audit Committee at their next meeting.

Chairman Wilk recessed the meeting at 4:30 p.m.

August 29, 2001
Morning Session

Chairman Wilk called the meeting to order at 9:10 a.m. Copies of letters from the Department on Aging and the Department of Social and Rehabilitation Services (SRS) in response to questions asked at the August 7, 2001, meeting were distributed (Attachment 18).

Staff presented information on sales tax rebates for capital improvements by educational attractions (Attachment 19). No fiscal note is available as the Division of the Budget said it could not be estimated at this time.

Phillip S. Frick, representing Exploration Place in Wichita, presented reasons for the proposed rebates of sales tax for certain not-for-profit corporations (Attachment 20). After walking the Committee through the proposed legislation, he pointed out that the rebate would not be automatic but would only be available to those not-for-profit organizations who submitted written plans for approval. He estimated the fiscal note of this bill at $500,000 per annum to the state but the match which would be required of the institutions would encourage additional private support and stimulate the raising of additional moneys locally and improve tourism throughout the state. This rebate on sales tax would not apply to restaurants on site. Oklahoma is the only known state to have such a tax rebate plan in place.

Jeff Ollenberger, Vice President, Kansas Cosmosphere, encouraged the Committee to support the legislation as tourist attractions are constantly in need of updating. This tax rebate would allow for such improvements, thus bringing in a higher attendance. He pointed out that repeat visitation is most important for the success of tourism.

Richard Cram, Director of Planning and Analysis, Department of Revenue, distributed copies of the agency's explanation of proposed SB 320 (Attachment 21). He explained that the usual process would be to establish an exemption rather than developing the proposed rebate. He explained the high administrative costs and recommended a straight exemption.

Staff presented information on the establishment of a state tourism advertising fund (Attachment 22).

Lt. Governor Gary Sherrer, Secretary, Department of Commerce and Housing, explained that the agency's opposition to 2001 SB 293 does not reflect a lack of support for tourism. The bill would not allow for long-term planning by the Tourism Division as it would be unsure of funding from year to year. He recommended a more consistent level of additional funding for the advertising budget for tourism.

Jeff Mercer, Travel and Tourism Division, Department of Commerce and Housing, reported to the Committee that the existing Tourist Information Center in the Kansas City area is being closed but one will be open near the Kansas Speedway at the expense of the Speedway. There is also a Tourist Information Center in Belle Plain and a request has been made for the construction of one south of Liberal. Mr. Mercer stated Kansas is 50th in the nation in tourism advertising. He suggested increased promotion of our western heritage which is receiving international interest at this time.

The Committee discussed their reluctance to decrease the sales tax base through tourism rebates. It was pointed out that the argument that money should not be promised for the future was not plausible as the Legislature has consistently approved long-term transportation plans. Additional suggestions for increased funding included charging sales tax for parking recreational vehicles. The private tourism industry in Kansas is currently bypassing the state in its efforts to promote tourism.

Michael Pickering, Chair, Governor's Council on Travel and Tourism, spoke in support of SB 293 as it is an industry promoted funding proposal

Judy Billings, Director, Lawrence Convention and Visitors Bureau, and President, Travel Industry Association of Kansas, reported on the organization's collaborative advertising efforts with sponsors (Attachment 23).

Marci Penner, Executive Director, Kansas Sampler Foundation, provided a perspective on rural tourism in Kansas (Attachment 24). She explained the need to educate Kansans on the tourist attractions of their own state.

Mr. Hein explained that for every dollar spent on tourism advertising, there is a return of $50.00 (Attachment 25). He encouraged the development and promotion of a website for Kansas tourism.

The Committee acknowledged the need for a long-term plan for tourism which would include media support and the promotion of rural communities and state parks. It was suggested that perhaps the departments of parks and tourism should be combined.

Chairman Wilk recessed the meeting at 11:30 a.m.

Afternoon Session

Chairman Wilk called the meeting back to order at 1:35 p.m. Representative Lisa Benlon, Chairperson, Legislative Post Audit Committee, appeared before the Committee and announced that the Division of Legislative Post Audit had been instructed to provide an audit on controlling the types and costs of covered medical services. An audit on controlling fraud and abuse would be contracted out. The other two topics were being held for future consideration.

