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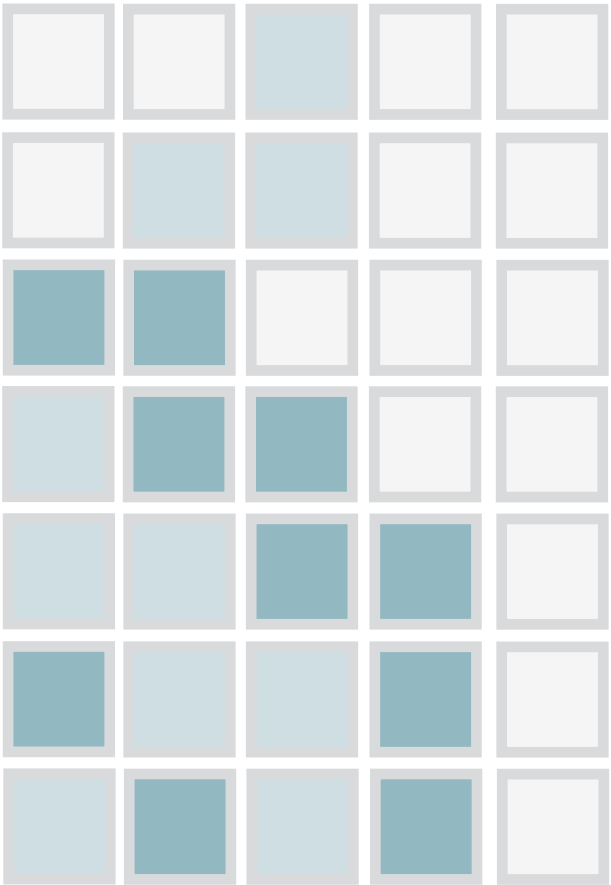
Kansas Medicaid: *Beyond the Basics*



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A supplement to
Kansas Medicaid: A Primer 2014

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www.khi.org/medicaidprimer

Notes

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KHI is a nonprofit, nonpartisan, independent health policy and research organization based in Topeka. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI conducts research and policy analysis on issues that affect the health of Kansans.

ABOUT THIS REPORT

Kansas Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance to more than 385,000 low-income Kansans. Medicaid and CHIP represent a significant portion of the total spending on health care services in Kansas, costing about $3 billion annually to the federal and state governments. The report, *Kansas Medicaid: A Primer 2014,* provides policymakers with basic facts about the Kansas Medicaid program, including recent trends and state budget information. This supplemental guide, *Kansas Medicaid: Beyond the Basics*, provides an in-depth look at six key issues. Using this guide, policymakers can learn some fast facts about two major policies impacting the Kansas Medicaid and CHIP programs: the shift to KanCare (the state's new managed care model), and the implementation of the federal Affordable Care Act (ACA). This guide also explains two ways in which Medicaid pays for services through provider taxes and the safety net system. Policymakers can also understand more about Medicaid's two largest expenditures — home and community-based services and the pharmacy benefit. Each of these topics are relevant, timely and have implications for the future of the Medicaid program. Through *Kansas Medicaid: Beyond the Basics*, the Kansas Health Institute presents state policymakers with key information to consider as they continue to monitor the Medicaid program and discuss its future.

KANCARE AND MEDICAID

At the start of 2013, Kansas folded Medicaid and HealthWave into three private managed care organizations (MCOs) under the umbrella of KanCare. These MCOs coordinate the physical and behavioral health care, community-based services and long-term care services for most of the 385,000 Kansans in Medicaid and CHIP. The KanCare system seeks to coordinate each individual's care among providers, decrease repeated hospitalizations, better manage chronic conditions and reduce reliance on nursing homes, long-term care facilities and hospitals.

Under KanCare, Medicaid and CHIP spending is directed into managed care for most groups, including children, pregnant women, low-income adults, seniors, people with disabilities and people with both Medicare and Medicaid eligibility. Medicaid and CHIP enrollees were automatically assigned to one of three MCOs to achieve a fair distribution of age, health care needs and geographic location. KanCare contracts require the MCOs to provide all services previously available through Medicaid, such as prenatal care, well-child visits, preventive services, prescription drugs, hospital care, in-home care, community-based services and nursing facility care. According to contracts between the MCOs and the state, the MCOs also must ensure services are available statewide and meet federal Medicaid requirements.

