PERFORMANCE AUDIT REPORT

Medicaid Cost Containment: Controlling Costs of Medical Services

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

02-09

Legislative Post Audit Committee
Legislative Division of Post Audit

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March 18, 2002

To: Members, Legislative Post Audit Committee

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Senator Derek Schmidt	Representative Dean Newton
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This report contains the findings, conclusions, and recommendations 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.

We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

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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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.* ..... 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 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 ..... page 21

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. *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.*

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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. *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.*

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In 2000, providers were billing much closer to the maximum amount allowed than they did in 1998. *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).*

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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. *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.*

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

Question 1 Conclusion ..... page 29

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 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.* ..... page 30

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. ..... page 31
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.

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 ..... page 35

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.*

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.*

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 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.*

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.

Medicaid Cost Containment: Controlling Costs of Medical Services

The Kansas Medicaid Program provides medical assistance for about 270,000 Kansans who have very limited income and resources. This program, established in Title XIX of the federal Social Security Act, is funded jointly with federal and State moneys. Currently, the federal government pays about 60% of the costs of health care and the State pays the remaining 40%.

Department of Social and Rehabilitation Services reports show that total Medicaid expenditures have increased by about $1 billion in the past 10 years, from $481 million in fiscal year 1991 to $1.5 billion in 2001. Program spending increased steadily from 1991 to 1998, but began escalating rapidly in 1999.

These increases have prompted legislative concern that Kansas isn't doing all it could to contain Medicaid expenditures. For this audit, the concerns focused on why medical costs paid for by Medicaid had increased so much in recent years.

This audit answers the following questions:

1. **Why has the cost of medical services in the State's Medicaid program increased?**

2. **What steps can be taken to control increasing Medicaid costs?**

For reporting purposes, we recast the single question shown in the audit scope statement into the 2 questions listed above. That scope statement, approved by the Legislative Post Audit Committee, is included in Appendix A.

To answer these questions, we obtained data from the Medicaid Management Information System for claims paid through November 2001 for services provided in fiscal years 1998 and 2000. To help identify where and why costs were increasing, we reviewed changes in the number and types of people using medical services, the frequency with which they used various types of services, the reimbursement rates for those services, and SRS' policies regarding those services. For all our analyses, we used the "allowed" amount paid.

We also looked for policies that would have allowed more people to become eligible for Medicaid services, or to receive more services than in the past. In addition, we interviewed SRS officials about why changes had been made. Finally, we reviewed relevant literature, contacted other states, and interviewed knowledgeable people to identify things SRS could do to control Medicaid costs.

In conducting this audit, we followed the applicable government auditing standards set forth by the U.S. General Accounting Office, except that, because of time constraints, we didn't test the data contained in the Medicaid Management Information System (MMIS). However, we concluded that the computer-processed data were reliable enough for the purposes of this audit, for the following reasons: The MMIS is included in the Statewide audit, and our review of the findings from the most recent audit identified no significant problems. In addition, the recently completed contracted performance audit: *Medicaid Cost Containment: Controlling Fraud and Abuse* included testing of a limited sample of claims from the MMIS, and again, identified no significant problems. Lastly, during this audit, when we found claims that looked unusual, our follow-up work with agency officials identified reasonable explanations for the claims. Our findings begin on page 9, following a brief overview.

Created in 1965, Medicaid is a joint state and federal program that provides long-term care and health care coverage for the needy. Medicaid is administered by the states, with funding matched by the federal government. In Kansas, the matching rate is approximately 60%, which means the State pays 40% of all joint expenditures. (In contrast, Medicare is a federally funded and administered health insurance program for the elderly, regardless of income.)

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 set the eligibility standards; determine the type, amount, duration and scope of services; set payment reimbursement rates; and administer the overall program. However, state Medicaid programs generally must provide 3 types of critical health protection:

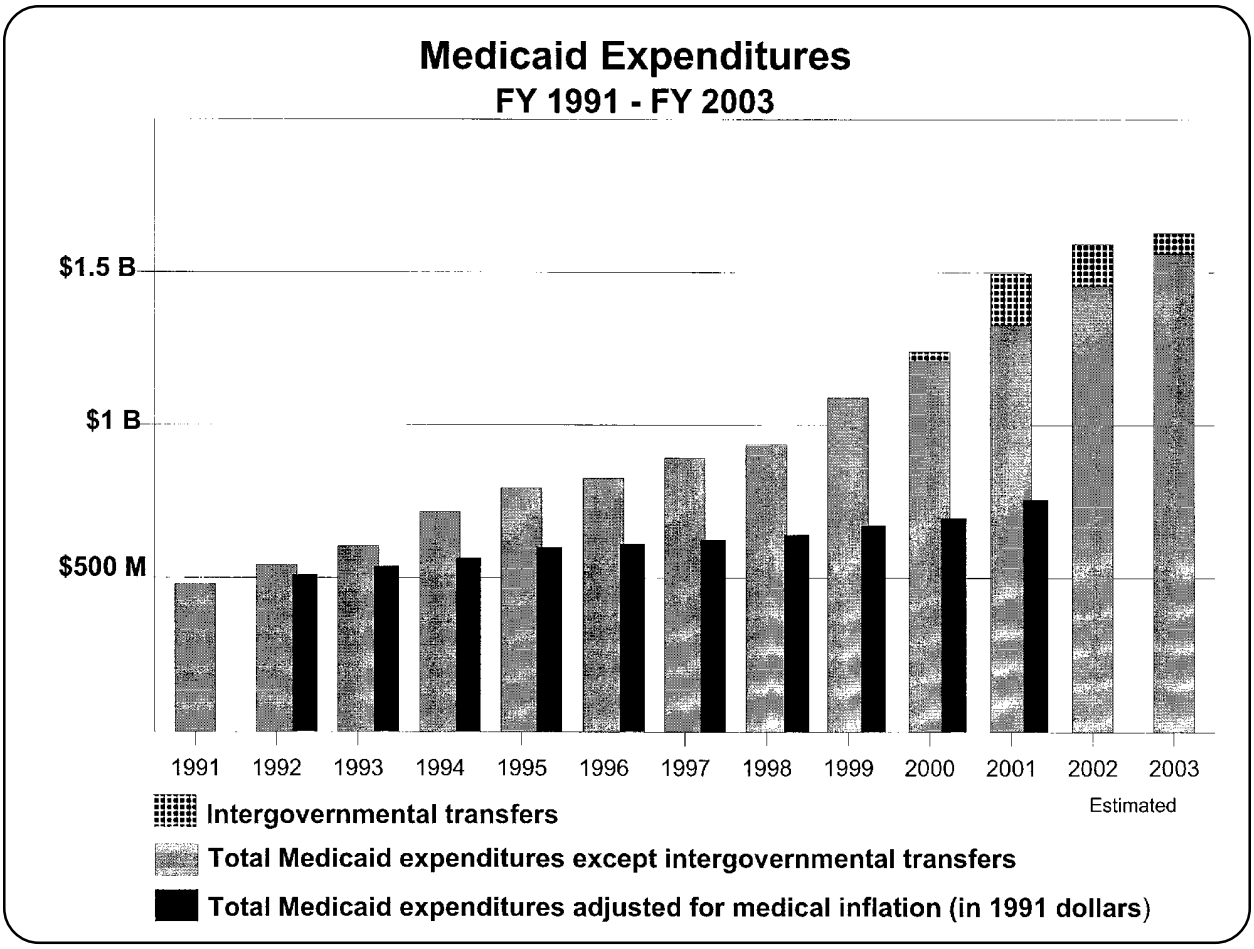
- **health care** for low-income families with children and people with disabilities
- **long-term care** for elderly and disabled people
- **supplemental coverage for low-income Medicare beneficiaries** to pay for services not covered by Medicare, as well as for Medicare premiums, deductibles, and co-payments

Federal regulations define mandatory and optional categories for the people covered—and the services provided—under the Medicaid Program. The 60% federal match is provided at the same level, whether the person served or the service provided is mandatory or optional.

There are, however, some low-income people who Medicaid doesn't cover at all. For example, adults who aren't elderly, or who don't have a child or a disability, aren't eligible for Medicaid no matter how poor they are. If a state includes any of those people in its medical assistance program, as Kansas does, it receives no federal match for their care.

Increases in Medicaid Expenditures Had Slowed Somewhat In the Mid-1990s, But Began To Increase Sharply Again After 1998

SRS reports show that overall Medicaid spending in Kansas has increased by more than $1 billion in the past 10 years, from $481 million in fiscal year 1991 to $1.5 billion in 2001, or about 12 % per year. As the chart on page 4 shows, although expenditures have been on a steady rise, they began climbing more steeply in 1999, and officials expect them to continue to climb for the next several years, approximately 10% in fiscal year 2002 and 7% in 2003.



Since 1998, Medicaid expenditures have increased in almost every category of covered service. SRS generally reports those expenditures in 3 categories: long-term care, regular medical, and non-client-specific.

- **Long-term care services.** This category refers to costs for residential and community-based services that are provided in adult care homes and through home and community based service waiver programs (there are 7 such programs, the largest of which serve the frail elderly and the physically disabled).

- **Regular medical services.** This category refers to medical services provided by doctors, hospitals, mental health centers, laboratories, and the like, as well as medical supplies and transportation. The medical costs for people living in nursing homes or group homes are included in this category. Pharmacy also is included in this category. Pharmacy refers to prescription drugs provided to all Medicaid clients, regardless if they live at home or in long-term care facilities.

