# PERFORMANCE AUDIT REPORT

## Medicaid Cost Containment: Controlling Costs of Long-Term Care

# *Executive Summary*

## *with Conclusions and Recommendations*

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

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# *Legislative Post Audit Committee*
# *Legislative Division of Post Audit*

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*Legislature of Kansas*

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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 Long-Term Care*.

The report also contains appendices explaining how nursing home rates are set, showing total expenditures for each of the 6 home and community-based service waivers, and listing SRS responses to related recommendations we made during an earlier audit.

This report includes several recommendations for the Department of Social and Rehabilitation Services, the Department on Aging, and the Legislature. We would be happy to discuss these recommendations or any other items in the report with you at your convenience.

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

If you would like a copy of the full audit report, please call our office and we will send you one right away.

Barbara J. Hinton
Legislative Post Auditor

# EXECUTIVE SUMMARY

**LEGISLATIVE DIVISION OF POST AUDIT**

## *Overview of Medicaid Funded Long-Term Care in Kansas*

**Medicaid long-term care includes health-related services, personal care, social services, and individual supports, but not traditional medical services.** *To receive services, an applicant must qualify both financially and functionally. Any person eligible for care must be given the choice of receiving that care in an institution or through community-based programs.*

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*Total Medicaid spending in fiscal year 2001 was nearly $1.5 billion–a $560 million increase from fiscal year 1998. Long-term care accounted for 29% of that increase. Most of the increase for long-term care was for "waiver" services provided in the home or community.*

## *Question 1: Why Have Long-Term Care Costs Increased?*

**Medicaid spending for long-term care increased $157 million from fiscal year 1998 to fiscal year 2001.** *Nursing facility costs accounted for almost $47 million of the increase, despite a 7% decline in the average number of people in nursing facilities. The remaining $110 million cost increase was caused by increases for long-term care services in the community.*

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**All of the increase in spending for nursing facilities can be attributed to increases in Medicaid reimbursement rates, because the number of people served in these facilities declined.** *The average daily rate used to provide reimbursement to most nursing facilities increased by $18, or 26%, with most of the increase reflecting increased pay for direct care staff. Nursing facilities are reimbursed a daily rate per patient based on actual costs incurred for administration, property, room and board, and health care. For fiscal year 2003, costs are likely to increase by at least $11 million. Despite this anticipated increase, Kansas may still rank in the bottom quarter of the states in average nursing facility rates.*

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**Much of the increase in spending for community-based long-term care services can be attributed to more people getting services.** *The number of people getting home and community-based services by grew about 47%, or nearly 5,100 people, between fiscal years 1998 and 2001. We estimated this accounted for about $80.5 million of the increase in spending. The biggest increases in numbers of consumers were in the frail elderly and physically disabled groups. It's difficult to definitively say why so many more people are getting these services; these are among the likely reasons:*

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- **the "woodwork" effect:** *Many people won't seek long-term care if the only setting for that care is in an institution, but they'll "come out of the woodwork" if services are available in the community. (The estimated impact of this phenomenon is unknown.)*

- **SRS changed financial eligibility requirements for waivers in 1997, making it easier for adults to qualify for services.** *The changes allow a single person with no dependents to keep about $700 a month; formerly that amount had been about $500 a month. (The estimated impact of this change is unknown.)*

- **Long-term care institutions closed, causing people with extensive developmental disabilities to seek services in the community.** *Winfield State Hospital began closing in 1996 and closed completely in January 1998. Five intermediate care facilities for the mentally retarded closed between 1999 and 2001. (Estimated impact: 250 former Winfield State Hospital residents were added to the developmental disability waiver and 228 intermediate care facility beds were closed.)*

- **The Legislature appropriated additional moneys, which allowed agencies to provide community-based services to more people.** *Generally, this money could be used to provide more services to people already receiving some services, to allow more people to receive services, or a combination. (Estimated impact: $5 million in additional appropriations in fiscal year 2000 and $7.5 million in additional appropriations in fiscal year 2001 for the developmental disabilities waiver; $10 million in additional appropriations in fiscal year 2000 and $3.2 million in additional appropriations in fiscal year 2001 for the frail elderly waiver.)*

- **A new program to prevent hospitalization of children with severe emotional disturbances started in fiscal year 1998 and grew rapidly.** *Most of the services children receive under this program are regular medical services (e.g. therapy) provided through community mental health centers. (Estimated impact: 1,400 more waiver consumers.)*

**Factors that had a smaller impact on the increase in spending for community-based long-term care services include increases in reimbursement rates and in the number of services people received.** *Large increases in spending for day and residential services for people with developmental disabilities reflect 6% rate increases. Overall, we estimate that increases in rates accounted for at least $8 million in increased costs.*

