PERFORMANCE AUDIT REPORT

Medicaid Cost Containment: Controlling Costs of Long-Term Care

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

02-16

Legislative Post Audit Committee
Legislative Division of Post Audit

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August 9, 2002

To: Members, Legislative Post Audit Committee

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Senator Anthony Hensley	Representative John Ballou
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This report contains the findings, conclusions, and recommendations from our completed performance audit *Medicaid Cost Containment: Controlling Costs of Long-Term Care*.

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

The report includes several recommendations for the Department of Social and Rehabilitation Services, the Department on Aging, and the Legislature. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

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

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of Medicaid Funded Long-Term Care in Kansas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion ..... page 15

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

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

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

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

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Tighten financial eligibility criteria. *(No legislation is required for this option.) This could happen in several ways: reduce the amount of assets applicants are allowed to legally shelter, be more aggressive in identifying people who have transferred assets or created trusts, and lower the amount of "protected income," so applicants would be required to use more of their own income to pay for long-term care services.*

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

Continue to use waiting lists–capping the number of people who can get long-term care waiver services each year. *(No legislation*

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required for this option.) States can limit the number of people who get long-term care services in the community. Anyone who is eligible for long-term care services and who is placed on a waiting list still could choose to get services in a nursing facility or appropriate institutional setting. Kansas already has waiting lists for 4 waiver programs.

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

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

Strengthen efforts to identify and recoup amounts paid in error. *(No legislation required for this option.) In 1999 and 2001, SRS conducted systemwide reviews of payments to Medicaid providers to assess the appropriateness and accuracy of those payments. In the latest review, if just the non-documentation errors SRS found are projected to the entire payment population, they could total as much as $19.6 million on an annual basis. During our testwork, we also identified about $186,000 in potentially inappropriate payments made to long-term care providers, including paying providers twice for nursing home and residential days, as well as paying for services that should have been provided as part of other services, and paying for services after a consumer's death.* ..... page 23

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

Take steps to ensure that people pay for their own long-term care–provide financial incentives for long-term care insurance. *(Legislation would be required.) About half of Kansans rely on Medicaid to* ..... page 25

pay for their long-term care. Kansas should consider offering a tax credit or deduction that is separate from currently available itemized deductions. In addition, because low-income seniors often can't afford the cost of long-term care insurance, making that insurance more affordable could still reduce the State's costs.

Provide better case management to ensure that services are provided in the most cost-effective manner. *(No legislation required.) For the 3 largest waiver programs, developmental disability, frail elderly, and physical disability, Kansas spent $288 million in 2001. In addition to waiver services, generally these consumers also have access to regular Medicaid-paid medical services. Many have extensive health care needs, making it important to ensure that services are provided by the most cost-effective provider–whether a waiver provider or a medical service provider. According to SRS officials, in an attempt to control spending for medical services, Kansas will begin to use nurses to help manage the care for consumers with extensive needs.* ..... page 26

Freeze nursing facility reimbursement rates or delay rate increases. *(Legislation may be required.) As noted in Question 1, Department on Aging officials limited nursing facility reimbursement rate increases for 2003, after the 2002 Legislature reduced the Medicaid nursing facility budget by $8.9 million. According to Department on Aging officials, 2003 costs could have increased as much as $19 million if rates paid to nursing facilities in 2002 hadn't been used to set reimbursement rates for the first half of 2003.* ..... page 26

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

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

The Kansas Medicaid Program provides funding for long-term care for nearly 37,000 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. The federal government pays about 60% of the costs and the State pays the remaining 40%.

Kansas Medicaid expenditures increased by about $1 billion between fiscal year 1991 and fiscal year 2001. These increases prompted legislative concerns that triggered a series of audits looking at whether Kansas is doing all it can to contain Medicaid expenditures. Previously issued audits include:

- Medicaid Cost Containment: Controlling Costs of Medical Services, March 2002
- Medicaid Cost Containment: Controlling Fraud and Abuse, January 2002 (contracted out)
- Medicaid for Long-Term Care: Reviewing SRS' Efforts to Identify Inappropriate Means of Sheltering Assets to Qualify for Medicaid, March 2001
- Reviewing the Medicaid Program's Use of Generic Drugs, March 2000

This audit focuses on Medicaid long-term care services, which include services received in nursing facilities and through Home and Community Based Services ("waiver") programs. The audit answers the following questions:

1. **Why have long-term care costs increased?**

2. **Are the Department of Social and Rehabilitation Services (SRS) and the Department on Aging doing all they can to control the costs of long-term care?**

For reporting purposes, we recast the single question shown in the audit scope statement into the 2 questions listed above. A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A. Although the scope statement refers to controlling "residential" facility costs, the legislative interest had been raised in the broader aspect of Medicaid-funded long-term care–including home and community-based services.

To answer these questions, we obtained and analyzed 2.9 million records from the Medicaid Management Information System (MMIS) for claims paid through April 2002 for services provided in fiscal years 1998 and 2001. We reviewed changes in the number of people receiving services, the types and amounts of services they received, and the amounts paid for those services. We also reviewed policies that might have allowed more people to become eligible for long-term care services or to receive more services than in the past. We interviewed SRS and Department on Aging officials, reviewed relevant literature, and contacted other states.

In conducting this audit, we followed the applicable government auditing standards except that, because of time constraints, we didn't test the data contained in the MMIS. However, we concluded that the computer-processed data were reliable enough for the purposes of this audit because the MMIS is included in the Statewide audit and our review of the findings from the most recent audit identified no significant problems. The audit *Medicaid Cost Containment: Controlling Fraud and Abuse* included testing of a limited sample of claims from the MMIS and also identified no significant problems. Lastly, 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 8, following a brief overview.

Long-Term Care Includes Health-Related Services, Personal Care, Social Services, and Individual Supports, But Not Traditional Medical Services

For a person to receive Medicaid benefits in a nursing facility or through a community-based program, that person must be found to be both financially and "functionally" eligible:

- Financial eligibility is based on a person's income and asset levels, and is determined by SRS.

- "Functional" eligibility is based on a person's physical and health-related conditions. To determine functional eligibility for services, nursing facilities, area agencies on aging, independent living centers, and community mental health centers use standardized assessment instruments that measure or "score" the level of care a person needs. The higher the score, the greater the functional need.

When first enacted in 1965, Medicaid paid for long-term care only in skilled nursing facilities. In the early 1980s, high costs and concerns about overly restrictive environments led the federal government to allow states flexibility to use Medicaid for long-term care services in the community to prevent or delay institutionalization. Medicaid community-based services programs often are referred to as "waiver programs" because, in order to offer them, states must apply to the federal government for a waiver of the institutionalization requirement.

Any person determined to be eligible for care must be given the choice of receiving services in an institution–such as a nursing facility or State hospital–or in a community setting.

Kansas provides long-term care for Medicaid recipients in 3 types of nursing facilities and 6 types of community-based programs. In Kansas, SRS is the designated Medicaid agency. It manages all waiver programs with the exception of the frail elderly waiver. In addition, SRS also fiscally manages nursing facilities for the mentally ill and intermediate care facilities. The Department on Aging fiscally manages nursing facility operations, and started managing the frail elderly waiver program in July 1997. *Tables OV-1 and 2* summarize information about the different types of facilities and waivers, including who they provide services to.

Table OV-1 Types of Nursing Facilities	
Types of Facilities	**Who Is Served in the Facility**
Nursing Facility	People requiring 24-hour ongoing observation and treatment or care for long-term illness, disease, or injury.
Nursing Facility for Mental Health	People diagnosed with a mental illness or behavior disorder.
Intermediate Care Facility for Mental Retardation (ICF/MR)	People who are mentally retarded and have related health and physically disabling conditions.
Source: Agency Provider Manuals	

Table OV-2 Community-Based Waiver Programs	
Community-Based Waiver Programs	**Who They serve, and the Institutional Alternative**
Frail Elderly (FE) Started: 1982 (a)	People age 65 and older who need help with multiple activities adults normally perform for themselves, such as bathing and shopping Alternative: nursing facility
Physical Disability (PD) Started: 1982 (a)	People age 16 and older who meet Social Security standards for being physically disabled and who need personal assistance during a normal day Alternative: nursing facility
Developmental Disability (DD) Started: 1982 (a)	People age 5 and older who meet the statutory definition of developmentally disabled, which includes mental retardation evident before age 22 Alternative: State institution, ICF/MR
Head Injury (HI) Started: 1991	People age 16-55 who have functional disabilities as a result of traumatic head injury Alternative: rehabilitation facility
Technology Assistance (TA) Started: 1991	Children and youth, age birth-18, who need a medical device, (such as a ventilator) to continue to live Alternative: hospital
Severe Emotional Disturbance (SED) Started: 1997	Children and youth age 4-21 with severe emotional problems Alternative: mental hospital
(a) Originally, frail elderly, physically disabled, and developmentally disabled persons were covered by a single nursing facility waiver. Separate waivers were created in 1997. Source: waiver documents provided by SRS and the Department on Aging.	

Nursing Facilities and Community-Based Programs Offer Different Levels of Care

Nursing facilities serving Medicaid residents are required to provide licensed nursing care 24 hours a day, as well as such rehabilitation services as occupational, physical, respiratory, and speech therapy. Other services include food and dietary consultation, and assistance with daily living skills. Facilities also must provide routine medical equipment and supplies needed for a resident's care.

Waiver programs provide services designed to address the specific needs of the people for whom the waiver was designed. Certain general types of services are common to more than one waiver. However, the specifics of each type of service vary by waiver, as do provider requirements. *Table OV-3* shows the major waiver services available to those who qualify for long-term care:

Table OV-3
Services Offered by Community-Based Programs

Type of service(a)	Waiver					
	DD	FE	HI	PD	SED	TA
Case management (assessment, coordinating services, and the like)	(b)	(b)	✓	✓	✓	✓
Environmental modifications (assistive technologies (e.g., van lifts, ramps, smaller devices)	✓	✓	✓	✓		
Personal services (help with activities an adult would normally do for himself/herself)	✓	✓	✓	✓		
Help with building independent living skills	✓		✓		✓	
Respite care (care when the primary caregiver isn't present)		✓			✓	✓
Overnight assistance	✓	✓				
Wellness monitoring (nursing assessment of health status)	✓	✓				
Rehabilitation therapies			✓			
Family training					✓	
Medical equipment not covered by regular Medicaid						✓

(a) This is not an exhaustive list of all the services that may be paid for using Medicaid waiver moneys.
(b) This service is provided to waiver participants, but is a service provided under the State Medicaid Plan (regular medical).

Source: waiver documents provided by SRS and the Department on Aging

Two waiver programs–Severe Emotional Disturbance and Technology Assistance–have few waiver-specific services. Participants on these waivers are more likely to make use of services available to anyone with a Medicaid-paid medical insurance card, such as psychiatric counseling.

