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KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
Out-of-State Services

Description

Kansas Medicaid maintains an out-of-state program for situations which require a Kansas Medicaid beneficiary to receive services in another state. The out-of-state program, described in this review, includes only those services provided to individuals enrolled in the fee for service program. The Managed Care contractors manage the out-of-state services provided to the HealthWave population. The Kansas Medicaid out-of-state program functions under the guidance of the Code of Federal Regulations (C.F.R):

> *42 C.F.R. 431.52 Payments for services furnished out-of-state. Defines that a State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met: (1) Medical services are needed because of a medical emergency; (2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence; (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; (4) It is general practice for recipients in a particular locality to use medical resources in another State.*

By KHPA policy, all services provided in another state require prior authorization (PA) except in the following instances:

- The service is provided by an enrolled Kansas Medicaid provider located in a border city. These providers are in another state, but are located within 50 miles of the Kansas state line. For example Kansas City, Missouri is considered a border city.
- The service is provided emergently.
- Services such as laboratory and test interpretation services where the beneficiary remains in Kansas but their specimen or test results are sent to an enrolled provider in another state.

Providers are classified as being a border city provider if their facilities are in a state other than Kansas and are within 50 miles of the Kansas border. Currently, Kansas has a total of 3,035 active border city providers (51 hospitals, 2,106 physicians, and 878 “other”).

For the purpose of this report, a hospital provider is defined as an acute care hospital and a physician is defined as a medical practitioner who is listed as a “physician” by KHPA. The other category is comprised of several different provider types such as durable medical equipment (DME) suppliers, clinics, other medical professionals, and emergency transportation.

In order for providers to receive reimbursement for services, they must have an active provider number. If providers have not submitted a claim to KHPA in an 18 month period, their status is changed to inactive; however, providers can request that their number remain active for another 18 months. An upcoming change in provider agreements will require providers to submit a new application if the provider goes beyond the 18 months without any claims submissions. This change is being made to meet federal regulations.

Of the 3,035 active border city providers, a total of 1,134 border city providers received reimbursement from KHPA between FY 2005 and FY 2008. Of the 1,134 providers that were reimbursed; 63 were hospitals, 703 were physicians, and 368 fall under the other category. Border city providers do not require prior authorization (PA), and claims for reimbursement from these providers process through KHPA's automated claims processing system.

Providers are classified as being out- of- state if their facilities are in a state other than Kansas and are not within 50 miles of the Kansas border. Currently, there are a total of 3,620 active out-of-state providers (526 hospital providers, 2,389 physician providers, and 705 "other"). Of the 3,620 active out-of-state providers, KHPA had a total of 642 out-of-state providers who received reimbursement between FY 2005 and FY 2008. Of the 642 providers that were reimbursed; 232 were hospitals, 229 were physicians, and 181 fall under the other category.

Through policy, KHPA uses the out-of-state PA process to ensure that services and procedures are medically necessary. Prior authorization, which must be obtained prior to performing services, does not override program coverage limitations. A facility, or professional, must be a Kansas Medicaid provider in order to be approved for possible KHPA reimbursement for services and the patient must be eligible to receive the service.

In order for an out-of-state PA to be approved, the service being requested must either be unavailable in the state of Kansas or a border city, or the service is available through a closer out-of-state provider. KHPA has few large medical providers in the western half of the state and the medical centers in Denver are significantly closer for some beneficiaries than similar centers located in Wichita and Kansas City. In these situations, KHPA will take the distance to services into consideration when reviewing out-of-state PA requests.

All non-emergent services provided out-of-state require PA. If services provided by an out-of-state provider are emergent, PA is not required; however, the provider's documentation must support that the services provided were emergent. An emergency situation is defined as a service that must be performed immediately to preserve life or function, or both, and time does not permit the provider to obtain a PA.

An out-of-state PA process is initiated when the Kansas physician contacts the PA unit at KHPA's fiscal agent for Medicaid, HP Enterprise Services (HP), and provides the following information:

- A letter of medical necessity explaining what services are being requested, where these services are to be provided (hospital, physician, etc.), and why these services cannot be provided in Kansas. The explanation also must identify why the beneficiary needs to see this specific provider and not a provider that may be closer to Kansas.
- A recent (within 6 months) history and physical describing the patient's current medical condition and medical history.