- **Non-client-specific services.** This category includes intergovernmental transfer funds (89% of the total in 2001), payments to hospitals that serve a disproportionate share of indigent people (4%), State match for mental health centers in order to draw down federal funding (6%), and adjustments to payments previously made to providers (1%). Under the

Intergovernmental Transfer Program, the State gets to draw down and keep federal dollars, with the amount based on the difference between what the State paid to nursing facilities under Medicaid and what it would have paid those facilities if it had reimbursed them at the higher Medicare rate. The State pays long-term-care providers $2,500 per quarter for participating in this program and reimburses the State General Fund for the match it provided to draw down these funds. Under the 2000 legislation that set up the intergovernmental transfer program, the additional moneys to the State are used 3 ways: 70% goes to the Senior Services Trust Fund, 25% is used for Medicaid State match, and 5% goes to a loan and grant fund for long-term care.

The table on the next page details the change in expenditures for each of these 3 categories from fiscal year 1998 through 2001. As the table shows,

- **intergovernmental transfer moneys, most of which actually come back to the State, are included in total spending reported for Medicaid.** As noted above, most of the moneys the State gets to keep are held in trust, the income to be used to aid seniors.

- **drug rebates—which effectively reduce the cost of the pharmacy program—aren't deducted from the costs reported for prescription drugs.** Because these rebates are deposited into the Medicaid Fee Fund, SRS doesn't report their offsetting influence when it reports pharmacy expenditures. Drug rebates totaled about $36 million in fiscal year 2001, or about 19% of pharmacy expenditures that year. The State keeps about 40% – the same share as it pays for claims – or about $14 million in fiscal year 2001.

- **this audit addresses expenditures for only some of the "regular medical" services.** The group we looked at accounted for about 25% of the increase in total Medicaid expenditures between 1998 and 2001 (or about 35% if the intergovernmental transfer is excluded from the total). Although long-term residential and community-based care services aren't covered in this audit, they 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. However, updated information about cost controls in the prescription drug category is provided in the box on page 7.)

Changes in Medicaid Expenditures by Category

Fiscal Years 1998 to 2001

	Spent in 1998	Spent in 2001	Percentage change, '98 to '01	Change in expenditures, % of total increase, '98 to '01
Long-Term Care				
Adult Care Homes	$284,343,252	$327,605,291	15%	$161,212,635
HCBS	$177,321,782	$295,272,378	67%	
subtotal	**$461,665,034**	**$622,877,669**	**35%**	28.8%
Regular Medical				
Services Covered in This Audit:				
Inpatient Hospital	$137,983,072	$147,109,482	7%	
Physician Services	$47,612,127	$58,517,985	23%	
Managed Care	$15,540,069	$57,270,717	269%	
Home Health Services	$23,226,267	$39,306,831	69%	$137,614,047
CMHC	$24,379,307	$36,487,774	50%	
Rehabilitation	$14,662,662	$34,271,244	134%	24.6%
Early Intervention	$7,292,854	$24,357,665	234%	
Outpatient Hospital	$13,134,568	$20,512,987	56%	
Transportation	$4,329,568	$7,939,856	83%	
subtotal	**$288,160,494**	**$425,774,541**	**48%**	
Pharmacy	$116,165,505	$188,582,079	62%	$72,416,574 12.9%
Medicare Buy-In	$25,312,043	$28,123,374	11%	
Dental Services	$8,936,633	$11,521,459	29%	
Supplies	$8,914,840	$10,133,285	14%	
Health Centers	$7,389,001	$8,109,226	10%	
Vision	$2,032,016	$2,832,092	39%	
Other (FE TCM)	$2,325,598	$2,599,684	12%	
Lab/Radiology	$2,224,438	$2,557,859	15%	
ARNP	$1,877,898	$2,380,881	27%	
Local Health Dept.	$1,463,869	$1,288,617	-12%	$81,950,713
Psychology Services	$970,696	$1,117,427	15%	
Ambulatory Surgery Center	$473,704	$711,877	50%	1.7%
Hearing Services	$313,599	$413,406	32%	
HIPPS	$426,038	$350,156	-18%	
QMB Services	$40,703	$117,364	188%	
Podiatrist	$15,318	$10,806	-29%	
Chiropractor	$1,068	$207	-81%	
Non-CMHC Partial Hospital	$16,119	$0	-100%	
subtotal	**$178,899,086**	**$260,849,799**	**46%**	
Subtotal, all regular medical	**$467,059,580**	**$686,624,340**	**47%**	$219,564,760 39.2%
Non-Client-Specific				
Intergovernmental Transfers	$0	$168,340,692	100%	$179,498,428
Other	$7,356,454	**$18,514,190**	152%	
subtotal	**$7,356,454**	**$186,854,882**	**2,440%**	32.0%
Grand Total	**$936,081,068**	**$1,496,356,891**	**60%**	**$560,275,823**

Policy Changes in the Pharmacy Program in Fiscal Year 2000 Were Projected To Save About $4 Million Annually

Three changes account for most of the calculated savings:

- instituting a uniform dispensing fee for pharmacists (savings estimated at $1.8 million)
- making it easier for long-term-care pharmacy providers to return medications that aren't used ($1.4 million)
- not allowing prescriptions to be refilled until 80% of the medication should have been used ($0.5 million)

Policies also were changed in 2000 in a number of areas to encourage services that are expected to prevent or postpone additional medical costs. For example, coverage was added for certain drugs to treat obesity after an in-house study showed that costs for obese Medicaid recipients were twice those of non-obese recipients.

Similarly, coverage was added for injections to relieve osteoarthritis in knees, which is expected to delay or prevent costly knee replacement surgery. Finally, reimbursement rates for flu and pneumonia vaccine were raised from $2.30 to $10 to encourage providers to promote these cost-effective services.

Lastly, drug rebate activities and collections continue to be enhanced. Medicaid laws require pharmaceutical manufacturers to offer rebates to states based on the volume of drugs purchased. States are responsible for billing the manufacturers and collecting the amounts due. Rebates have risen from $16.5 million in fiscal year 1997 (16.5 % of pharmacy expenditures) to $36 million in fiscal year 2001 (19.1% of expenditures).

SRS officials attribute this increase to automation of rebate information and more assertive efforts to collect moneys due from manufacturers. Drug rebates effectively reduce the cost of the pharmacy program, but because these moneys are deposited into the Medicaid Fee Fund, the Department doesn't report their offsetting influence when it reports pharmacy expenditures.

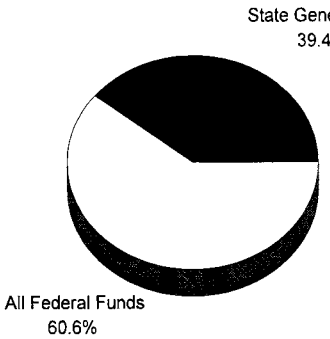
The Kansas Medicaid Program
AT A GLANCE

Authority: Originally created in 1965 by Title XIX of the federal Social Security Act, Medicaid provides health benefits coverage to eligible individuals.

Staffing: The Medicaid/Medical Policy Division is overseen by the Department of Social and Rehabilitation Services, Health Care Policy Section. The Division has 56 FTE, with an additional 23 FTE at its application processing clearinghouse, for a total of 79 FTE.

Budget: A joint federal and State program, Medicaid's medical services are funded 40% with State funding and matched by 60% federal moneys.

FY 2001 Funding Sources



Total Funding: $1,496,356,891

FY 2001 Expenditures

Service	Amount	% of Total
Adult Care Homes	$327,605,291	22%
Home & Community Based Services	295,272,378	20%
Pharmacy	188,582,079	13%
Inpatient Hospital	147,109,482	10%
Non-Client Specific Dollars	186,854,882	12%
Other Medical Services	350,932,779	23%
Total Expenses: $1,496,356,891		**100%**

Sources: SRS Fiscal section, FY 2001 Medical Assistance Report.

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

Three factors–the number of people getting services, the frequency with which they use services, and the amount paid per service—determine how much the State spends on its medical assistance program. We saw increases in all three factors when we looked at changes in spending between fiscal years 1998 and 2000. First, enrollment in Medicaid increased by about 3.4 % over the 2 years, and the percent of enrolled clients who actually used services increased as well. Most of the growth was for poverty-level children who were identified during outreach efforts for HealthWave, but there also was growth in the number of disabled people and children in State custody or receiving adoption support. Having more people enrolled resulted in more visits to physicians offices and emergency rooms, which in turn may have caused an increase in use of diagnostic procedures. Second, we saw increases in the amount of services used per person. This was most striking in the area of home health services, and SRS has already proposed a number of changes to better control use of these services. There were also large per-person increases for many alcohol and drugs treatment programs and behavior management programs, particularly by juvenile offenders. Third, legislatively approved increases in reimbursement rates for physician and outpatient services, as well as for managed care, have cost far more than projected, primarily because more people than anticipated are using those services. In addition, we found providers billing closer to the maximum amount allowed for services, as well as the use of more expensive services than before.

Our detailed findings begin on page 13, following a discussion of our general methodology, including information about the people and services we reviewed

In Conducting Our Review, We Focused on Claims Paid Through November 2001 for Medical Services Provided in Fiscal Years 1998 and 2000

Most discussions of Medicaid expenditures focus on the amounts paid in a given year, regardless of when the services being paid for actually were provided. (Medical providers have 12 months from the date of service to submit bills for payment, and another 12 months to make corrections or adjustments to those bills.)

In our analyses, however, we focused on claims paid through November 2001 for services provided in 1998 and in 2000. The reason: we wanted to address the impact that rate increases may have had on Program costs, and rate increases generally affect only those services provided after a certain date, not all payments made for such services after that date.

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 complete billing data were available at the time our audit was being conducted.

Relatively Few Services and Groups of Clients Accounted for Almost All the Increase in Regular Medical Costs Between 1998 and 2000

We analyzed 7.9 million individual claims paid for services provided in fiscal years 1998 and 2000. Each claim had information about the specific medical procedure performed, its cost, and the type of person receiving the service.

In all, 9 types of medical services provided in 1998 and 2000 accounted for much of the increase in non-pharmacy, regular medical costs. Our analysis showed that the increase in cost for these 9 services accounted for 90% of the total increase in costs for non-pharmacy regular medical services in the 2 years (some of the other services decreased in cost). That information is shown in the following table.