Except in a very few circumstances, none of the waiver programs pay for room and board. Waiver participants who live in group homes or assisted-living facilities pay room and board costs from their personal funds, which may include Social Security.

Overall Medicaid Expenditures Increased by $560 Million From Fiscal Years 1998 to 2001; Long-Term Care Costs Accounted For 29% of that Increase

From fiscal years 1998 to 2001, total Medicaid expenditures in Kansas increased from $936 million to $1.5 billion (60%). The overall growth in Medicaid is shown in *Table OV-4*.

Table OV-4
Changes in Total Medicaid Expenditures by Category
FY 1998 to FY 2001

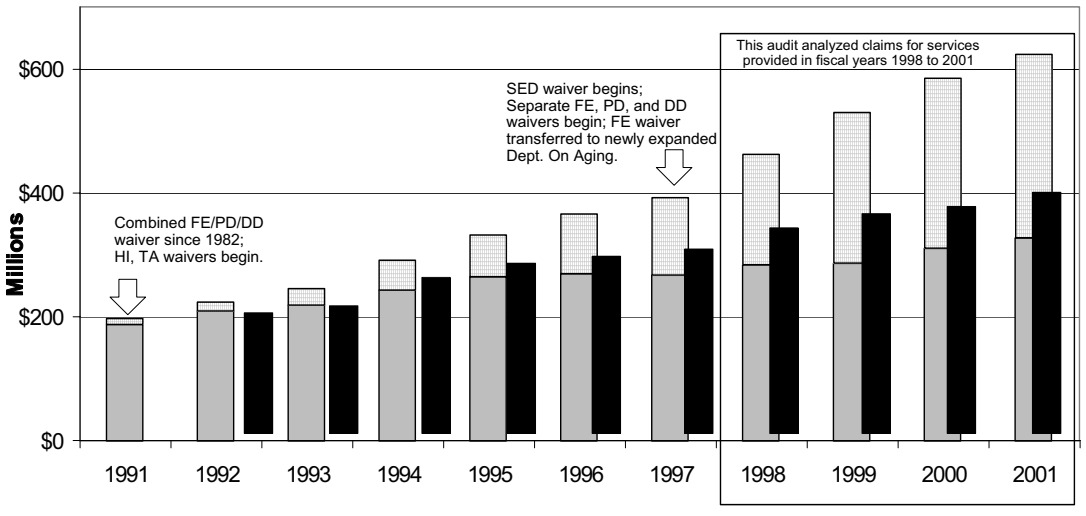
	Total Expenditures		Change (FY 98 to FY 01)		Percent of Total Increase (FY 98 to FY 01)
	FY 1998	FY 2001	Dollars	Percent	
Long-Term Care					
Nursing Facilities	*$284,343,252*	*$327,605,291*	*$43,262,039*	*15%*	
HCBS	*$177,321,782*	*$295,272,378*	*$117,950,596*	*67%*	
Long-Term Care Subtotal	**$461,665,034**	**$622,877,669**	**$161,212,635**	**35%**	**29%**
Regular Medical	$350,894,075	$498,042,261	$147,148,186	42%	26%
Pharmacy	$116,165,505	$188,582,079	$72,416,574	62%	13%
Non-Client-Specific(a)	$7,356,454	$186,854,882	$179,498,428	2,440%	32%
Total	**$936,081,068**	**$1,496,356,891**	**$560,275,823**	**60%**	**100%**

(a) Includes intergovernmental transfer funds, payments to hospitals that serve a disproportionate share of indigent people, State match for mental health centers in order to draw down federal funding, and adjustments to payments previously made to providers.

Source: Medical Assistance Reports provided by SRS

As shown in *Graph OV-1*, during that same 4-year period Medicaid-funded long-term care costs increased from more than $460 million to more than $600 million. Most of the increase in long-term care costs was for "waiver" services provided in the community.

Graph OV-1
Medicaid Long-Term Care Expenditures
1991-2001



Source: Medical Assistance Reports provided bySRS

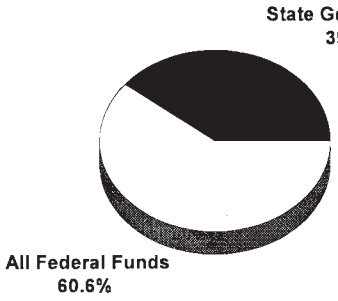
The Kansas Medicaid Program
AT A GLANCE

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

Staffing for Long-Term Care: The Department on Aging employs 23 central office employees for the Nursing Facility and the Frail Elderly waiver programs, and has 30 employees conducting qualify assurance for the Frail Elderly waiver. SRS has 20 central office employees in the Community Services and Support and Mental Health divisions for the waiver programs. SRS also has 54 employees conducting quality assurance in the field for the waiver programs.

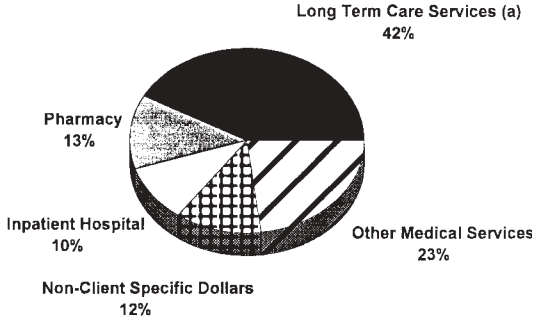
Budget: A joint federal and State program, Medicaid's medical services are funded 40% with State funding for medical services matched by 60% federal moneys.

FY 2001 Funding Sources



Total Funding: $1,496,356,891

FY 2001 Expenditures



Total Expenditures: $1,496,356,891

(a) This includes nursing facilities ($327 million) and home and community based services ($295 million).

Sources: Staffing information provided by agency officials; FY 2001 Medical Assistance Report.

Medicaid expenditures for long-term care rose $157 million from fiscal years 1998 to 2001. Rising costs for providing services in nursing facilities accounted for almost $47 million of the overall increase and were caused primarily by higher reimbursement rates to cover higher direct-care salary costs. Slightly more than $110 million of the increase for long-term care services was for "waiver" services provided in the community. Nearly three-fourths of that increase can be attributed to more people receiving services and the rest is due to relatively small increases in reimbursement rates and in the average amounts of services provided per person. There were several reasons more people received services: people who wouldn't have gone to an institution accepted services in the community (a phenomenon also known as the "woodwork factor"), new funds to reduce waiting lists were appropriated, and a new program to prevent hospitalization of children with severe emotional disturbances was expanded. These and related findings are discussed in more detail in the sections that follow.

Medicaid Spending for Long-Term Care Increased $157 million, Or 33%, from 1998 to 2001

Medicaid expenditures for long-term care include spending on care provided in nursing facilities as well as in the community through the waiver programs. The $157 million increase in expenditures reviewed in this audit doesn't include Medicaid spending for regular medical procedures or the pharmacy services people in long-term care may receive. Increases in costs for those services were already reviewed in earlier reports for this series of Medicaid audits.

In total, Kansas spent nearly $630 million in fiscal year 2001 to provide long-term care services to an average of about 28,000 people per month. *Table I-1* shows that the average number of people served each month increased by about 17%, while total spending increased by 33%.

Table I-1
Changes in Long-Term Care Population and Spending
FY 1998 to FY 2001

Service Setting	Average Number of People Served Monthly				Total Spending[a] (in millions)			
	FY 1998	FY 2001	# Change	% Change	FY 1998	FY 2001	$ Change	% Change
All Nursing Facilities	13,599	12,655	(944)	(7%)	$281.5	$328.0	$46.5	17%
All Community-Based Waivers	10,742	15,792	5,050	47%	$190.6	$301.4	$110.8	58%
Total Long-Term Care	**24,341**	**28,447**	**4,106**	**17%**	**$472.2**	**$629.4**	**$157.2**	**33%**

(a) Our analyses are based on claims for services provided in fiscal years 1998 and 2001 and paid through April 2002. In the Overview, we show total expenditures for these same years. Those totals are based on calculations from Medical Assistance Reports (MARs), which are based on claims paid during the fiscal years. They won't match total spending shown in this chart.

Source: LPA analysis of FY 1998-2001 Medicaid Claims data provided by Blue Cross/Blue Shield of Kansas.

Three things can cause spending to go up: increasing the number of people served, the amount of services per person, and the reimbursement rate for each service. The sections that follow look at each of these factors, first for nursing facilities, then for waivers.

Spending for Long-Term Care in Nursing Facilities

All of the Increase in Medicaid-Paid Nursing Facility Costs Can be Attributed to Increases in Medicaid Reimbursement Rates Because The Number of People Served in Nursing Facilities Has Declined

Spending for long-term care in nursing facilities rose 17% from fiscal years 1998 to 2001, despite a decline in the number of people served in them. The number of people served in nursing facilities fell by 7% over this 3-year period, mostly in regular nursing facilities and intermediate care facilities for mental retardation (ICF-MR). *Appendix B* summarizes the decline in populations by type of nursing facility. In addition, we compared the percent of Kansans over age 65 living in nursing facilities with the 4 surrounding states and Iowa. We found that although Kansas had a higher percentage of that age group in nursing facilities overall, the percentage of Kansans in nursing facilities paid for by Medicaid was in line with the other states.

Nursing facility costs increased because the average daily reimbursement rates for the largest categories of nursing facilities increased about 26% during the past 3 years. *Table I-2* compares nursing facility reimbursement rates for fiscal years 1998 and 2001.

Table I-2
Changes in Nursing Facility Average Daily Reimbursement Rates
FY 1998 to FY 2001

Type of Facility	FY 1998	FY 2001	$ Change	% Change
Nursing Facilities and Nursing Facilities/ Mental Health (accounts for 96% of all days paid)	$72	$90	$18	26%
Intermediate Care Facilities/ Mental Retardation (4% of days)	$170	$186	$16	9%

Source: LPA analysis of fiscal years 1998-2001 Medicaid claims data provided by Blue Cross/Blue Shield of Kansas, SRS, and Department on Aging.

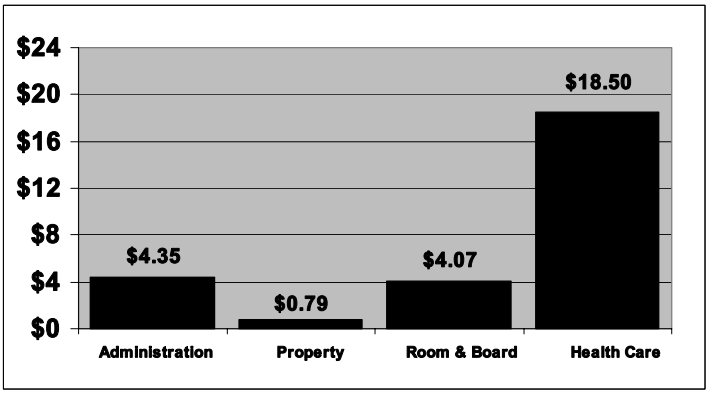
As the table shows, rates for regular nursing facilities and mental health nursing facilities increased an average of 26%. Those types of facilities accounted for 96% of total days paid. Rates for intermediate care facilities for the mentally retarded increased an average of 9%, but they only account for about 4% of total days.