Once the required data is obtained, the fiscal agent's nursing staff review the submitted information for medical necessity. If the medical necessity is met, the out-of-state PA is

approved; if not, the request is denied. If information needs additional review, the nursing staff will contact the KHPA out-of-state PA program manager for a review. Once the state program manager receives the information, it will be further reviewed and the state program manager will make a determination based on the medical necessity. If the case presents complications not addressed in established policies, the case is reviewed by KHPA's internal medical work group, which consists of medical doctors, registered nurses, and other staff.

Some out-of-state services are provided only for children. These services include heart and lung transplants, which are not included as covered services in the Kansas state Medicaid plan, but are required services for children under the federally mandated Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. Currently, KHPA only covers heart and lung transplants for children and all of these services are provided out-of-state. In general, organ transplants and specialized surgeries are usually referred to out-of-state providers who are considered centers of excellence by the medical community.

Some services delivered by out-of-state providers do not require PA because they are technical in nature and are usually performed by independent laboratories or other specialized providers. The beneficiary's samples are sent out-of-state for testing or interpretation and a report is sent back to the physician or hospital who ordered the test. These procedures can be highly specialized and there are limited providers capable of performing them.

Out-of-state emergency transportation services also do not require PA. These services are reviewed for medical necessity and the reimbursement rates mirror in state providers. The expenditures are primarily for air ambulance services transport medically fragile beneficiaries.

KHPA scrutinizes the use of individually contracted out-of-state services, but certain circumstances require a beneficiary receive specialized services from an out-of-state provider. For example, a child requiring a specialized life-saving heart procedure that is currently covered by KHPA, but Kansas lacks providers who can provide this service and a Kansas Medicaid provider in California specializes in those services. KHPA has approved receipt of those specialized services from this provider. KHPA then negotiates a contract with that provider for those services. Three different providers have had at least one special reimbursement contract with KHPA from FY2005 to FY 2008. Those contracts have included reimbursement levels exceeding standard Kansas Medicaid rates, and typically tie payments to a percentage of billed charges, for specialized treatments for specific beneficiaries. The three out-of-state providers are St. Louis Children's Hospital in St. Louis, Missouri, Lucile Packard Children's Hospital in Stanford, California, and Madonna Rehabilitation Hospital in Lincoln, Nebraska. These providers perform specialized services that are currently not available in Kansas.

The traumatic brain injury (TBI) waiver managed by the Kansas Department of Social and Rehabilitation Services (SRS) uses out-of-state head injury rehabilitation centers that provide services for TBI waiver beneficiaries. These services and PAs are approved and managed by SRS. The out-of-state head injury rehabilitation centers had an average total expenditure of $1,507,790 from FY 2005 to FY 2008. These expenditures are paid through the KHPA billing system, Medicaid Management Information System, but are part of the SRS waiver's budget.

KHPA surveyed all 50 states plus the District of Columbia and received responses from 19 states and the District of Columbia. The survey collected information about coverage of out-of-state services and the states' Medicaid reimbursement methodologies for these services. Of the 20 respondents, 19 of them cover services provided in another state, 12 of them require PA for these services, and 13 of them use some form of special reimbursement for specialized

services (some through special contracts). In this report, the responses from the four states bordering Kansas (Colorado, Missouri, Nebraska and Oklahoma) are included in Table 1.

The other states' out-of-state program limitations are very similar to those applied by Kansas Medicaid. Services provided in another state require PA unless provided emergently or have specifically been identified as not requiring PA. All of the Medicaid programs, except Oklahoma, reimburse out-of-state providers using different methodologies than that used for comparable in state providers. Nebraska uses a percent of billed charges. Colorado pays at 90% of its comparable in state rate, and Missouri pays the lesser of billed or the MO HealthNet established rate.

Table 1: Kansas and Other State PA and Reimbursement Information

	Kansas Medicaid	Colorado Medicaid	Missouri Medicaid	Nebraska Medicaid	Oklahoma Medicaid
Cover services provided out-of-state?	YES	YES	YES	YES	YES
Prior Authorization for out-of-state services?	YES	YES	YES	YES	YES
Emergency services out-of-state require prior authorization?	NO	NO	NO	NO	NO
How are out-of-state providers reimbursed	Same as the instate/border city providers, unless a special contract for increased reimbursement is negotiated.	Out-of-state hospitals are reimbursed at 90% of what we would pay the average in-state peer group hospital (rural or urban) for the same DRG.	Inpatient out-of-state hospitals are reimbursed at the lower of the hospital's billed charge or a rate established by MO HealthNet times the applicable number of days. This is based off of the in state weighted average rate.	All out-of-state hospitals are paid at a % of billed charges - currently 51%. Other practitioners are reimbursed from the Medicaid fee schedule which is the same for all like provider types.	Covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals
Are special contracts used?	YES	YES	YES	YES	YES

Service Utilization and Expenditures

The out-of-state PA volume and expenditure information, reported in Table 2, represent the out-of-state PAs that were initiated and approved during fiscal years 2005 - 2008. These expenditures make up an average of 36% of the total out-of-state expenditures. Out-of-state PA hospital expenditures make up an average of 58% of the overall out-of-state hospital expenditures. Out-of-state PA physician expenditures make up an average of 71% of the overall out-of-state physician expenditures.

