



**Social Services Budget Committee**  
**Testimony on Medicaid Spending on the Aged and Disabled**  
**February 3, 2009**  
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**Background**

The costs per person to a state's Medicaid program are determined by a number of factors. Among these factors are:

- The extent of coverage and the structure of the benefit packages
- The size and health care needs of the eligible population
- The scope of the medical benefits provided
- Service utilization levels
- The amount of payment for the services provided
- The extent to which states cover and fund long-term care benefits
- The level at which disproportionate share hospital (DSH) funds are used to offset direct state spending
- The mix of services provided (i.e., states that cover sicker populations are purchasing more expensive services) and the quantity of services used by the case-mix (i.e., sicker people use more services)
- The proportion of the state's population that is low-income
- The variation in the availability of employer-sponsored insurance and the degree to which public programs cover those who are without insurance

Broader conditions that influence variation among the states are:

- The poverty rate
- The unemployment rate
- The age and make-up of the population
- Variations in health care practice and adoption of technology
- Labor and other operating costs

The 2008 Medicaid Transformation plan includes a review of spending and comparisons to other states that reveal the distinctiveness of Kansas' Medicaid program, and its emphasis over time.

- *Total spending.* Overall Medicaid spending per beneficiary is relatively high in Kansas: \$5,902 per beneficiary in FY 2005, compared to the national average of \$4,662. Per-person spending is higher than average for each major population group (aged, disabled, adults, and children), with the aged and disabled ranking highest among those three populations.
- *Population that benefits most from Medicaid spending.* Compared to other states, Medicaid spending in Kansas is somewhat concentrated among the aged and disabled populations. Kansas ranks above-

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average in spending per-person for both the aged (16th highest) and the disabled (also 16th highest), and ranks 14th highest in the percentage of the Medicaid population who are disabled.

- *Insurance coverage through Medicaid.* While coverage of children is typical at 200% of the poverty level, coverage for non-disabled adults is very low. Kansas ranks 39th in the percentage of Medicaid eligibles who are low-income, non-disabled, working-age adults, and is ranked between the 41st and 46th in income threshold for adults in this category. Partly as a result, Kansas ranks near the bottom (43rd) in the percentage of its population covered by Medicaid (13%).

More recent analysis using Kaiser Health Foundation's State Health Facts on-line:

- Kansas ranks 3<sup>rd</sup> highest nationally in the percentage of Medicaid spending attributable to home health and personal care, including the HCBS waivers, and devotes 25% of its Medicaid spending to these services, 66% higher than the national average of 15%.
- Kansas devotes the ninth-highest percentage of its program to the disabled.
- Kansas ranks just 43<sup>rd</sup> in the percent of SSI disabled as a proportion of its population. Kansas has about 1% more aged in its population than the national average.
- Kansas ranks 23<sup>rd</sup> highest nationally in the number of people enrolled in the MR/DD waiver.
- Kansas ranks 4<sup>th</sup> highest nationally in the number of people enrolled in the frail and elderly waiver.
- Kansas ranks 4<sup>th</sup> highest nationally in the number of people enrolled in the physical disability waiver.

This data indicates that, in comparison to other states, Kansas' Medicaid program spends more – proportionally – on the aged and disabled than on other populations.

## Long Term Care Expenses

One of the most influential factors impacting Medicaid spending per-enrollee is the extent to which long-term care benefits are covered and funded.<sup>1</sup> Long-term care services are provided to both elderly and non-elderly people living in institutional settings (i.e., nursing homes and intermediate care facilities for people with mental retardation and developmental disabilities (ICFs-MR)), and in homes and other community-based settings. Although provision of community based services has increased over the past several decades, the bulk of long-term care spending still remains in institutional settings.

People who receive long-term care services in Kansas are:

- Individuals with mental retardation and developmental disabilities
- Individuals with mental illness
- Individuals with spinal cord injuries and traumatic brain injuries
- Individuals with Alzheimer's disease and dementia
- Individuals with neuro-degenerative conditions
- Children with special health care needs

Providing coverage to these individuals is expensive, not only because of the nature of their disabilities and complex needs, but also because many experience multiple chronic conditions.

Long-term care varies among the states as a share of their total Medicaid spending. According to a 2002 Urban Institute analysis, Kansas is among one of seven states where long-term care accounts for more than 50 percent

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<sup>1</sup> Holahan, J. (2007). State variation in Medicaid spending: hard to justify. *Health Affairs Web Exclusive*, w667-w669. Retrieved January 27, 2009, from <http://content.healthaffairs.org/cgi/content/abstract/26/6/w667>

of Medicaid spending.<sup>2</sup> Other states spending more than 50 percent of their total Medicaid spending on long-term care are: Connecticut, Iowa, Minnesota, North Dakota, Wisconsin, and Wyoming; the national average is 38 percent.<sup>3</sup>

Additionally, the extent to which states cover home and community-based long-term care varies. In some states, significant resources are dedicated to home and community-based care (i.e., home health, waiver services and personal care). A breakdown of long-term care spending within each of the seven states spending more than 50 percent of their total Medicaid spending on long-term care follows. Of all of the comparison states, Kansas has the highest percentage of disabled people within their total Medicaid population. Information presented in the table confirms the focus on home-and community-based services in Kansas, where we have closed three public, and numerous private, institutions in the past 20 years.