Most of the increase in reimbursement rates was for the salaries of direct care staff. Nursing facilities are reimbursed a daily rate per patient based on actual costs previously incurred by the facilities for each of the following cost categories:

- **Administration** -Includes costs such as administrator salaries, office supplies, and liability insurance.
- **Property** -Includes costs such as utilities and maintenance and repairs.
- **Room and Board** - Includes costs such as food, dietary salaries, linen, and housekeeping supplies.
- **Health Care** -Includes costs such as nursing salaries, therapist salaries, and resident transport.

More about how rates are computed can be found in *Appendix C.*

Graph I-1
Increases in Payment Limits for Components of the Nursing Facility Reimbursement Rate
FY 1998 to FY 2001



Rate Component	FY 1998	FY 2001	Change $	Change %
Administration	$10.05	$14.40	$4.35	43.3%
Property	$11.06	$11.85	$0.79	7.1%
Room & Board	$19.24	$23.31	$4.07	21.1%
Health Care	$49.21	$67.71	$18.50	37.6%

Source: Kansas Department on Aging

Compared to many other Medicaid costs, Kansas has less control over increases in nursing facility reimbursement rates. That's because nursing facilties' reimbursement rates are directly tied to providers' costs, while rates set for other Medicaid-funded services—such as office visits and therapies—aren't directly tied to costs.

Graph I-1 shows the 4 cost categories that contribute to the average daily nursing facility rate. The health care category, which includes salaries for direct care staff, had the biggest dollar increase.

A small part of the increase in salaries was due to the Quality-Enhancement Wage Pass-Through Program, which the Legislature funded in 2000 and 2001. That program, which was funded at about $4.3 million, was aimed at helping to curb high turnover rates in direct care staff in nursing facilities. The money could be used to increase salaries and benefits or to hire additional staff.

Medicaid costs for providing nursing facility care are likely to increase by about $11 million in fiscal year 2003. However, these increased costs could have been as high as $19 million. After consensus caseload estimating, Kansas' nursing facility budget for fiscal year 2003 was estimated to be $321 million. A Legislative directive reduced the 2003 estimated budget down to $313 million. To stay within that budget, Department on Aging officials used rates paid to facilities in fiscal year 2002 and "trended" them forward to set the rates for the first half of 2003.

Kansas' average nursing facility reimbursement rate is in the bottom quarter of all states' rates. Data weren't available to allow us to compare 2001 rates, but comparisons for 1998-2000 showed that Kansas' average rate was consistently in the lowest quartile. Even with the anticipated rate increases for fiscal year 2003 noted above, Kansas' average rate is still likely to be less than the average rate in about three-quarters of the states.

Spending for Long-Term Care Through Community-Based Programs

This audit focuses on 4 of the 6 waiver programs: developmental disability, frail elderly, physical disability, and severe emotional disturbance. Those 4 accounted for 98% of the total spent on waiver programs in fiscal year 2001—$301 million—and all of the $111 million increase in spending for such services between fiscal years 1998 and 2001. Here's a summary of the increases in costs for community-based long-term care programs:

- An estimated $80.5 million increase caused by more people getting services in 2001
- An estimated $31 million increased caused by people getting more services per person and increased rates

Appendix D summarizes the change in expenditures from fiscal year 1998 to fiscal year 2001 for all 6 waivers.

More People Getting Services Was the Primary Cause of the Increased Costs in Community-Based Long-Term Care Services

People who qualify for Medicaid long-term care assistance have a choice of whether to receive that care in an institutional setting or in the community through any of 6 waiver programs. For more information about waiver programs, see *Overview Tables OV-2 and 3.*

Table I-1 showed that the average number of people getting home and community-based waiver services grew by nearly 5,100 people between fiscal years 1998 and 2001—or by 47%. This steep rise in

the number of people getting services increased spending by nearly $81 million, as shown in *Table I-3*.

Table I-3
Increases in Average Monthly Populations for Home and Community-Based Services and Resulting Cost Increases FY 1998 to FY 2001

Waiver	Average Number of People Served Monthly		Increase in # of people	Increased Percent	Estimated Cost Increase (millions)
	FY 1998	FY 2001			
Developmental Disabilities (DD)	4,213	5,393	**1,180**	**28%**	**$37.6**
Frail Elderly (FE)	4,115	5,796	**1,681**	**41%**	**$14.8**
Physically Disabled (PD)	2,238	3,683	**1,445**	**65%**	**$21.2**
Severe Emotional Disturbance (SED)	123	843	**720**	**586%**	**$6.9**
					$80.5

Source: LPA calculations from FY 1998 and 2001 data from the Medicaid Management Information System.

As the table shows, the increased populations occurred across the board, but the largest increases occurred among the frail elderly and physically disabled waiver groups.

It's difficult to definitively say why so many more people are getting community-based long-term care services. Based on our interviews with agency staff, our review of waiver policies, and our review of relevant literature, we identified the types of factors that likely contributed the most. Those factors are described in *Table I-4*.

Increases in Reimbursement Rates And in the Amount of Waiver Services People Received Had a Smaller Impact on the Rise in Waiver Costs

In addition to the $80.5 million in increased costs caused by more people getting services in 2001, $31 million in increases was caused by people getting more services and higher reimbursement rates for services. Of the $31 million increase, $25 million came from the 4 largest waiver services–day services and residential services for the developmental disability waiver, health care attendant services for the frail elderly waiver, and personal services for the physical disability waiver. Therefore, we focused our remaining analyses on these 4 services. (See *Appendix E* for more details about these services.) *Table I-5* shows our estimates of the increases in costs for these services that can be attributed to increased services per person and increased reimbursement rates respectively.

Table I-4
Summary of Reasons Why So Many More People Got Community-Based Long-Term Care Services in FY 2001 Compared to FY 1998

Reason	Program(s) Involved & Estimated Impact
"Woodwork" effect: Many people won't seek long-term care if the only setting for that care is in an institution, but they'll "come out of the woodwork" if services are available in the community. Both SRS and Department on Aging officials also said people are more likely to apply for help because available services are better publicized and applicants can apply for services somewhere other than an SRS office (with its attached stigma of "welfare"). While the impact of the "woodwork effect" is difficult to quantify, there is evidence that it is likely taking place: the number of elderly Kansans served in nursing facilities or on the frail elderly waiver between fiscal years 1998 and 2001 grew by nearly 7% even though the Kansas population over age 75 grew by 3% during that same time period.	Developmental Disabilities (DD) Frail Elderly (FE) Physical Disabilities (PD) estimated impact: unknown
In 1997, SRS changed financial eligibility requirements for waivers, making it easier for adults to qualify for services. The changes allow a single person with no dependents to keep about $700 a month; formerly that amount had been about $500 a month. Any income above the $700 must go toward that person's long-term care services. Raising this "protected income level" by $200 reduced the amount consumers must financially contribute to their own long-term care.	Frail Elderly (FE) Physical Disabilities (PD) estimated impact: unknown
Long-term care institutions closed, causing people with extensive developmental disabilities to seek services in the community. Winfield State Hospital began closing in 1996 and closed completely in January 1998. In addition 5 intermediate care facilities for the mentally retarded (ICFs/MR) closed between the beginning of fiscal year 1999 and the end of calendar year 2001, leaving only one large ICF/MR.	Developmental Disabilities (DD) 250 former Winfield State Hospital residents added to waiver 228 ICF/MR beds closed
The Legislature appropriated additional moneys, which allowed agencies to provide community-based services to more people. Generally, this money could be used to provide more services to people already receiving some services, allow more people to receive services, or a combination. Only the appropriations for the frail elderly waiver clearly specified that the additional money was to be used to serve people who'd been placed on a waiting list–eligible people who hadn't been served because there wasn't enough money. (However, the frail elderly, the developmental disabilities, and physical disability waiver programs have had waiting lists.	Developmental Disabilities (DD): appropriations of $5 million in fiscal year 2000, $7.5 million in fiscal year 2001 Frail Elderly (FE): appropriations of $10 million in fiscal year 2000, $3.2 million in fiscal year 2001 Of the 367 waiting for FE services in late 1999, 190 people got waiver services.
A new program to prevent hospitalization of children with severe emotional disturbances started in fiscal year 1998 and grew rapidly. Most of the services children receive under this program are regular medical services (e.g., therapy) provided through community mental health centers. This program began statewide on January 1, 1998, and eligibility criteria changed slightly in fiscal year 2001 to include more children with depression. Although its growth through fiscal year 2001 was substantial, it still serves fewer children than its developers expected: they expected about 1,600 consumers, and it actually served 1,400. We couldn't compare estimated total costs with actual costs, because developers estimated costs only for waiver-specific services.	Severe Emotional Disturbance (SED) 1,400 more waiver consumers, $7.6 million

Table I-5
Estimated Increases in Costs for Home and Community-Based Services Attributable Either to More Services Provided Per Person or Increased Rate
FY1998 to FY2001

Service and Waiver	Estimated increase caused by more services per person(a)	Estimated increase caused by changes in rates
Residential Services for the Developmentally Disabled	$6.2 million	$4.3 million
Day Services for the Developmentally Disabled	$1.6 million	$2.1 million
Health Care Attendant II Services for the Frail Elderly	$2.2 million	$1.5 million
Personal Services for the Physically Disabled (b)	$7.1 million	
Total	**$25.0 million**	

(a) Because information about the number of units of service provided wasn't reliable enough for us to determine how much the units per person increased, we estimated the cost increase by using the change in total expenditures, change in number of consumers, and change in reimbursement rates.
(b) For this service, computerized data include only how much Medicaid spent each month for each person. Because of this, we couldn't separate how much of the increase was caused by an increase in services and an increase in rates.

Source: LPA analysis of data from the Medicaid Management Information System.

Rates paid to providers for many widely used community-based services increased about 6% between fiscal years 1998 and 2001. As shown in *Table I-5*, increases in rates accounted for at least $8 million in increased costs. Rates varied by different types of services and by different waivers. Some of those changes:

- **Rates for residential and day services for people getting developmental disability services increased 6%.** In fiscal year 2000, the Legislature allocated $4 million to improve pay for direct care staff.

- **Rates for most services provided to frail elderly people increased 6%.** For example, maximum rates for health care attendant services (one of the most-used services for this waiver) increased by 6% in 2000. Rates for case management services were increased by 33% in fiscal year 1998.