KanCare in Kansas

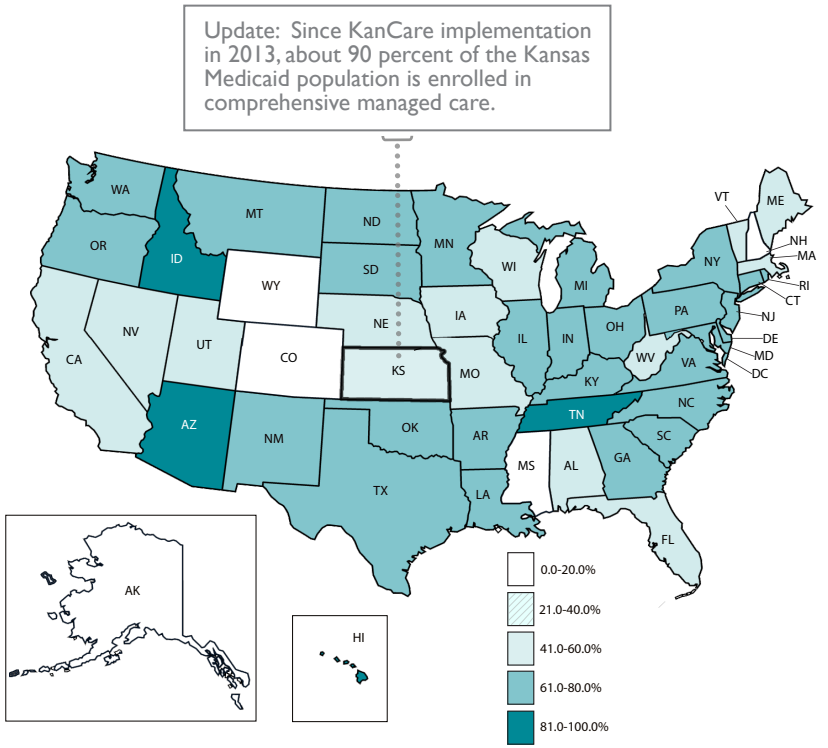
Prior to implementation of KanCare, about 59 percent of Kansas Medicaid beneficiaries were enrolled in a managed care plan, compared to the national average of 66 percent. With KanCare, more than 90 percent of Kansas Medicaid members are enrolled in managed care. Nationally, 44 states mandate enrollment for children and families in managed care, 33 states mandate managed care

for people with disabilities and 29 states mandate managed care for the elderly. Figure 1 shows the percentage of each state's Medicaid members in comprehensive managed care plans as of July 1, 2011.

KanCare: *Looking Forward*

One outstanding issue since the implementation of KanCare is whether to include long-term supports and services for people with developmental disabilities in managed care.

Figure 1. Percent of Medicaid Population in Comprehensive Managed Care, July 2011



Notes: The percentages include those enrolled in Medicaid-only comprehensive managed care and primary care case management. There were no states within the 21.0–40.0% range. The most recent data available for all states is from 2011. Kansas data from 2013 shows 90 percent of Medicaid population is enrolled in comprehensive managed care; 2013 data was not available for the other states at the time of this publication.

Source: Medicaid Managed Care Enrollment Report, 2011, Centers for Medicare & Medicaid Services

Because of concerns about the ability of MCOs to provide in-home supportive care more effectively than the current system of community-based service providers, the 2012 Legislature required a one-year exemption from KanCare for specialized services for people with developmental disabilities. That exemption was not continued by the 2013 Legislature and ended January 1, 2014. However, the approved fiscal year (FY) 2014 budget includes provisions allowing people with developmental disabilities to keep their case managers and residential service providers after January 1, 2014. It also requires the state to approve any reductions in these services.

The state must receive federal approval in order to include services for people with developmental disabilities in KanCare. In August 2013, the state submitted an amendment to the federal government to make that change. The state's planned January 1, 2014, implementation for this amendment has been postponed until the state receives federal approval.

THE AFFORDABLE CARE ACT AND MEDICAID

The ACA is the national health reform law passed in 2010. The ACA, as originally written, expanded the Medicaid program to all Americans with annual income under 138 percent of the federal poverty level (FPL), or about $32,500 for a family of four. The 2012 Supreme Court ruling on the ACA made Medicaid expansion for adults essentially optional for states. Kansas, like most states, already covers children at that income level through Medicaid or the related Children's Health Insurance Program (CHIP). As of the date of this publication, Kansas had not decided to expand its Medicaid program.

From 2014 through 2016, the law requires the federal government to fund 100 percent of the cost for the expansion population. In 2017, the federal contribution drops to 95 percent, with the state covering 5 percent of the cost. The federal contribution continues to drop each year until 2020 when it reaches 90 percent.

The ACA requires states to maintain current Medicaid and CHIP eligibility standards until 2014 for adults and until 2019 for children. The law adjusts the application and enrollment process for Medicaid, aligning it more closely with the application process for federal premium tax credits available through health insurance marketplaces, sometimes called exchanges. In addition, the ACA requires states to raise Medicaid reimbursement rates for primary care physicians and changes payments to hospitals.

