PERFORMANCE AUDIT REPORT

Medicaid Cost Containment: Controlling Costs of Medical Services

Executive Summary

with Conclusions and Recommendations

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
March 2002

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Legislative Post Audit Committee
Legislative Division of Post Audit

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To: Members of the Kansas Legislature

This executive summary contains the findings and conclusions, together with a summary of our recommendations and the agency responses, from our completed performance audit, *Medicaid Cost Containment: Controlling Costs of Medical Services*.

The report includes several recommendations for controlling Medicaid-funded regular medical costs, including developing an aggressive "utilization management" program for people with extensive medical needs to ensure the services they receive are appropriate and necessary, systematically analyzing Medicaid claims data and using that data to manage the Medicaid Program in a cost-effective manner, and taking the steps necessary to reduce the number of errors in amounts paid to providers.

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Barbara J. Hinton
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EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of Medical Assistance Provided Under Kansas' Medicaid Program

Although there are broad national guidelines for Medicaid, States have a great deal of flexibility in developing their programs. *Within limits, states are allowed to determine eligibility standards. However State Medicaid programs must provide 3 types of critical health protection—health care for low-income families with children and people with disabilities, long-term care for low-income elderly and disabled, and supplemental coverage for low-income Medicare beneficiaries. Federal regulations define mandatory and optional categories for people covered–and the services provided—under Medicaid.*

Increases in Medicaid expenditures had slowed somewhat in the mid-1990s, but began to increase sharply again after 1998. *Medicaid spending in Kansas has increased by more than $1 billion in the past 10 years, from $481 million fiscal year 1991 to $1.5 billion in 2001, or about 12% per year. Since 1998, Medicaid expenditures have increased in almost every category of covered service, including long-term care and regular medical services. This audit addresses expenditures for 9 regular medical services like doctors, hospitals, and mental health services that accounted for most of the increase in non-pharmacy regular services from 1998 to 2000. Long-term residential and community-based care services aren't covered in this audit, but will be the focus of another audit approved by the Legislative Post Audit Committee. Cost containment efforts related to prescription drugs aren't included because we audited those efforts in March 2000.*

Question 1: Why Has the Cost of Medical Services in the State's Medicaid Program Increased?

In conducting our review, we focused on claims paid through November 2001 for medical services provided in fiscal years 1998 and 2000. *We chose fiscal year 1998 because it was the last year before SRS' outreach campaign for Healthwave, which resulted in the identification and enrollment of a large number of new Medicaid-eligible recipients. We chose fiscal year 2000 because it was the last year for which completed billing data were available at the time our audit was being conducted.*

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Relatively few services and groups of clients accounted for almost all the increase in non-pharmacy regular medical costs between 1998 and 2000. *We analyzed 7.9 million individual claims paid for services provided in fiscal years 1998 and 2000. In all, 9 types of medical services accounted for $75 million of the $83 million increase in non-pharmacy, regular medical costs. Expenditures for these 9 types of services rose more than 20% in just 2 years. In all, 4 groups of Medicaid clients accounted for almost all the increase in costs: disabled people under 65, aged people 65 or older, poverty-level children, and children in State custody, including juvenile offenders.*

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Changes in Cost by Type of Service and Population Group
Fiscal Years 1998-2000

We looked at 7.9 million medical claims for services provided in fiscal years 1998 and 2000, and found that certain services and groups of consumers accounted for most of the cost increase. In the table below, we've shaded the 13 areas on which we focused our analyses. These 13 areas accounted for $67 million of the $75 million increase. In addition, the first 4 consumer groups listed in the table, accounted for essentially all cost increases.