- **Rates for some of the mental health services used most often by children with severe emotional disturbances increased by 100%.** This was part of an SRS initiative in 2000 to increase resources and services provided by community mental health centers. Because the centers use other State funds they already receive for the State's portion of Medicaid reimbursements, it's likely these rate increases didn't significantly increase expenditures from the State General Fund.

Increases in the number of services per client for the largest waiver services cost Medicaid at least an estimated $10 million. As shown in *Table I-5*, residential and day services for developmentally disabled clients accounted for $8 million of that

increase. In addition, clients on the frail elderly waiver got more health care attendant services, accounting for another $2 million. Officials cited 2 main reasons:

- Compared to a few years ago, people receiving home and community-based services have greater needs. Some data appear to support this contention. The combined needs assessment scores for new and continuing clients on the developmental disability waiver went up by almost 5% from fiscal year 1998 to 2001 (the higher the score, the greater the need). Scores for people entering the frail elderly waiver program went up by 2% over the same time period. However, other comparison scores weren't available.

- Elderly people have fewer family members and neighbors available to help them now than in previous years, Department on Aging officials said. Again, we couldn't verify this contention because information about the amount of help provided by clients' family and friends is kept only in each person's paper file. Department officials told us they've been working on a way to try to compile and maintain this information centrally.

Conclusion

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

Services provided in nursing facilities accounted for the remaining 30% of the overall increase in Medicaid long-term care costs. That portion of the increase was caused entirely by increases in the reimbursement rates paid to facilities. (The number of people served in those facilities actually declined by about 7%.) The main driver behind the reimbursement rate increases was health care costs incurred by the facilities. Those costs, which accounted for about $18.50 of the $27.71 increase in maximum daily reimbursement rates, include such things as nursing and therapist salaries and resident transportation costs. Medicaid costs for providing nursing facility care are likely to increase by about $11 million in fiscal year 2003, but could have increased as much as $19 million if the 2002 Legislature had not reduced the Medicaid nursing facility budget by $8.9 million.

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

SRS and the Department on Aging have a number of good processes in placed to help control long-term care costs, but they could do more. They could slow the growth in the number of people who become eligible for Medicaid paid long-term care services by raising minimum scores required for functional eligibility. This would ensure that only the most needy people qualify. They also could tighten financial eligibility requirements by doing such things as reducing the assets a person can shelter and still qualify for services, being more aggressive in identifying people who have transferred assets or set up trusts prior to applying for Medicaid, and by reducing the amount of protected income. Other actions the Departments could take include capping the number of people who can receive services, instituting spending caps that would disallow community services when they are overly expensive, using available data to identify areas where costs need to be controlled, and enhancing efforts to identify and recoup payments that shouldn't have been made. Also the Departments could work with the Legislature to develop ways to encourage people to obtain long-term care insurance. These and related findings are discussed in the sections that follow.

SRS and the Department On Aging Could Do More To Limit the Number of People Who Become Eligible for Long-Term Care Services and To Limit What Kansas Pays for Such Services

SRS and the Department on Aging have several processes in place that appear to help contain costs. For example, staff are trained in how to assess applicants' long-term care service needs, cases are monitored to ensure that consumers continue to be eligible, the claims system has edits in place to help ensure that appropriate payments are made, and two review teams do post-payment reviews. Still, we found that Kansas could do more to contain costs. The cost containment options we identified fell into 2 major categories:

- limiting the number of people eligible for Medicaid-funded long-term care services
- limiting the amount the State pays for long-term care services

As we noted in an earlier audit of Medicaid, some of the options presented here may not represent the most desirable health-care policy over the long term. However, in light of continually increasing State spending for long-term care and the State's fiscal constraints, we thought it was important to identify them.

OPTION: LIMITING THE NUMBER OF PEOPLE ELIGIBLE FOR MEDICAID-FUNDED LONG-TERM CARE SERVICES

Federal Medicaid law requires the same eligibility criteria to be applied to all people regardless of whether they are to receive services in a long-term care facility or in the community. Once an individual has qualified for Medicaid, he or she may choose whether or not to enter a long-term care facility, except that the State may require services to be provided in a facility if providing them in the community would be more costly.

People applying for Medicaid must qualify functionally and financially. Accordingly, the number of consumers who are eligible could be limited in at least 2 ways:

- tighten functional eligibility criteria
- tighten financial eligibility criteria

We discuss each in more detail below.

Raising the minimum score needed to functionally qualify for Medicaid.

(No legislation is required for this option.) As discussed in Question 1, the increase in the number of people getting waiver services was the primary cause of increased costs for community-based long-term care. Generally, home and community based services (HCBS) waiver programs use an assessment tool to determine whether an individual needs help with everyday activities that most people can do for themselves, such as bathing or preparing meals. The extent of need is measured with a score; the higher the score, the greater the assessed need. People must meet or exceed the minimum score to qualify for Medicaid-funded long-term care services. *Appendix F* gives an example of the activities that are assessed and how they are scored for an applicant needing frail elderly or physical disability waiver services. SRS raised the minimum scores from 15 to 26 in late 1999 for the Physical Disability

Table II-1
Current Average Assessment Scores for Long-Term Care Services

Recent average scores have far exceeded the minimums SRS and Department on Aging require to receive services.

Waiver program	Average score upon entry to the program	Minimum score needed to receive services
Frail Elderly	48.5 (for FY2001)	26
Physical Disability	43 (as of June 2002)	26
Developmental Disability	111 (for FY2001)	35

Source: Waiver documents, Department on Aging and SRS officials

waiver and in mid-2000 for the Frail Elderly waiver. (Minimum scores for other waivers didn't increase during our review period.)

During the 2002 legislative session, legislators considered whether to further raise the minimum qualifying score. On average, participants in Kansas' 3 largest waiver programs significantly exceed the minimum score needed to get long-term care services (as shown in *Table II-1*). Raising the minimum score would mean fewer people would qualify for Medicaid-funded long-term care services, thus reducing Medicaid spending. The Department on Aging has contracted with the University of Kansas to study where the threshold score should be set for nursing facilities and the Frail Elderly waiver. The results are due in October 2002. Officials expected this study also could affect the waiver for physically disabled people.

Table II-2 shows estimates the Department on Aging provided to the 2002 Legislature to show the effect of increasing the minimum eligibility score for nursing facilities and frail elderly waiver services from the current minimum score of 26.

Table II-2
Impact of Raising the Eligibility Score for the Frail Elderly Waiver and Nursing Facility Programs

If score were raised from 26 to...	Estimated number of people not qualifying	Estimated Savings (a)
30	301	$493,149
40	994	$1,838,241
50	1,883	$4,571,209

(a) The estimates assume all people currently in these programs would continue to receive services, regardless of their scores.

Source: Kansas Department on Aging, Feb. 2002 Legislative Testimony.

Colorado has recently considered raising their eligibility scores as a way to contain community based long-term care costs. Colorado officials told us they decided against raising the score because it would impact both the waiver and nursing facility populations. Missouri raised the score for waiver and nursing facility service from 19 to 21 points.

Tightening financial eligibility criteria.

(No legislation is required for this option.) Generally, even if an applicant functionally qualifies for long-term care, he or she still can't get those services paid for by Medicaid unless the need for those services exceeds his or her ability to pay for them. Kansas

could do several things to make it tougher to financially qualify for Medicaid-funded long-term care benefits:

- **Kansas could reduce the amount of assets applicants are allowed to legally shelter to become eligible for Medicaid.** In a March 2001 performance audit, we compared Kansas' methods for determining whether an applicant's assets were "countable" or "non-countable" toward paying for their own long-term care costs. Specifically, we found that Kansans can convert a larger portion of their countable assets into non-countable assets and become eligible for Medicaid sooner than they would in other states.

  In that audit, we recommended that SRS bring these eligibility requirements in line with neighboring states. To date, SRS hasn't implemented these recommendations. (A more complete listing of recommendations and SRS' responses to that audit are in *Appendix G*.)

- **Kansas could be more aggressive in identifying people who have transferred assets or created trusts within 3-5 years of applying for Medicaid.** Our March 2001 performance audit also found that SRS could do more to ensure applicants provide complete information about their assets. Currently, when determining whether applicants have made transfers or created trusts SRS officials rely on information applicants provide themselves.

  In that audit, we recommended that SRS require applicants to provide additional documentation, and routinely and systematically conduct cross-matches with State agency databases. To date, SRS hasn't implemented these recommendations. (A more complete listing of recommendations and SRS' responses to that audit and a summary of how Illinois estimates it could save $9 million if it looked for Medicaid applicants' sheltered assets are included in *Appendices G and H*.)

- **Kansas could lower the amount of "protected income," so applicants would be required to use more of their own income to pay for long-term care services and fewer would be eligible.** Federal rules allow states to designate how much of an applicant's income will be "protected income"–income that can be used for personal expenses, such as room and board. Anything above that amount must be used to help pay for his or her own long-term care services. If the amount available to pay for services exceeds the expected cost of those services, that individual doesn't qualify for any Medicaid long-term care services.

  SRS policies currently allow an applicant with no dependents to keep $716 a month (the federal poverty level) for personal expenses. The example in *Table II-3* illustrates how this works for an applicant with a monthly income of $850.

Table II-3 How Changing the Protected Income Level Affects Medicaid Spending–An Example	Using the current protected income amount	Using the "medically needy" amount for protected income (a)
Applicant's total income	$850/mo.	$850/mo.
"Protected income" -the amount an applicant can keep for personal expenses (including room and board)	$716	$475
Remaining income available for services	$134	$375
Amount services are expected to cost	$300	$300
How much the consumer pays toward his own long-term care costs	$134	$300 - person doesn't qualify for waiver services
How much Medicaid pays for long-term care (b)	$166/mo.	$0

(a) Federal rules don't permit the protected income level to be less than the "medically needy" level.
(b) This number doesn't include any regular medical benefits for which the person is eligible.
Source: LPA analysis

In information provided to legislators in March 2002, SRS estimated that reducing the protected income level for 3 waiver programs by $50 could save the State $977,000 a year. Reducing it by $100 could save about $2.1 million annually. However, SRS and Department on Aging officials have raised serious concerns about reducing the protected income level beyond that because State Medicaid Policies must allow eligible people to be able to pay for room and board.

To keep people out of institutions, agency officials told us, State Medicaid policies must allow eligible people to be able to pay for their own room and board. Waiver programs don't cover room and board expenses. If the protected income amount is reduced too much, according to agency officials, people may not be able to stay in the community because they can't afford their housing expenses. In addition, they may be unable to meet other expenses, and they may lose eligibility for regular medical coverage. SRS officials suggested that if the protected income level is reduced at all, that it be reduced a maximum of $100 and that any reduction be uniformly applied to all waiver programs.