Table 2: Comparison of Out-of-State PA Expenditures to Total Out-of-State Expenditures

	Average Exp. FY 05-08	
Total Out-of-state Expenditures	$7,144,787	
Total Out-of-state PA Expenditures	$2,558,582	36%
Total Out-of-state Hospital Expenditures	$3,907,573	
Total Out-of-state PA Hospital Expenditures	$2,252,226	58%
Total Out-of-state Physician Expenditures	$254,498	
Total Out-of-state PA Physician Expenditures	$181,446	71%

Figure 1: Total Out-of-State PAs by Age Group FY 2005 – 2008

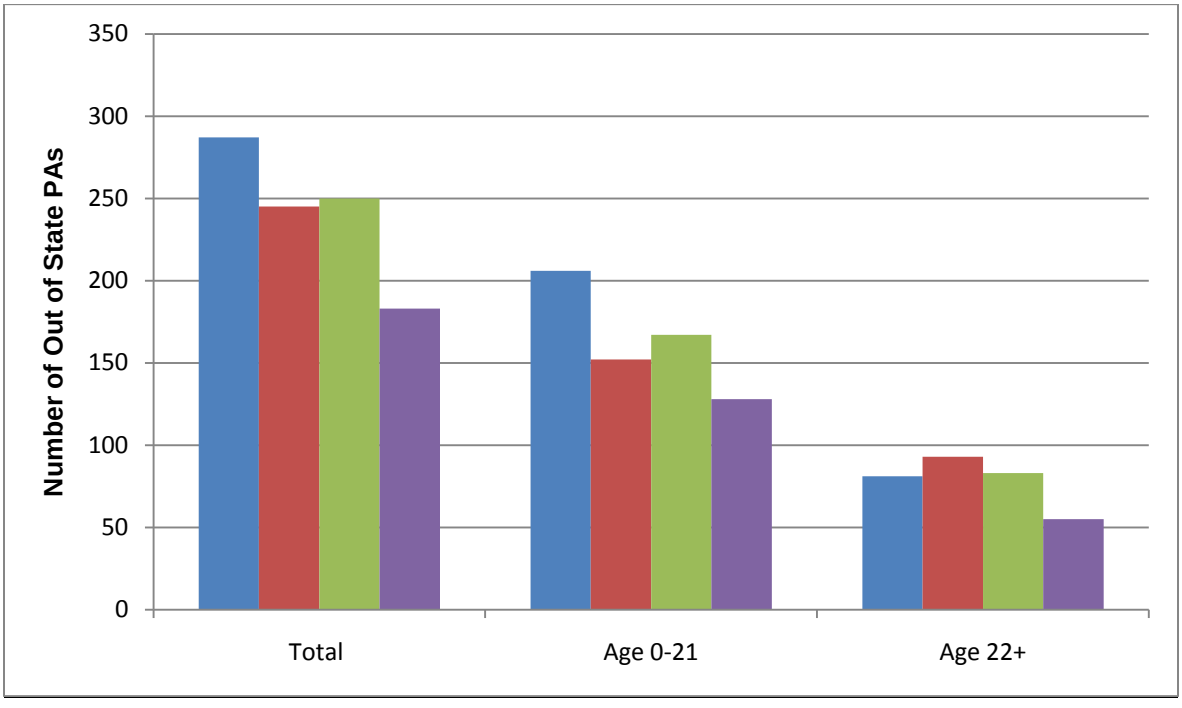

Figure 1 portrays the total number of approved PAs by age group. From FY 2005 to 2008 the overall number of approved out-of-state PAs decreased by 36% from 287 to 183. On average, 67% of approved out-of-state PAs were for beneficiaries under the age of 21. From FY 2005 to FY 2008, there was a 38% percent decrease in approved PAs for beneficiaries under age 21 and a 32% decrease for over age 21. In FY 08, KHPA was directed by CMS to no longer approve out-of-state PAs for services performed by non-Kansas Medicaid providers. The majority of the decline was a result of that directive. Some of the decline in out-of-state PAs can also be attributed to the program managers maintaining program guidelines and requiring out-of-state PAs prior to receipt of services. KHPA's expansion of the managed care program by approximately 50,000 beneficiaries who had previously received FFS reimbursed medical services also contributed to the decline in out-of-state PAs.