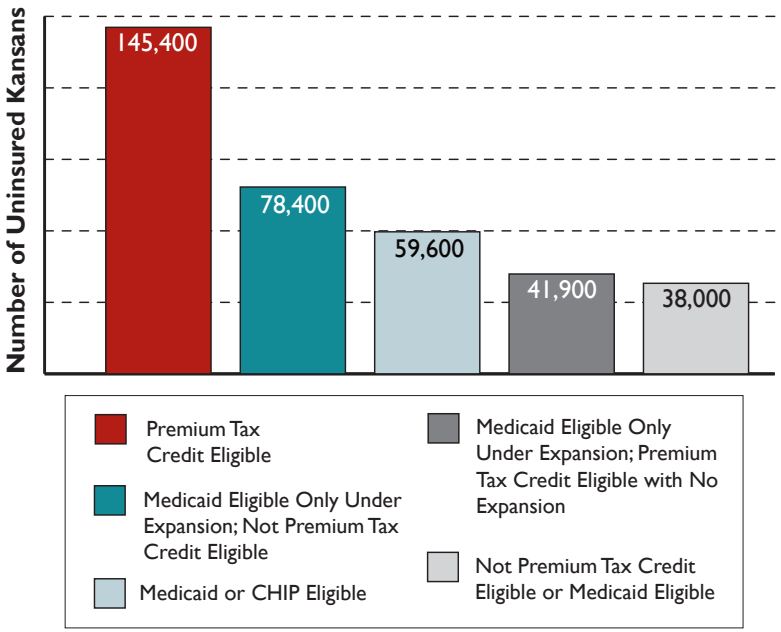
The ACA in Kansas

While it does not increase the number of people eligible, the ACA changes Medicaid income counting rules, resulting in higher income-eligibility levels in 2014 than in 2013. The Medicaid income level for Kansas caregiver adults (such as parents and guardians) is among the lowest in the country, 33 percent of FPL, or about $7,770 annual income for a family

of four in 2014. Childless Kansas adults under age 65 who are not disabled cannot qualify for Medicaid today regardless of how poor they are.

The ACA provides premium tax credits to help people purchase private insurance through the federal health insurance marketplace. If Kansas

Figure 2. Eligibility for Medicaid and Federal Premium Tax Credits through the ACA: Uninsured Kansans Under Age 65 (2011)



Notes: While it does not increase the number of people eligible, the ACA changes Medicaid income counting rules, resulting in higher income-eligibility levels in 2014 than in 2013. Children are eligible for Medicaid or CHIP if their families have incomes up to 245 percent of FPL in 2014. Parents and caregiver adults with incomes under 33 percent of FPL are Medicaid-eligible. Childless adults are not eligible for Medicaid without expansion. The premium tax credit eligible population includes adults between 138 percent and 400 percent of FPL and children between 245 percent and 400 percent of FPL. In states that don't expand Medicaid, premium tax credits are available for adults between 100 percent and 138 percent of FPL. Adults and children above 400 percent of FPL are not eligible for premium tax credits or Medicaid. All adults between 33 percent and 100 percent of FPL and childless adults under 33 percent of FPL are not eligible for premium tax credits and are Medicaid-eligible only with expansion of the program. The figures above do not include individuals who are eligible for Medicaid due to disability or other health needs.

Source: Estimates based on KHI analysis of U.S Census Bureau, American Community Survey data, 3-year estimates (2009–2011).

policymakers decide not to expand Medicaid eligibility, the ACA allows these premium tax credits to be provided to individuals starting at 100 percent of FPL. 41,900 uninsured Kansans with incomes between 100 percent and 138 percent of FPL would be eligible for premium tax credits to purchase health insurance in the marketplace if Medicaid is not expanded. A decision to not expand Medicaid would leave 78,400 uninsured Kansas adults both ineligible for the program *and* ineligible for premium tax credits, as shown in Figure 2 (page 5).

The ACA: *Looking Forward*

The Kansas Legislature adjourned its 2013 session without deciding whether to expand the Medicaid program. The Legislature did adopt a budget provision prohibiting the state from expanding Medicaid unless lawmakers explicitly agree to the expansion. Kansas still can decide to expand Medicaid to cover low-income adults in future years, but 100 percent federal funding for the expansion population is only available through 2016.

Expanding Medicaid to cover more adults creates several budget implications for Kansas officials. Included in this complex policy decision are the costs of uncompensated care to hospitals and providers for the 78,400 adults who would likely remain uninsured because they make too little to qualify for premium tax credits and too much to qualify for Medicaid.