OPTION: PAYING LESS FOR LONG-TERM CARE

Kansas could limit how much it pays for long-term care services by doing the following:

- Capping the number of people who can get Medicaid-paid waiver services
- Instituting spending caps per consumer
- Taking steps to reduce unnecessary services by analyzing and using key data
- Improving steps taken to identify and recoup amounts paid in error
- Taking steps to ensure that people can pay for their own long-term care
- Coordinating Medicaid-paid medical care and long-term care
- Freeze nursing facility reimbursement rates
- Claim all federal matching moneys possible

We discuss each in more detail below.

Continue to use waiting lists–capping the number of people who can get long-term care waiver services each year.

(No legislation is required for this option.) States can limit the number of people getting Medicaid-paid waiver long-term care services by using waiting lists. Kansas already has waiting lists for 4 waiver programs, as shown in *Table II-4*.

Table II-4
Waiting Lists at the End of Fiscal Year 2002

Waiver	number on waiting list at the end of fiscal year 2002 (a)	number of people receiving fewer services than needed: "underserved" (b)
Physical Disability	568	N/A
Developmental Disability	407	856
Frail Elderly	381	N/A
Head Injury	26	N/A

(a) These numbers were current as of April 30, 2002 (physical disability), May 2, 2002 (developmental disability), July 5, 2002 (frail elderly), and July 25, 2002 (head injury).
(b) (N/A) Not Applicable Numbers are collected only for the Developmental Disability waiver program.

Source: memos provided by SRS and the Department on Aging

Like Kansas, Colorado, Missouri, Oklahoma, and Iowa also are using waiting lists for at least some of their waiver programs to help control long-term costs. Nebraska is the only nearby state without a waiting list, but officials recently considered changing eligibility rules that may impact 19,000 people and save $22 million.

Anyone who is eligible for services and placed on a waiting list still could choose to get services in a nursing facility or other appropriate institutional setting, and Medicaid would have to pay for it. However, many people aren't willing to consider institutional care, so limiting the number of people who can receive community-based waiver services would likely reduce costs in the short-run.

In the long run, however, increasing or maintaining the number of people on waiting lists may not reduce long-term care costs. If those waiting choose to enter an institutional facility, the costs will likely be higher than the cost to provide community-based services. For example, the average cost to provide services to a person in the community in 2001 was just over $15,000, while average costs per consumer in nursing facilities was $19,000. More complete average cost per consumer information is in *Appendix I*.

Use spending caps per consumer to deny community services when institutional services would cost Medicaid less.

(No legislation is required for this option.) Federal Medicaid laws allow states to set a maximum dollar limit on the benefits a waiver consumer can get. If Kansas were to set a limit, applicants whose care costs exceeded that limit could be denied community services.

Kansas has chosen not to refuse community-based services for individuals for whom institution-based care would cost Medicaid less. However, *Table II-5* shows that, in fiscal year 2001, more than 900 people who received services under these waiver programs likely cost the Medicaid Program about $9 million more than they would have if they had received services in institutions.

Table II-5
For Some Consumers in Fiscal Year 2001,
Community-Based Services Were More Expensive

Waiver program	Number of consumers whose fiscal year 2001 costs exceeded institution costs and % of the total waiver population		Estimated difference in costs
Developmental Disability	546	9% of this waiver population	$3,579,000
Frail Elderly	76	1%	$595,000
Physical Disability	302	7%	$4,867,000
TOTAL	924	5% (a)	$9,241,000

(a) This is based on an annual count population of 18,251 for these 3 waivers. That estimate may be overstated slightly because some consumers may have been on more than one waiver.
Source: LPA analysis of Medicaid Information Management System Data

SRS and Department on Aging officials told us it's difficult to predict how much service any waiver participant will use, but it seems likely the application or review processes could identify some applicants for whom community-based services aren't cost-effective.

Reduce unnecessary services by analyzing and using key data to help manage program costs.

(No legislation required for this option.) The increases in the number of services per person noted in Question 1 could mean that SRS and the Department on Aging allow payment for more services than waiver beneficiaries really need. Although both Departments have some good processes in place to ensure that Medicaid pays only for necessary services, agency officials need to analyze key data available to them.

Analyzing and tracking this key data would help Department staff identify trends and determine whether consumers are getting more services because they really need them. *Table II-6* summarizes the

key data pieces and additional steps that agency officials should take to ensure that consumers get only the services they need.

Table II-6

Steps SRS and the Department on Aging Take To Ensure Medicaid Pays Only for Necessary Services	Additional Steps That Would Help Assure Tha Kansas Pays Only for Services Needed
• a written plan of care for each waiver beneficiary specifies the type and number of services to be provided and who is to provide them. • State agency staff review each plan of care. • State staff train case managers to address in the plans of care only needs that aren't met by any other means. • State quality assurance staff review plans of care and the services that are provided. • higher-level staff review exceptionally expensive plans of care.	• **determine which services are being used more often and why** and investigate less costly ways to provide those services. • **determine whether consumer needs are increasing over time by tracking assessment scores;** if needs identified on plans of care increase but assessment scores don't, find out why and ensure that it's because consumer needs increased. • **determine, over time, whether more or fewer needs are being met by unpaid supports;** if fewer unpaid supports are being used, determine the reasons why.

Source: Review of agency processes, agency data, and interviews with agency officials.

Strengthen efforts to identify and recoup amounts paid in error.

(No legislation is required for this option.) In 1999 and 2001, SRS conducted systemwide reviews of payments to Medicaid providers to assess the appropriateness and accuracy of those payments. These reviews looked at a sample of claims for 1 month and projected the results over a year. The second review, which is scheduled to be released in August 2002, found that 21% of the dollars paid for community-based services were made in error. That compares to 40% found in the earlier review.

Although many of these errors involved documentation problems, others did not. In 2001, about 6% of the dollars were paid in error for such things as double billing or providing services beyond a program's limits. If just the non-documentation errors are projected to the entire payment population, they could total as much as $19.6 million on an annual basis. This shows there's the potential for significant savings if these errors can be reduced or eliminated.

SRS and the Department on Aging already have a number of processes in place to try to control inappropriate Medicaid payments, including the following:

- The computerized claims system has edits in place to prevent inappropriate claims from being paid in the first place.

- SRS has a Medicaid Surveillance and Utilization Review (SUR) team, as required by the federal government, to review claims,

identify and recoup inappropriate payments, and help correct problems with the payment system. The SURS Unit includes a special team that focuses only on claims for community-based long-term care services.

Although the potential for recovery identified in the Department's payment accuracy reviews is large, actual amounts recovered recently have been relatively small.

- In 4½ years, the SUR Unit has identified and recouped about $200,000 in inappropriate claims to nursing facilities.

- Since its start in January 2001, the SUR staff group reviewing payments for community-based long-term care services has identified almost $340,000 in inappropriate payments to 15 providers. However, the effectiveness of this group is limited, because there are only 3 reviewers while there are hundreds of community providers, and the group opens reviews on only 4 to 6 providers each quarter.

We also identified more than $186,000 in potentially inappropriate payments made to long-term care providers that hadn't been identified by the Department's efforts. We reviewed almost 1.7 million computer records for the claims paid for long-term care services provided in 2001 to identify potential overpayments related to things such as paying for nursing facility stays more than once, paying for medical services that should have been provided by nursing facilities, and paying for waiver services while a client was actually in a hospital. Here's what we found:

- **Paying twice for nursing facility or residential days** (*$128,000*) - We found more than 1,500 days of nursing facility and residential care that were double billed to Medicaid. Examples of double billing include paying a nursing facility twice for the same client on the same day, paying both a nursing facility and a hospice agency for the same client on the same day, and paying a community residential service provider for a day that a developmentally disabled person was in the hospital.

- **Paying for services that should have been provided as part of another service** (*$53,000*) - This occurs most often with nursing facility stays which are supposed to include a variety of services that otherwise might be billable to Medicaid. For example, we found *$41,000* in claims for kidney dialysis for nursing facility patients–a service that is supposed to be provided by the nursing facilities.

- **Paying for continued services after a client's death** (*$5,300*) - We found 146 nursing facility days that were paid for even though the dates of service were after the clients died.

It appears the Department could do several things to improve the identification and recoupment of erroneous payments:

- **Commit more resources to the special Surveillance and Utilization Review team that focuses on community-based long-term care services**. This unit has been in existence less than 2 years and has identified about $340,000 in erroneous payments to providers. However, because this unit consists of only 3 people, it can review only a limited number of providers each year.

- **Continue to conduct payment accuracy reviews but modify the scope of these reviews**. As noted earlier, these reviews include a sample of claims from one month and results are projected onto a year. If the reviews looked at a sample of claims from an entire fiscal year, the results would be more reliable and more representative of claims paid in error.

Take steps to ensure that people pay for their own long-term care–provide financial incentives for long-term care insurance.

(Legislation would be required.). About half of Kansans rely on Medicaid and about half rely on their own resources to pay for their long-term care, regardless of whether they get services in the community or in an institutional setting. One way to reduce long-term care costs over the long run is to increase the number of people who have long-term care insurance.

Both the Kansas Insurance Department and the Kansas Long-Term Care Task Force have supported finding ways to encourage private long-term care insurance. Two issues to consider further:

- **Offering a tax credit or deduction that is separate from currently available itemized deductions.** Under current federal tax law, relatively few people would be able to deduct the cost of long-term care insurance premiums, because they are part of medical deductions which must be greater than 7.5% of their adjusted gross income to be deductible. (Only 28% of Kansans itemized deductions in 2001, so it is likely that few could take advantage of this federal deduction.) Colorado allows individuals with income less than $50,000 to deduct up to 25% of long-term care premiums paid from their State income tax. Missouri also allows a deduction equal to 50% of the premiums if they aren't reimbursed and aren't included in itemized deductions. Kansas may want to limit the income on which premiums are deductible, because people with high incomes are less likely to later qualify for Medicaid services.

- **Because low-income seniors can't afford the cost of long-term care insurance, making that insurance more affordable could still reduce the State's costs**. Recent literature shows that private insurance is bought mostly by upper-middle and upper-income elderly people with substantial assets, and that long-term care insurance will have little impact on public spending through Medicaid. For policies sold to the elderly, the projected Medicaid savings are 2-4 percent. If Kansas intends to have long-term care insurance help defray Medicaid costs for the immediate and upcoming low-income seniors, then insurance must be affordable.

For example, California and New York both allow Medicaid applicants to keep more assets than normally allowed–if they've bought state-approved long-term care insurance.

Senate Concurrent Resolution #1614, passed by the 2002 Legislature, urged SRS and the Department on Aging to begin an education awareness campaign to make Kansans aware of the potential costs of long-term care and to encourage them to invest in long-term care insurance when it's affordable. Before this Resolution had passed, the Insurance Department had recommended educating the public about the benefits of long-term care insurance and standardizing long-term care insurance benefits.

