MINUTES

SPECIAL COMMITTEE ON MEDICAID REFORM

November 2, 2005
Room 313-S—Statehouse

Members Present

Senator Derek Schmidt, Chairman
Representative Melvin Neufeld, Vice-Chairman
Senator Jay Emler
Senator Anthony Hensley
Senator Tim Huelskamp
Senator Laura Kelly
Representative Jerry Henry
Representative Bob Bethell
Representative Mike Kiegerl
Representative Nancy Kirk
Representative Don Myers

Member Absent

Senator Dwayne Umbarger

Staff Present

Audrey Dunkel, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Lisa Montgomery, Office of the Revisor of Statutes
Norman Furse, Office of the Revisor of Statutes
Judy Swanson, Committee Secretary

Conferees

Scott Brunner, Division of Health Policy and Finance
Karla Finnell, Executive Director, Kansas Association for the Medically Underserved (KAMU)
Carol Pangborn, EDS Client Delivery Executive
Deborah Donaldson, Director, Division of Human Services, Sedgwick County
Robert St. Peter, M.D., President and CEO of Kansas Health Institute
Richard Warner, M.D, President-Elect of the Kansas Medical Society
Michael Bond, Ph.D., Cleveland State University
Howard Rodenberg, M. D., MPH, Director, Division of Health, Kansas Department of Health and Environment
Representative Sydney Carlin

Others Attending

See attached list.

Morning Session

The Special Committee on Medicaid Reform was called to order by Committee Chairman, Senator Derek Schmidt, on Tuesday, November 2, 2005, in Room 313-S of the Statehouse at 9:05 a.m.

It was moved by Representative Bethell that the minutes of the October 3, 2005, Committee meeting be corrected to reflect that Senator Huelskamp was present and the minutes be approved as corrected, along with the minutes of the September 19 and September 26, 2005, meetings. Representative Neufeld seconded the motion which carried with no opposition.

Regular Medicaid Program

Scott Brunner, Director of Medicaid, Division of Health Policy and Finance, reviewed the Regular Medicaid program (Attachment 1). He discussed covered services and the cost of such services. During discussion, Mr. Brunner said the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program serving children and youth under 21 has generated some appeals based on denial of services, but no lawsuits have been filed to date.

There was discussion of the tables in Attachment 1 indicating the top 25 inpatient and outpatient procedures paid for by Medicaid in fiscal year 2005. In discussion of the table that includes data on regular medical expenditures for fiscal years 2001-2005, including the percent change by fiscal year, it was noted the data do not include regular Medicaid expenditures for nursing facility or Home and Community Based Services (HCBS) clients. A companion table that indicates the number of persons receiving services for the same time period also does not include regular Medicaid expenditures for nursing facility and HCBS clients. Asked if the Kansas numbers have been compared to other states, Mr. Brunner responded they had not. It was suggested by a member of the Committee that it would be useful to have such a comparison.

Mr. Brunner discussed the chart that compares Kansas, Nebraska, Missouri, Iowa, Oklahoma, and Colorado in terms of the eligibility standards that apply both to mandatory and optional Medicaid groups (Attachment 2). In response to a question, Mr. Brunner stated the children covered in the "Katie Beckett" programs in the other states are covered through the technologically dependent children community-based service waiver in Kansas.

MediKan

Mr. Brunner presented an overview of MediKan (Attachment 3). MediKan is a health care coverage program, funded with state-only money, for adults applying for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) who do not qualify for Medicaid. Currently, about 4,500 people receive health care services under MediKan. Mental health services and prescription drugs make up a little over 50 percent of MediKan claims. Reference was made to "Health Care Status and Utilization Patterns of MediKan Enrollees," by Theresa Shireman, Ph.D., R.Ph., University of Kansas School of Pharmacy, data from which is included in Attachment 3. The data were reviewed briefly. In response to a question, Mr. Brunner clarified that MediKan does not include any cash assistance for eligible individuals.

Mr. Brunner reviewed a proposed change in the manner in which eligibility for MediKan is determined that will involve a more detailed review of the disabling condition that gives rise to an application for Social Security Disability Insurance or Supplemental Security Income. The procedure to be implemented is known as presumptive eligibility determination and should lead to insuring that a larger number of persons who qualify for MediKan will, indeed, be determined eligible for SSDI or SSI. The steps that will make up the eligibility determination are outlined in Attachment 3. The Division of Health Policy and Finance believes the use of presumptive eligibility determination in MediKan can serve as a pilot for moving to presumptive eligibility determination for Medicaid.

Kansas Association for the Medically Underserved

Karla Finnell, Executive Director, Kansas Association for the Medically Underserved (KAMU), testified concerning services in Kansas (Attachment 4). She reviewed services that are required to be provided by Federally Qualified Health Centers (FQHCs) including, primary medical care, behavioral health care, substance abuse, diagnostic lab, and x-ray services. Ms. Finnell noted FQHCs and FQHC "look-a-likes" in Kansas serve 79,000 people. Medicaid covers 17.5 percent of the clients served. Sixty-five percent are uninsured. The primary care health centers in Kansas would like to grow strategically based on areas of highest need defined by both populations and services. They have successfully implemented dental "hubs" and would like to expand in the areas of prenatal care and obstetric delivery. Discussion revealed there are 13 FQHCs and FQHC look-a-likes and 160 rural health clinics in Kansas. Six of the primary care clinics have capital projects underway and Ellis County has a planned look-alike clinic. Committee members noted a long-term expansion plan would be beneficial to the Legislature. Ms. Finnell said members of the Association have considered that and they would strive to work in that direction. Association members believe a loan guarantee program would be of great benefit. It was noted that clinic services are community-based, and community organization is extremely difficult.

Medicaid Pharmacy Program

Scott Brunner reviewed the Medicaid Pharmacy program (Attachment 5). The pharmacy program is the largest of the Regular Medical program in Medicaid. It currently accounts for 26 percent of the Regular Medical program costs. The FY 2005 pharmacy budget surpassed $300 million. Approximately 6,000 Medicaid beneficiaries are receiving ten or more prescriptions per month. Mr. Brunner reviewed the top five therapeutic drug categories by payment amounts for FY 2005 and the top five categories by claims. The greatest increase in Medicaid expenditures in the past ten years has been on outpatient prescription drugs. There was discussion of drugs prescribed for behavioral health, national trends in Medicaid expenditures for outpatient prescription drugs, and cost saving strategies.

Carol Pangborn, Client Delivery Executive, Electronic Data Systems (EDS), testified regarding the claims override process (Attachment 6). Provider initiated claims overrides are only permitted on pharmacy claims. Whoever enters the data at the pharmacy has the authority to do an override. There is no certification that a pharmacist has approved the override required. As provided in the Medicaid Pharmacy Manual, providers may override certain alerts if the patient meets state-specified criteria. Ms. Pangborn said the procedure under discussion is not unique to Kansas Medicaid. There are industry standards that are used by all healthcare payers. Committee members discussed the claims override system. Ms. Pangborn gave an update on the DeFever Pharmacy overpayment of $1 million. The money is continuing to be collected through a set-off. EDS has contacted the pharmacy nine times, but has been unsuccessful in securing a refund of the overpayment.

In response to a question, Ms. Pangborn said a prescriber is not listed on all claims. The pharmacy is required to list the prescriber. Between 40 and 50 percent of prescription claims contain an identifiable DEA number.

Sedgwick County Recommendations

Deborah Donaldson, Director, Division of Human Services, Sedgwick County, in response to the Committee's previous request, presented recommendations they felt would be beneficial. in controlling Medicaid costs (Attachment 7).

The Community Developmental Disability Organization (CDDO) recommended:

- Investing funding on the front end to save dollars over an individual's lifespan;
- revising access to Medicaid cards; and
- enhancing flexibility.

The Area Agency on Aging (AAA) recommended:

- Shared risk in the HCBS-frail elderly waiver program; and
- area agency case managers stationed at hospitals.

The Community Mental Health Center recommended:

- Shifting mental health coverage to the private sector;
- using evidence-based methods; and
- reducing premature admission to nursing homes through increased mental health outreach to older adults.

Ms. Donaldson discussed the other concepts and initiatives included in Attachment 7. Representative Myers commended the conferee on developing the recommendations and asked the Legislative Research Department to research which recommendations would need statutory changes and which would need only Committee direction.

Kansas Health Institute

Robert St. Peter, M.D., President and CEO of the Kansas Health Institute, testified about cost sharing in the Medicaid program (Attachment 8). The testimony indicates there are numerous types of cost sharing, including premiums, deductibles, co-payments and excluded or limited benefits, that can be applied to health benefits programs. However, Dr. St. Peter emphasized that any changes made should be monitored and evaluated carefully. Changes can generate unexpected results. For example, enrollment and service use can be expected to decline with cost sharing, but the program impact and total cost impact are unclear.