Regardless of the state's decision about Medicaid expansion, Kansas will likely see an increase in Medicaid enrollment for those people who are currently eligible but not enrolled. This increase in Medicaid enrollment is due to a "woodwork" or "welcome mat" effect in which Medicaid or CHIP-eligible people enroll due to increased awareness and publicity. Children would likely make up most of this Medicaid enrollment increase, where the state pays about 43 percent of their Medicaid costs and the federal government pays about 57 percent.

MEDICAID PROVIDERS AND REIMBURSEMENTS

For health care services provided through Medicaid, states determine the rate paid to providers like physicians, hospitals and nursing homes. Depending on the type of provider and the type of service, rates are adjusted so Medicaid beneficiaries have access to a sufficient number of health care providers, as required by the federal government. Medicaid payment rates can be based on market rates, the cost of providing services, or what the Medicare program pays for an equivalent service or direction from the Legislature. To increase rates, state Medicaid officials usually must request more State General Fund money from the Legislature and approval from the federal government. Most states use provider taxes to generate additional state funds to support Medicaid programs and increase provider rates. As shown in Figure 3 (page 8), the provider pays the state a tax or fee, and the state deposits this revenue. The state uses this money to pay providers for Medicaid services.

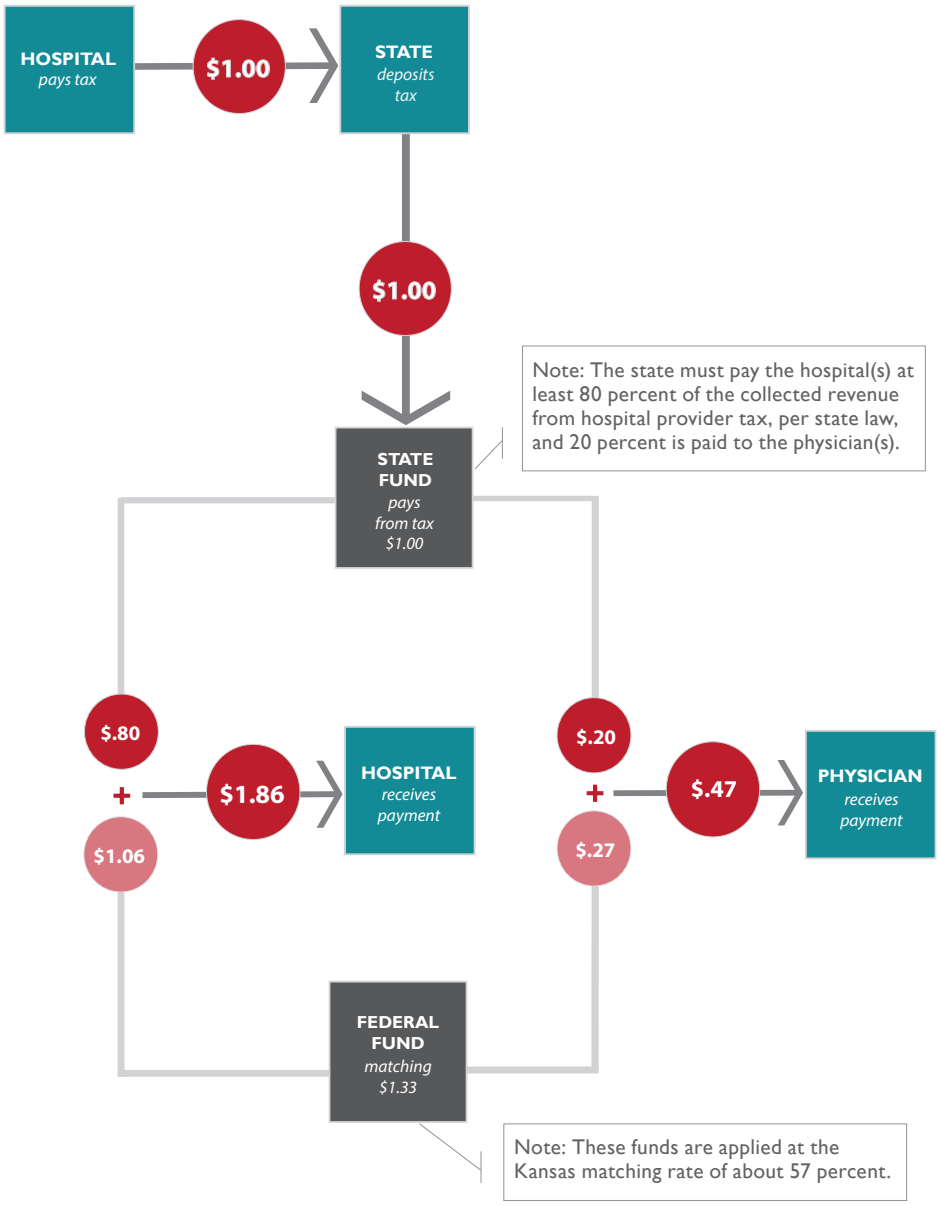
For every dollar Kansas spends on Medicaid, the federal government provides $1.33 (this means the provider tax payment — when combined with the federal funding — is more than doubled).