Provide better case management to ensure that services are provided in the most cost effective manner.

(No legislation is required for this option.) Some consumers of Medicaid-paid long-term care services tend to have extensive health care needs. For the 3 largest waiver programs, developmental disability, frail elderly, and physical disability, Kansas spent $288 million in 2001. In addition to waiver services, generally, these consumers also have access to regular Medicaid-paid medical services. It's important that cases of consumers with extensive needs be closely monitored so that services are provided by the most cost effective provider–whether a waiver provider or a medical service provider. In our March 2002 performance audit, *Medicaid Cost Containment: Controlling Costs of Medical Services,* we recommended that SRS implement an aggressive utilization management program for those consumers with extensive health care needs, many of whom are elderly or physically disabled. Such a program would ensure that the range of services provided –whether medical or long-term care services—are appropriate, necessary and cost effective.

According to SRS officials, Kansas will join Florida, Washington, and other states in attempting to control spending for medical services by managing Medicaid consumers with chronic medical conditions: SRS plans to begin using nurses to manage care for those high-use consumers (including those in long-term care) in October 2002.

Freeze nursing facility reimbursement rates or delay rate increases.

(No legislation is required for this option.) As noted in Question 1, Department on Aging officials limited nursing facility reimbursement rate increases for 2003, after the 2002 Legislature

reduced the Mediciaid nursing facility budget by $8.9 million. According to Department on Aging officials, 2003 costs could have increased as much as $19 million if rates paid to nursing facilities in 2002 hadn't been used to set reimbursement rates for the first half of 2003.

Other states are proposing to maintain or reduce nursing facility reimbursement rates, including Illinois, Indiana, and Michigan. Iowa has proposed freezing rates in 2003 and Nebraska is modifying its payment system to contain costs. Hawaii reduced the increase in nursing facility rates by one-half the increase in the inflation factor. In addition, for fiscal year 2002, Oklahoma delayed implementing the SSI cost of living adjustment for nursing facility rates.

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

(Legislation is likely not required for this option.) 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, as part of an initiative to increase mental health resources and services, SRS increased reimbursement rates for certain mental health services. Because Community Mental Health Centers were able to use other State funds they already received–to fund the State's portion of Medicaid reimbursement, it's likely these rate increases didn't significantly increase State General Fund expenditures. We couldn't look at this issue in-depth during this audit, but SRS and the Department on Aging should ensure that State agencies and contractors use all possible current spending to match federal dollars.

Conclusion

Because Medicaid costs consume a large portion of the State's budget and those costs are growing at a rapid rate, it's important that they be closely monitored and controlled particularly in light of the State's recent fiscal problems. SRS and the Department on Aging already have established a number of good processes to manage costs and to help identify payments that shouldn't be made. There are still a number of things the Departments could do to control program costs, such as analyzing available data to identify trends in the use of services that might indicate clients are overusing certain services, or strengthening efforts to identify and recoup payments made in error.

Unfortunately, the options that are most likely to have a large impact on costs don't present easy choices for policy makers. They involve limiting the number of people who are eligible to receive services so that only the most needy can have Medicaid pay for their care and limiting the amount or types of services eligible beneficiaries can receive. Any of these options will mean that some people will be forced to pay for more of their own services or will receive a reduced level of service.

Recommendations

1. To ensure that Medicaid long-term care services are provided to the most needy Kansans at a level the State can afford, SRS and the Department on Aging should collaborate on a concrete plan that contemplates options for restricting eligibility, reducing services, or other actions that could reduce or slow the growth of spending. They also should seek input from the appropriate legislative committees during the 2003 legislative session on actions to take to control Medicaid spending.

2. To ensure that those who apply for Medicaid assistance under existing eligibility criteria are truly eligible, SRS officials should strengthen their efforts to ensure that applicants haven't transferred assets or created trusts within 3-5 years of applying for Medicaid, simply to become financially eligible for the program. (*This is a repeat recommendation from our March 2001 audit "Reviewing the Department of Social and Rehabilitation Services' Efforts to Identify Inappropriate Means of Sheltering Assets to Qualify for Medicaid."*)

3. To ensure that Medicaid moneys aren't paid out when they shouldn't be, SRS should continue to conduct payment accuracy reviews on payments including those for long-term care at least every 2 years, and should select its sample from an entire year's worth of claims rather from a single month. This sample selection method would improve the accuracy of the Department's

projection of claims paid in error and help to identify more clearly the true problems with claim payments. In addition, the Department should commit more resources to the Surveillance and Utilization Review team that focuses on community-based long-term care services.

4. To help identify key trends in service usage that might indicate ways to control spending, SRS and the Department on Aging should assign staff to periodically review factors including:

   - the number and types of services being used by Medicaid long-term care clients, individually and in groups
   - whether fewer needs are being met by unpaid providers and why
   - average eligibility assessment scores over time

5. To ensure that Medicaid moneys are used in the most cost-effective manner, SRS should coordinate intensive health-care management of chronic conditions (a program it's anticipating implementing in October 2002) with case management for community-based long-term care services.

6. To help reduce overall Medicaid costs, SRS and the Department on Aging should study ways to increase the amount of services provided by unpaid providers such as family members or charitable or faith-based organizations.

7. As a more long-term solution to reducing Medicaid costs, the Legislature should review the findings of the Kansas Long-Term Care Task Force and study the cost-effectiveness of providing subsidies or tax incentives to lower-income individuals to encourage them to obtain long-term care insurance.

8. To help reduce overall Medicaid costs, the Legislature and Department on Aging should consider further delaying increasing reimbursement rates to nursing facilities.

9. SRS and the Department on Aging should 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.

Medicaid Cost Containment: Controlling Residential Facility Costs

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 residential facility costs would address the following question:

1. **What measures do the Departments of SRS and Aging take to control residential facility 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 for residential placements. We would look at policies governing who is eligible for specific types of residential placements (eg. group home placement, or skilled nursing care versus assisted living). We would review the basis for determining reimbursement rates for these facilities. We would compare Kansas' practices to innovative practices identified in other states, and would do testwork looking at specific placements

Estimated completion time: 10-12 weeks

Appendix B
Changes in Nursing Facility
Average Monthly Population
FY 1998 to FY 2001

Type of Facility	FY 1998	FY 2001	Population Change	% Change
Nursing Facilities	12,119	11,515	(604)	(5%)
Nursing Facility/Mental Health	681	680	(1)	0%
Intermediate Care Facilities/ Mental Retardation	803	463	(340)	(42%)
Total (Unduplicated)	**13,599**	**12,655**	**(944)**	**(7%)**

Source: LPA analysis of fiscal years 1998-2001 Medicaid claims data provided by Blue Cross/Blue Shield of Kansas.

Appendix C

Nursing Facility Reimbursement Rate Setting Methodology

Nursing facilities are reimbursed for the costs they incur to provide treatment and care to residents. The system used to determine the reimbursement rate is developed by the Department of Social and Rehabilitation Services.

- **Daily rates are based on costs incurred by the facilities.** Nursing facilities submit an annual cost report to the Department on Aging. Allowable cost are reported under 4 components: administration, property, room and board, and health care. All facility cost reports are reviewed for accuracy by the Department on Aging.
- **Occupancy level of the facility has an impact on the daily rate.** To determine the daily costs, the total expense for each component is divided by the number of inpatient days. If a facility has less than 85% occupancy, the total expense is divided by the greater of the number of inpatient days or 85% of total licensed and certified beds for the facility. That dollar amount is then adjusted for inflation.
- **The level of need of the residents affects part of the facility's daily rate.** Since1994 a case mix index has been applied to the health care cost component. The case mix index is based on the annual assessments of residents' level of care. Each resident is assigned a case mix factor, based on their assessment, and the average of all the case mixes becomes the case mix index for the facility. Facilities are paid the lower of the case mix index limit or the inflated per diem rate for the health care cost component.
- **Upper payment limits for each component are set.** The Department establishes upper payment limits for each component based on the costs reported by all facilities. The limits are based on a certain percentage of the median cost for all facilities. The current percentages for each component are: Administration – 115%; Property – 130%; Room and Board – 130%; and Health Care – 125%. The facilities are paid the lower of their actual daily costs, or the cost component upper payment limit.
- **An incentive is added for controlling of costs.** An incentive factor is offered to facilities for maintaining low costs in the administrative and property cost components. An incentive of up to $.50 can be added onto the calculated daily rate.
- **Daily rates are compared to private pay rates.** The final daily rate for a facility is then compared to the private pay rate on file with the Department on Aging. The facilities are paid the lower of their calculated daily rate or the private pay rate of record.

Appendix D
Total Expenditures for
Home and Community-Based Service Waivers
FY 1998 to FY 2001

Waiver	FY1998	FY2001	Change $	Change %
Developmental Disability	$124,169,548	$176,905,751	$52,736,203	42.5%
Physical Disability	27,903,495	57,215,580	29,312,086	105.0%
Frail Elderly	31,970,475	54,059,817	22,089,342	69.1%
Severe Emotional Disturbance	756,915	8,322,045	7,565,130	999.5%
Head Injury	4,057,157	3,514,753	(542,404)	(13.4%)
TechnologyAssisted	2,150	188	(1,963)	(91.3%)
Unallocated (a)	*1,780,844*	*1,372,093*	*408,751*	—
Total	**$190,640,584**	**$301,390,227**	**$110,749,643**	**58.1%**

(a) These are claims submitted by waiver providers that we couldn't allocate to a specific waiver. They include things like screening clients to determine if they are even eligible for waiver services.

Source: LPA analysis of FY 1998-2001 Medicaid Claims data provided by Blue Cross/Blue Shield of Kansas.

Appendix E
Definitions for Community-Based Long-Term Care Services that Medicaid Spent the Most On in Fiscal Year 2001

The 4 "waiver" services defined below are listed on page 14 of the report. Together, they accounted for about $100 million, about 90%, of the $111 increase in costs for community-based long-term care services from fiscal year 1998 to 2001. Below, we also show total spending for each service for fiscal year 2001.