State	Long-Term Care as a Share of Medicaid Spending	Spending as a Share Of Total Medicaid Long-Term Care		
		Nursing Facilities	ICF-MR	Home Care
North Dakota	62%	61%	18%	21%
Iowa	59%	71%	14%	16%
Wisconsin	55%	61%	10%	29%
Connecticut	54%	54%	11%	35%
Kansas	53%	54%	7%	39%
Minnesota	53%	40%	9%	52%
Wyoming	50%	42%	9%	50%

Source: O'Brien, E., & Elias, R. (2004). Medicaid and long-term care. *Kaiser Commission on Medicaid and the Uninsured*, 1-24. Retrieved January 27, 2009 from <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296>

### Acute Care Costs

Kansas Medicaid coverage of medical services, or acute care, includes services such as physician and hospital care, prescription drugs and laboratory and diagnostic testing. For some aged and disabled beneficiaries, who are dually eligible for Medicaid and Medicare, prescription drugs are now covered by Medicare Part D.

In January, 2009, the Kansas Health Policy Authority (KHPA) published a program review on medical services for the aged and disabled. Findings presented in the report identified the top Medicaid cost drivers for the aged and disabled. A brief description is listed below.

The aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending. Almost half (47%) of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged. The top Medicaid cost drivers for the aged and disabled include: inpatient services, pharmacy, outpatient services, mental health services, hospice and Medicare premiums and co-pays. Inpatient services represent the highest costs among the Supplemental Security Income disabled category, accounting for 71% of the \$183.83 million of inpatient costs. Pharmacy is the second highest cost driver for the disabled.

<sup>2</sup> O'Brien, E., & Elias, R. (2004). Medicaid and long-term care. *Kaiser Commission on Medicaid and the Uninsured*, 1-24. Retrieved January 27, 2009 from <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296>

<sup>3</sup> Ibid.

<b>Kansas Medicaid FY 2007</b>	<b>Supplemental Security Income – Disabled*</b>	<b>Medically Needy – Disabled (SSI)</b>	<b>Supplemental Security Income – Aged*</b>	<b>Medically Needy – Aged (SSI)</b>	<b>Qualified Medicare Beneficiary</b>
<b>Average Monthly Caseload (number of people)</b>	32,798	16,591	6,305	17,114	8,156
<b>Total Medical Costs</b>	\$336.51 million	\$107.56 million	\$29.39 million	\$61.58 million	\$11.13 million
<b>Average Monthly Costs (per person) paid by Medicaid</b>	\$855	\$540	\$388	\$300	\$114
<b>Top Three Medicaid Cost Drivers</b>	<ol style="list-style-type: none"> <li>1. Inpatient</li> <li>2. Pharmacy</li> <li>3. Mental Health</li> </ol>	<ol style="list-style-type: none"> <li>1. Inpatient</li> <li>2. Pharmacy</li> <li>3. Medicare Premiums and Co-pays</li> </ol>	<ol style="list-style-type: none"> <li>1. Medicare Premiums and Co-pays</li> <li>2. Inpatient</li> <li>3. Pharmacy</li> </ol>	<ol style="list-style-type: none"> <li>1. Hospice</li> <li>2. Medicare Premiums and Co-pays</li> <li>3. Inpatient</li> </ol>	<ol style="list-style-type: none"> <li>1. Medicare Premiums and Co-pays</li> <li>2. Inpatient</li> <li>3. Outpatient</li> </ol>

## Conclusion

Some of the differences in costs when Kansas is compared to other states cannot be fully explained and some of the comparison data is not readily available. A closer examination of acute care costs and long-term care costs for Kansas' aged and disabled beneficiaries is needed. KHPA has already taken steps in this direction; plans for further examination are in place. Among the key findings reported in the January 2009 program review on medical services for the aged and disabled are:

- Medical expenditures for the aged and disabled population are projected to show steady increase in 2008 and 2009.
- Using funds from a Center for Medicare and Medicaid Services (CMS) transformation grant awarded to KHPA, we looked at whether we could improve preventive care to the aged and disabled. Our analysis showed:
  - Preventive care opportunities are being missed for beneficiaries struggling with diabetes, depression, coronary artery disease, hypertension, congestive heart failure, and asthma.
  - Preventive care opportunities are also being missed for cancer screenings, cardiac event prevention, osteoporosis screening, and pain management.
- The overall trends in expenditures and the implications of chronic health conditions that plague the aged and disabled population suggest the need to more effectively manage and support the needs of this population. KHPA is currently conducting two pilot projects that aim to improve health outcomes for people with disabilities:
  - The “Health Promotion for Kansans with Disabilities” pilot project, the CMS Transformation Grant program to identify and improve primary care needs among the chronically ill, and
  - The “Enhanced Care Management” pilot program targeting high-cost Medicaid beneficiaries in Sedgwick County for intensive care management.

- Given the high incidence of chronic illness and high level of interaction with the medical system, the need to implement a medical model of care is significant for the aged and disabled. Goals for improving care in this population mirror closely the established goals of a patient-centered medical home.

**Recommendation from 2008 Medicaid Transformation Plan**

- Develop and utilize a medical home model of care for the aged and disabled population. The development of a medical home model for Kansas is currently underway with the passage of Senate Bill 81 during the 2008 legislative session. Over the next year, a large group of stake-holders will design a care management model based on existing evidence and the needs of our state. The recommendations will be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget.