PERFORMANCE AUDIT REPORT

Medicaid and Medicare Services: Comparing Program Services and Costs in Kansas to Other States

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

December 2017

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December 15, 2017

To: Members, Legislative Post Audit Committee

This report contains the findings and conclusions from our completed performance audit, *Medicaid and Medicare Services: Comparing Program Services and Costs in Kansas to Other States*. The audit was requested by the Legislative Post Audit Committee. The audit team included Matt Etzel and Kaci Dillingham. Justin Stowe was the audit manager.

We would be happy to discuss the findings and conclusions presented in this report with any legislative committees, individual legislators, or other state officials.

Sincerely,

Scott Frank
Legislative Post Auditor

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Medicaid and Medicare Services: Comparing Program Services and Costs in Kansas to Other States

Background Information

The 1965 Social Security Act established both the Medicare and Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) is the federal agency within the U.S. Department of Health and Human Services that oversees and manages these two programs. Medicare is administered by the federal government and provides insurance for individuals 65 or older, and individuals under 65 with certain disabilities. Medicaid is overseen by CMS but administered by individual states and provides health insurance to low-income adults, families, the elderly, and people with intellectual or physical disabilities. Legislators have expressed interest in knowing whether Medicaid and Medicare services and costs vary from state to state.

Objectives, Scope and Methodology

On April 28, 2017, the Legislative Post Audit Committee approved an audit of the state's Medicaid program. For reporting purposes, we divided the three objectives included in that original request into three separate audit reports. A copy of the original audit proposal is included in ***Appendix E***. This performance audit answers the following question:

1. **How do Medicaid and Medicare services and costs in Kansas compare to other states for a select sample of services?**

To determine how Medicaid services and costs in Kansas compared to other states, we compared optional Medicaid services in Kansas to those in five comparable states: Colorado, Idaho, Iowa, Nebraska, and Oklahoma. These states were selected because their Medicaid programs were similar to Kansas in terms of per-capita spending and the size of their beneficiary populations. When possible, we worked with officials from these states to confirm our understanding of their Medicaid programs. However, we were unable to confirm our understanding of the Iowa or Oklahoma Medicaid state plans with officials from their Medicaid agencies. We also interviewed CMS officials and reviewed relevant CMS reports to understand any differences between states' Medicaid costs.

To determine how Medicare services and costs in Kansas compared to other states, we interviewed CMS officials and reviewed relevant reports from CMS and the Kaiser Family Foundation, a non-profit and non-partisan organization that focuses on national health issues. We then compared covered services under Original Medicare (Parts A and B) to a non-projectable

sample of Medicare Advantage plans (Part C) offered in the five comparable states we reviewed. Finally, we compared Medicare out-of-pocket costs for a non-projectable sample of five services across a small sample of Medicare plans. Those services included ambulance services, durable medical equipment, group psychotherapy, intravitreal eye shots, and x-rays. These services were selected because they cover a wide variety of medical procedures, services, and supplies. We did not conduct any work on internal controls as part of this audit.

Compliance with Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

OVERVIEW OF THE MEDICAID PROGRAM

Medicaid is an Insurance Plan for Low-Income Individuals That is Jointly Funded by States and the Federal Government

Medicaid provides medical and long-term care to low-income children, families, the elderly, and individuals with intellectual or physical disabilities. Medicaid was originally established as part of the 1965 Social Security Act and traditionally pays for the medical and long-term care of low-income pregnant women, children, families, the elderly, and individuals with physical or intellectual disabilities. As part of the federal Affordable Care Act which was passed in 2010, states were given the option to expand Medicaid to cover low-income adults without disabilities (frequently referred to as "Medicaid expansion"). As of November 2017, Kansas was among a group of 18 states that had chosen not to expand Medicaid to this new group of adults.

Medicaid is jointly funded by states and the federal government. As a program for low-income individuals, Medicaid generally does not require beneficiaries to pay for their benefits. Rather, states and the federal government pay the costs associated with beneficiaries' medical and long-term care services. The amount of federal assistance a state receives to help pay its Medicaid expenditures depends on its per-capita income—lower-income states receive more federal assistance. Federal Medicaid reimbursements are discussed in more detail on page 11 of the report.

Kansas Has Some Discretion in How it Structures its Medicaid Program

States administer their own Medicaid programs, and have some discretion over which services to offer and the rates they pay health care providers. The federal Centers for Medicare and Medicaid Services (CMS) oversees state Medicaid programs. CMS has established mandatory services each state must offer as part of their Medicaid plans. Beyond that, states can decide to offer up to 28 other optional services. These include services like chiropractic care, dental services, and physical therapy. In addition to deciding which services are covered, states also get to decide how much to reimburse providers for delivering these services to Medicaid beneficiaries.

States can also decide whether to administer their Medicaid programs under a fee-for-service model, a managed-care model, or some combination of the two. These very different approaches to administering Medicaid work as follows:

- **Under a fee-for-service model, the state is responsible for processing and paying Medicaid claims.** Health care providers bill the state directly for the services they provide. The state then

processes and pays the providers directly. Under this model, the state takes on the risk associated with paying beneficiary claims. For example, if the total cost of the claims is especially high during a given period, the state is still responsible. On the other hand, if the claims are especially low, the states would benefit from the reduced costs.