Change in Costs for Regular Medical Services (Excluding Pharmacy)
For Services Provided in Fiscal Years 1998 and 2000
(in millions)

Type of Service	FY 98 Costs	FY 00 Costs	Change from FY 98	
Managed Care	$ 18.2	$ 33.5	$ 15.4	84.6%
Rehabilitation	19.1	34.0	14.9	77.6
Physician Services	55.1	67.3	12.2	22.1
Home Health (medical only)	23.4	32.4	9.0	38.4
Early Intervention (mostly special ed.)	26.7	34.3	7.6	28.4
Outpatient Hospital	14.1	20.6	6.6	46.8
Inpatient Hospital	173.0	178.5	5.4	3.2
Transportation	4.4	7.0	2.5	57.4
Mental Health	38.0	39.6	1.6	4.2
SUBTOTAL	**$ 372.0**	**$ 447.2**	**$ 75.2**	**20.2%**
All Other Services	*$ 51.4*	*$ 59.2*	*$ 7.8*	*15.2%*
TOTAL	***$ 423.4***	***$ 506.4***	***$ 83.0***	***19.6%***

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information System (MMIS) claims data.

As the table shows, expenditures for these 9 types of services rose more than 20% in just 2 years. That increase ranged from 3.2% to more than 80%. Because these 9 services accounted for essentially all the increase in costs between 1998 and 2000, we focused our review of claims on these services.

In all, 4 types of Medicaid clients accounted for an amount exceeding the increase in the regular medical services we reviewed. In analyzing the claims data to see which types of Medicaid clients received regular medical services, we grouped SRS' 40 eligibility categories into broader categories. Definitions for these groups of clients are shown in the box below.

Definitions for Types of Clients Enrolled in Medicaid

- **Poverty-Level Children:** Children under 19 who aren't financially eligible for Supplemental Security Insurance (SSI) or the Family Medical Program (formerly Temporary Aid to Families or TAF). and whose income doesn't exceed 150% (infants) 133% (for ages 1 to 5) and 100% (for ages 6 to 18) of federal poverty level.
- **Poverty-Level Pregnant Women:** Pregnant women who aren't financially eligible for Supplemental Security Insurance (SSI) or the Family Medical Program (formerly Temporary Aid to Families or TAF) and whose income doesn't exceed 150% of federal poverty level.
- **Family Medical (formerly TAF):** Coverage for low-income families with dependent children.
- **Disabled < 65:** Adult or child recipients of SSI whose countable income doesn't exceed allowable limits. Adults must have a disability that prevents them from working. Children must have a disability that results in severe functional limitations.
- **Aged > 65:** Recipients of federal SSI payments who are 65 or older and whose countable income doesn't exceed allowable limits. Some of these individuals are covered by Medicaid waivers, which are designed to save money by keeping them out of more expensive institutional care.
- **Children in State Custody:** All foster care children who are in the custody of SRS, recipients of adoption subsidy, and juvenile offenders in the custody of the Juvenile Justice Authority.
- **Medicare Cost Sharing:** Low-income Medicare beneficiaries are eligible to have Medicaid pay all or some portion of their Medicare premiums, deductibles, and co-payments.
- **General Assistance:** Low-income disabled adults who are unable to work for at least 12 months, have limited resources, and are waiting a decision on SSI eligibility.
- **Medically Needy:** Children and people who are aged, disabled, or pregnant who have very high medical expenses but whose income is otherwise above allowable limits.
- **Other:** Includes data for people without a population code assigned, and refugees, people with tuberculosis, the working disabled, and people with breast/cervical cancer.

The table on the next page shows the **cost increases** for each type of service included in our sample, and each client group that got those services.

As the table shows, 4 groups of clients accounted for an amount exceeding the increase in costs for these services between 1998 and 2000:

- disabled people under age 65
- aged people 65 or older
- poverty-level children
- children in State custody

For disabled people, the table shows there were significant increases (noted with shading) in nearly every service area. For the 3 other groups, significant cost increases tended to be limited to 1 or 2 types of services.

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

Ultimately, 3 factors drive the amount the State spends on its medical assistance program:

- the number of people who use services
- the number of services each person uses
- the amount paid for those services

Increases in any of these factors will cause the amount the State pays for medical services to rise. In recent reports to the Legislature, SRS has pointed to all 3, citing increases in the number of low-income families and children using services, an increased use of services by disabled people, and higher costs for prescription drugs.

We analyzed the claims paid data for these factors for the population groups and services we focused on and found that the use of services per person grew faster than the population. The results are shown in the table on pages 14 and 15.

The sections that follow discuss the changes we saw in each of these areas, the reasons we could identify behind these changes, and, when possible, the impact these changes had on Medicaid costs.

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

In fiscal year 1998, nearly 259,000 people were determined to be eligible for medical assistance under the Medicaid Program. That number increased to nearly 268,000 in 2000.

Overall enrollment levels rose for most client groups—but especially for the 4 groups we focused on. Overall, the number of people enrolled in Medicaid increased by about 3.4 %. As the table below shows, however, most of that increase occurred within these 4 client groups. If it weren't for the significant drop in the number of enrollees in the Family Medical group because of welfare reform, the overall growth rate actually would have been about 11%.

Changes in Enrollment in Medicaid

Client Group	# Enrolled 1998	# Enrolled 2000	# Change 98-00	% Change 98-00
Poverty-Level Children	74,292	99,244	24,952	33.6%
Children in State Custody	10,263	11,843	1,580	15.4%
Disabled < 65	43,563	45,815	2,252	5.2%
Aged > 65	29,323	29,376	53	.2%
Family Medical (formerly TAF)	76,914	56,829	(20,085)	-26.1%
All Other Client Groups (detail in Appendix B)	24,591	24,613	22	0.1%
Total	**258,946**	**267,720**	**8,774**	**3.4%**

Source: LPA analysis of FY 1998 and 2000 Medicaid Management Information System (MMIS) beneficiary data.

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.

Between fiscal years 1998 and 2000, SRS took a number of actions that increased the number of people enrolled in Medicaid. Some of these actions were taken at the Legislature's specific direction, others were initiated by agency officials, and one was in response to federal mandates. As the following table shows, these changes significantly affected the 4 client groups primarily responsible for the large increases in costs:

Changes that Increased Enrollments from FY 1998 to 2000	Population Affected and Estimated Cost Impact
SRS's Outreach Efforts :	
• **SRS' Healthwave recruitment efforts helped identify many more poverty-level children who were eligible for Medicaid.** In trying to identify children eligible for Healthwave, SRS found more than 20,000 additional children that were eligible for Medicaid.	Poverty-level children **Estimated cost impact = $15.4 million**
• **More people coming off the waiting list for Home and Community Based Services (HCBS)**. Once a person is covered by the HCBS waiver, it's easier for them to qualify for Medicaid.	Disabled and Frail Elderly Clients **Estimated cost impact = $900,000**
• **A new HCBS waiver for children and adolescents with severe emotional disturbances (SED) was created** in 1997, but services weren't provided until early in calendar year 1998. The 1997 legislature appropriated $1 million for this children's mental health initiative.	Disabled Children **Estimated cost impact = $1.5 million**
Changes that Loosened Eligibility Requirements:	
• **Counting less of the applicant's income.** SRS made several changes in eligibility requirements that caused less income to be counted when determining eligibility.	Poverty-level children/pregnant women Aged over 65 Disabled children and adults
• **Cash assistance eligibility was no longer tied to Medicaid eligibility.** By federal requirement, even if a person isn't eligible for cash assistance he or she may still be eligible for Medicaid.	Poverty-level children/pregnant women **Can't quantify estimated impacts**
Changes that May Have Made Access Easier:	
• **In-person interviews are no longer required and applications are centrally processed.** People can now mail-in their applications.	Poverty-level children/pregnant women
• **Verification of eligibility simplified.** Only 2 months, instead of 3 months, of pay stubs are required to verify income.	All applicants

In addition, at least 2 changes in State and federal law increased the number of children in State custody who received Medicaid services. Our analyses of Medicaid clients showed that children receiving adoption support increased by 33% and the number of children in custody of the Juvenile Justice Authority (JJA) increased by 42%. On page 17, we've summarized the changes that most likely contributed to these increases:

- State legislation that took effect in July 1999 restricted placement in juvenile correctional facilities to those juvenile offenders guilty of the most serious crimes. Juvenile Justice Authorities told us that, previously, some juveniles with less serious crimes, but who needed intensive mental health care, also were sent to juvenile correctional facilities, where their services weren't eligible for Medicaid reimbursement. Now these offenders are being placed in community residential facilities, where services are paid by Medicaid.

- Also in 1998, to comply with the federal Adoption and Safe Families Act of 1997, the Legislature amended State law to make it easier for parental rights to be terminated and for children to be adopted. With more children being adopted, it's likely more adoptive families received help for special-needs children, including Medicaid coverage for physical health needs.

The Percentage of Enrolled Clients Who Received The Services We Reviewed Also Generally Increased

Not everyone who has been determined to be eligible for Medicaid actually uses medical services. But as the following table shows, that percentage increased somewhat between 1998 and 2000 for poverty-level children and children in custody. It stayed the same or decreased somewhat for disabled and aged people.

Client Group	% of enrolled clients who received services (a) 1998	2000
Poverty-Level Children	89%	93%
Children in State Custody	79%	80%
Disabled <65	89%	89%
Aged > 65	58%	56%
Family Medical (formerly TAF)	88%	90%
All Other Client Groups (detail in Appendix B	74%	76%
Total	**84%**	**85%**

(a) These figures relate only to the 9 services we reviewed in detail.
Source: LPA analysis of FY 1998 and 2000 Medicaid Management Information System (MMIS) claim data.