	Managed Care	Rehabilitation Services	Physician Services	Home Health	Early Intervention	Outpatient Hospital	Inpatient Hospital	Transportation Services	Mental Health	Total change, FY98-FY00	Population group's % of total
Disabled < 65	$72,246	$4,654,285	$8,586,445	$6,232,575	$2,892,996	$3,490,490	$5,746,828	$1,290,561	$3,206,238	$36,172,665	48.1%
Poverty-Level Children	$9,264,989	$820,449	$2,865,644	-$393,174	$3,643,890	$1,222,066	-$883,334	$363,307	$578,697	$17,482,534	23.3%
Aged >65	$754	$250,425	$1,502,645	$3,480,954		$1,018,821	$5,236,365	$714,928	$80,444	$12,285,336	16.3%
Children in State Custody	$46,903	$7,947,279	$654,931	$107,485	$1,335,414	$193,375	$942,949	$194,220	-$567,293	$10,855,263	14.4%
Other	$257	-$8,568	$361,958	-$7,884	$38,652	$11,093	$1,192,809	-$2,850	-$29,851	$1,555,616	2.1%
Poverty-Level Pregnant Women	$2,258,178	$132,301	-$759,673	-$36,997	$10,073	$224,517	-$1,041,019	$635	-$17,077	$770,939	1.0%
Medicare Cost Share	$107	$12,651	$226,267	-$39,317	$885	$193,899	$18,449	$2,440	$28,496	$443,878	0.6%
General Assistance	$5,239	$10,246	$170,264	-$504	-$1,486	$98,782	$277,736	-$1,054	-$183,079	$376,143	0.5%
Medically Needy	-$18,710	-$34,942	-$47,558	-$87,536	-$68,229	-$3,757	-$422,435	-$6,298	-$34,101	-$723,565	-1.0%
Family Medical	$3,745,597	$1,070,700	-$1,388,310	-$262,388	-$265,568	$134,067	-$5,601,978	-$18,673	-$1,460,089	-$4,046,641	-5.4%
Total	**$15,375,561**	**$14,854,827**	**$12,172,612**	**$8,993,213**	**$7,586,629**	**$6,583,353**	**$5,466,371**	**$2,537,217**	**$1,602,384**	**$75,172,168**	
Service Area's % of total	20.5%	19.8%	16.2%	12.0%	10.1%	8.8%	7.3%	3.4%	2.1%		

Medicaid costs are driven by three primary factors. *These are the number of people who use services, the number of services each person uses, and the amount paid for those services. The table at the end of this summary summarizes the increases related to these 3 factors for the client groups we focused on.* ..... page 13

Factors Relating to Increases in the Number of Clients Receiving Services

Overall the number of people eligible for Medicaid-funded services increased by about 3.4% between 1998 and 2000. *Overall enrollment levels rose for most client groups–but especially for the 4 groups we focused on. Between 1998 and 2000, several legislative or agency actions helped increase the number of people enrolled in or eligible for Medicaid. Healthwave recruitment efforts helped identify at least 20,000 additional Medicaid-eligible children. In addition, more people came off the waiting list for Home and Community Based Services (HCBS), and a new HCBS waiver for children with severe and emotional disturbances was created. SRS also changed eligibility requirements so that less income would be counted when determining eligibility, and cash assistance was no longer tied to Medicaid eligibility.* ..... page 13

A change in State law caused fewer juvenile offenders to be treated in correctional facilities and more to be housed and treated in the community, where the treatment and therapy services they receive are covered by Medicaid. That contributed to a 42% increase in the number of Medicaid-eligible juvenile offenders. The federal Adoption and Safe Families Act also may have resulted in more families who adopted children with special needs eligible for Medicaid-covered services. Children receiving adoption support increased by 33%. ..... page 17

The percentage of clients who used medical services also generally increased. *More clients who go to the emergency room now have their costs covered under Medicaid because of a change in federal law requiring Medicaid to pay for emergency room visits if a "prudent layperson" would reasonably expect the absence of immediate medical attention to result in harm. Emergency room visits for the disabled, aged, and children went up 48% between 1998 and 2000. A significant increase in rates also apparently brought more client in through the "front door" of the medical system, and the "ripple" effect resulted in them receiving more diagnostic services. We also saw an overall increase in the percent of disabled and aged clients being hospitalized for such things as digestive and respiratory disorders and mental health treatments.* ..... page 17