- **Under a managed-care model, the state contracts with one or more Managed Care Organizations (MCOs), which are then responsible for processing and paying Medicaid claims.** The state pays its MCOs a per-member-per-month rate for the beneficiaries on their plans. The MCOs are then responsible for processing and paying providers for services provided to Medicaid beneficiaries. Under this model, the MCOs, not the state, take on the risks associated with paying beneficiary claims. Additionally, managed-care programs tend to emphasize routine preventative care to help prevent future, high-cost medical services.

In 2013, Kansas transitioned nearly all its Medicaid population to KanCare, a new managed care program. Even before KanCare, about 90% of the state's Medicaid population—primarily children and families—were already served under a managed-care model. The remaining 10%, mostly the elderly and individuals with disabilities, were still served under a fee-for-service model.

KanCare was established in 2013. By 2014, following a one-year transition period for individuals with developmental disabilities, nearly all the state's Medicaid population, including the elderly and individuals with disabilities, were being served under KanCare. As of fiscal year 2016, about 96% of the state's nearly 426,000 Medicaid beneficiaries were served through KanCare. The remaining 4% were still served under a fee-for-service model.

In Kansas, Medicaid Expenditures Were About $3.4 Billion for 426,000 Beneficiaries in Fiscal Year 2016

The Medicaid enrollment and expenditure information below includes KanCare, Children's Health Insurance Program, and Fee-for-Service populations. Additionally, expenditures cited below include both state and federal Medicaid funds. Finally, Medicaid expenditures have not been adjusted for inflation.

- **Medicaid expenditures in Kansas were about $3.4 billion in fiscal year 2016.** Because Medicaid is jointly funded by the state and the federal government, the state paid about $1.5 billion (44%) of total expenditures in fiscal year 2016, while the federal government paid the remaining $1.9 billion (56%).

- **Medicaid enrollment in Kansas was about 426,000 in fiscal year 2016.** As is discussed below, the majority of the state's Medicaid population in fiscal year 2016 consisted of children and families, while the elderly and individuals with disabilities made up a smaller portion of the state's Medicaid population that year.

While children and families were the state's largest Medicaid population, the elderly and individuals with disabilities were the most expensive. In fiscal year 2016, children and families made up about 75% of the state's Medicaid population, but only accounted for 30% of the program's costs. In the same year, seniors and individuals with disabilities only made up about 25% of the state Medicaid population, but accounted for 70% of the program's costs. This is because seniors and individuals with disabilities are more likely to require expensive long-term care services, such as nursing facility care or ongoing in-home support.

OVERVIEW OF THE MEDICARE PROGRAM

Medicare is a Federal Insurance Plan for the Elderly and Individuals with Certain Disabilities

Medicare is a federal health insurance program for individuals over 65 years old and those under 65 with certain disabilities. Like Medicaid, Medicare was established as part of the 1965 Social Security Act. Its primary focus is on individuals over the age of 65, which accounted for over 80% of the Medicare population in 2011. The program also covers individuals under the age of 65 who receive disability benefits from Social Security, as well as people with end-stage kidney disease.

Medicare consists of four parts (A, B, C, and D). When Medicare was originally established in 1965, it included hospital insurance (Medicare Part A) and medical insurance (Medicare Part B). Together, these two parts are commonly referred to as "Original Medicare". In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) made two significant changes to Medicare. First, Medicare private health plans became known as Medicare Advantage Plans, or Part C. Second, the MMA expanded Medicare to include prescription drug insurance, known as Medicare Part D. Medicare's four parts are described in more detail on page 11 of the report.

Medicare is funded through a combination of payroll taxes, beneficiary premiums, and general federal revenues. A key source of Medicare funding is the federal payroll tax. Most people who are employed pay a 1.45% federal Medicare tax on their earnings, which their employers are required to match. The payroll tax is the primary source of funding for Medicare Part A. A second key source of funding is general federal revenues, which is a primary source of funding for Parts B, C, and D. The final source of funding is premiums charged to beneficiaries, which are used to support all four parts of Medicare.

Because Medicare is Strictly a Federal Program, Kansas Has No Discretion Over How the Program is Structured

Like other states, Kansas has no discretion over how Medicare is structured because it is strictly a federally operated and funded program. The Centers for Medicare and Medicaid Services (CMS) establishes national requirements for which services Medicare will provide and how much Medicare will pay for those services. As such, states do not have any discretion over which services Medicare will cover, or how much it will fund services in their state.

Total Medicare Expenditures in Kansas Were About $4.8 Billion and Enrollment was About 477,000 in 2014

State-specific Medicare expenditure data is only available every five years, which required us to use 2014 data. More recent state data will be available from CMS in 2019.

- **Medicare services provided to Kansas residents accounted for about $4.8 billion (1%) of the national total in 2014.** National Medicare expenditures totaled about $581 billion that same year.

- **Medicare enrollment in Kansas accounted for about 477,000 (1%) of the national total in 2014.** National Medicare enrollment totaled about 52.4 million that same year.

Question 1: How Do Medicaid and Medicare Services and Costs in Kansas Compare to Other States for a Select Sample of Services?