Residential services for the developmentally disabled *$100.5 million*	**Activities that help with the acquisition, retention, and/or improvement in skills related to activities of daily living,** such as personal grooming and cleanliness, bed making and household chores, eating and preparing food, and social participation, skills needed to allow the waiver participant to live in a non-institutional setting
Day services for the developmentally disabled *$46.5 million*	**Regularly occurring activities that provide a sense of participation, accomplishment, personal reward,** or personal contribution and that increase skills, independence, and/or participation in the community; the participant may or may not be paid.
Health care attendant II services for the frail elderly *$42.2 million*	**Health maintenance activities** (any activity requiring nursing or physician authorization), such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, medication administration/assistance, wound care, range of motion, reporting changes in function or condition. **In addition to health maintenance activities, as of July 1, 2000, this service included accompanying to obtain necessary medical services plus physical assistance with activities of daily living,** such as bathing, grooming, dressing, toileting, transferring (e.g., from the bed to a wheelchair), walking/mobility, and eating.
Personal services for the physically disabled *$54.9 million*	**Assisting with tasks an adult would typically do for himself during the "normal rhythm of the day":** • **activities of daily living** (e.g., bathing, grooming, toileting, transferring, feeding, mobility, assistance in getting necessary medical services, shopping, housecleaning, meal preparation, laundry, financial management) • **health maintenance** (e.g., supervising and/or training others on nursing procedures, catheter care, assistance with or administering medicines, wound care, range of motion)

Appendix F

Example Factors in the Score for the Physical Disability and the Frail Elderly Waiver Eligibility

Eligibility for each waiver requires a minimum score on an assessment instrument. The simplest is the Uniform Assessment Instrument (UAI) that is used for the physical disabilities and the frail elderly waivers. In general, to be eligible, an applicant must score at least 26. Below are examples of activities that factor into the score.

Activity	**Reviewer's assessment of applicant's ability to perform this task** ***(examples shown)***	**Multiplier**(a)	**Weight**(b)	**Score** (multiplier times weight)
Activities of daily living:				
Bathing	physical assistance needed	1	4	4
Dressing	independent	0	3	0
Toileting	independent	0	5	0
Transfer	independent	0	5	0
Walking, mobility	physical assistance needed	1	3	3
Eating	independent	0	4	0
Instrumental activities of daily living:				
Meal preparation	unable to perform	2	5	10
Shopping	unable to perform	2	3	6
Money management	supervision needed	1	4	4
Transportation	physical assistance needed	1	3	3
Use of telephone	independent	0	3	0
Laundry/ housekeeping	unable to perform	2	3	6
Management of medications, treatments	supervision needed	0	5	0
Additional factors that place a person at risk for institutionalization:				
Has the person fallen? Is the person unsteady?	person has fallen twice in the past month	1	3	3
Is there neglect, abuse, or exploitation?	no	1 (if yes)	5	0
Is support or a caregiver available?	no	1 (if no)	4	4
Is there memory difficulty?	has trouble with short-term memory and with decision-making	2	4	8
Is there bladder incontinence?	occasionally incontinent	1	5	5
Total score(26 is minimum needed for eligibility)				56

(a) If the assessment is "independent", the multiplier is 0; if it's "supervision needed" or "physical assistance needed," the multiplier is 1; if the assessment is "unable to perform," the multiplier is 2. For the "additional" risk factors, the multiplier is specific to the risk factor.
(b) "Weight" is a measure of the importance of the task to independent living

Source: adapted from materials provided by the Kansas Department on Aging

APPENDIX G

Recommendations from the March 2001 Performance Audit *Medicaid for Long-Term Care: Reviewing SRS' Efforts to Identify Inappropriate Means of Sheltering Assets to Qualify for Medicaid*

The following recommendations appeared on pages 13, 19, and 20 of that report. Our summary of the SRS's response is provided in italics after each recommendation. As part of preparing our Annual Follow-up Report, we contacted SRS to determine whether the recommendations had been implemented. As noted on page 19, the Department hadn't implemented the bulk of these recommendations, as of July 2002.

1. **To ensure that only needy applicants receive Medicaid assistance for long-term care, the Department of Social and Rehabilitation Services should review and adjust its eligibility requirements accordingly to bring them more in-line with other states in terms of caps, criteria, limits, and the like.** The Department should seek legislative input as needed, and should report back to the Legislative Post Audit Committee and other appropriate committees regarding any changes it plans to make. If the Department determines that changes aren't needed, it also should provide the rationale for making those decisions.

   ***March 2001 agency response**: SRS said it had not seen evidence of Medicaid applicants taking advantage of Kansas policies with regard to vehicles, income-producing property, personal effects and furnishings, and pre-paid funeral arrangements, 4 areas where Kansas policies are more liberal than those of comparison states. It said it would continue to monitor these issues.*

   ***June 2002 agency response**: SRS officials told us they are looking into two policies related to this area. First, they are reviewing the income producing property exemption. Secondly, they are reviewing treatment of home property which is incorporated in a revocable trust. SRS noted that it was successful in getting a bill adopted which would allow the agency to recovery excess funeral monies remaining in a prepaid funeral agreement.*

2. **To help ensure that applicants for Medicaid assistance for long-term care provide complete information about the assets they own or have recently sold or placed in trust**, the Department of Social and Rehabilitation Services should do the following:

   a. **require applicants to provide additional documentation at the time they apply for Medicaid assistance**, including recent residential addresses, copies of income tax returns, real estate deeds and local property tax bills, bank statements, and life insurance policies.

   b. **routinely and systematically conduct cross-matches with the Computer-Assisted Mass Appraisal (CAMA) and motor vehicle registration databases, as well as any other relevant databases** maintained by other State agencies, to determine whether applicants own additional assets that could be used to help pay for their long-term care.

   ***March 2001 agency response**: SRS partly concurred and partly disagreed with the recommendation. It disagreed that additional documentation would be productive. It said it would continue to review other State agency databases for usefulness, accessibility, and cost-effectiveness.*

   ***June 2002 agency response**: SRS officials continue to disagree with recommendation 2a, that applicants for Medicaid assistance be required to provide additional documentation about financial*

status at the time they apply for Medicaid assistance. As for recommendation 2b, officials stated they are continuing to explore use of the CAMA system. Beyond that system, officials stated that there aren't other databases that they've found that would be useful to ensure that applicants are financially eligible.

3. **To help ensure that SRS and the Legislature have relevant information to plan for the future needs of long-term care, SRS should routinely compile cumulative data about the number of people applying for Medicaid assistance for long-term care**. At a minimum, that information should include the number of applicants and the number of applications denied and approved. The Department also should identify and compile information about the methods applicants are using to inappropriately shelter assets, and should provide that information to its staff.

   ***March 2001 agency response**: SRS said it was unclear as to the necessity of tracking this information and said the computer system being used would make that difficult. It suggested greater use of its Quality Assurance and Performance Evaluation group to monitor the extent to which applicants may be sheltering assets and the methods applicants use to shelter assets.*

   ***June 2002 agency response**: SRS officials noted that their Qualify Assurance unit will be conducting a review of applicants to look for sheltering of assets. The review hasn't begun yet because of ongoing workloads, but agency officials expected the review to begin within a year.*

4. **To ensure that applicants who've inappropriately transferred assets don't have to wait longer than federal regulations require to receive Medicaid benefits, SRS should promptly and regularly update the figure it uses to calculate the penalty period that should be imposed**. That figure should reflect the current average monthly cost of nursing home care for a private-pay patient, but the Department hasn't updated that figure since 1993.

   ***March 2001 agency response**: SRS said it would update the figure as of July 1, 2001.*

   ***June 2002 agency response**: SRS officials adjusted the figure it uses to calculate penalty periods when applicants inappropriately transfer assets. It was adjusted to $3,000 as of July 1, 2001. Officials also noted that the Legislature had asked the agency to pursue extending the period in which they can review applicants' financial information for inappropriate transfers–changing it from 3 to 5 years. Officials plan to report their findings to the 2003 Legislature.*

APPENDIX H

Illinois Estimates It Could Save $9 million if It Looked for Medicaid Applicants' Sheltered Assets

- A long-term care asset discovery initiative within the Illinois Department of Public Aid estimated savings of $2.8 million from several phases of that initiative and $9 million if the initiative had been expanded statewide. Here's what they did:
- investigated 787 cases to determine whether applicants for long-term care weren't disclosing all their assets or income or were transferring assets improperly
- developed a profile of applicants most likely to fail to disclose assets, so that eligibility workers could more closely check those applications
- The investigators estimated savings could be even higher if the tougher investigative process were completely adopted and publicized; they noted some applicants for Medicaid assistance withdrew when they learned of the investigation.

Appendix I
Average Cost per Consumer for Long-Term Care(a)
FY 1998 to FY 2001

	FY1998	FY2001	Change	
			$	%
Waiver programs				
Developmental Disability	$24,424	$28,925	$4,501	18%
Physical Disability	$8,497	$12,709	$4,212	50%
Frail Elderly	$5,480	$7,082	$1,602	29%
Severe Emotional Disturbance	$2,301	$5,949	$3,648	159%
Head Injury	$37,222	$32,544	-$4,678	-12%
Technology Assisted	$1,075	$63	-$1,012	-94%
Average, all waiver programs	$13,020	$15,252	$2,232	17%
Nursing facilities				
Nursing facilities	$14,272	$18,209	$3,937	28%
Intermediate Care Facilities - Mentally Retarded	$38,666	$48,099	$9,433	24%
Nursing facilities - Mental Health	$13,042	$16,633	$3,591	28%
Average, all nursing facilities	$15,564	$19,062	$3,498	23%

(a) Note that these totals do not include regular medical services, such as physician visits that these consumers may have received through Medicaid. These averages were derived by dividing expenditures by the total number of users, not by the monthly average number of consumers reported in Appendix D.

Source: LPA analysis of FY1998-FY2001 Medicaid claims data provided by Blue Cross/Blue Shield of Kansas.

APPENDIX J

Agency Responses

On July 26 we provided copies of the draft audit report to the Department of Social and Rehabilitation Services and to the Department on Aging. Their responses are included in this Appendix.

In response to Recommendation 2, SRS officials told us that requiring additional documentation from Medicaid applicants and implementing and investigating applicants more stringently would be counterproductive and a barrier to those applicants providing accurate financial information. In addition, SRS officials told us they've begun working with the Department on Aging to explore expanding the look-back period for property transfers.

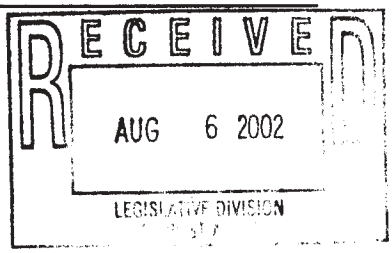
After carefully reviewing the Department on Aging's response, we made some minor clarifications to the report. Department on Aging officials generally concurred with the audit recommendations.

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

August 6, 2002



Barbara J. Hinton
Legislative Division of Post Audit
800 SW Jackson St., Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

SRS has received and reviewed the August 2002 performance audit completed by your office, *Medicaid Cost Containment: Controlling Costs of Long-Term Care*. We appreciate the work you and your staff put into this audit. In response to the recommendations outlined in the audit report, SRS submits the following comments:

Recommendation 1:

SRS will continue to collaborate with the Department on Aging in exploring options for restricting eligibility, reducing services, or other actions that could reduce or slow the growth of spending. As noted in the *Medicaid Cost Containment* audit report, actions such as raising the long term care scores for the PD and FE HCBS waiver programs have been considered in past Legislative sessions, and information regarding the impact of such actions has been presented to the Legislature. Additionally, SRS is considering entering into a contract with an outside entity to review the assessment tool and its impact related to persons with physical disabilities and their needs. Discussions as to lowering the protected income level have also occurred within SRS, and per request of the Legislature, HCBS waiver cost-saving measures are presented each year. Prior to making decisions about adopting any cost-saving measures, SRS would meet with stakeholders in the Kansas long-term care community and consider the impact on consumers of any potential eligibility criteria changes, service reductions, etc.