Provider Taxes in Kansas

Kansas collects a hospital provider tax (approved by the Legislature in 2004) and a nursing facility tax (approved by the Legislature in 2010). The hospital assessment equals 1.83 percent of each hospital's net inpatient operating revenue during state FY 2010. In FY 2012, the assessment raised about $47.6 million, as shown in Figure 4 (page 9). State law specifies at least 80 percent of that revenue be distributed to hospital providers.

The nursing home assessment is $1,950 per licensed bed. All of these funds must be used to maintain or increase the quantity and quality of nursing home care. This includes restoring cuts to

Figure 3. Example of Hospital Assessments in Kansas Medicaid



Notes: The Kansas Hospital Assessment combines the tax payment with federal Medicaid dollars to increase payments to hospitals and physicians.

nursing facility rates made by Gov. Mark Parkinson and the Legislature in January 2010 and covering the administrative costs of enacting the assessment.

In FY 2012, the nursing home assessment generated about $21.5 million, as shown in Figure 4.

In 2011, the Legislature approved an assessment on providers

Figure 4. Kansas Provider Assessments in Medicaid, FY 2012

PROVIDER ASSESSMENT	HOSPITAL	NURSING FACILITY
Tax Amount	1.83 percent of each hospital's net inpatient operating revenue in FY 2010	$1,950 per licensed bed for nursing facilities $325 per licensed bed for continuing care retirement facilities, skilled nursing facilities (fewer than 40 beds) and high Medicaid volume facilities
Total Tax Collected	$47,552,769	$21,466,078
Regulations on Use of Tax Revenue	At least 80 percent must be used for hospital providers through access payments and increased rates. No more than 20 percent can be paid to physicians, surgeons and dentists. No more than 3.2 percent can be used to fund medical education training programs.	Must be used to finance activities that maintain or increase the quantity and quality of nursing home care. Can include restoring cuts to nursing facility rates and making inflationary adjustments to rates. Must pay administrative costs of enacting the assessment.

Notes: Critical Access Hospitals (designated by Medicare), state hospitals and state educational institutions are exempt from the assessment. Nursing facilities cannot pass the costs of the assessment back to residents, but the cost of paying the assessment is reimbursable by Medicaid.

Source: KSA 65-6207 to 65-6220, KSA 65-6201 and KSA 75-7435; Dollar figures provided by Kansas Division of the Budget.

of home and community-based services for people with developmental disabilities. This assessment has not been implemented because the state is awaiting federal approval.

Provider Reimbursements and Taxes: *Looking Forward*

Kansas provider assessments were developed prior to KanCare. With its implementation, the state no longer directly sets payment rates for providers. The KanCare contracts require the managed care organizations to set provider rates using the state's rates prior to KanCare, but the state does not intervene in contract decisions between the MCOs and providers. It is uncertain whether the KanCare managed care organizations will continue to use the provider taxes to increase provider reimbursements in the same way.

HOME AND COMMUNITY-BASED SERVICES WAIVERS AND MEDICAID

The federal government requires states to manage their Medicaid programs within federal regulations that specify the eligibility and coverage requirements for mandatory and optional services. Waivers allow states to develop programs beyond these regulations with the permission of the federal government.

The most common waiver is for home and community-based services, which allows Medicaid beneficiaries who are medically eligible for placement in an institution, such as a nursing home, to remain in a community setting and receive services.

States must provide Medicaid coverage for institutional care and nursing home facilities, while home and community-based services are optional. In choosing to provide Medicaid services in the community rather than an institution, states must demonstrate the program is budget-neutral while still providing appropriate care. This means the home and community-based services will not cost more than services in an institution and will protect the client's health and welfare, meet the client's needs and follow an individualized plan of care.

Because home and community-based services are provided through waivers, the state is allowed to limit the amount of money budgeted to pay for waiver services. This limitation often results in a waiting list to access services. Waiting lists typically are maintained so the number of people receiving services fit the available budget.

Home and Community-Based Services Waivers in Kansas

Each waiver is limited to a specific population. In Kansas, seven populations may be eligible for home and community-based services, as shown in Figure 5 (page 12).