Some of the major reasons we could identify to help explain why more of the clients enrolled in Medicaid were receiving services in 2000 than in 1998 are summarized in the sections that follow.

More clients who go to emergency rooms now have their costs covered under Medicaid because of a change in federal law. The "prudent layperson" standard, adopted in the federal Balanced Budget Act of 1997, required Medicaid to pay for emergency room visits if a prudent layperson, who possesses an average knowledge

of health and medicine, would reasonably expect the absence of immediate medical attention to result in serious harm. Before this ruling, many Medicaid claims had been denied as being not serious enough to require emergency room care. However, hospitals still would have been required to provide emergency care services.

Our analyses showed that the number of Medicaid clients using emergency room services went up 24% between 1998 and 2000. For the 4 client groups we focused on, that number went up 48%, and when combined with the rate increases for these services, caused a cost increase of $2.4 million. For these same client groups,12% more people got office visits in 2000, and again, when that increase is combined with the rate increases for these services, it caused costs to increase nearly $4.0 million.

A combination of factors apparently brought more clients in through the "front door" of the medical system. For our 4 population groups we noted large increases in the number and percent of clients who had office visits, emergency room visits, intensive neonatal care, and the like between 1998 and 2000. At least 2 factors appeared to contribute to these increases:

- the change in the prudent layperson standard mentioned above.

- significant increases in rates for these types of services (described in more detail later), which had been reimbursed at historically low levels. These rate increases might have encouraged more doctors to provide services to Medicaid clients, and may have resulted in more doctors and emergency rooms submitting bills that they otherwise would have written off.

Although these factors impacted all clients regardless of their eligibility status, most of the increases caused by these factors involved disabled people under 65 and poverty-level children.

Increases in the number of clients seeing the doctor or going to the emergency room also appeared to have a ripple effect, resulting in more diagnostic services being performed. The table on page 19 shows large increases in certain diagnostic procedures for disabled clients. The number of clients receiving such services increased most for services that also had large rate hikes, but they also increased for diagnostic services where the reimbursement rates were unchanged.

Examples of Increased Use of Diagnostic Services						
Procedure	Rate at start of FY 98	Rate by end of FY 00	# of Disabled clients receiving service FY98	FY00	% Change Rate	Clients
MRI, brain	$475	$916	126	246	93%	95%
Left heart catheterization	$220	$1,431	36	128	551%	256%
Computerized axial tomography, thorax	$280	$287	218	349	3%	60%
Echocardiagraphy	$200	$200	385	553	0%	44%
Mammogram	$115	$115	1,129	1,648	0%	46%
Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.						

We noted large increases in the number of juvenile offenders receiving services between 1998 and 2000. For the first 9 months of 1998, SRS was responsible for providing services for juvenile offenders. During the final 3 months of that year, juvenile offenders gradually were transferred to the Juvenile Justice Authority. The Authority provides grants to counties to supervise these offenders, determine the types of services offenders need, and ensure that those services are provided.

Between 1998 and 2000, the number of juvenile offenders in State custody who were enrolled in Medicaid increased by about 42%. This was likely due to a change in State law in July 1999 which caused some juvenile offenders with less serious crimes to be placed in community residential facilities, where services are paid by Mediciad. Previously, these juveniles were sent to juvenile correctional facilities where their services weren't eligible for Medicaid reimbursement. As the table on the following page shows, there were huge increases in the number of juvenile offenders being placed in various facilities for behavior management, as well as major increases in alcohol and drug treatment services for offenders.

Counties receiving grant moneys from the Juvenile Justice Authority to serve offenders have greatly increased their use of intensive residential services, which are reimbursable under Medicaid. Of the nearly $7 million increase in costs for these children from fiscal year 1998 to 2000, virtually all resulted from providing more juvenile offenders with behavior management and drug and alcohol services.

Increases in the Number of Juvenile Offenders Receiving Medicaid Services						
Procedure	Juvenile Offenders Receiving Services 1998	2000	Expenditures 1998	2000	% Increase Clients	$
Level 6 Group Home Care	15	152	$507,565	$2,700,954	913.3%	432.1%
Level 5 Group Home Care	200	578	$1,172,661	$3,120,567	189.0%	166.1%
Family Treatment	79	163	$928,330	$1,505,700	106.3%	62.2%
In-Home Family Treatment, 1 hr	3	229	$2,072	$509,920	7533.3%	24510.0%
Residential Treatment, Dually Diagnosed Youth	0	19	$0	$442,349	n/a	n/a
Alcohol & Drug, Residential	67	126	$224,821	$516,410	88.1%	129.7%
Alcohol & Drug, Hourly Group Therapy	43	257	$9,683	$155,675	497.7%	1507.6%
Alcohol & Drug, Hourly Individual Therapy	29	187	$11,001	$66,625	544.8%	505.6%

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

Costs also increased about $803,000 for behavior management and alcohol and drug treatment for children in foster care or receiving adoption support. SRS officials identified 3 changes that likely contributed to these increases:

- **In January 2000, area offices received additional funding to contract for time-limited services for children** who needed intensive behavior management
- **each area office added at least one additional substance abuse specialist to its staff in fiscal year 1999.** Although the staff were added to help identify substance abuse problems that might inhibit cash assistance recipients' ability to get jobs, it's likely those outreach efforts may have identified more children needing substance abuse treatment
- **There was a fairly big increase in the number of Medicaid - eligible children receiving adoption support (33%, or about 900 children),** possibly because the passage of the federal Adoption and Safe Families Act made it easier to terminate parental rights, and freed more children for adoption. We saw a large increase in the number of adoption support children placed in Level 6 group homes for behavior management.

We saw an overall increase in the percent of disabled and aged clients being hospitalized. For disabled clients, those increases generally were for many different types of diagnoses, although the largest increases were for mental health treatments (psychoses), digestive disorders, and respiratory disorders (including pneumonia and chronic pulmonary obstructive disease). For aged clients, the largest increases in hospital admissions were for respiratory disorders such as pneumonia and other diseases, including heart failure.

We weren't able to tell why more disabled and aged clients were hospitalized. Oftentimes, changes in the numbers of clients hospitalized for any particular reason were very small. But depending on how serious or complex the client's problem was, small differences could have a large impact on the costs. For example, for the time period we reviewed, only 9 more disabled clients received a cardiac valve, which accounted for increased costs of $472,432. In addition, 5 more aged clients received a tracheostomy in 1998 compared to 2000, causing a cost increase of $371,193.

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

The "units" of service a client receives can range from a 15-minute meeting with a case manager, to one hour of group psychotherapy treatment, to one day of residential therapy in a group home, to an entire stay in the hospital, to one month of medical-related special education services. Because of this variety, it's difficult to make overall statements about changes in the average number of services Medicaid clients receive.

Nonetheless, our review of the claims paid data for the population groups and services we focused on revealed a number of important patterns or trends in the average number of services provided per client, as described below:

We Saw a Large Increase in the Number of Home Health Services Each Disabled and Elderly Client Received

The number of "units" of home health services grew by almost 90 per disabled client between 1998 and 2000 (a 44% increase), and by almost 22 units of service (40%) for aged clients. The table on the following page shows some of those increases for individual types of procedures:

Medicaid spends a considerable amount of money for such home health services. For example, in fiscal year 2000 it spent more than $16 million on skilled nursing services for the disabled and aged.

Disabled and Aged Clients Received Many More Home Health Services Per Person						
Procedure	Hourly Rate	Population	Avg. Annual Hours/Person FY98	FY00	Increase Units	Percent
Skilled Nursing Services (RN)	$60	Aged	35	62	27	78%
		Disabled	62	123	61	99%
LPN Skilled Visit	$45	Aged	20	38	18	91%
		Disabled	28	62	34	122%
Home Health Aide Service	$40	Aged	55	67	12	21%
		Disabled	80	86	6	8%
Attendant Care for Independent Living-Skilled Nursing	$24	Disabled	605	805	200	33%

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

In a report to agency management in January 2002, SRS staff noted that their review of home health services for a sample month (March 2001) found that some of the services clients received (in particular medication management) were covered by the Home and Community-Based Services (HCBS) waiver. In other words, those services were built into a capitated waiver rate, and the HCBS provider should have been paying for them, rather than Medicaid being billed. HCBS recipients incurred about 60% of all the home health expenditures in fiscal year 2001.

SRS officials are considering policies that will prevent home health agencies from being reimbursed for services provided to HCBS recipients, if those services are included under a waiver. Staff said that policy, as well as others intended to reduce unnecessary expenditures in home health, are being reviewed and could be adopted as soon as July 1, 2002.

We Also Saw Increases in Services Per Client In Other Areas

As noted earlier, more clients went to the emergency room in 1998 than in 2000. They also went more often. For the 4 client groups we focused on, our analyses showed an increase in emergency room visits by one-half visit per client. Although this doesn't seem like a large increase in emergency room visits per client, that combined with a rate increase for these visits caused a $2.0 million cost increase from fiscal year 1998 to 2000.

Besides increases in the number of home health services and emergency room visits per person, we also saw increases in the number procedures per person in other areas. These increases occurred whether or not rates for these procedures were raised.

We've outlined the client groups impacted and the specific procedures below:

For disabled clients under age 65:

- alcohol and drug group outpatient therapy,15 more units per person in 2000 than in 1998.
- alcohol and drug adult intermediate treatment, 8 more units per person in 2000.
- Paclitaxel, 19 more units per person in 2000 than in 1998 (Paclitaxel is a cancer fighting drug and is often used to fight ovarian cancer)
- Carboplatin,16 more units per person in 2000. (Carboplatin is chemotherapy used to fight ovarian cancer.)
- adult pyschosocial group treatment, 40 more units per person in 2000 than in 1998.

For children in State custody:

- alcohol and drug group outpatient therapy, 13 more units per person in 2000 than in 1998.
- behavior management community-based residential treatment for dually diagnosed youth, increased 227 units per person.