Factors Relating to Increases in the Number of Services Each Client Received

We saw a number of important patterns. The most striking was a large increase in the number of home health services for each disabled and elderly person. The number of "units" of home health services grew by ..... page 21

almost 90 per disabled client between 1998 and 2000 (a 44% increase), and by almost 22 (40%) for aged clients. SRS staff had finished a review of home health services in January 2002, which showed that those services are built into a capitated waiver rate, and the HCBS provider should have been providing for and paying for them, rather than Medicaid being billed, and that some of the services they received under Medicaid were also paid for by the HCBS waiver.

We also saw increases in services per client for emergency room visits, for alcohol and drug therapies, and for cancer-fighting drugs. ..... page 22
Some children received more services per person because they were eligible for Medicaid for longer periods of time. A change in SRS policy effective January 1999 provided 12 months of continuous eligibility for children enrolled in Medicaid, regardless of change in family income. This change was designed to prevent "churning," where clients would drop in and out of eligibility.

Factors Relating to Increases in the Amount Paid per Service

Reimbursement rates for many physician and outpatient services were increased significantly in 1998 and 2000. ..... page 24
Rates for these two categories had been particularly low. For example, reimbursement rates for emergency room visits that had ranged from $10-$25 per visit before the increases were raised to $29-$133 per visit afterwards. SRS had projected that these higher rates would cost the State an additional $9.5 million a year and that the use of such services would stay fairly constant. Usage actually went up 18%, and actual spending per year increased by more than $14.5 million. We also noted reimbursement rates for inpatient hospital charges increased fairly consistently across the board.

In 2000, providers were billing much closer to the maximum amount allowed than they did in 1998. ..... page 25
The most striking example occurred in the area of rehabilitation services for mentally retarded or developmentally disabled people–primarily for targeted case management services. SRS raised the rate for that service from $30 to $40 during fiscal year 1997. In fiscal year 1998, even though the rate was $40 per hour, the average amount providers billed was slightly less than $30 per hour. By fiscal 2000, the average amount billed climbed to nearly $37, accounting for approximately $3 million in increased costs for this service alone. Providers also appear to have made major billing errors. In 1998, for example, one provider under-billed one procedure by about $4.3 million (submitting bills for $4 instead of $40).

For several different types of services, we saw a number of shifts to more expensive services being billed under Medicaid when a range of services was available. ..... page 25
For example, in fiscal year 2000, providers billed for more clients under the more expensive types of visits to physician' offices and emergency rooms. For home health services, we saw that both aged and disabled clients were more likely to receive services from a skilled nurse in 2000 than in 1998. In 1998, these clients received more services from home health aides–a service that is reimbursed at a lower rate than skilled nursing.

For children enrolled in Medicaid, many of the "medical" special education services schools provide (such as speech and occupational therapy) ..... page 28

are eligible for federal Medicaid cost-sharing. Between fiscal years 1998 and 2000, a category with a relatively high monthly reimbursement rates had a huge increase in disabled clients (+905). At the same time, all categories with lower reimbursement rates declined. In all we identified 470 disabled children whose services had been billed in a lower-paying category in fiscal year 1998, who were billed in the higher-paying Special Education category in 2000.

Question 1 Conclusion. *Costs have increased for regular medical services in the Medicaid Program because of a complex, interrelated web of factors involving the number of people enrolled in the Program, the amount of services they use, and the amount paid for those services. More clients who are disabled, aged, or children are enrolled in Medicaid now than in the past, and more of the clients enrolled are receiving services, including some costly inpatient services for disabled or aged clients. On average, each disabled or aged client uses many more services now than before—primarily in the areas of home health services, certain alcohol and drug therapies or treatments, and special education services. Also, children in State custody (particularly juvenile offenders) now receive many more Medicaid-covered residential and treatment services on average for behavioral, mental health, or alcohol and drug problems. Rates for many services have increased, but the decision to raise rates for physician and outpatient services has cost far more than originally anticipated, largely because of increases in the number of people using those services and increases in the number of services used per person. In some cases, we also saw a number of shifts to using more expensive services once rates were increased or new higher-cost services were offered.*

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Many of these increases have been the byproduct of legislative or agency decisions to broaden the safety net for low-income adults and children, but some decisions clearly appear to have had unexpected consequences. The next question presents options for controlling increases in Medicaid costs, which include identifying and monitoring expected outcomes of decisions relating to eligibility, coverage, and rates under the Medicaid Program.