Mr. Timothy J. Stroup, Director, National Consolidated Mail Outpatient Program, U.S. Department of Veterans Affairs, Leavenworth, explained that the agency is able to contain pharmaceutical costs through the use of prime venders from which it can buy pharm-aceuticals at a discount rate due to the high volume (Attachment 26). The program will fill 100 million prescriptions for qualified veterans next year. The center in Leavenworth fills 5,000 prescriptions per hour between the hours of 6:00 a.m. and midnight with a two-day turnaround time for incoming mail orders. He pointed out that the program is just the dispensing portion or the drug therapy without the overhead factors of pharmaceutical education of the clinical side. There are veterans on Medicaid who could be shifted to the Veterans Affairs (VA) system in order to receive their pharmaceuticals at a much reduced rate. A mechanism for this procedure would have to be developed through the medical centers where Medicaid clients receive their care. Capsules which sell for $4 a piece at a private pharmacy cost only $.20 through the VA. The Committee discussed the possibility of establishing a system similar to the VA through the formation of buying co-ops with other states. Mr. Stroup pointed out that the biggest problem in the establishment of a pharmacy dispensing business is being sure of the compliance of the patient in the use of the drug. The VA has a comprehensive record of each patient's medical history and prescribed treatment for a variety of ailments. Some patients require more explicit direction and

supervision of their drug therapy than others so the use of more readily available drug centers might have to be considered.

Dr. Jack E. Fincham, Dean, University of Kansas School of Pharmacy, pointed out in his testimony on the rising cost of pharmaceuticals that the over-65 population in Kansas is a higher percentage than any other state (Attachment 27). These persons use 9 to 12 prescriptions per year while those in the 30-40 range use two to three per year. By Kansas statutes, the cost control of the Medicaid program is compromised. The United States does not allow reference based pricing, *i.e.* if two equally effective but differing chemical products are available, the less expensive product is used. Medicaid has to pay the lowest available price. There may be as many as 15 different pricing levels for various agencies and buying entities in the United States. There may be a lower price for certain agencies of the federal government due to the ability to leverage buying power through a group, *i.e.* medical centers throughout the United States called the University Health Consortium with members such as the KU Medical Center who band together and buy from certain manufacturers.

Dr. Day explained that prices are set and the agency cannot negotiate. The sealed bids they receive are not available for evaluation.

Dr. Fincham pointed out that when drug rebates come into play, the manufacturers are able to set the best price themselves and thus the initial price of the drug goes up in order to offset the amount of the rebate. There is a 70 percent plus initial cost differential for drugs between the VA system and that available to the general public.

The Committee discussed with Dr. Fincham the importance and benefit to the tax payer for Kansas institutions to participate in private company drug research at state-supported institutions. The research institutions evaluate how drugs work at the cellular level through entry and effect once in the system. Drugs are then created to work in that fashion. The next step is to discover some medium to deliver that drug to a cell to do what it is that it is supposed to do. This information is published in research journals and becomes public information. A pharmaceutical company can use that basic research to develop a product and put it on the market. Thus, a new, more refined, and many times purer product becomes available to the public. Without the research done at public institutions or through grants by the federal government, drugs would be more expensive if the drug companies had to do their own research. The information would not be shared with other companies for product development.

Dr. Fincham described a product which was improved upon through research and development in the Department of Pharmacy at the KU Medical Center and is now being produced at a laboratory in Kansas. This laboratory hires professionals from Kansas who pay taxes, thus the cycle continues. Many times pharmaceutical companies will contract out research such as distribution, solubility, or toxicology studies with institutions such as the University of Kansas. KU has the policy that pharmaceutical companies with which they have contracts must pay at least the same amount for indirect costs as the federal government. Some types of research such as educational studies have a lower rate for indirect costs but it is similar.