Some children are receiving more services because they're 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 changes to family income. This change was designed to prevent "churning," where clients would drop in and out of eligibility. Our analysis showed that poverty-level children receiving managed care services were covered on an average, of one month longer in fiscal year 2000 compared to 1998. This lengthened period of eligibility also gives children more time in which to receive other medical services funded by Medicaid.

Factors Relating to Increases in the Amount Paid Per Service

Increases in the average amount paid for services covered under Medicaid could be caused by a variety of factors, including rate hikes, the use of more expensive services, and the amount providers bill. Together, such changes impact the average cost per client who uses such services.

As the following table shows, the average cost per client increased by $237 between 1998 and 2000. For 3 client groups, however, those increases were much higher. Thus, as these populations increase, they have a proportionately greater impact on Medicaid costs.

Client Group	Average cost per client (a) 1998	2000	$ Change 98-00
Poverty-Level Children	$801	$769	-$32
Children in State Custody	$2,211	$3,043	$832
Disabled <65	$4,408	$5,038	$630
Aged > 65	$2,030	$2,843	$813
Family Medical (formerly TAF)	$885	$1,099	$214
All Other Client Groups (detail in Appendix B	$2,000	$2,091	$91
Total	**$1,722**	**$1,959**	**$237**

(a) These figures relate only to the 9 services we reviewed in detail.
Source: LPA analysis of FY 1998 and 2000 Medicaid Management Information System (MMIS) claim data.

The following sections identify factors we saw that contributed to the increased Medicaid costs between 1998 and 2000.

Reimbursement Rates for Many Physician and Outpatient Services Were Increased Significantly in 1998 and 2000

In 1998, SRS increased rates significantly for about 100 medical procedures related to physician and outpatient services—two categories where rates had been particularly low. For example, reimbursement rates for emergency room visits had ranged from $10-$25 per visit before the increase, depending on the level of complexity involved. After July 1998, those rates were raised to $20-$91 per visit. Rates for some procedures were increased again in January 2000. For example, rates for emergency room visits were raised to $29-$133 per visit.

When it raised rates for physician and outpatient services, SRS program officials projected these higher rates would cost the State about $9.5 million a year more. That estimate factored in a 1.4% increase in the overall use of services. However, our review of claims paid data showed the use of these services actually went up about 18% between 1998 and 2000, and actual spending per year increased by more than $14.5 million.

During this period, SRS also increased rates for fully-capitated managed care by $11 per month, on average. SRS estimated these increased rates would cost about $2 million more per year.

Given the unexpected increase in the number of Medicaid-eligible children who were identified during the State's outreach efforts for HealthWave, however, actual spending per year for capitated managed care actually increased by about $25 million.

Reimbursement rates for inpatient hospital charges also increased fairly consistently across the board. Each year SRS reviews cost reports filed by hospitals, and prices out an average rate for each diagnostic-related group (DRG). It then adjusts the rates to reimburse hospitals for 100% of the average cost of each DRG. Individual hospitals may not receive an overall increase in payments; however, because of changes in weights assigned to each DRG.

Some Providers Started Billing Medicaid For Much Closer to the Maximum Amount Allowed

We noted numerous instances where providers had billed less than the maximum allowed in 1998, but were billing closer to the maximum allowed rates by 2000. 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 per hour 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 year 2000, the average amount billed had climbed to nearly $37. The overall increase in the average billed amount was responsible for approximately $3 million in increased costs for this service alone.

In several cases, providers also appeared to have made major errors in billing. In 1998, one provider appeared to have under-billed one procedure by about $4.3 million. SRS pays the amount providers bill, up to the maximum allowed for each procedure.

We Saw a Number of Shifts To More Expensive Providers and Services Being Billed Under Medicaid

Medicaid is increasingly being billed for more complex or expensive services when a range of services is available. Although some clients will have more complex needs than others, we wouldn't expect to see patterns of overall shifts in the services provided. We saw this with several different types of services, as described below:

a. *Visits to physician' offices and emergency rooms.* As the table on the next page shows, more of the growth in clients between 1998 and 2000 was for services that were more complex or costly. We saw the same pattern with poverty-level children's use of these services.

Examples of Increased Use of More Complex and Costly Medical Procedures						
Procedure	Rate at start of FY 98	Rate by end of FY 00	# of Disabled clients receiving service FY98	FY00	% Change Rate	Consumers
Office Visits for Disabled Clients						
Established patient, low complexity	$15	$17	9,714	9,741	13.3%	0.3%
Established patient, expanded history, low complexity	$17	$24	14,755	16,768	41.4%	13.6%
Established patient, moderate complexity	$30	$36	5,806	6,977	21.2%	20.2%
New patient, low complexity	$25	$42	1,837	2,263	69.3%	23.2%
Consultation, low complexity	$30	$59	1,297	1,638	98.1%	26.3%
Consultation, moderate complexity	$45	$83	1,111	1,458	85.3%	31.2%
Emergency Room Visits for Disabled Clients						
Low complexity	$10	$29	3,498	5,606	188.9%	60.3%
Moderate complexity, expanded history	$12	$55	5,557	9,375	360.3%	68.7%
Moderate complexity, detailed history	$20	$85	2,270	4,371	325.3%	92.6%
High complexity	$25	$133	320	1,635	433.7%	410.9%

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

A Kansas Hospital Association official said it's possible Medicaid receives claims for more complex procedures than in the past because medical professionals have become better at documenting the services each client receives. If the documentation doesn't support a claim for reimbursement for a more complex procedure, the hospital or office must submit a claim for the less complex one.

b. *Mental health community support services.* In the last third of fiscal year 2000, SRS created two new direct service procedures: Community Psychiatric Supportive Treatment, (reimbursed at $70 per hour), and Individual Community Support (reimbursed at $20 per hour). It created these procedures because mental health centers had been inappropriately coding many direct services as Targeted Case Management, a procedure federal guidelines say should apply only to assisting clients in accessing services.

To partially offset the cost of these new services, SRS lowered the rate for Targeted Case Management from $60 to $40 per hour. However, as the following table shows, use of the new services was far greater than the decrease in

Targeted Case Management, and the increased usage was greatest for the most expensive service. In addition, rates for all 3 services increased substantially in January 2001, after the period we reviewed. As a result, this will be an area of continuing cost increases in the future.

Results of Lowering the Rate for One Service to Help Offset New Services

Procedure	Units of Service (Hours) FY98	Units of Service (Hours) FY00	Rates FY98	Rates 3/1/00	Rates 1/1/01
Targeted Case Management	196,219	148,513	$60	$40	$100
Individual Community Support	n/a	27,360 (for 4 months)	n/a	$20	$40
Community Psychiatric Supportive Treatment	n/a	91,222 (for 4 months)	n/a	$70	$110

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

c. *Home health nursing services.* As the following table shows, 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 home health aide services, a service that is reimbursed at a lower rate than skilled nursing.

Aged and Disabled Clients Received Home Health Services Through Medicaid, Rather than from a Home and Community Based Services (HCBS) Provider

Procedure	Rate	Population	Consumers FY98	Consumers FY00	% Change
Home Health Aide Services	$40.00	Aged	70	50	-28.6%
		Disabled	305	153	-49.8%
LPN Skilled Services	$45.00	Aged	157	213	35.7%
		Disabled	315	313	-0.6%
Skilled Nursing Services	$60.00	Aged	1,343	1,454	8.3%
		Disabled	2,418	2,288	-5.4%

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

SRS officials were aware of this situation, and said they thought it had occurred because they'd required prior authorization for home health aide services (to prevent duplication of services paid for under HCBS waivers), but not for LPN or skilled nursing services. By providing services with more highly skilled staff, home health agencies avoided the prior authorization requirement.

SRS' review of a sample of payments from March 2001 also found that 83% of the skilled nursing visits it looked at did not require a skilled nursing level of service. Agency officials calculated that, if those services had been performed by a home health aide, the cost of those services would have been reduced by 33%.

d. *Early intervention services for children.* For certain children enrolled in Medicaid, many of the "medical" special education services schools provide (for example, speech therapy, occupational therapy, attendant care) are eligible for federal Medicaid cost-sharing. Services are billed at a bundled monthly rate, which varies depending on the type of special education services a child needs. For example, the bundled rate for autism is higher than the rate for behavior disorder or learning disability. (Bundled rates are set at a level that is supposed to cover what Medicaid would pay in total for all the individual services a child with that exceptionality typically receives.)

Changes in How Disabled Children were Enrolled in Early Intervention Services

Payment Category	2000 Rate	Disabled Consumers FY 98	FY 00	% Change
Learning Disability	$168	512	371	-27.5%
Physical Impairment	$225	147	102	-30.6%
Speech/Language	$235	345	186	-46.1%
Behavior Disorder	$276	589	507	-13.9%
Other Health Impairment	$312	455	424	-6.8%
Early Childhood Special Education	$325	534	435	-18.5%
Mental Retardation	$329	1,777	1,279	-28.0%
Special Education	$361	171	1,076	529.2%
Hearing Impairment	$384	123	111	-9.8%
Autism	$531	67	182	171.6%
Severe Multiple Disabilities	$647	327	273	-16.5%
Deaf-Blindness	$709	13	18	38.5%

Source: LPA analysis of claims paid through November 2001 for services provided in fiscal years 1998 and 2000; Kansas Medicaid Management Information Systems (MMIS) claims data.

The table above shows that for disabld children, between fiscal years 1998 and 2000, a category with a relatively high monthly reimbursement rate (generically called "Special Education") had a huge increase in clients (+905). At the same time, all the categories with lower reimbursement

rates declined (a total of -1,055 clients). 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.

While this type of reclassification increases Medicaid expenditures, it doesn't cost the State any more money, and helps school districts draw down more federal match. That's because school districts "pay" the State share as a certified match. That is, they use the money they were already spending on services for these children as the required match. When the monthly rates for children are higher, the draw-down of federal funds is greater.