The following data shows the expenditures incurred by KHPA for services by providers classified as out-of-state and border city, including both expenditures requiring PA and those without that requirement. The out-of-state PA expenditure data is for services to beneficiaries with out-of-state PAs approved in fiscal years 2005, 2006, 2007, and 2008. For this report, the data was gathered through claims review of all out-of-state expenditure data for the beneficiaries who received an out-of-state PA. Data set limitations prevent linkage of detailed out-of-state claims with the out-of-state PA.

The contracted expenditures for out-of-state services are included in the total out-of-state expenditure calculations. The contract claims are paid as a lump sum and are not processed as a regular claim through the state's fiscal system. Since these contract amounts are paid as expenditures, the detail information normally included in a claim is absent.

Figure 2: Total Expenditures by Location for FY 2005 – 2008

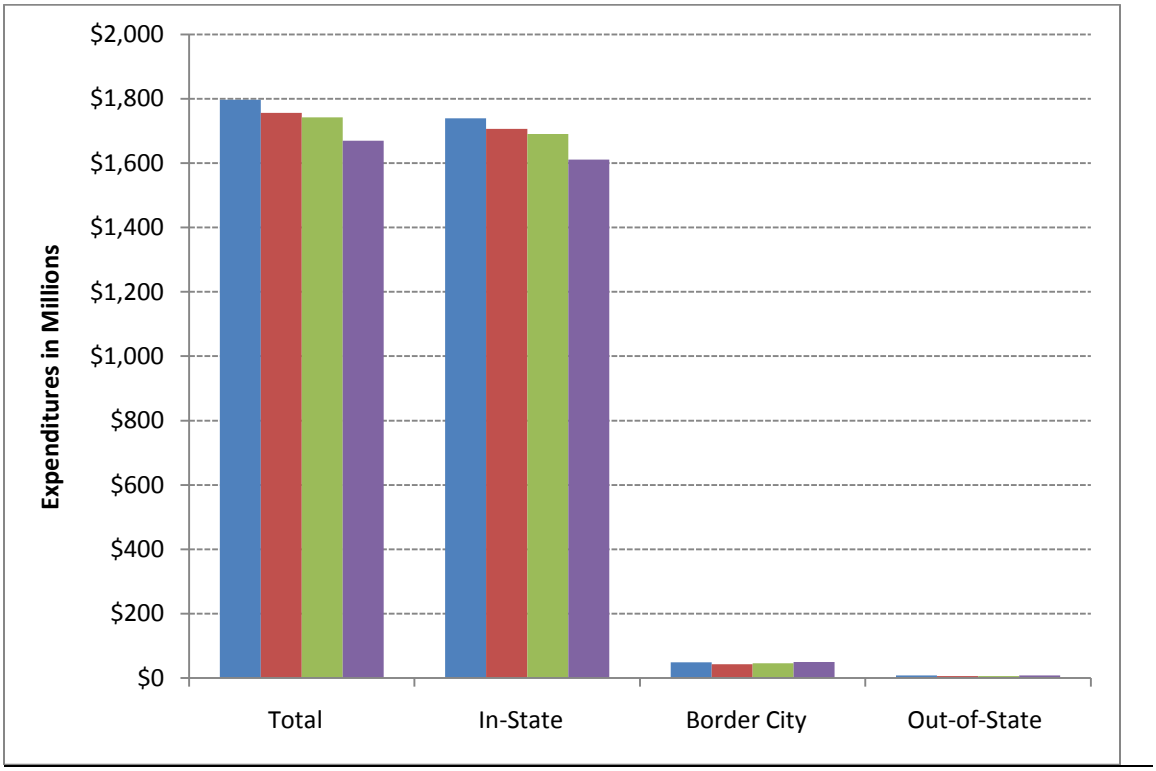

Figure 2 displays the total fee for service expenditures spent for in-state, border city, and out-of-state providers FY 2005 - 2008. On average, Kansas Medicaid spent 2.8-3.5% of its total expenditures for services by providers outside of Kansas, border city expenditures accounting for 2.4-3.0% of total expenditures and out-of-state expenditures making up 0.3-0.5%.