Although Medicaid services in Kansas were similar to those in other states, Medicaid costs varied by state. *Kansas' Medicaid services—including mandatory, optional, and community-based services—were similar to those in a sample of other states we reviewed (p. 7). However, state and federal costs for Medicaid services varied from state to state for two reasons: differences in provider reimbursement rates and federal cost sharing (p. 10).*

Additionally, we found that Medicare services and beneficiary costs varied across Medicare plans, but not necessarily from state to state. *We found that Medicare consists of four parts, each offering different services to beneficiaries (p. 11). We found that Medicare covered services and beneficiary out-of-pocket costs varied from plan to plan, but not necessarily from state to state (p. 13 - 15).*

FINDINGS RELATED TO MEDICAID SERVICES AND COSTS

Kansas' Medicaid Services Were Similar to Those Offered in a Sample of Five Other States

We compared Medicaid plans in Kansas to those in five comparable states: Colorado, Idaho, Iowa, Nebraska, and Oklahoma. These states were selected because their Medicaid programs were similar to Kansas in terms of per-capita spending and the size of their beneficiary populations. When possible, we worked with officials from these states to confirm our understanding of their Medicaid plans. However, we were unable to confirm our understanding of the Iowa or Oklahoma Medicaid state plans with officials from their Medicaid agencies.

The Centers for Medicare and Medicaid Services (CMS) requires all states offer 15 mandatory Medicaid services. These core services include physician, nursing facility, and hospital services. States must offer these mandatory services to receive federal funding for their Medicaid programs. A complete list of all 15 mandatory services is included in ***Appendix B***.

Kansas' Medicaid program offered 23 of 28 optional services, which was similar to five comparison states. In addition to the 15 mandatory services, CMS also gives states the choice to offer up to 28 optional Medicaid services, including dental, optometry, and podiatry services. We compared optional Medicaid services offered in Kansas to those offered in a sample of five states, including Colorado, Idaho, Iowa, Nebraska, and Oklahoma. These states were selected because they had similar Medicaid populations and per-capita expenditures as Kansas.

Figure 1-1
Comparison of Optional Medicaid Services Covered in Kansas and a Sample of Five Comparable States

Optional Benefits	KS	IA	NE	ID	CO	OK
Optional Services Offered in All 6 States						
Dental Services	✓	✓	✓	✓	✓	✓
Eyeglasses	✓	✓	✓	✓	✓	✓
Inpatient Psychiatric (a)	✓	✓	✓	✓	✓	✓
Intermediate Care Facility (I/DD)	✓	✓	✓	✓	✓	✓
Occupational Therapy	✓	✓	✓	✓	✓	✓
Optometry Services	✓	✓	✓	✓	✓	✓
Physical Therapy	✓	✓	✓	✓	✓	✓
Podiatry Services	✓	✓	✓	✓	✓	✓
Prescription Drugs	✓	✓	✓	✓	✓	✓
Preventative and Rehabilitative Services	✓	✓	✓	✓	✓	✓
Private Duty Nursing	✓	✓	✓	✓	✓	✓
Services for Mental Disease (b)	✓	✓	✓	✓	✓	✓
Speech, Hearing, and Language Disorder	✓	✓	✓	✓	✓	✓
State Plan Home and Community Based Services	✓	✓	✓	✓	✓	✓
Optional Services Offered in Kansas and Some Other States						
Case Management	✓	✓		✓	✓	✓
Clinic Services	✓	✓	✓		✓	✓
Hospice	✓	✓	✓	✓	✓	
Prosthetics	✓		✓	✓	✓	
Other Practitioner Services	✓			✓	✓	
Personal Care	✓			✓		✓
Respiratory Care	✓	✓	✓			
Tuberculosis Services	✓					✓
Other Services Approved by the Secretary (c)	✓					
Optional Services Not Offered in Kansas						
Denture Services		✓	✓	✓	✓	✓
Chiropractic Services		✓	✓	✓		
Health Homes for Chronic Conditions		✓	✓			✓
HCBS Attendant Services and Supports		✓	✓			
Personal Assistance						

(a) Inpatient psychiatric services are only for individuals under the age of 21.
(b) Mental disease services are only for individuals over the age of 65.
(c) Includes inpatient services provided in a religious non-medical health care institutions, emergency hospital services by a non-Medicare certified hospital, and critical access hospitals (CAH) approved by the Secretary of the U.S. Department of Health and Human Services.
Source: Kansas and other state's Medicaid benefit summaries (audited).

Figure 1-1 on the previous page compares the optional Medicaid services offered in Kansas to those offered in five comparison states. As the figure shows, Kansas' Medicaid program offered 23 of the 28 optional services. As the figure also shows, the five comparison states also offered between 20 to 22 optional services, many of which were the same as Kansas.

Kansas' Medicaid program covered similar Home and Community Based Service (HCBS) populations as those in the comparison states. HCBS waivers give states the option to provide medical and long-term care services to certain populations in the community instead of in an institutional setting. States can offer any number of waiver services, so long as they are approved by CMS.

Figure 1-2
Summary of Home and Community Based Service Waivers in Kansas and a Sample of Five Comparable States

HCBS Waiver	KS	CO	NE	IA	OK	ID
Broad HCBS Waiver Populations						
Elderly	✓	✓	✓	✓	✓	✓
Intellectual and Developmental Disability	✓	✓	✓	✓	✓	✓
Physical Disability	✓	✓	✓	✓	✓	✓
Targeted HCBS Waiver Populations (a)						
Traumatic Brain Injury	✓	✓	✓	✓		
Autism	✓	✓				✓
Serious Emotional Disturbance	✓			✓		
Technology Assisted	✓				✓	
Spinal Cord Injury		✓				
HIV/AIDs				✓		

(a) For Kansas, a missing check mark means the population is not covered by a HCBS waiver. For the other states, a missing check mark does not necessarily mean a state did not cover this population, but rather that we could not confirm a separate waiver for that population.
Source: CMS Summary of HCBS programs by state (audited).