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*Increases in the number of services per client for the largest waiver services cost Medicaid at least an estimated $10 million. Of that increase, residential and day services for developmentally disabled clients accounted for $8 million, and increases in the number of health care*

*attendant services for frail elderly people accounted for another $2 million. Agency officials said people got more services because they have greater needs, and some data appear to support that. Officials also said fewer friends and family members are available to provide unpaid support.*

**Conclusion.** *Medicaid long-term care costs have increased by 33% just from fiscal year 1998 to fiscal year 2001, from about $472 million to $629 million. Services provided in the community under Medicaid waiver programs account for almost 70% of that increase. The main factor driving cost increases in community-based services was a 47% increase in the number of people getting services–nearly 5,100 additional beneficiaries. Part of that increase in people was due to SRS' efforts to keep children out of mental hospitals, but the reasons why more disabled and elderly people sought community services are not clear. The remainder of the increase in community-based service spending was the combined effect of beneficiaries getting more services, on average, and increased rates being paid for some of those services.*

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*Services provided in nursing facilities accounted for the remaining 30% of the overall increase in Medicaid long-term care costs. That portion of the increase was caused entirely by increases in the reimbursement rates paid to facilities. (The number of people served in those facilities actually declined by about 17%.) The main driver behind the reimbursement rate increases was health care costs incurred by the facilities. Those costs, which accounted for about $18.50 of the $27.71 increase in maximum daily reimbursement rates, include such things as nursing and therapist salaries and resident transportation costs. Medicaid costs for providing nursing facility care are likely to increase by about $11 million in fiscal year 2003, but could have increased as much as $19 million if the 2002 Legislature had not reduced the Medicaid nursing facility budget by $8.9 million.*

## *Question 2: Are SRS and the Department on Aging Doing All They Can To Control Long-Term Care Costs?*

**SRS and the Department on Aging could do more to limit the number of people eligible for long-term care services and to limit what Kansas pays for such services.** *The cost containment options we identified fell into 2 major categories: limit the number of people eligible for Medicaid-funded long-term care services, and limit the amount the State pays for long-term care services. Some of the options may not represent the most desirable health-care policy over the long term. However, in light of continually increasing State spending for long-term care and the State's fiscal constraints, we thought it was important to identify them.*

**OPTION: Limiting the Number of People Eligible for Medicaid-Funded Long-Term Care Services.** *The number of consumers who are eligible could be limited in at least 2 ways: by tightening functional eligibility criteria and by tightening financial eligibility criteria.*

**Raise the minimum score needed for people to functionally qualify for Medicaid.** *(No legislation is required for this option.) Most of the increase in community-based long-term care costs was caused by more people qualifying for and getting waiver services. Raising the minimum score would mean fewer people would qualify, thus reducing Medicaid spending. The Department on Aging has contracted with the University of Kansas to study where the threshold score should be set for nursing facilities and the Frail Elderly waiver. The results are due in October 2002.* ............... page 17

**Tighten financial eligibility criteria.** *(No legislation is required for this option.) This could happen in several ways: reduce the amount of assets applicants are allowed to legally shelter, be more aggressive in identifying people who have transferred assets or created trusts, and 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.* ............... page 18

**OPTION: Paying Less for Long-Term Care.** *Kansas could limit how much it pays for long-term care services in several ways, including the following:*

**Continue to use waiting lists–capping the number of people who can get long-term care waiver services each year.** *(No legislation required for this option.) States can limit the number of people who get long-term care services in the community. Anyone who is eligible for long-term care services and who is placed on a waiting list still could choose to get services in a nursing facility or appropriate institutional setting. Kansas already has waiting lists for 4 waiver programs.* ............... page 21

**Use spending caps per consumer to deny community services when institutional services would cost Medicaid less.** *(No legislation required for this option.) Federal Medicaid laws allow states to set a maximum dollar limit on the benefits a waiver consumer can get. Kansas could, for example, deny community services when institutional services would cost less. If this limit had been in place for 2001, Kansas would have spent $9 million less for 924 people whose community-based long-term care services costs exceeded average institutional costs.* ............... page 22

**Reduce unnecessary services by analyzing and using key data to help manage program costs.** *(No legislation required for this option.) Although both Departments have some good processes in place to ensure that Medicaid pays only for necessary services, agency officials need to analyze key data available to them. For example, the Departments should determine which services are being used most often and why, and should track assessment scores to determine whether consumer needs are increasing over time. The Departments could use the key data to better manage program costs.* ............... page 22

**Strengthen efforts to identify and recoup amounts paid in error.** *(No legislation required for this option.) In 1999 and 2001, SRS conducted* ............... page 23