Of the seven populations covered by waiver services in Kansas, three have significant waiting lists: individuals with developmental disabilities, individuals with physical disabilities and children who have an early autism diagnosis.

Waivers: *Looking Forward*

KanCare, the state's new Medicaid managed care initiative, includes all existing waiver services formerly operated by the state. The KanCare contracts require the services of each waiver be

Figure 5. Monthly Average Numbers of Consumers by Home and Community-Based Services Waiver, FY 2012

WAIVER POPULATION	MONTHLY AVERAGE NUMBER OF CONSUMERS
Individuals with developmental disabilities*	7,682
Individuals with physical disabilities*	6,106
Individuals determined as frail elderly	5,357
People with traumatic brain injury	392
Children who have a severe emotional disturbance	3,610**
Children who require technology-based assistance	378
Children who have an early autism diagnosis*	35

Notes: Consumers are those for whom a payment, including managed care capitation payments, was made during the month. They are determined by the date of payment.
* Indicates a waiver that maintains a waiting list.
** The number of children with a severe emotional disturbance receiving waiver services was not available using the Kansas Medical Assistance Report (MAR). Kansas Department for Aging and Disability Services (KDADS) provided data for this population for FY 2013.

Source: Kansas Department of Health and Environment, Medical Assistance Report (MAR), 2012, and KDADS.

retained and included in the managed care benefit package. The KanCare contracts also require the same amount of services be available to participants, based on individual need and given existing service limitations.

All waiver services transitioned to KanCare on January 1, 2013, with the exception of services for individuals with developmental disabilities. In August 2013, the state submitted an amendment to the federal government to include services for individuals with developmental disabilities in the managed care benefit package beginning in 2014. The state's planned January 1, 2014, implementation has been postponed until the state receives federal approval for this amendment.

In 2013, the Legislature approved spending $18.5 million to reduce the waiting list for two groups: individuals with developmental disabilities and individuals with physical disabilities. As of that time, approximately 3,100 individuals with developmental disabilities and nearly 3,000 individuals with physical disabilities were on the waiting list, according to the Kansas Legislative Research Department. The governor's office has said the additional funds will reduce the waiting list by approximately 250 people with developmental disabilities and 400 people with physical disabilities by the end of fiscal year 2014. The additional funding was approved by the Legislature contingent upon inclusion of waiver services for individuals with developmental disabilities into KanCare.

THE HEALTH CARE SAFETY NET AND MEDICAID

In the health care system, the "safety net" is a group of providers whose main purpose is to improve access to care for low-income, uninsured and vulnerable people. These include community health centers, hospitals and outpatient health programs.

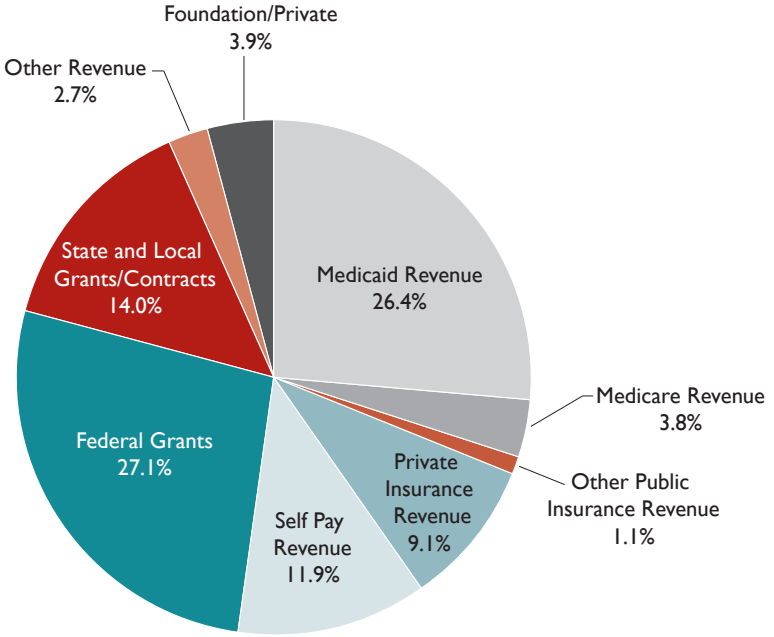
Safety net providers receiving special reimbursement though Medicaid include federally qualified health centers, rural health clinics, critical access hospitals and hospitals receiving disproportionate share hospital (DSH) payments. Federally qualified health centers and rural health clinics provide primary care services, preventive care, lab and radiology, pharmaceutical care and other services on a limited basis. Critical access hospitals in rural areas provide emergency services as well as most inpatient and outpatient services. In addition, hospitals receiving DSH payments must provide substantial uncompensated care for low-income and uninsured patients.