Recommendation 2:

As noted in our June 2002 update response, the agency believes that its current process of relying on information provided by the consumer and representatives, as well as use of crossmatches available to the agency, has been effective. Establishing additional documentation requirements for the consumer or implementing a more stringent investigative process at the point of application is seen as counterproductive and would create an unnecessary barrier to access to the majority of consumers who provide

accurate information. The one additional crossmatch mentioned in the previous recommendations, the CAMA system, has not been adopted, as it continues to be a non-user friendly system and is currently tightly controlled by the Department of Revenue. SRS has also begun working with the Department on Aging in exploring a waiver to expand the lookback period for property transfers. The state of Connecticut has submitted such a waiver, and, based on the Federal response, Kansas may also look at a similar measure. SRS regularly reviews policies to gauge their effectiveness at preventing asset sheltering, and the agency is currently looking at both the income-producing property exemption and treatment of homes incorporated in trusts for future change.

Recommendation 3:

Many significant steps already underway in this area are connected with the transition from the previous fiscal agent, Blue Cross/Blue Shield of Kansas, to EDS. As part of the new design of the Medicaid Management Information System (MMIS), a much more sophisticated Fraud & Abuse Detection System (FADS) will be used. In addition to the peer profiling and outlier exception techniques of a Surveillance Review and Utilization System (SURS), the FADS incorporates artificial intelligence, in conjunction with more flexible ad hoc reporting. This will provide for more focused queries and investigation of problematic areas, such as HCBS providers. The report stated that the effectiveness of the SURS staff is limited as there are only two reviewers for this purpose. In fact, in addition to the State staff, the EDS fiscal agent SURS/FADS team consists of a team of eleven, any of which can play a role in identifying potentially inappropriate provider actions. This year, State staff are conducting a systematic review of front end edits and claims audits to better identify claims for recycling and recovery and/or to reduce inappropriate initial payments. In conjunction with this, we are also reviewing our system edits for Third Party Liability assignments and are investigating enhanced data match capabilities as a means of better managing and limiting payments made from the MMIS. We will be extending the sampling methodology for the Payment Accuracy study to include more representative time periods.

Recommendation 4:

In order to review the number and types of Medicaid long term care services, SRS can request that the Medicaid fiscal agent develop special reports from paid claims history. The agency will explore the feasibility of developing these special reports.

All of the community-based long-term care systems in Kansas encourage the use of natural/unpaid supports as much as possible. At this point in time, however, SRS does not have baseline data regarding the level of natural/unpaid supports each person uses. A database or databases to begin to collect this information would have to be built. It is possible that such data could be obtained from case managers and independent living counselors or through plans of care. The types of natural/unpaid supports currently in use across the state vary greatly from consumer to consumer and based on age and disability type. This type of support also changes frequently, which makes it difficult to maintain current data. SRS will study whether the administrative costs, both for the agency and for long term care providers under contract with SRS, associated with this concept would be cost-prohibitive.

SRS has developed databases which allow staff to routinely review the average eligibility assessment scores over time for Kansans who receive long-term care services. State staff routinely utilize these databases and continually seek ways to improve the collection and analysis of this data.

Recommendation 5:

SRS is currently preparing an RFP for a care coordination program for Medicaid beneficiaries who have a history of high utilization of inpatient and emergency room care. This program, designed to begin in January of 2003, will involve the overlay of a care management/coordination service to assure that utilization of services is at an appropriate level and quality. The RFP will require that the provider will be at risk for specific savings. Data indicates that a number of the individuals who will be enrolled in this service are also recipients of HCBS services. It is anticipated that persons served in this program will have their care coordinated with HCBS providers.

Recommendation 6:

As mentioned above under the response to Recommendation 4, baseline data about the level of natural/unpaid supports currently being utilized would be needed to achieve this recommendation. It would also be necessary to restructure payment systems to incentivize and take into account the value/impact of such supports. Realistic amounts of available natural supports that actually decrease the need for paid supports would have to drive policy decisions. The use of significant volunteer resources does not have a direct impact on the amount of paid supports needed (particularly in a daily rate structure) for people with disabilities or the costs of those services. Additionally, significant volunteer resources support the infrastructure of our service systems and impact the quality of life for people receiving services, but do not impact direct Medicaid/waiver services needed.

SRS contracts with the Self Advocacy Coalition of Kansas (SACK) to develop and provide training programs for people with developmental disabilities and their families. One of the training programs SACK is currently developing involves ways to encourage the use of natural/unpaid supports. SACK is in the process of developing a training program geared towards case managers, independent living counselors and other interested parties to assist in education regarding wants vs. needs and the use of natural/unpaid supports. SRS anticipates this effort undertaken by SACK will assist in our efforts to continually increase the awareness and utilization of natural/unpaid supports.

Recommendation 7:

This was a recommendation for the Legislature, therefore the agency has no response.

Recommendation 8:

This was a recommendation for the Legislature and the Kansas Department on Aging, therefore the agency has no response.

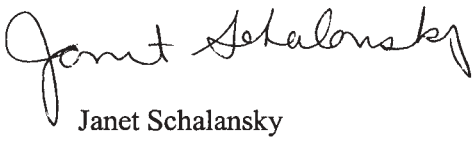
Recommendation 9:

It is the agency's practice to match state and local service and administrative dollars for federal financial participation (FFP) to the maximum extent feasible. The agency routinely reviews the level of FFP for which state and local funds are matched. Within

the MRDD waiver program, SRS has just completed a year-long analysis of the level of FFP maximization in that system. This analysis was undertaken in partnership with community stakeholders and contractors in the MRDD system. This effort, and similar efforts in other long-term care service systems, will continue to be a routine part of the way we evaluate our budget.

Thank you for the opportunity to respond to the recommendations presented in the *Medicaid Cost Containment* audit report. If you have any questions, please contact Laura Howard, Assistant Secretary of Health Care Policy, or Tanya Dorf, Health Care Policy Special Assistant.

Sincerely,



Janet Schalansky
Secretary

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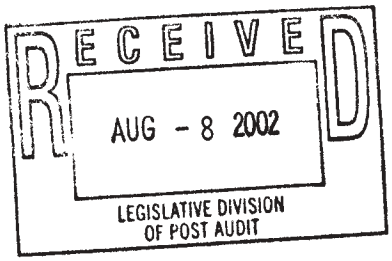
August 8, 2002



Ms. Barbara Hinton, Director
Division of Legislative Post Audit
800 SW Jackson, Suite 1200
Topeka, Kansas 66612

Dear Ms. Hinton:

Thank you for the opportunity to review and comment on the performance audit, *Medicaid Cost Containment: Controlling Costs of Long-Term-Care.* I will respond in two parts; first my comments and clarifications and second my response to your audit recommendations.

Comments and Clarifications

Page 13 – **"Woodwork" effect Reason:** During the first fiscal year, FY98, of the HCBS/FE elderly waiver program a policy was in place that required all state funded Income Eligible customers to apply for Medicaid services, if it appeared they would be eligible. As a result, the caseload increase in the HCBS/FE waiver program the first year was significant. The policy requirement has since been changed as it was shown that services under the Income Eligible program cost less, overall. Caseload increases in the Medicaid HCBS/FE program since FY99 have grown at a significantly slower pace.

Page 14 – **Rates for case management services…:** Targeted Case management rates in the aging service network were increased from $30 to $40 dollars in fiscal year 1998. That increase matched the rate of other case management services in the State Medicaid Plan. The $30 rate was not competitive and the aging service system was not able to retain sufficient case managers to meet the needs of senior Kansans.

Page 20 – **Second paragraph, last sentence:** Reducing the protected income level by $100 was not a recommendation of KDOA agency officials. It was a response to a question of impact from the Legislature.

Page 26 – **California and New York example:** These are two of the four states that implemented such a program before Congress restricted such innovation in estate recovery legislation. Kansas cannot implement such a program until the federal restrictions are removed.

Responses To Recommendations

Recommendation 1: SRS and KDOA have been collaborating on all the variables mentioned in response to Legislative requests for the last two sessions. We will continue to do so in conjunction with appropriate Legislative committees and appreciate the guidance they will provide.

Recommendation 4: KDOA has been exploring alternative ways to meet service needs on a continuing basis. We believe telemedicine, high technology, and universal design in housing can safely substitute for some hands-on services. At this time, the investment in education and resources to implement these in a short time period is considerably more than current service costs. Pursuit of alternatives is a long term strategy contained in our updated Strategic Plan.

KDOA is also developing technology capability to assess service provision and use of informal supports by individuals, providers, and Area Agencies on Aging (AAA). We anticipate data input occurring in December, 2002.

KDOA will have the data available to assess scores over time after December 2002.

Recommendation 6: KDOA and the AAAs are in the second fiscal year of a statewide Caregiver Support program. The principle goal of the program is to develop informal supports for caregivers. This program will enable unpaid caregivers to provide support longer, thus reducing the need for paid services.

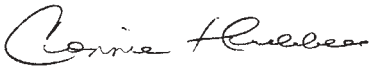
Recommendation 7: KDOA supported the introduction of Senate Concurrent Resolution #1614 and continues to work with SRS on the development of an effective educational awareness campaign.

Recommendation 8: For FY03, KDOA responded to a Legislative directive to reduce the overall nursing facility budget by $8.9 million. Chapter 205, Section 5(c) of the 2002 Session Laws in Kansas directs the agency to report on cost containment alternatives for nursing facility reimbursements for consideration prior to publication of the proposed rules and regulations for the fiscal year ending June 30, 2004. KDOA has meetings scheduled in August with stakeholders and other interested parties to assist in reviewing cost containment alternatives. If there is Legislative direction to change the rate setting methodology for FY04, again, we will take the necessary steps to make the required changes.

Recommendation 9: We are always alert for opportunities to maximize the use of federal funds and have had some success, i.e. the Kansas Intergovernmental Transfer program which has brought almost $300 million to Kansas and will continue in future years, although the amount will be reduced. Additionally, we have met with representatives from the entity that SRS contracts with to review potential maximization of federal dollars.

I did not speak to the other recommendations, as they appear to be an SRS concern. Again, thank you for the opportunity to respond. I appreciate the professional approach of the audit staff and look forward to future cooperation.

Sincerely,



Connie Hubbell
Secretary

CH:jd:ps

c: Janis DeBoer
Doug Farmer