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 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.

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
- Reduce or limit coverage of non-mandatory services
- Ensuring the State pays less 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 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 identify them.

OPTION: REDUCE ENROLLMENT IN THE MEDICIAID PROGRAM

Reduce the Number of Optional Recipients Covered

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.

Kansas covers some "optional" populations, including:

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

The table below shows SRS' estimates for the cost of providing regular medical services, including pharmacy costs, for these optional recipients. As the table shows, the additional costs to the State total at least $73.4 million.

Medical Assistance Costs for Different Population Groups (a)
Fiscal Year 2001 (in millions)

	Total Expenditures	State General Fund Portion
Mandatory Recipients	$ 435.9 (b)	$ 141.4
Optional Recipients (with federal matching funds):		
Medically Needy		
Disabled or Blind	83.1	30.9
Aged	66.0	26.3
Other children & adults	2.9	1.1
Adoption Support	8.7	2.4
Institutionalized Children	.3	.1
Optional Recipients (without federal matching funds):		
General Assistance	12.6	12.6
Subtotal, Optional	$ 173.5	$ 73.4
TOTAL	**$ 609.4**	**$ 214.8**

Source: SRS Fiscal Section.
(a) This table excludes $29.2 million in expenditures because SRS wasn't able to link those expenditures to specific population groups.
(b) We backed into this number based on the total expenditures SRS reported spending on services for mandatory and optional recipients (see page 33), and the total SRS reported spending on optional recipients.

Neighboring states provide Medicaid coverage for most of the optional populations Kansas currently covers, as shown below. However, 2 of the 4 states with General Assistance programs don't provide medical coverage to their General Assistance clients. Kansas' General Assistance Program served 2,535 adults in fiscal year 2000. In its 2003 budget request, SRS proposed eliminating coverage for this Program altogether.

Population		Colorado	Iowa	Missouri	Nebraska	Oklahoma
medically needy (federal match available)		no medically needy pgm.	✔	has a similar program involving spend-downs	✔	✔, although the state recently considered eliminating this coverage
general assistance (no federal funding)	cash	✔	✔	✔	✔	no general assistance pgm.
	medical coverage	doesn't cover	doesn't cover	✔	✔	no general assistance pgm.

Make It Tougher for "Mandatory" Populations To Qualify for Services

Medicaid Program guidelines specify certain minimal eligibility requirements states must follow. Kansas eligibility guidelines in most areas are about as restrictive as they can be, but it could take steps to reduce eligibility in 2 ways:

- **imposing limits on the amount of resources certain groups may have before they are eligible for Medicaid coverage.** States can set limits on the value of a person's assets (home, car, personal belongings, etc.) that isn't counted when considering whether that person meets income limits for Medicaid eligibility. For example, single individuals applying for Medicaid coverage for long-term care expenses can have only $2,000 in "countable" assets. Implementing a resource test could have an effect on people in the Family Medical Program (formerly TAF), poverty level pregnant women and children up to 18, and on certain newborns.

- **reducing the levels of income "disregarded" or "protected" when considering a person's income level for Medicaid eligibility purposes.** SRS recently increased these amounts by $110 for poverty-level eligible children (estimated impact of $700,000) and by a total of about $60 since 1998 for disabled people (no estimate available). In its Briefing on the SRS 2003 Budget Proposal, SRS proposed to reduce the protected income level for people who became eligible for Medicaid under the HCBS waiver from $716 to $475 per month.

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. In certain areas, Kansas exceeds that minimum. For example,

- In 1999, SRS changed its policy to grant Medicaid children 12 months of continuous eligibility, rather than the 6 months federal rules require. They did this to make Medicaid parallel to HealthWave. This additional eligibility cost the State an estimated $1.7 million.

- Kansas provides 12 months of medical coverage for people no longer eligible for Family Medical coverage because their earnings were too high. Medicaid guidelines require only 6 months.

SRS recently decided to limit the length of time people can receive benefits under the General Assistance Program to 24 months, effective July 2002.

OPTION: Reduce or Eliminate Coverage for Non-Mandatory Services

The State must provide certain services for all people enrolled in Medicaid. These include inpatient and outpatient hospital, physician services, lab, home health, and Medicare buy-in. Many other services Kansas provides aren't mandatory, however, unless the recipients are children. SRS estimates the State's cost for providing these optional services to optional recipients is $93.1 million. This information is shown in the following table:

Regular Medical Expenditures for Mandatory and Optional Services

Fiscal Year 2001 (in millions)

	Expenditures For Required Services	Expenditures for Services Not Required	State's Cost for Services Not Required
Mandatory services (a)	$ 304.8	$ 0.0	$ 0.0
Optional services			
Pharmacy	26.0	179.0	71.6
Mental Health Centers	9.2	18.7	7.5
Early Intervention (spec. ed.)	18.7	2.1	.8
Supplies	4.2	9.0	3.6
Dental	9.0	.8	.3
Behavior Management	0.0	9.5	3.8
FE Targeted Case Management	0.0	6.4	2.6
Hospice	.9	2.7	1.1
Alcohol & Drug Abuse	0.0	3.2	.9
Vision	1.4	.9	.4
Local Health	0.8	.3	.1
Psychologist	.4	.5	.2
Ambulatory Surgery	.2	.3	.1
Hearing	.1	.3	.1
Chiropractor	0.0	<.001	<.001
Subtotal, optional services	$ 70.9	$ 233.7	$ 93.1
Total (b)	$ 375.7	$ 233.7	$ 93.1

(a) primarily inpatient and outpatient hospital, physician services, lab, home health, and Medicare buy-in.
(b) This table excludes $29.2 million in expenditures because SRS wasn't able to link those expenditures to specific population groups. As a result, we couldn't accurately divide the expenditures between mandatory and optional recipients.

Source: SRS Fiscal Section

Expand the Use of Co-Payments

The Department 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.

For the medical services in our sample, if a $2 co-payment for each physician "visit" had been in effect and paid in fiscal year 2000, the State would have spent about $1.7 million less. It should be noted, however, that services can't be denied if a person fails to meet the co-payment requirement.

Reduce Errors in Amounts Paid to Providers

In April 2000, SRS reported the results of its first payment accuracy review of the Medical Assistance Program. That review involved looking at 600 claims **paid** totaling about $538,000 from March 1999, and determining whether the service billed had actually been provided, whether medical records supported what the provider billed for, and whether the Medicaid Management Information System paid the claim correctly. SRS summarized the number and dollar amount of the errors identified as follows:

Description of Error	# of Occurrences	$ Paid Inaccurately
Incomplete documentation	67	$13,274
Absent documentation	15	5,210
Lack of medical necessity	18	7,940
Incorrect units billed	10	$2,524
Payment calculated incorrectly by system	8	73
DRG incorrectly reported	4	3,648
Noncovered services	3	145
Other insurance not billed first	3	9,363
Keying error	3	1,448
PRO's submitted adjustment not provided	2	72
Duplicate billing by same provider	1	65
Edit problem	1	7,300
Lack of referral from primary care physician	1	7
Incorrect procedure coding	1	75
Service provided beyond program limits	1	403
Provider blames software for keying prob.	1	750
Date discrepancy	1	3,187
Outpatient or observation billed as inpatient	1	1,427
TOTAL	**142**	**$66,374**

In all, 99% of the amount paid in error involved claims that had been overpaid.

Based on these results, SRS calculated an overall payment accuracy rate of 76% with a margin of error of 9%. Projecting the sample results to the whole, SRS indicated the number of claims paid inaccurately could be as high as $185 million. Many of the problems identified related to documentation, which SRS didn't pursue further in this review. Thus, it's not possible to know whether documentation existed to justify the service provided and simply wasn't sent in, or whether documentation didn't exist, didn't support the services provided, etc.

Excluding the documentation problems, SRS determined that 77% of the remaining errors were associated with inadvertent billing errors made by providers, 18% were associated with errors made by the fiscal agent in adjudicating claims, and 5% were "questionable" errors (questions were raised about the intentions of the provider to bill accurately, but no intent was proven).

SRS officials indicated they have increased efforts to get providers to submit documentation since that first study, and they were in the process of completing a second review at the time this audit was written. Because of the large dollars involved when claims are paid incorrectly or inappropriately, these results suggest there are still many things SRS could do to strengthen pre- and post-payment reviews processing of Medicaid claims, and investigation of questionable claims to ensure the State doesn't pay more than it should.

Reduce Unnecessary Services

As described earlier, we saw increases in the percentage of enrolled beneficiaries who used services between 1998 and 2000, and increases in the use of more expensive services. The following options are designed to help identify and control such increases.

- Monitor trends in usage. As one of the largest providers of health care services in Kansas, SRS also should systematically review, analyze, and act on Medicaid claims paid data for both consumers and providers (including diagnoses, types of services provided, where and by whom services were provided, and the dates and amounts paid). That includes monitoring and comparing expenditure and usage information against expected outcomes to identify costs or utilization rates that are rising higher than expected or that are different from what was

expected. Monitoring could identify, for example, repeated visits to the emergency room by individuals and alert physicians to better manage health care for the emergency room users.

- Coordinate care for beneficiaries not currently under managed care. Very few elderly and only about half of disabled people—the most expensive beneficiaries—are in managed care. Capitated managed care programs may not work because of the difficulty in establishing appropriate rates for people with widely varying medical needs, and because of the need to ensure that their access to services isn't limited inappropriately.

  However, developing an aggressive "utilization management" program for people with extensive medical needs, many of them elderly or disabled, would help ensure that the services being delivered are appropriate and necessary, that duplicate services are eliminated, and that costs are being controlled. SRS could do this with policies specifying preferred medical utilization, or it could use a medical services coordinator for each beneficiary with extensive medical needs. This coordinator's duties could include ensuring the person received routine and preventative medical care, that medical care follows current "best practices" for treating that person's conditions or illnesses, and that each beneficiary received sufficient (not necessarily all possible) medical services. SRS would need to investigate these alternatives and determine the most cost-effective management technique.