Question 2: What Steps Can be Taken To Control Increasing Medicaid Costs?

We identified a number of options for controlling costs for medical services paid for by Medicaid. *The options we identified fell into 3 major categories: limiting enrollment by eliminating "optional" populations and reducing the length of time specific populations can keep their benefits, reducing or limiting coverage of non-mandatory services, and ensuring the State doesn't pay more than it should or needs to for services. Some of the options available to reduce Medicaid costs would represent a significant departure from the State's current approach to providing medical services to low-income individuals, and they may not represent the most desirable*

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health-care policy over the long term. However, in light of continually escalating medical costs and the State's fiscal constraints, we thought it was important to mention them.

OPTION: Reduce Enrollments in the Medicaid Program. *Federal rules require Medicaid coverage for poor people who are disabled, 65 or older, children, pregnant women, and family medical recipients. However, they give states flexibility in deciding which other populations may become eligible for Medicaid.* ..... page 30

Kansas could reduce the number of optional recipients covered. *Kansas currently covers several "optional" populations:*

- *certain people who are medically needy but who don't qualify for Medicaid because they exceed the set income guidelines*
- *children receiving adoption subsidy payments who aren't eligible for mandatory coverage under Title IV-E*
- *institutionalized children*
- *disabled adults who are unable to work and are receiving general assistance cash payments and some medical coverage while awaiting eligibility determination for federal SSI payments*

Providing medical coverage for these populations, including pharmacy costs, totaled at least $73.4 million in fiscal year 2001. ..... page 31

Kansas could make it tougher for "mandatory" populations to qualify for services. *Most of Kansas' eligibility guidelines are about as restrictive as they can be, but the State could take at least 2 additional steps to further restrict eligibility requirements. First, it could impose more restrictive limits on the amount of resources that certain population groups may have before they are eligible for Medicaid coverage. Second, Kansas could reduce the level of income that is "disregarded" or "protected" when considering a person's income level for Medicaid eligibility purposes.* ..... page 32

Kansas could reduce the length of time people are eligible for services. *Federal Medicaid rules require eligibility to last for a certain period of time after SRS determines a person is qualified to receive Medicaid benefits. Kansas exceeds that minimum by granting Medicaid children 12 months of continuous eligibility, rather than 6 months. SRS did this to make Medicaid parallel to HealthWave eligibility. Kansas also provides 12 months of medical coverage (versus 6 months required by Medicaid guidelines) for people no longer eligible for family medical coverage because their earnings are too high.* ..... page 32

OPTION: Reduce or Eliminate Coverage for Non-Mandatory Services. *Kansas must provide certain medical services for all people enrolled in Medicaid. These include inpatient and outpatient hospital, physician services, lab, home health, managed care, and Medicare buy-in. Many other services, including but not limited to pharmacy, dental care, and hospice aren't mandatory unless the recipients are children. SRS estimates the State's cost for providing these optional services to optional recipients is at least $93 million.* ..... page 33

OPTION: Pay Less for Services

SRS could expand the use of co-payments. *SRS currently requires a co-payment of $2 for most prescription drugs dispensed. Although co-payments can't be required for certain services, such as prenatal care, requiring Medicaid recipients to make small co-payments for other services would reduce expenditures and could discourage unnecessary services.* ..... page 34