Safety Net Providers in Kansas

Kansas has 171 rural health clinics and 59 community health center locations, many of which are federally qualified health centers. Rural health clinics and federally qualified health centers must be in areas designated as "medically underserved" by the federal government. Kansas also has 83 critical access hospitals — more than any other state.

Kansas Medicaid provides federally qualified health centers and rural health clinics with enhanced reimbursements for their services. In Kansas, the Medicaid program is the second largest revenue source for federally qualified health centers, as shown in Figure 6 (page 15). Payments to federally qualified health centers and rural health clinics amounted to about $28.5 million, or about 1 percent of total Kansas Medicaid expenditures in FY 2012.

Figure 6. Distribution of Revenue by Source for Kansas Federally Qualified Health Centers, 2011



Source: National Association of Community Health Centers analysis of the 2011 Uniform Data System, Health Resources and Services Administration, March 2013.

The Safety Net System:
Looking Forward

The number of uninsured Kansans is projected to decrease due to provisions in the ACA which require individuals to obtain health insurance and allow for purchasing of private insurance through federal health insurance marketplaces. Even with the projected decrease in the number of uninsured Kansans, some researchers suggest many states will likely continue to rely on safety net providers to meet the demand for services by the newly insured and to provide care to those who remain uninsured.

Since its passage, the ACA has provided nearly $41 million to Kansas federally qualified health centers and other community

health centers to support ongoing operations, establish new sites, expand services and finance capital improvement projects. Clinics in all 50 states have received $150 million in federal grants, including $1.6 million in Kansas, to help the uninsured enroll in health insurance coverage.

The ACA also affects disproportionate share hospital payments to safety net hospitals across the country. The ACA originally reduced these payments by $500 million in federal FY 2014 and continues to reduce payments through 2020, totaling about $18 billion. However, in December 2013, Congress passed and President Obama signed into law a budget agreement that delayed the reductions for two years. According to the legislation, reductions would double for federal FY 2016.

As of September 2013, the federal government had not determined how the reductions would be calculated in states that do not expand Medicaid, as these states are likely to have larger numbers of uninsured. The reductions will vary by state, with the largest reductions applying to states with the lowest percentages of uninsured individuals.

States that do not target their DSH payments to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care will also see lower payments.

Within KanCare, some funds have been reserved for hospitals that incur costs for uncompensated care. KanCare will provide incentives to hospitals for programs enhancing access to health care and improving the quality of care. The state also requires the three KanCare managed care organizations to contract with all federally qualified health centers, rural health clinics and critical access hospitals.

Notes

PHARMACY BENEFITS AND MEDICAID

Federal Medicaid rules do not require coverage of prescription drugs, though all states choose to cover this optional benefit. States use several techniques — including preferred drug lists and drug utilization review — to manage medication costs and promote clinically effective care. By federal law, state Medicaid agencies must use a committee of physicians, pharmacists and other appropriate individuals to guide management techniques for prescribed drugs.

Medicaid pays for medications only if the manufacturer enters into a drug rebate agreement with the federal government. Nearly all U.S. medication manufacturers have entered into drug rebate agreements. Under these agreements, for every unit of medication dispensed (such as one pill), the manufacturer pays a rebate, which is split between the state and federal governments. In exchange for these federally mandated rebates, Medicaid must cover every medication for which the manufacturer has a rebate agreement.

In addition to the federally mandated rebates, most states collect supplemental rebates. These rebates are negotiated directly between the state, or a group of states, and manufacturers. Most often, supplemental rebates are paid in exchange for a spot on the state's preferred drug list. Medications on the list are determined to be the most cost-effective and clinically effective.

Pharmacy Benefits in Kansas

Prior to KanCare implementation, Kansas FY 2012 spending on prescription drugs was $178 million (these figures do not include prescription drugs provided to beneficiaries enrolled in MCOs because pharmacy services are included in the rates the state pays to the MCOs). Figures 7–9 (pages 19–20) present some key statistics about medication use in Kansas Medicaid.

Figure 7. Average Monthly Kansas Medicaid Pharmacy Use and Expenditures, FY 2012

Average monthly pharmacy expenditures	$14,822,914
Average monthly pharmacy consumers	54,069
Average monthly number of prescriptions dispensed	217,103
Average monthly cost per pharmacy consumer	$274
Average cost per prescription	$68

Notes: The table includes fee-for-service pharmacy data only and therefore does not include data for those in managed care (prior to KanCare). Data includes claims for which Medicaid is the secondary payer (for example, Medicare Part D co-pay claims). Inclusion of these claims lowers the average cost per claim because Medicaid is paying only a small portion of the total drug cost.