Figure 1-2 above compares HCBS waivers offered in Kansas to those offered in five comparison states. As the figure shows, Kansas and all five comparison states covered the same broad HCBS populations, including the elderly, individuals with intellectual or developmental disabilities, and individuals with physical disabilities. In Kansas these three groups account for 82% of the state's total HCBS population.

States can also offer smaller, targeted HCBS waivers to specific populations, but our ability to compare them was limited. ***Figure 1-2*** also shows targeted HCBS waivers in Kansas and comparison states. As the figure shows, Kansas offered a waiver specific to children with serious emotional disturbances. Similarly, Colorado offered a waiver specific to individuals with spinal cord injuries. As the figure shows, the types of targeted HCBS waivers states offered varied widely. Although not all states offered the same targeted waivers, it is possible that they could serves some of these populations under their broader HCBS waivers.

Iowa was the only state in our sample that administered HCBS waivers through a managed-care model, like Kansas. As discussed on page 4 of the Overview, Kansas established a comprehensive managed-care model in 2013 (KanCare). Among other things, KanCare transitioned the state's HCBS populations into managed care. Prior to KanCare, these populations were served under a fee-for-service model. As of fiscal year 2016, 96% of Kansas' total Medicaid population, including 100% of its HCBS population, was served under a managed-care model.

In 2016, Iowa also transitioned to a managed-care model for most of its Medicaid population. As of 2016, 92% of Iowa's Medicaid population, including 94% of those served under HCBS waivers, were served under managed care. Although the other four comparison states utilized managed care for some services or populations, all four continued to provide HCBS waiver services through a fee-for-service model.

State and Federal Costs for Medicaid Services Varied from State to State Because of Differences in Provider Reimbursement Rates and Federal Cost Sharing

We interviewed CMS officials and reviewed relevant reports from CMS and the Kaiser Family Foundation to understand why state and federal spending on Medicaid services could vary from state to state. We also reviewed reports from the U.S. Department of Health and Human Services to determine how federal Medicaid cost sharing varied by state.

Because setting Medicaid provider reimbursement rates is a state policy decision, these rates vary by state. Each state establishes its own Medicaid provider fee schedule. Fee schedules clearly establish how much a state Medicaid program will reimburse providers for services delivered to beneficiaries. CMS does not set minimum reimbursement rates for most Medicaid services. Rather, states consider their demand for Medicaid services, their current state budgets, and other policy issues when setting their own rates. However, CMS does review and approve state's methodologies for setting payment rates and ensures they are sufficient enough to ensure an adequate provider network. We

did not compare specific reimbursement rates between our sample of five other states and Kansas. Rather we focused our resources on identifying whether cost differences exist within the Medicare program, which is discussed starting on page 14 of the report.

The federal government's share of Medicaid costs is based on each state's per-capita income, and thus also varies by state. The federal government pays a percentage of every state's Medicaid costs. Known as the Federal Medical Assistance Percentage, this percentage is based on each state's per-capita income. States with higher per-capita income have a smaller federal cost share, and receive less federal funding for Medicaid. Conversely, states with lower per-capita income have a higher federal cost share, and receive more federal funding for Medicaid.

In 2017, the federal government's share of Medicaid costs in Kansas was 56%—similar to the national average of 59%. Four of the five comparison states had similar federal matches as Kansas (Oklahoma – 60%, Iowa – 57%, Nebraska 52%, and Colorado – 50%). However, Idaho's 72% federal match was significantly higher than Kansas and the four other comparison states. A table summarizing the Federal Medical Assistance Percentage in all 50 states and the District of Columbia is included in ***Appendix C***.

Additionally, certain Medicaid groups are eligible for enhanced federal funding. The most prominent of these populations is tied to Medicaid expansion under the 2010 Affordable Care Act. States that opted for Medicaid expansion were eligible for an enhanced cost share of 100% from 2014 to 2016 for their new low-income adult population. This enhanced cost share will be phased down to 90% over the course of three years, from 2017 to 2019. As of 2017, Kansas had not extended Medicaid to this population.

FINDINGS RELATED TO MEDICARE SERVICES AND COSTS

Medicare Consists of Four Parts, Each Offering Different Services to Beneficiaries

We interviewed CMS officials and reviewed relevant reports from CMS and the Kaiser Family Foundation, a non-profit and non-partisan organization that focuses on national health issues, to understand Medicare's four parts. ***Figure 1-3*** on the next page summarizes these parts and how they fit together. As the figure shows, Medicare beneficiaries can choose between Original Medicare (Parts A and B) or a private Medicare Advantage plan (Part C). Additionally, beneficiaries can choose to add prescription drug coverage (Part D) to their Original Medicare, or choose a Part C plans that also includes Part D coverage.

Original Medicare (Parts A and B) covers hospital and medical services for Medicare beneficiaries. Original Medicare operates under a fee-for-service model, meaning the federal government is

responsible for processing and paying Medicare claims directly. Generally, Medicare Part A covers hospital services while Medicare Part B covers basic medical services, like physician visits, laboratory tests, and x-rays. Beneficiaries do not pay a premium for Medicare Part A, so long as they worked for 10 years before turning 65. Beneficiaries who worked fewer than 10 years pay a Part A monthly premium of $227 to $413 depending on the number of years worked. Most beneficiaries pay an income-based premium for Part B, which on average was about $134 per month in 2017.

Figure 1-3
Summary of Medicare's Four Parts

<table>
<tr><th>Original Medicare</th><th>Medicare Advantage Plans</th></tr>
<tr><td><u>Part A: Hospital Insurance</u>

Covers: Inpatient hospital stays, skilled nursing facility stays, some home health visits, hospice care, and other inpatient hospital services.</td><td rowspan="2"><u>Part C: Advantage Plans</u>

Covers: At a minimum, Advantage plans cover everything covered under Parts A and B. In some cases, Advantage plans also cover additional dental, hearing, vision, and some value-added services.(a)</td></tr>
<tr><td><u>Part B: Medical Insurance</u>

Covers: Physician visits, outpatient services, preventive services, and other basic medical services.</td></tr>
<tr><td colspan="2"><u>Part D: Prescription Drug Coverage</u>

Coverage can be added to Original Medicare (Parts A and B) or included in an Advantage Plan (Part C).

Covers: Outpatient prescription drugs.</td></tr>
<tr><td colspan="2">(a) Value-added services are optional services offered by insurance companies, such as fitness membership, or over-the-counter allowance.
Source: CMS 2017 "Medicare and You" Handbook (unaudited)</td></tr>
</table>

Medicare Advantage plans (Part C) are a managed-care alternative to Original Medicare. Beneficiaries can choose between original Medicare (Parts A and B) or a Medicare Advantage plan (Part C). Unlike Original Medicare, Medicare Advantage plans operate under a managed-care model. This means the federal government pays federally approved health insurance companies a per-member-per-month rate for Medicare beneficiaries enrolled in their plans. The health insurance companies, not the federal government, are then responsible for processing and paying the Medicare claims. CMS requires Medicare Advantage plans offer, at a minimum, the same services covered under Original Medicare. Advantage plan premiums are generally the same as Original Medicare, but premium costs can vary by plan.

According to a 2017 Kaiser Family Foundation report, national enrollment in Medicare Advantage plans has increased by 71% since 2010. The report found that nearly 19 million Medicare beneficiaries were enrolled in a Medicare Advantage plan in 2017, as compared to 11 million in 2010.

Medicare Part D provides additional prescription drug insurance. Medicare Part D is strictly prescription drug health insurance and is designed to supplement Original Medicare and Medicare Advantage plans. Beneficiaries who opt for Original Medicare can also choose to enroll in a Part D plan for an additional monthly premium. Alternatively, individuals who select a Medicare Advantage plan can choose one that includes Part D coverage. Additional premiums for Medicare Advantage plans that include Part D coverage can vary by plan.

Medicare-Covered Services Varied from Plan to Plan, but not Necessarily from State to State

To better understand Medicare covered services we reviewed relevant Kaiser Family Foundation and CMS reports and interviewed CMS officials. We also collected detailed information about Medicare Advantage plans offered in Kansas and a sample of four other Midwest states and Idaho. We used this information to determine whether Medicare-covered services varied by state. Finally, our analysis focuses on medical services. We did not evaluate any differences in coverage or costs for prescription drugs offered under Medicare Part D.

The services covered under Original Medicare (Parts A and B) are the same for all beneficiaries and do not vary by state. According to CMS officials, Original Medicare offers just one Part A plan and one Part B plan nationwide. As such, covered services do not vary by plan under Original Medicare. Because they are national plans, covered services do not vary by state under Original Medicare either.

Coverage for dental, hearing, and vision services varied between Original Medicare (Parts A and B) and the Medicare Advantage plans (Part C) we reviewed. Unlike Original Medicare which has only one plan, there are numerous Medicare Advantage plans offered nationally. For the most part, Original Medicare and Medicare Advantage plans cover the same set of services, though there are important exceptions. Specifically, some Medicare Advantage plans offer expanded dental, hearing, and vision services that are not covered by Original Medicare. Nine of the 11 Medicare Advantage plans we reviewed covered these additional dental, hearing, or vision services. In addition to these types of services, some Medicare Advantage plans offer so-called

"value-added" benefits that also are not covered by Original Medicare, such as a fitness membership or an over-the-counter drug allowance.

The type of Medicare Advantage plan available to beneficiaries can vary depending on where a beneficiary lives. Insurance companies offer different types of Medicare Advantage plans across the country. As discussed above, some of these plans include expanded services, while others do not. Therefore, depending on where a beneficiary lives, it may not be possible for them to access a Medicare Advantage plan with the expanded benefits discussed above. However, any geographic differences in Medicare covered services is the result of the type of Advantage plans insurance companies make available, not state policy decisions.

Out-of-Pocket Costs for Beneficiaries Under Medicare Also Varied from Plan to Plan, but not Necessarily from State to State

As is the case with most health insurance plans, Medicare beneficiaries must pay a share of their medical costs**.** There are four components to out-of-pocket costs:

- Deductible – The amount of money a beneficiary must pay each year to cover medical expenses before Medicare starts paying.
- Co-Insurance: The share a beneficiary is required to pay for medical care after they meet their deductible. Co-insurance is typically expressed as a percent (%).
- Co-Payment – A flat fee a beneficiary pays every time he or she receives a medical service. Co-payments are typically expressed as a fixed amount ($).
- Out-of-Pocket Maximum – The cap on how much a beneficiary will pay each year for health care services through their deductible, co-insurance, and co-payments.

We compared these cost variables across a non-projectable sample of five services covered under Original Medicare and a non-projectable sample of 11 Medicare Advantage plans in Kansas, Colorado, Idaho, Iowa, Nebraska, and Oklahoma. The five services we compared were ambulance services, durable medical equipment, group psychotherapy, intravitreal eye-shots, and x-rays.

Out-of-pocket costs for the same services varied between Original Medicare (Parts A and B) and the Medicare Advantage Plans (Part C) we reviewed. We compared the four components of out-of-pocket costs—deductibles, co-insurance, co-payments, and out-of-pocket maximums—for five sampled services. A table comparing these components across plans and services can be found in ***Appendix D***. Overall, we found the four components of out-of-pocket costs did vary by plan.

- **Deductibles for the plans we reviewed varied from $0 to $1,499.** Beneficiaries must meet their deductible before Medicare will help pay for their services. On average, beneficiaries on Original Medicare pay a $1,316 deductible for Part A services, and a $183 deductible for Part B. However, 9 of the 11 Medicare Advantage plans we reviewed (plans in Iowa were the exception) offered a $0 deductible to beneficiaries, meaning beneficiaries are not required to meet any cost obligations before accessing their Medicare benefits.

- **Co-insurance rates varied by as much as 25% for the five services we reviewed**. Original Medicare had a standard 20% co-insurance rate for most covered services. This means once a beneficiary reaches their deductible, Medicare pays 80% of the cost for a service and the beneficiary pays the remaining 20%. However, co-insurance rates varied within the sampled Medicare Advantage plans. For example, co-insurance rates for durable medical equipment ranged from 9% for one plan in Iowa, to 20% in plans offered in Oklahoma, Colorado, Idaho, and Nebraska. Co-insurance rates also varied for the other services we reviewed. A full summary of our comparison can be found in ***Appendix D***.

- **Co-Payments varied by as much as $225 for the five services we reviewed.** Original Medicare did not charge co-payments for the five services in our sample. However, Medicare Advantage plans did charge co-payments for four of the five services. The amounts of the co-payments varied by plan. For example, we found co-payments for ambulance services varied from $100 to $300 between two Oklahoma Advantage plans. Similarly, intravitreal eye injections ranged from $0 to $35 for an Advantage plan in Kansas, to $195 to $225 for an Advantage plan in Oklahoma. Co-payments also varied for other services we reviewed. A full summary of our comparison can be found in ***Appendix D***.

- **Out-of-Pocket maximums are only offered under Medicare Advantage plans and varied between $3,000 to $6,700 for the plans we reviewed.** Original Medicare does not include an annual out-of-pocket maximum. This means there is no annual limit on how much a beneficiary pays for Medicare covered services. However, all 11 Medicare Advantage plans in our sample had an out-of-pocket maximum, which ranged from $3,000 in an Oklahoma plan to $6,700 in plans offered in Kansas, Iowa, and Nebraska.

Beneficiaries' out-of-pocket costs under Medicare Advantage plans can vary depending on where a beneficiary lives. Our review showed that beneficiary out-of-pocket costs varied between Medicare Advantage plans. Because insurance companies offer different Advantage plans across the country, beneficiaries' out-of-pocket costs can vary depending on the number and type of Advantage plans available where they live. However, as was the case above, any geographic differences in out-of-pocket costs is caused by which Advantage plans insurance companies make available, not state policy decisions.

In addition to the plans they select, other factors play a less significant role in how much a Medicare beneficiary pays in out-of-pocket costs. We identified a few other variables that could affect beneficiary out-of-pocket costs. First, how much Medicare will pay for covered services is set by CMS and calculated based on regional differences in medical costs. However, differences between Kansas and the sampled states was between 2% to 11% for our sampled services. Additionally, services received out-of-network can require beneficiaries to pay a higher share of their medical costs. Finally, some beneficiaries also have private insurance in addition to Medicare. In some cases, private insurance plans may act as the primary payer, reducing the amount paid by Medicare and ultimately the beneficiary.

Conclusion

Because states are given some discretion in how they structure their Medicaid programs—in terms of both the services they offer and how much they reimburse providers—it is reasonable to expect variation in Medicaid services and costs. Based on our review, however, the types of Medicaid services offered and the types of individuals receiving those services (e.g. children, pregnant women, and individuals with disabilities) were very similar across states. The state costs associated with those services varied based on the reimbursement rates set by states and the federal government's share which is set by a formula.

On the other hand, because Medicare is strictly a federal program, we would expect Medicare services and costs to be consistent across states. This assumption appears to hold true for Original Medicare (Parts A and B), which provides hospital and medical services to beneficiaries. However, we found significant variation in the services available and the beneficiary costs associated with the variety of Medicare Advantage plans (Part C). Those plans, which are a managed care form of Medicare and administered by private companies, can vary widely both within and across states.

Recommendations

None

APPENDIX A
Agency Response

On November 17, 2017, we provided copies of the draft audit report to the Kansas Department of Health and Environment. The agency was not required to submit a formal response because this audit did not have any agency recommendations. Agency officials chose not to submit a formal response for this audit.

APPENDIX B
Summary of Federally Required Medicaid Services

This appendix lists the 15 Medicaid services CMS requires all states offer.

Mandatory Medicaid Services

- Certified Pediatric and Family Nurse Practitioner Services
- Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)
- Family Planning Services
- Federally Qualified Health Center Services
- Freestanding Birth Center Services
- Home Health Services
- Inpatient Hospital Services
- Laboratory and X-Ray Services
- Nursing Facility Services
- Nurse Midwife Services
- Outpatient Hospital Services
- Physician Services
- Rural Health Clinic Services
- Tobacco cessation Counseling for Pregnant Women
- Transportation to Medical Care

APPENDIX C
Federal Medical Assistance Percentages

This appendix contains a summary table comparing 2017 Federal Medical Assistance Percentages across all states and Washington D.C.

Appendix C Summary of 2017 Federal Medical Assistance Percentages for all States and Washington D.C.			
States	**Federal %**	**States**	**Federal %**
1. Mississippi	75%	**27. Iowa**	**57%**
2. West Virginia	72%	**28. Kansas**	**56%**
3. Idaho	**72%**	29. Texas	56%
4. South Carolina	71%	30. South Dakota	55%
5. New Mexico	71%	31. Hawaii	55%
6. Kentucky	70%	32. Vermont	54%
7. Alabama	70%	33. Delaware	54%
8. District of Columbia	70%	**34. Nebraska**	**52%**
9. Utah	70%	35. Pennsylvania	52%
10. Arkansas	70%	36. Illinois	51%
11. Arizona	69%	37. Rhode Island	51%
12. Georgia	68%	**38. Colorado**	**50%**
13. North Carolina	67%	39. Alaska	50%
14. Indiana	67%	40. California	50%
15. Montana	66%	41. Connecticut	50%
16. Michigan	65%	42. Maryland	50%
17. Tennessee	65%	43. Massachusetts	50%
18. Nevada	65%	44. Minnesota	50%
19. Oregon	64%	45. New Hampshire	50%
20. Maine	64%	46. New Jersey	50%
21. Missouri	63%	47. New York	50%
22. Ohio	62%	48. North Dakota	50%
23. Louisiana	62%	49. Virginia	50%
24. Florida	61%	50. Washington	50%
25. Oklahoma	**60%**	51. Wyoming	50%
26. Wisconsin	59%		
Source: United States Department of Health and Human Services 2017 Federal Medical Assistance Percentage Report (unaudited)			

APPENDIX D
Comparison of Medicare Out-of-Pocket Costs

This appendix contains a summary table comparing Medicare out-of-pocket costs for Original Medicare and a sample of 11 Medicare Advantage plans.

Appendix D
Comparing the Four Components of Out-of-Pocket Costs
for Original Medicare and 11 Sampled Medicare Advantage Plans

		Plan Deductible	Plan Out-of-Pocket Max	Co-Payment or Co-Insurance for 5 Selected Services (a)				
				Durable Medical Equipment	Intravitreal Eye Injections (b)	Chest X-Ray	Ambulance (Ground)	Mental Health Outpatient Group Therapy
Original Medicare								
Hospital Part A		$1,316 (c)	N/A	N/A	N/A	N/A	N/A	N/A
Medical Part B		$183	N/A	20%	20%	20%	20%	20%
Medicare Advantage Plans								
Kansas	Plan 1	$0	$6,700 (f)	19%	$20 - $50 (d) 0% - 20%	$20- $50 30%	$265	$40 - $50 20%
	Plan 2	$0	$4,900	15%	$0 - $35 25%	$0 - $35 20% - 25%	$265	$35 25%
Colorado	Plan 1	$0	$5,500	20%	20%	$14	$275	$30
	Plan 2	$0	$4,900	18%	$0 - $50	$0 - $50	$265	$20 - $50 25%
Idaho	Plan 1	$0	$3,400	10%	10%	10%	$175	$25
	Plan 2	$0	$3,600 (f)	20%	$0 - $50 25%	$10 - $50 25%	$265	$25 - $55 25%
Iowa	Plan 1	$1000 (e)	$6,700 (f)	9%	$0 - $50	$10 - $50	$265	$40 - $55
	Plan 2	$250 (e)	$6,700	13%	$0 - $100	$15 - $100	$265	$40 - $100
Nebraska	Plan 1	$0	$6,700	20%	20%	$14	$250	$30
Oklahoma	Plan 1	$0	$3,900	20%	$195 - $225	$0	$300	$40
	Plan 2	$0	$3,000	20%	$20	20%	$100	$10

(a) Co-payment amounts are shown in dollars, whereas co-insurance amounts are shown in percentages.
(b) These costs only include the physical injection, the drug costs which can also vary significantly is not included.
(c) Part A deductible is "per benefit period", which is generally equivalent equal to one inpatient hospital stay.
(d) Costs share may vary depending on the specific service and where the service is provided.
(e) Deductibles vary depending on whether services are received in or out-of-network
(f) These out-of-pocket maximums are combined in and out-of-network.
Source: CMS 2017 "Medicare and You" handbook and a sample of 11 Medicare Advantage Plans (audited)

APPENDIX E
Audit Proposal

This appendix contains the original audit proposal approved by the Legislative Post Audit Committee at its April 28, 2017, meeting. For reporting purposes, we divided the three objectives included in the original request into three separate audit reports. This report addressed objective two of the original audit proposal.