SRS also could pay less for services if it reduced the errors in amounts paid to providers. *In April 2000, in its first payment accuracy review of the Medical Assistance Program, SRS projected that the number of claims paid inaccurately could be as high as $185 million. Many of the problems identified in the review related to documentation problems, but SRS didn't follow up to see whether they represented payment problems. Other problems not related to documentation included paying for unnecessary or noncovered services, not billing other insurance first, and keying or other errors. SRS could take a number of steps to strengthen its pre-payment and post-payment reviews of Medicaid claims and its investigations of questionable claims.* ..... page 34

SRS could reduce unnecessary services by systematically reviewing, analyzing, and acting on Medicaid claims paid data for both consumers and providers. *In reviewing this data, SRS needs to look for trends in diagnoses, in types of services provided, where and by whom services were provided, and the dates and amounts paid. In addition, SRS could develop an aggressive "utilization management" program for people with extensive medical needs, many of them elderly or disabled. Very few aged and only about half of disabled people—the most expensive clients–are in managed care. Such a program would ensure that the services being delivered are appropriate and necessary, that duplicate services are eliminated, and that costs are being controlled.* ..... page 34

SRS also could ensure that services are being provided by the most cost-effective providers. *In a recent review of home health services, SRS found that 83% of skilled nursing visits–a service for which Kansas Medicaid paid $16 million in fiscal year 2000–could have been provided by a person with less formal training. That study estimated Medicaid costs would have been 25%-33% lower in this area ($4-5 million less) if the service had been performed by the lowest-level qualified provider. In this same area, SRS should take steps to ensure that the State isn't double paying for services. The study found the State may be paying the cost of home health medication management services under both the waiver programs and under regular Medicaid.* ..... page 36

Lastly, to ensure that the State pays less for medical services, SRS should ensure that State agencies and contractors use all possible current spending to match federal dollars. *Increases in Medicaid spending can mean that the State is doing a better job of maximizing federal funding for services the State must provide. For* ..... page 37

example, beginning in 1995, SRS policies made it easier for schools to bill Medicaid for medical-related special education services. Many districts had been paying for these services anyway, but not submitting them to Medicaid and receiving the federal match. School districts are paying the "local" or "State" share of the funding for these services, so the State's costs don't increase. There may be other opportunities to claim federal matching moneys. We couldn't look at this issue in-depth during this audit, but SRS should ensure that State agencies and contractors use all possible current spending to match federal dollars.

Question 2 Conclusion. *As noted earlier, medical service costs under Medicaid have increased because of a combination of factors related to the number of people enrolled, the number of services they receive, and the amount paid per service. Adjusting any one of these factors can have a significant impact on the Program's costs. Given the State's budget woes and its finite resources, difficult policy decisions may have to be made in the short-term about who can receive Medicaid services, and which services are covered. However, SRS officials also can and should take a number of administrative actions to ensure that the Program doesn't pay more than it should—or than the Legislature or SRS intended—for medical assistance services. Given the huge dollars involved and the complexity of the Program, it's incumbent on both the Legislature and SRS to provide sufficient resources to ensure that trends in costs and usage are systematically and aggressively monitored, analyzed, reported on, and acted on.*

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Question 2 Recommendations. *If the Medicaid Program must be cut significantly because of shortfalls in the State's budget, the appropriate legislative committees should consider the options present in this report for reducing enrollment in the Program. These options include reducing the number of optional recipients covered, and reducing or eliminating coverage for non-mandatory services.*

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SRS also should consider taking actions discussed in this report, including

- *reducing enrollments by imposing limits on resources for some groups of clients, reducing "disregarded" or "protected" income, or reducing the length of time people are eligible to federal minimums*
- *paying less for services by expanding co-payments, reducing errors in payments to providers, analyzing and acting on data about services clients are getting, and ensuring services are provided by the most cost-effective providers*

Lastly, SRS should ensure that State agencies and contractors use all possible current spending to match federal dollars.