Ensure Services Are Being Provided by the Most Cost-Effective Providers

Also, as noted earlier SRS' recent review of home health services 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 could have saved 25%-33% of its costs in this area ($4-5 million) by having the service performed by the lowest-level qualified provider. SRS officials told us they are taking steps to change policies and provide additional training to home health providers. This is an area that needs to be monitored closely.

According to SRS officials, if "treatable" diseases like asthma, diabetes, congestive heart disease, and the like are appropriately managed, clients should almost never have to be treated for them in the hospital. For the services we reviewed during this audit, however, disabled adults had increases in hospitalizations for

pneumonia, as did aged individuals. SRS recently raised reimbursement rates for flu and pneumonia vaccines from $2.30 to $10, but there may be other opportunities to encourage preventive care and more cost-effective treatments for such conditions.

Ensure the State Isn't Double Paying for Services

SRS officials found that the State may be paying the cost of medication management services to providers of the services both under the waiver programs and under regular Medicaid. SRS officials told us they expect to determine whether other types of services, such as hospice services, also are being paid "twice." Other problems could exist. For example, a recent audit of Idaho's Medicaid program noted that a recipient could receive psychosocial treatments as part of an approved service plan, while getting potentially duplicative services by visiting a private mental health clinic or receiving targeted case management from a private provider.

Ensure That State and Local Agencies Are Claiming All the Federal Matching Moneys They Can

Increases in Medicaid spending can mean the State is doing a better job of maximizing federal funding for services the State must provide. For example, beginning in 1995 SRS policies made it easier for schools to bill Medicaid for medical-related special education services by providing a single code for all the services provided to a child during a month. Many districts had been paying for those services anyway, but not submitting them to Medicaid and receiving the federal match. Those districts are paying the "local" share of funding for these services, so the State's costs don't increase.

There may be other opportunities. 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. The Department also could work with the Department of Education and the Department of Health and Environment to ensure local school districts, health departments, and others are doing the same.

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.

RECOMMENDATIONS

1. If the Medicaid Program must be cut significantly because of shortfalls in the State's budget, the appropriate legislative committees should consider the options presented on pages 30, 31, and 33 of 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.

2. To reduce the number of people eligible for Medicaid, the Department of Social and Rehabilitation Services should consider the options presented on page 32 of this report. These options include imposing limits on the amount of resources certain groups may have before they are eligible for Medicaid coverage, and reducing the levels of income "disregarded" or "protected" when considering a person's income level for Medicaid eligibility purposes. Also, to reduce the length of time people are eligible for services, SRS should consider dropping its eligibility requirements to the minimums required under federal guidelines. In considering these options, SRS should document the anticipated cost savings from making such changes, and any other anticipated impacts those changes would have, and should report that information to the appropriate legislative committees.

3. To ensure that the State doesn't pay more than it should or needs to for medical services under the Medicaid Program, SRS should consider the options presented on pages 34-37 of this report. Those options call for SRS to do the following:

a. consider expanding the co-payments Medicaid clients must pay for medical services under Medicaid. As part of this effort, SRS should document the anticipated cost savings from requiring small co-payments for these services, and any other anticipated impacts those co-payments would have, and should report that information to the appropriate legislative committees.

b. reduce the number of errors in the amounts paid to providers. In this area, SRS should continue to conduct systematic payment accuracy reviews for the program, follow-up with providers who don't submit documentation to support the claims they submit, and take prompt action to address the types of problems identified in those studies. By August 1, SRS should report the findings of its most recent payment accuracy study—as well as its plan for addressing payment errors—to the Legislative Post Audit Committee and other appropriate legislative committees.

c. assign or obtain the resources necessary to systematically analyze Medicaid claims data, including, at minimum, analyzing data based on diagnoses, types of services provided, where and by whom services were provided, and the dates and amounts paid. SRS should also monitor and compare actual expenditure and usage information against expected outcomes to identify costs or utilization rates that are rising higher than expected or that are different from what was expected. SRS should report to the Legislative Post Audit Committee within 6 months from the date of this report on it's progress in implementing the above recommendation.

d. develop an aggressive "utilization management" program for people with extensive medical needs, many of them elderly or disabled, to ensure the services they receive are appropriate and necessary, that those services are being provided by the most cost-effective providers, and that costs are being controlled.

e. identify the extent to which other services besides home health medication management services are being paid "twice" under the Medicaid Program and the Home and Community Based Services waiver programs, and take immediate steps to change policies and stop such payments if they are occurring.

f. ensure that State agencies and contractors use all possible current spending to match federal dollars.

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on August 29, 2001. The audit was requested by the Interim Committee on Ways and Means/Appropriations.

SCOPE STATEMENT

Medicaid Cost Containment: Controlling Costs of Medical Services

Medicaid is a federal/State matching-funds program for preventive, primary, and acute health services for low-income individuals, children, and families. The Medical Policy/ Medicaid Program is the third largest purchaser of health care services in Kansas, after Medicare and Blue Cross/Blue Shield, and the single largest purchaser of children's health care services. For Fiscal Year 2001, the total Medicaid budget was $1.3 billion.

In addition to funding health care services, Medicaid is the major source of financing for other programs in Kansas. For example, more than $583 million was spent on long term care programs for the elderly and disabled in Fiscal Year 2000. All services provided by the Medical Policy/Medicaid Program are financed through a combination of State and federal dollars under Title XIX (Medicaid) or Title XXI (State's Children's Insurance Program, or HealthWave).

Medicaid costs have risen sharply in recent years. For example, medical assistance costs rose from $544 million in Fiscal Year 1999 to an expected $730 million for Fiscal Year 2002, a 34% increase in 4 years. These increases have prompted legislative concern that Kansas isn't doing all it could to contain Medicaid expenditures. Audits examining cost containment in the Program would focus on 5 key areas:

- Controlling growth in **caseloads**
- Controlling the types and cost of covered **medical services** (including mental health and substance abuse treatment)
- Controlling the provision of **residential services** (including nursing homes, hospitals, and group homes)
- Controlling **fraud and abuse**
- Controlling the cost of **prescription drugs**

The prescription drug issue was audited in detail in our March 2000 performance audit, *Reviewing the Medicaid Program's Use of Generic Drugs*. A performance audit dealing with controlling the cost of medical services would address the following question:

1. **What measures does the Department of SRS take to control medical services and costs in the State's Medicaid program, and do those measures seem reasonable?** We would focus our efforts on the programs that receive the greatest amounts of Medicaid moneys–nursing homes, HCBS waivers for the developmentally disabled and the physically disabled, and Temporary Assistance for Families. In the area of medical services, we would look at policies limiting the number and type of services people can receive, and whether preventive and lower cost services are being adequately emphasized. In the area of costs, we would look at co-pay levels, whether 3rd party reimbursements are being received, whether people receive the lowest cost service that meets their needs, and whether Kansas

is receiving all the federal reimbursement for which it is eligible. We would compare Kansas' practices to innovative practices identified in other states, and, where applicable, would review utilization data from the Medicaid Management Information System, and do other testwork as necessary.

Estimated completion time: 12-16 weeks

APPENDIX B

Changes in Enrollment, Consumers, and Average Cost Per Consumer

This appendix contains a summary of our analyses of paid claims data for fiscal years 1998 and 2000 from the Medicaid Management Information System, showing the changes in enrollment, consumers, and the average cost per consumer by eligibility group.

Appendix B

Changes in Enrollment, Clients, and Average Cost Per Client

Consumer Group (a)	# Enrolled 1998	# Enrolled 2000	% Clients 1998	% Clients 2000	Avg. Cost Per Client 1998	Avg. Cost Per Client 2000	$ Change, Cost Per Client
Poverty-Level Eligible Children (PLE)	74,292	99,244	89.4%	92.7%	$801	$769	($32)
Family Medical (formerly TAF) (b)	76,914	56,829	88.2%	89.6%	$885	$1,099	$214
Aged > 65	29,323	29,376	57.8%	55.9%	$2,030	$2,843	$813
Disabled <65	43,563	45,815	88.5%	89.3%	$4,408	$5,038	$630
Medicare Cost Share	5,564	6,531	45.9%	42.0%	$1,519	$1,577	$58
Children in State Custody	10,263	11,843	79.0%	79.8%	$2,211	$3,043	$832
General Assistance	2,733	2,535	89.1%	91.5%	$1,253	$1,478	$224
Medically Needy	2,433	1,133	38.7%	38.7%	$1,502	$1,572	$70
Poverty-level Pregnant Women	12,293	12,911	87.9%	89.7%	$2,228	$2,250	$22
Other	938	1,503	81.0%	86.8%	$2,921	$2,874	**($47)**
Total	**258,946**	**267,720**	**83.5%**	**85.3%**	**$1,722**	**$1,959**	**$237**

Source: LPA analysis of FY 1998 and 2000 Medicaid Management Information System (MMIS) claim data.
(a) There are 40 different eligibility groups or populations eligible for Medicaid medical services. For the purposes of this audit, we've combined those populations into 10 groups.
(b) Temporary Assistance to Families is now called Family Medical.

APPENDIX C

Agency Response

On March 14, 2002, we provided copies of the draft audit report to the Department of Social and Rehabilitation Services. Its response is included as this Appendix.

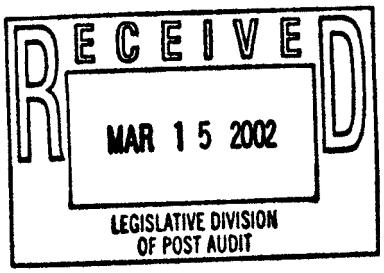
BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

March 14, 2002



Barbara J. Hinton
Legislative Division of Post Audit
800 SW Jackson, Suite 1200
Topeka, KS 66612

Dear Ms. Hinton:

We have reviewed the draft report completed by Legislative Post Audit regarding Medicaid Cost Containment. We appreciate the time and effort your staff put into completing this report. We have enclosed our comments regarding the recommendations made by LPA. You will note by our response that we concur with your recommendations and will move forward to implement changes that allow us to further manage the Medicaid program in a cost-effective, quality-oriented manner.

Thank you very much for the opportunity to review and comment on the draft report.

Sincerely,

Janet Schalansky
Secretary

JS:BD

SRS Response to Legislative Post Audit Recommendations Regarding Medicaid Cost Containment: Controlling Costs of Medical Services

Recommendations 1 and 2. Actions to reduce enrollment.

These policy options have been presented to legislature as the session has proceeded. We have provided various options for how they may decide to reduce optional services and populations. However, the policy decisions required to make these changes entails a higher level of involvement than SRS alone. The Governor, legislature and stakeholders would need to be involved in these decisions.

Recommendation 3.

3a. Expansion of consumer co-payments.

The Federal government does not allow Medicaid co-payments to be applied to specific populations, including children or pregnant women, nursing home residents, women receiving breast and cervical cancer treatment, or home and community based service (HCBS) waivers recipients. In addition, co-payments cannot be required for some specific services provided to any population (i.e., emergency, family planning, local health department). As a result, only 23% (approximately 55,600) of the Kansas Medicaid population can have a co-pay required of them. We already have a co-pay in place for inpatient care. In addition, the Governor's budget recommendations for FY03 includes raising the co-pay on pharmacy from $2 to $3 on all prescriptions.

Because federal law prohibits providers from refusing to provide a service if a consumer cannot afford to pay a co-pay, our concern with increasing the co-pay for physician services centers around the issue of the provider absorbing the costs of the co-pay in instances when consumers cannot pay. Given the currently low rate of reimbursement assigned for physician care, their having to assume any other fiscal responsibility could create more problems than it solves, including encouraging physicians to no longer serve Medicaid consumers.

3b. Improvements in payment accuracy.

The Kansas Medicaid Program processes nearly 14,000,000 claims annually. It has over 17,000 providers. These providers encompass physicians, pharmacists, hospitals, community service providers and a plethora of other provider types. Our goal is to assure that claims are paid appropriately and in a timely fashion. By appropriately, we mean that we maintain an acceptable level of payment accuracy of which detecting fraud and abuse is but one part. There are two approaches to this, the first is to develop methods that avoid unnecessary payments, referred to as cost avoidance, the second and more time consuming involves what is referred to as pay and chase, trying to recover monies that have been inappropriately paid.

Every claim that is filed with the program is sent through a series of over 800 pre-payment

electronic edits to assure that the claim meets a minimum criteria of acceptability. Examples of these edits are: assuring the beneficiary and provider are enrolled in the program, checking to make sure the claim is not a duplicate already filed, that the codes for services are acceptable and relate to diagnosis, and perhaps most importantly that there is no other insurance payment source since Medicaid is a payer of last resort. These edits guarantee that the claim meets a minimal standard of acceptability.

Approximately 20% of all claims are rejected and returned to the provider as not meeting the appropriate standard. The vast majority of these returned claims simply lack correct information to allow for the Medicaid Management Information System, MMIS, to electronically review the information. This front end process allows us to cost avoid a number of potentially inappropriate claims.

The Surveillance and Utilization Review (SURS) staff contracted at Blue Cross and Blue Shield, our current fiscal agent, review claims on both a random basis and on the basis of specific referrals. It has been their experience that reviews based on referrals have been the most productive and cost effective method of assuring payment accuracy. Reviews of claims is by and large a labor intensive process requiring staff to pour over the actual medical records to assure the appropriateness of the claims.

We have recently announced the awarding of a new MMIS contract to Electronic Data Systems, EDS. This contract will replace our current MMIS with state of the art information technology. The phase-in of the new system will occur across a one-year period. A key component of this system is the acquisition of a Fraud and Abuse Detection System or FADS which will replace our current system. The FADS is a dynamic and adaptive system which can create its own algorithms based on claims history. This fuzzy logic model means that the FADS will be able to detect abnormalities in claims history and to better profile providers and beneficiaries. We will be one of a handful of states to have this system.

In addition to the new information system we are assigning an additional staff person to assist the claims manager to the State unit to assure payment accuracy. Finally, the Senior Manager of Contracts and Fiscal Agent Operations will be applying a rigorous Contract Administration Plan approach to the new fiscal agent as well as working with the claims review staff to set specific targets designed to improve payment accuracy, including streamlining the SURS unit to assure more efficient utilization of services. These actions are part of a continuing focus we are placing on strengthening our approach to contract monitoring and developing more meaningful management tools. We believe we are taking many of the appropriate steps to recognizing and addressing the issue of accurate payment to providers.

Finally SRS already monitors the accuracy of inpatient hospital claims through a contract with the Kansas Foundation for Medical Care to carry out extensive post pay reviews. Last year over 50% of all impatient claims were reviewed resulting in over $6.5 million dollars in recoupments. Kansas Medicaid in partnership with the new fiscal agent to continue to monitor payment accuracy.

3c. Monitoring and analysis of claims data to make necessary program adjustments.

We concur that the key to managing any health program is the gathering and analyzing of health care data. As the Medicaid program moves from a bill payer to a health care purchaser it must use data to assure that the purchasing strategies are grounded in objective information, not simply built on anecdotal accounts. In addition, the dynamic nature of the health care market place means that the decision making process is built around continuous and real time information and not at captured moments in time. As indicated in the previous response, the Kansas Medicaid Program processes nearly 14,000,000 claims annually, with each claim averaging three or more separate procedures. Medicaid has over 17,000 providers across the state submitting claims.

Analysis of data requires having sufficient staff who have sufficient training to enable them to understand the data and interpret them in the context of current health care trends and to relate these trends a health care system that is in constant flux shifts across time among both populations and programs. With the new implementation of the new Medicaid Management Information System, MMIS, we will have a technology that will allow for advanced decision support. While SRS is committed to assuring that the Medicaid/Medical Policy program is staffed to a level that will allow the program to take advantage of this increased capacity for analysis, the current budget situation has resulted in significant constraints on staff resources.

3d. Development of utilization management program for people with extensive medical needs.

We agree that we need to examine this topic further. We have already begun consulting with knowledgeable others around the country regarding how to better manage this population. Further analysis is needed to determine whether using a nursing case management model to coordinate care and assure patient compliance is a feasible and practical solution. However, as noted in the initial review, we may be able to make significant inroads into the rising costs of this population by contracting with an organization which can develop a managed system of care for beneficiaries who are high service utilizers.

An initial review of disabled beneficiaries under age 65 found 5800 who had one or more inpatient hospital visits in FY 01. These individuals accounted for a total cost of $64,000,000 during the fiscal year. Seventy five individuals had more than nine visits in a single year. Their costs accounted for $6.9 million dollars. Another 336 individuals had between five and nine admissions costing $18.1 million dollars. Finally 1,986 persons had between two and four admissions costing $19 million during FY 01. In short, 41% of these individuals account for 69% of the inpatient costs for the disabled population under 65 years of age. A recent study for the Center on Health Care Strategies suggested that managing the care of individuals with multiple rates of admission could reduce their costs by up to fifteen per cent. When the case management program was taken in to account actual savings were closer to five per cent. If one were to remove the ten costliest beneficiaries from the total enrolled members, totaling 528, the

net savings is 17% over fee-for-service. The study, conducted in Oklahoma, notes that case management and other administrative costs were $145 per member per month. An estimate of the costs for a similar program assuming we manage only the top 500 costliest beneficiaries would be approximately $900,000 per year.

Identifying these beneficiaries will place additional demands upon already over-extended staff. In addition, any savings to be captured would require additional resources to contract external supports (e.g., a medical management organization). Therefore, conducting this work will require the expansion of internal resources. As indicated above, SRS is committed to ensuring that there is a sufficient number and quality of staff to manage the regular medical budget.

Finally, SRS has expanded its contract with the KU School of Pharmacy to analyze pharmacy use for beneficiaries in long term care settings. We anticipate that we will be able to provide by August an initial review and have available a work plan to ensure appropriate utilization.

3e. Identification of duplication of services.

As the report notes, we are taking steps to reduce double-billing for home health services. The Governor's budget already contains the elimination of duplication of services within home health, as well as NFMHs, and Hospice.

- NFMH: The proposal eliminates the current practice of reimbursing Community Mental Health Centers (CMHCs) and psychologists for services provided to persons living in nursing facilities for mental health (NFMHs). There are two major reasons for this proposal. First, NFMHs are residential facilities for persons with mental illness in which mental health services should be part of the daily care and therefore, should be covered by the daily rate paid to the facility. Second, because NFMHs fall under the Institutions for Mental Disease (IMD) restrictions, the payments must be made entirely with state general funds.
- Hospice: We have created a policy to prevent consumers from simultaneously receiving the PD waiver and Hospice services due to the potential for duplication of services. We also are examining Hospice care for any other forms of duplication.

In addition, we are reviewing the role of case management to ensure that services are provided and utilized appropriately.

The new MMIS system will be able to further assist in the identification of service duplication. Through a process of cross-referencing different types of service delivery, the system can identify when a consumer has been provided with overlapping forms of care. The current MMIS system is unable to do this.

3f. Continuation of maximizing federal dollars though appropriate use of certified match.

We are currently exploring with other state agencies ways in which to use all possible current spending to match federal dollars for appropriate Medicaid services when it meets the rules and regulations of Centers for Medicare and Medicaid Services.

As your report notes, SRS has already worked with a number of state and local agencies to maximize federal participation in paying for services to Medicaid beneficiaries. Currently, SRS staff are working with a private vendor to capture more federal dollars for Medicaid administrative services provided by mental health centers.