Dr. Fincham explained the three factors involved in any health care setting—quality, cost, and access. The aging population in Kansas is a higher proportion than other places in the United States, but the overall geriatric population is ten times what it was 100 years ago. He pointed out that lack of pharmaceutical compliance by individuals costs $15 to $20 billion per annum in the United States. Only half of all the drugs prescribed are used and taken as they should be. This leads to additional costs. The best way to increase compliance is to provide verbal and written counseling through the pharmacist. The pharmacist is the last link between the health provider and the patient. The annual cost of not being compliant with a hypertension preventing drug is determined by the likelihood of stroke, end-stage renal disease, or cardiovascular complications. There is more research and data in the compliance area than ever before because if the drugs are not taken correctly, the patient assumes they do not work and stops purchasing the drug. The drug industry has become interested in compliance because they sell more of the drug when it is taken effectively. Dr. Fincham suggested the following measures for the Legislature in securing drug compliance for Medicaid recipients:

- Provide incentives for persons to be involved with monitoring clients who are at risk for non-compliance—those with multiple diseases, multiple therapies, or living alone. Twenty-five percent of the persons in nursing homes are there because they cannot control their drugs (6 to 12 drugs) on an out-patient basis. Dr. Day said the agency has an inquiry underway to assist Medicaid clients in their drug therapy. Such a program is underway in Ohio now.

- Have this practice controlled so the effects can be measured.

- Encourage the practice of pharmacists working with physicians to increase communication.

- Allow changes to occur in Medicaid law in Kansas which will lower costs.

Dr. Fincham explained that during the training of pharmacists at KU, they are advised that they need not work in less than optimal conditions. They discuss what the practice should be, what they can do collectively, and teach them to be proactive in their profession.

The following cost control options being used throughout the United States are not statutorily or regulatorily allowed for Medicaid recipients in Kansas:

- Benefit Contracts. Medicaid recipients are able to use physicians, pharmacists, and hospitals to the extent desired. Persons who have their own insurance or health plans are not allowed this benefit.

- Physician Provider Network. Any Medicaid patient can use any physician in Kansas.

- Pharmacy Provider Network. Any Medicaid patient can use any pharmacy in Kansas.

- Pharmacy “Point Of Sale” System (prospective drug utilization review). This is in place through the fiscal intermediaries that deal with the Medicaid program.

- Therapeutic Substitution Not Available in the Out-Patient Setting (available through the VA). The Committee questioned whether there would be any savings if individuals in the out-patient setting were to have a reaction to the therapeutic substitution drug and ultimately were hospitalized. Dr. Fincham pointed out that 30 percent of all patients in hospitals experience an adverse drug reaction. There is more monitoring going on in the out-patient setting than in the in-patient setting.

- Drug Formulary. Open drug formulary means the pharmacist can use any drug on the market for any patient. A closed formulary means the pharmacist has only limited numbers of drugs which are eligible to be used. Kansas has an open formulary, so therapeutic substitution is not available. Dr. Day said that if therapeutic substitution were implemented, Kansas would lose not only the rebate from the drug companies, but also the federal portion of the rebate. Dr. Fincham questioned the possibility of the Centers for Medicare and Medicaid Services changing its position on the formulary issue.

- Patient Co-Payments. The Medicaid population being served is already in the poverty area so co-payments would probably not be possible. When Medicaid was created, the federal law set a maximum co-pay of $3. Kansas established a $2 co-pay, but does not require payment.

- Counter-Detailing. The pharmacist meets with the physician in his office and discusses with the physician a specific class or series of drugs.

Dr. Fincham warned that even if all or at least some of the above listed cost control options were put in place in Kansas, the cost of Medicaid pharmaceuticals would continue to rise at an alarming rate. Unless the Legislature empowers the health providers to make some decisions on how to provide more drugs for more people at a lower cost, the situation will continue. Close monitoring in the out-patient setting, much the same as the VA has done, would definitely have a positive effect on lowering the cost of drugs for Medicaid recipients. Dr. Fincham agreed to furnish the Committee with a list of suggestions for changes within the federal funding which would lower costs in the Medicaid program.

Staff distributed a memo on pharmaceutical purchasing pools in other states (Attachment 28).

The Department of Commerce and Housing provided the Committee with copies of the 2000 Advertising Effectiveness Study (Attachment 29).

Chairman Wilk adjourned the meeting at 5:00 p.m.

Prepared by Nikki Feuerborn
Edited by Deb Hollon

Approved by Committee on:

December 17, 2001

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