Medicaid: Evaluating Issues Related to KanCare and Other Important Components of the State's Medicaid System

SOURCE
The objectives included in this proposal were either requested or suggested by individual legislators or legislative committees.

BACKGROUND
Launched in January 2013, KanCare is the program through which the State of Kansas administers Medicaid. KanCare offers health care for people with limited income, which may include pregnant women, children, and low-income families with children. The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) jointly administer KanCare. KDHE maintains financial management and contract oversight of the KanCare program, and KDADS administers the Medicaid waiver programs for disabilities, mental health issues, and substance abuse problems, as well as overseeing the state hospitals and institutions.

As the state's Medicaid program, KanCare focuses on providing person-centered care coordinated through three private managed care originations (MCOs): Amerigroup of Kansas, Inc., Sunflower Health Plan, and United Healthcare Community Plan of Kansas. The state also contracts with Maximus, a private company that processes the state's Medicaid applications and provides support services during the eligibility process.

Developed and administered by the Kansas Department of Health and Environment (KDHE), the Kansas Eligibility and Enforcement System (KEES) was intended to create an information system to help determine eligibility for the state's Medicaid program (KanCare) and a variety of social service benefits. In December 2015, our office released an audit which found that the core of the KEES project was approximately two and half years behind its original implementation schedule. The audit also found that some important components of KEES had been significantly postponed or reduced.

In November 2016, members of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight heard testimony about the strengths and weaknesses of the KanCare program, including the KEES system. That testimony, in combination with legislators' communication with KEES users and constituents, raised several concerns about the automation, efficiency, and accuracy of KEES.

AUDIT OBJECTIVES AND TENTATIVE METHODOLOGY

The audit objectives listed below represent the questions that we would answer through our audit work. The proposed steps for each objective are intended to convey the type of work we would do, but are subject to change as we learn more about the audit issues and are able to refine our methodology.

Objective 1: What effect did transitioning to KanCare have on the state's Medicaid costs, the services provided, and client health outcomes? Our tentative methodology would include the following:

- Work with officials from the Kansas Department of Health and Environment (KDHE) and the Centers for Medicare and Medicaid Services (CMS) to identify any available metrics used to track Medicaid costs, services provided, and client health outcomes in the state.

- Review available metrics for the last 5-10 years to identify any significant changes to the state's Medicaid costs, services provided, or client health outcomes before and after KanCare was established.

- Survey a sample of health care providers and Medicaid clients to collect their opinions on the effect transitioning to KanCare had on the state's Medicaid costs, services, and outcomes.

- Interview officials from the Kansas Health Institute, Kansas Hospital Association, Kansas Medical Society, and other medical stakeholders to collect their opinions on the effect transitioning to KanCare had on the state's Medicaid costs, services, and outcomes.

- Based on that cumulative work, determine what effect transitioning to KanCare had on the state's Medicaid costs, services provided, and client outcomes.

Objective 2: How does Kansas' Medicaid and Medicare coverage compare to other states for a select sample of services? Our tentative methodology would include the following:

- Review Medicaid and Medicare benefit summaries and work with CMS and KDHE officials to select a small sample of common services covered by Medicaid and Medicare in the state.

- For the sample, review documentation and work with CMS and KDHE officials to determine how much Medicaid and Medicare will reimburse for the sample of services.

- Work with officials from KDHE, CMS, and a sample of other states to identify any differences in Medicaid and Medicare coverage and reimbursements, and the reasons why any differences exist.

Objective 3: Are reports and notices produced by the Kansas Eligibility Enforcement System useful and reliable? Our tentative methodology would include the following:

- Work with KDHE staff to develop an understanding of the types of reports that are produced by the KEES system and how they are used.

- Work with a sample of entities that receive reports out of the KEES system to identify reports they do not consider useful or reliable.

- For reports that are not considered useful, work with KDHE staff and the entities that receive the reports to identify ways they could be improved or to determine if they should be eliminated.

- For reports that are not considered reliable, work with KDHE staff and review system documents as needed to understand the controls in place to ensure the reliability of these reports.

- Compare a sample of reports to other records or information to determine whether the controls are working as intended.

- Follow up with KDHE staff as necessary to determine the root cause of any control failures we identify through our test work.

ESTIMATED RESOURCES

We estimate this audit would require a team of **four (4) auditors** for a total of **six (6) months** (from the time the audit starts to our best estimated of when it would be ready for the committee).

APPENDIX F
Cited References

This appendix includes a list of the reports and studies noted in this report.

1. Congressional Research Service, *Medicaid's Federal Medical Assistance Percentage (FMAP)* (February 2016).

2. Kansas Legislative Division of Post Audit, *Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program* (April 2010).

3. Kansas Health Institute, *Kansas Medicaid Primer* (January 2017).

4. Centers for Medicare and Medicaid Services, *Medicare and You* (November 2016).

5. Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (July 2017).

6. Kansas Department of Health and Environment, *Kansas Medical Assistance Report Fiscal Year 2017* (June 2017).

7. Kaiser Family Foundation, *Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending* (November 2012).

8. Kaiser Family Foundation, *Medicare Advantage 2017 Spotlight: Enrollment Market Update* (June 2017).