Table 3: Border City Expenditures

	2005	2006	2007	2008
Total Expenditures	$49,504,658	$42,986,522	$46,262,854	$50,042,753
Beneficiaries Receiving Service	35,691	37,436	34,198	32,773
Expenditures per Beneficiary	$1,387	$1,148	$1,353	$1,527

Table 3 depicts border city expenditure data. From FY 2005 to FY 2008 there was a modest (1%) increase in total border city expenditures. FY 2005 to FY 2008 showed a decline in expenditures for services to the aged population, with the largest decline (3 million dollars) in FY 2006. During this time frame, Medicare part D was initiated and resulted in a large reduction in pharmacy program expenditures. During the same time period there was an increase in expenditures for services to the disabled, with the largest increase (5 million dollars) in FY 2007. Those increases primarily occurred in hospital and behavior management expenditures and for diagnoses grouped under the headings: major medical, psychiatric, and childhood medical.

Border city expenditures are concentrated among Kansas City and Joplin, Missouri providers, accounting for approximately 84-90% of total border city expenditures. Hospital providers comprise 44-58% of the total border city expenditures. Four hospital providers (Children's Mercy, St. John's, Freeman, and St. Luke's) account for 24-36% of the total border city expenditures and 84-88% of the border city hospital expenditures. Children's Mercy hospital accounts for 52-63% of the border city hospital expenditures. Children's Mercy receives the majority of pediatric beneficiaries with severe medical problems not only from the Kansas City area, but also from several other regions of Kansas.

Historically, Children's Mercy Hospital (CMH) Disproportionate Share Hospital (DSH) payments offset costs incurred serving pediatric beneficiaries who had longer lengths-of-stay and received more expensive services. In recent DSH reform, out-of-state hospitals were limited to no more than 10% of the total Kansas hospital DSH allotment. This significantly reduced Kansas Medicaid DSH payments to CMH. Starting in FY 2009, KHPA implemented a modified outlier reimbursement methodology for CMH to cover costs incurred for provision of high acuity services to KHPA's pediatric beneficiaries.

Recently, KHPA has experienced a decline in volume of beneficiaries receiving services from border city providers, after a 5% increase from FY 2005 to FY 2006. In FY 07, KHPA expanded the managed care program, shifting approximately 50,000 beneficiaries from the fee for service program and this report does not reflect the utilization of those beneficiaries now served through managed care.

Although there has been a decline in volume of beneficiaries receiving services from border city providers, there has been an increase in expenditures per beneficiary. The increase in expenditures per beneficiary is due to a number of factors, including an increase in the disabled population, which has higher utilization patterns, an increase in hospital expenditures, and a shift of beneficiaries with low utilization patterns into managed care.

Figure 3: Expenditures to Border City Providers by Type

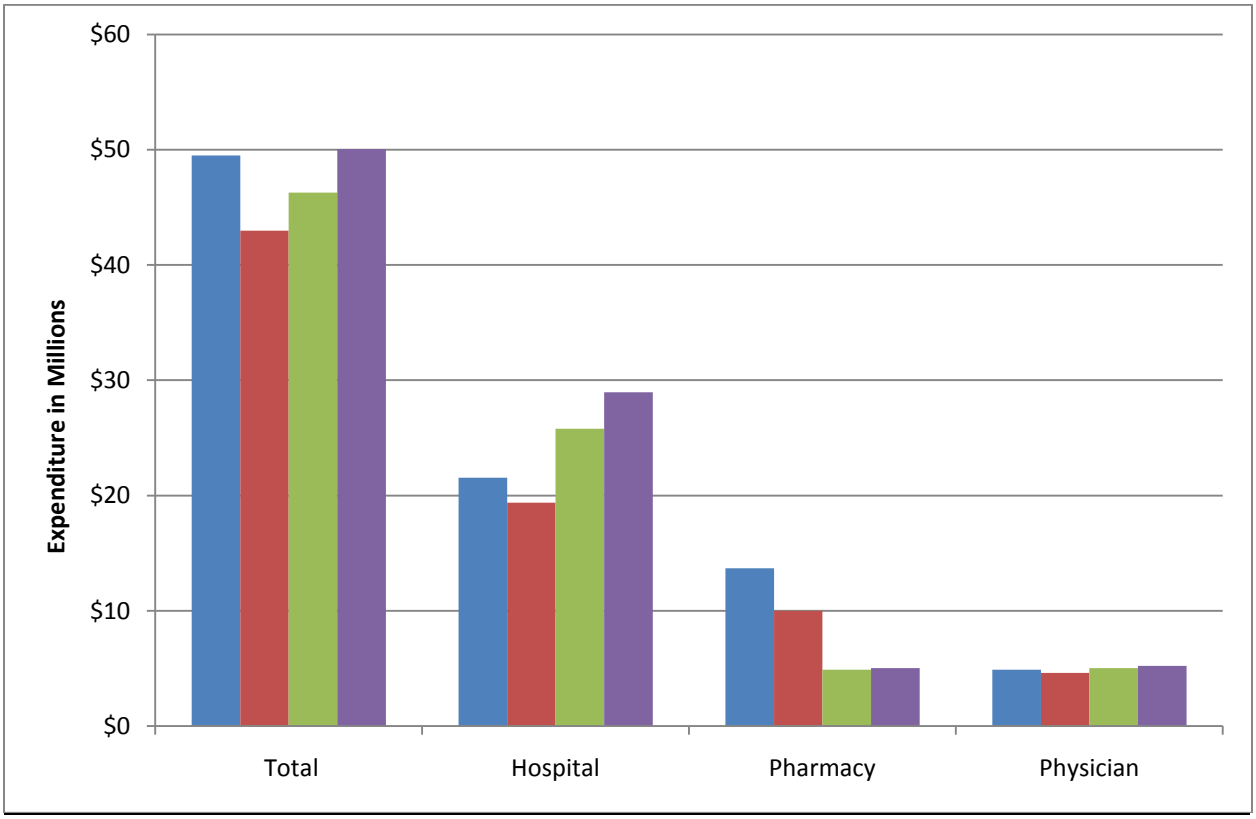

Figure 3 depicts the border city expenditures by service category for FY 2005 -2008. Hospital, pharmacy, and physician expenditures account for approximately 79% of the total border city expenditures. Hospital expenditures account for a majority of total expenditures from FY 2005 to FY 2008; 44% FY 2005, 45% in FY 2006, 56% in FY 2007, and 58% in FY 2008. The total increase for hospital expenditures in those fiscal years was 26% in border cities.

An examination of specific procedures provided by border city inpatient hospitals showed that in FY 2006, there was a decline in hospital expenditures for major cardiac procedures, neonatal services, and major chest procedures. In FY 2007, there was an increase in hospital expenditures for neonatal services, circulatory system procedures, and spinal fusion procedures. There was an increase in hospital expenditures for cardiac procedures, ventilator services, and blood disorder services, in FY 2008.

Table 4: Out-of-State Expenditures

	2005	2006	2007	2008
Total Expenditures	$8,087,550	$6,681,100	$5,826,662	$7,983,836
Beneficiaries Receiving Services	13,788	12,239	15,964	12,040
Expenditures per Beneficiary	$587	$546	$365	$663

Table 4 displays expenditures for services to beneficiaries by out-of-state providers for FY 2005 - 2008. There was a decline in expenditures from FY 2005 through FY 2007. A portion of this decline can be attributed to a decrease in out-of-state pharmacy expenditures. In FY 2005, the out-of-state Pharmacy expenditures were nearly to $1 million. With the implementation of Medicare Part D, those expenditures dramatically decreased. The out-of-state pharmacy expenditures from FY 2006 to FY 2008 decreased from $102,000 to $35,000. During FY 2005 to FY 2007 there was also a decline in overall out-of-state hospital expenditures. In FY 2008, there was a $2,157,173 increase in out-of-state expenditures primarily due to one hospital provider, Nebraska Medical Center, who had an approximate increase in expenditures totaling $2,036,011. This increase in expenditures was for services provided in FY 2007 and FY 2008. During FY 2007 and FY 2008 there was an increase in the number of beneficiaries requiring transplant services. The majority of these services were provided at the Nebraska Medical Center, a major Midwestern medical provider specializing in pediatric services.

All expenditures for hospital services provided in FY 2007 may not be incurred until FY 2008; because, a hospital does not bill for services until the beneficiary has been discharged. This lag time may encompass several months depending on the amount of care required by the beneficiary. When other providers, such as physicians, bill for services they usually bill their services within days of providing the service.

The out-of-state hospital and physician expenditures can fluctuate greatly depending on the number of beneficiaries and the severity of their medical conditions. Overall from FY 2005 to FY 2008, there was a 13% decrease in beneficiaries receiving services from out-of-state providers. There was also a 38% drop in expenditures from FY 2005 to FY 2007. However, in FY 2008 there was an 82% increase which was due the increase of over two million dollars in hospital reimbursements for services provided by Nebraska Medical Center.

Figure 4: Expenditures to Out-of-State Providers by Type

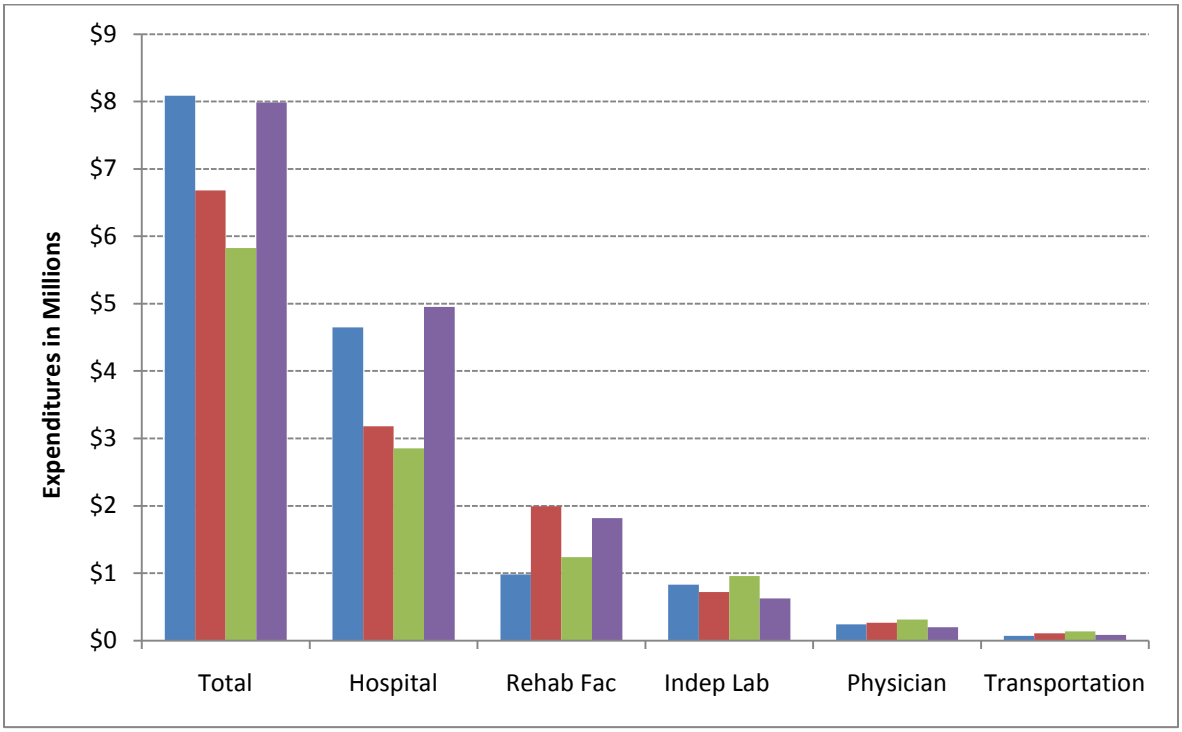

Figure 4 depicts out-of-state expenditures by service category. Five services account for 92% of the total out-of-state expenditures.

Hospital services account for approximately 54% of the total out-of-state expenditures from FY 2005 to FY 2008. From FY 2005 to FY 2007 there was a 39% decrease in out-of-state hospital expenditures due to reduced level of services provided by a number of out-of-state hospitals. Cooks Children's Hospital decreased expenditures nearly $750,000 and Cincinnati Children's Hospital decreased almost $420,000.

Independent laboratory expenditures showed modest variation over the four fiscal years. In FY 2007 expenditures increased, with Laboratory Corporation of America accounting for 58% of the $248,009 increase. The increase was due to an increase in the amount of drug screens performed.