Increase in Services for Disabled and Aged Clients Fiscal Years 1998 To 2000				
Type of Medicaid Client	**Type of Service Received, and Increase in Expenditures 1998-2000**	**Change in # of clients getting this service**	**Change in average # of units of service per client per year**	**Change in average cost per unit of service**
DISABLED PEOPLE UNDER 65 *Total Increases 1998-2000:* • *$36.2 million increase in expenditures* • *cost $630 more / client (to $5,038 total)* • *5% increase in number of enrolled clients*	**Rehabilitation Services** **$4.7 million more** *35.2%*	**1,337 more clients** *22.4%*	**9.3 fewer units of service** *-12.6%*	**$8 more per unit of service** 26.4%
	Physician Services **$8.6 million more** *49.9%*	**2,565 more clients** *8.4%*	**3.2 more units of service** *8.4%*	**$4 more per unit of service** 27.6%
	Home Health **$6.2 million more** *40.2%*	**31 fewer clients** *-1.2%*	**89 more units of service** *43.6%*	**$0.34 less per unit of service** -1.2%
	Early Intervention **$2.9 million more** *25.2%*	**125 more clients** *2.5%*	**6.3 more units of service** *59.5%*	**$50 less per unit of service** -23.4%
	Outpatient **$3.5 million more** *57.2%*	**3,748 more clients** *20.4%*	**.8 fewer units of service** *-4.6%*	**$7 more per unit of service** 36.9%
	Inpatient **$5.7 million more** *7.3%*	**904 more clients** *13.0%*	**No change** *-0.3%*	**$325 less per hospital stay** -4.7%
	Mental Health **$3.2 million more** *12.7%*	**654 more clients** *7.1%*	**15.4 fewer units of service** *-8.7%*	**$2 more per unit of service** 15.3%
AGED OVER 65 *Total Increases 1998-2000:* • *$12.3 million increase in expenditures* • *cost $813 more per client* • *0.2% increase in enrolled clients*	**Home Health** **$3.5 million more** *73.1%*	**377 more clients** *22.3%*	**21.5 more units of service** *39.5%*	**$0.77 more per unit of service** 1.5%
	Inpatient Hospital **$5.2 million more** *24.3%*	**612 more clients** *18.4%*	**No change** *-0.2%*	**$258 more per hospital stay** 5.2%

Increase in Services for Children in State Custody and Poverty-Level Children Fiscal Years 1998 to 2000				
Type of Medicaid Client	**Type of Service Received, and Increase in Expenditures 1998-2000**	**Change in # of clients getting this service**	**Change in average # of units of service per client per year**	**Change in average cost per unit of service**
CHILDREN IN STATE CUSTODY *Total Increases 1998-2000:* • *$10.9 million increase in expenditures* • *cost $832 more per client* • *15.4% increase in enrolled clients*	**Rehabilitation Services $7.9 million more** *184.3%*	**1,117 more clients** *152.4%*	**1.4 fewer units of service** *-1.2%*	**$7 more per unit of service** 14.1%
POVERTY-LEVEL CHILDREN *Total Increases 1998-2000:* • *$17.5 million increase in expenditures* • *cost $32 less per client* • *34% increase in enrolled clients*	**Managed Care $9.3 million more** *139.5%*	**27,625 more clients** *46.8%*	**1 month longer stay** in the capitated managed care program *18.7%*	**$3 more per monthly payment** for capitated managed care 4.0%
	Physician Services $2.9 million more *37.6%*	**9,202 more clients** *23.2%*	**.5 fewer units of service** *-4.4%*	**$3 more per unit of service** 16.8%
	Early Intervention $3.6 million more *55.1%*	**1,392 more clients** *30.2%*	**2.4 more units of service** *30.2%*	**$15.38 less per unit of service** -8.5%

One point to keep in mind in reviewing this chart: the "units" of service provided are in various increments- they may be for services that are provided in minutes, hours, days, or months, or for the entire service (such as a hospital stay). Also, some costs and services went down, offsetting increases in other costs and services.

This audit was conducted by Laurel Murdie, Allan Foster, Lisa Hoopes, and Jill Shelley. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Murdie at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.