*systemwide reviews of payments to Medicaid providers to assess the appropriateness and accuracy of those payments. In the latest review, if just the non-documentation errors SRS found are projected to the entire payment population, they could total as much as $19.6 million on an annual basis. During our testwork, we also identified about $186,000 in potentially inappropriate payments made to long-term care providers, including paying providers twice for nursing home and residential days, as well as paying for services that should have been provided as part of other services, and paying for service after a consumer's death.*

*Although SRS and the Department on Aging have a number of processes in place to try to control inappropriate Medicaid payments, they could do at least 2 things to improve identification and recoupment of erroneous payments. First, more resources could be committed to the special Surveillance and Utilization Review team that focuses on community-based long-term care services. Currently this team consists of only 3 people. Secondly, to make the results of payment accuracy reviews more reliable, the reviews should include a sample of claims for the entire fiscal year.*

**Take steps to ensure that people pay for their own long-term care–provide financial incentives for long-term care insurance.** *(Legislation would be required.) About half of Kansans rely on Medicaid to pay for their long-term care. Kansas should consider offering a tax credit or deduction that is separate from currently available itemized deductions. In addition, because low-income seniors often can't afford the cost of long-term care insurance, making that insurance more affordable could still reduce the State's costs.*

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**Provide better case management to ensure that services are provided in the most cost-effective manner.** *(No legislation required.) For the 3 largest waiver programs, developmental disability, frail elderly, and physical disability, Kansas spent $288 million in 2001. In addition to waiver services, generally these consumers also have access to regular Medicaid-paid medical services. Many have extensive health care needs, making it important to ensure that services are provided by the most cost-effective provider–whether a waiver provider or a medical service provider. According to SRS officials, in an attempt to control spending for medical services, Kansas will begin to use nurses to help manage the care for consumers with extensive needs.*

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**Freeze nursing facility reimbursement rates or delay rate increases.** *(Legislation is not likely required for this option.) As noted in Question 1, Department on Aging officials limited nursing facility reimbursement rate increases for 2003, after the 2002 Legislature reduced the Medicaid nursing facility budget by $8.9 million. According to Department on Aging officials, 2003 costs could have increased as much as $19 million if rates paid to nursing facilities in 2002 hadn't been used to set reimbursement rates for the first half of 2003.*

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**Ensure that State and local agencies are claiming all the federal matching moneys they can.** *(Legislation isn't required for this option.) For example, as part of SRS' mental health initiative in 2000, community mental health centers started using other State funds they already received–to provide the State's portion of Medicaid reimbursements. We couldn't look at this issue in-depth during this audit, but SRS and the Department on Aging should ensure that State agencies and contractors use all possible current spending to match federal dollars.* ............... page 27

**Question 2 Conclusion**. *Because Medicaid costs consume a large portion of the State's budget and those costs are growing at a rapid rate, it's important that they be closely monitored and controlled, particularly in light of the State's recent fiscal problems. SRS and the Department on Aging already have established a number of good processes to manage costs and to help identify payments that shouldn't be made. There are still a number of things the Departments could do to control program costs, such as analyzing available data to identify trends in the use of services that might indicate clients are overusing certain services, or strengthening efforts to identify and recoup payments made in error. Unfortunately, the options that are most likely to have a large impact on costs don't present easy choices for policy makers. They involve limiting the number of people who are eligible to receive services so that only the most needy can have Medicaid pay for their care, and limiting the amount or types of services eligible beneficiaries can receive. Any of these options will mean that some people will be forced to pay for more of their own services or will receive a reduced level of service*. ............... page 28

**Question 2 Recommendations.** *We recommend that SRS and the Department on Aging collaborate on a plan listing options for restricting eligibility and seek input from legislative committees on that plan. We also recommend that SRS officials strengthen their efforts to ensure that applicants haven't transferred assets or created trusts within 3 to 5 years of applying for Medicaid. In addition, we recommend that SRS and the Department on Aging assign staff to review factors that affect the numbers and types of services Medicaid consumers use, determine whether fewer needs are being met by unpaid caregivers, and determine whether there are changes in assessed needs. We recommend SRS continue its payment accuracy reviews, and the Department should also coordinate intensive health-care management of consumers with chronic conditions with case management for community-based long-term care services. Finally, the Legislature should review the findings of the Kansas Long-Term Care Task Force on long-term care insurance.* ............... page 28

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*The Department on Aging officials generally concurred with the recommendations addressed to their agency. With the exception of 1 recommendation, SRS officials concurred with the recommendations. Officials believe its current process of relying on financial confirmation provided by applicants and current computer cross-matches has been effective to ensure applicants' eligibility.*

This audit was conducted by Laurel Murdie, Scott Frank, Lisa Hoopes, Carol Porter, and Jill Shelley. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Laurel 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.