Luncheon Discussion

The Committee recessed its formal meeting from 12:30 to 1:30 p.m. Lunch was supplied tp the members and staff and Michael Bond, Ph.D., Cleveland State University, discussed reforms in Medicaid and responded to questions from the Committee.

Afternoon Session

Perspectives on Pharmaceutical Pricing

Richard Warner, M.D, President-Elect of the Kansas Medical Society, shared his perspective on pharmaceutical pricing (Attachment 9). He related personal experience and observations. He defined the problem with keeping the price of drugs down as that of purchasers (patients) spending the money of a third party (insurance company). When the purchaser is spending the money of a third party, who is perceived to have a whole lot of money, there is no reason for the buyer to have a serious concern about the total price the seller is asking or to take steps to find the lowest retail price available.

Noting some patients do not do as well on generic medicines as they do on brand medicines, Dr. Warner suggested Medicaid beneficiaries should have to participate on a percentage basis, however large or small, in the price of the prescriptions they use. There is currently no incentive for a consumer to shop around for prescriptions. As a part of his testimony, Dr. Warner provided an RX Drug Cost Comparison chart.

Medicaid Reform

Michael Bond, Ph.D., Cleveland State University, gave a presentation on reforming Medicaid (Attachment 10). Medicaid represented 1.2 percent of the Gross Domestic Product (GDP) in 2000 and is projected to reach 5.3 percent by 2075. Within the Medicaid system there are waiting lists and outright shortages; “Medicaid Mills” with low quality care; and a lack of early treatment which leads to serious medical conditions. According to Dr. Bond, Medicaid suffers from a lack of a real free market, with resulting cost and quality issues. He urged the Committee to look at several other state plans for complete system change and to recommend the best possible combination of system changes for Kansas.

Public Health

Howard Rodenberg, M.D., MPH, Director, Division of Health and State Health Officer, Kansas Department of Health and Environment, gave an overview of the role and responsibilities of the Division of Health (Attachment 11). The Division has 400 employees and works with a $111 million budget. The work of the Division complements Medicaid in numerous ways. The traditional public health focus is “primary prevention.” Long-term care which impacts quality of life and is a major expense can be impacted by improving health. The latter is the outcome for which the Division strives. The Division of Health can advise policy makers on behavioral changes that will lead to a healthier population.

In response to Committee questions, Dr. Rodenberg said the Department needs to study the data, determine the target population, figure out the health landscape, and make good fiscal decisions in order to contribute to improved health outcomes for all segments of the state’s population, including the population that depends on the Medicaid program for health care services.

False Claims Legislation

Representative Sydney Carlin testified concerning her proposed false claims bill (Attachment 12). She gave a brief history of false claims laws. Chairman Schmidt requested the Research

Department find a similar bill he introduced three or four years ago, noting that perhaps the two proposed bills could be combined.

Draft Legislation

Norman Furse, Revisor of Statutes, reviewed a draft copy of a bill that concerns who can serve as a payroll agent (Attachment 13) and a bill that would create the office of inspector general (Attachment 14).

Representative Neufeld questioned a parent being a payroll agent for a child and, following discussion, the Committee determined the issue should be further investigated. The Research Department was asked to find out the actual administrative cost of care providers and to report at the next meeting.

Three bills (HB 2538, HB 2294, and HB 2445) introduced during the 2005 Legislative Session will be reviewed at the next Committee meeting.

Information requested at the last Committee meeting was distributed, including:

Material from Pamela Johnson-Betts, Secretary, Kansas Department on Aging, reviewing the distribution of expenditures for individual frail elderly waiver consumers, an analysis of the resolution of waiting list clients, the marital status of frail elderly versus nursing facility clients, review of nursing facility rates in surrounding states, etc. (Attachment 15);

Material on total Home and Community Based Waiver expenditures for FY 2005 (Attachment 16); and

Flowcharts for Home and Community Based Services waivers (Attachment 17).

The Chairman announced he is ready to consider Committee action that should or could be taken. The final Committee meeting will allow each member to put forth his or her ideas for action – whether the introduction of bills, statements to be included in the Committee report, the endorsement of proposed legislation already before the Legislature, or proposals for long-term and short-term program changes.

Chairman Schmidt thanked members for their participation. The meeting was adjourned at 4:45 p.m.

Prepared by Judy Swanson
Edited by Audrey Dunkel and Emalene Correll

Approved by Committee on:

November 21, 2005
(date)