Source: Kansas Department of Health and Environment, Data Analytic Interface, 2013.

Figure 8. Highest Expenditure Medications in Kansas Medicaid, FY 2012

MEDICATION NAME	MEDICATION TYPE	TOTAL EXPENDITURES	AVERAGE COST PER PRESCRIPTION	PERCENT OF TOTAL PRESCRIPTION EXPENDITURES
Aripiprazole (Abilify)	Antipsychotic	$15,200,107	$544	8.5%
Quetiapine (Seroquel)	Antipsychotic	$10,638,755	$301	6.0%
Olanzapine (Zyprexa)	Antipsychotic	$5,077,494	$445	2.9%
Ziprasidone (Geodon)	Antipsychotic	$4,077,769	$321	2.3%

Notes: The table includes fee-for-service pharmacy data only and therefore does not include data for those in managed care (prior to KanCare). Data includes claims for which Medicaid is the secondary payer (for example, Medicare Part D co-pay claims). Inclusion of these claims lowers the average cost per claim because Medicaid is paying only a small portion of the total drug cost.

Source: Kansas Department of Health and Environment, Data Analytic Interface, 2013.

Pharmacy Benefits:
Looking Forward

For Medicaid beneficiaries, prescription medications are now covered under KanCare. According to federal rules, the managed care organizations must cover all rebate-eligible drugs as required for beneficiaries not in managed care. The Kansas Department of Health and Environment (KDHE) will continue working with the same committees that advised the pharmacy benefit prior to KanCare in order to create a standard drug list to be used by the three KanCare MCOs. Likewise, if managed care companies want to change which drugs must be approved for coverage before they are dispensed, the change must be reviewed by KDHE's advisory committee and the Legislature's Joint Committee on Rules and Regulations.

Figure 9. Most Often Dispensed Medications in Kansas Medicaid, FY 2012

MEDICATION NAME	MEDICATION TYPE	NUMBER OF PRESCRIPTIONS DISPENSED	PERCENT OF TOTAL PRESCRIPTIONS DISPENSED
Hyrodocone/Acetaminophen (Lortab, Vicodin)	Pain reliever	85,378	3.3%
Albuterol (Proair, Ventolin)	Bronchodilator	49,445	1.9%
Clonazepam (Klonopin)	Sedative	48,277	1.9%
Alprazolam (Xanax)	Sedative	47,312	1.8%

Notes: The table includes fee-for-service pharmacy data only and therefore does not include data for those in managed care (prior to KanCare). Data includes claims for which Medicaid is the secondary payer (for example, Medicare Part D co-pay claims).

Source: Kansas Department of Health and Environment, Data Analytic Interface, 2013.

Kansas law prohibits Medicaid officials from putting mental health drug prescriptions through the same screening procedures used for other drugs. It also prohibits the use of step therapy for all drugs, which commonly requires a cheaper type of medicine be tried before a more expensive one can be used. These exclusions continue to apply under KanCare.

Under the ACA, states can collect rebates for medications dispensed to managed care beneficiaries as of March 2010. Previously, managed care claims were not eligible for rebate collection. The ability to continue collecting drug rebates on claims for beneficiaries enrolled in MCOs allows the state to maintain a significant revenue stream. In federal FY 2009 — the last full year of reporting before the health reform law was approved — Kansas collected about $60.2 million in drug rebates, including about $19.4 million for the State General Fund.

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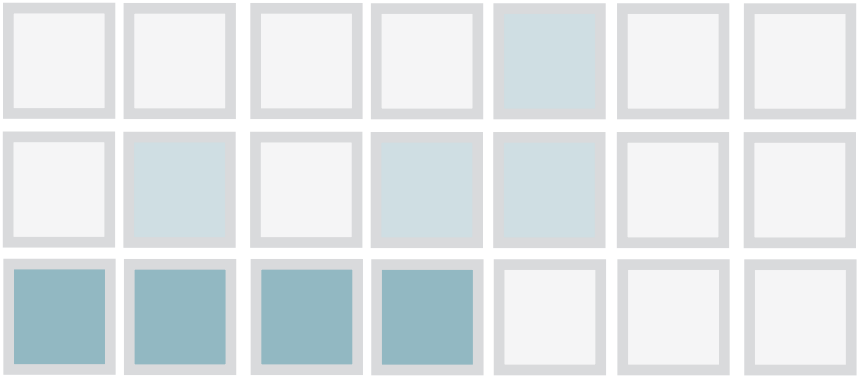
Notes



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