Figure 5: Out-of-State Contract Expenditures by Fiscal Year

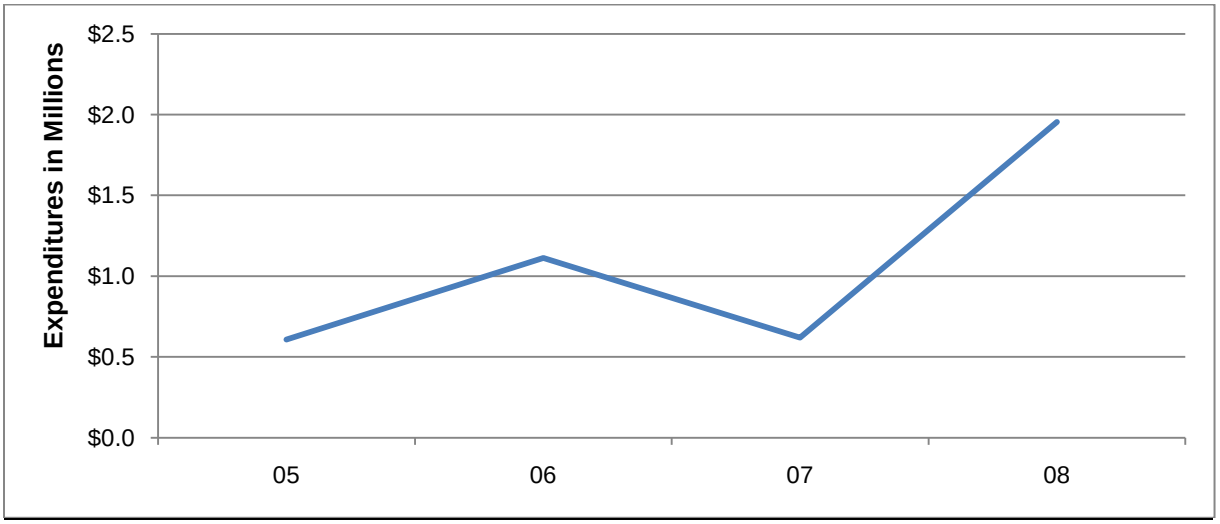

Figure 5 displays the total number of out-of-state contracted expenditures for FY 2005 - 2008. Three providers have been reimbursed by KHPA through special reimbursement rate contracts: St. Louis Children's Hospital, Lucile Packard Children's Hospital, and Madonna Rehabilitation Hospital. Each of those providers is reimbursed at a percentage of billed charges when the services are contracted.

Table 5: Out-of-state Contract Expenditures

	2005	2006	2007	2008
Madonna Rehabilitation Hospital	$475,083	$146,475	$193,323	$607,017
Number of Beneficiaries	3	1	1	3
St. Louis Children's Hospital	$132,767	$922,098	$314,682	$99,376
Number of Beneficiaries	1	2	1	1
Lucile Packard Children's Hospital	$0	$43,305	$112,049	$1,248,128
Number of Beneficiaries	0	1	1	2
Total Contract Expenditures	$607,850	$1,111,878	$620,054	$1,954,521
Total Number of Beneficiaries	4	4	3	6

Figure 6: Out-Of-State PA Expenditures by Fiscal Year

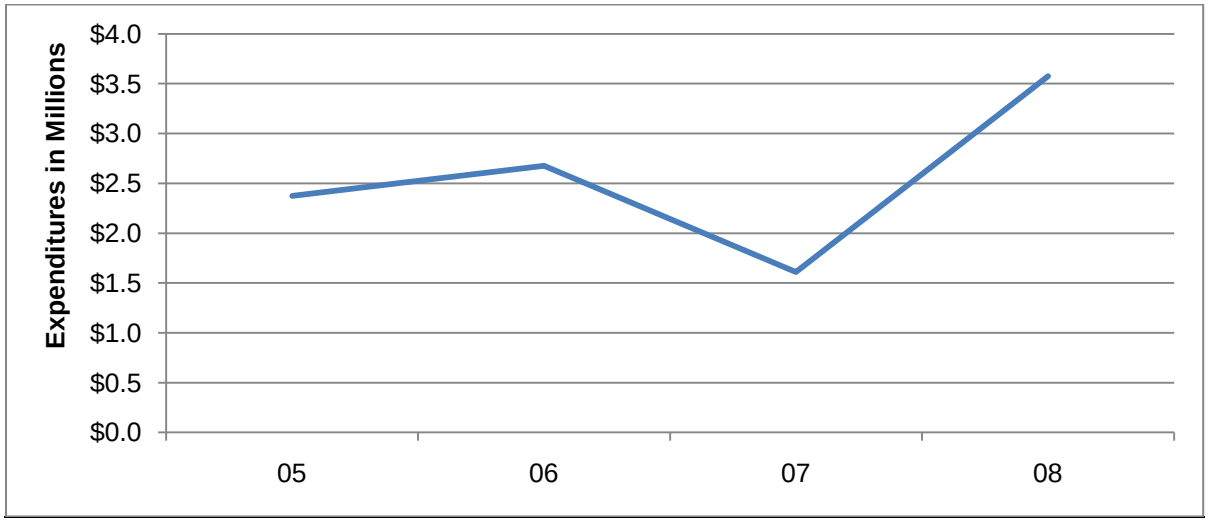

Figure 6 displays the total expenditures for the approved out-of-state PAs for FY 2005 - 2008. In FY 2008, there was a $1,967,941 increase in out-of-state PA expenditures corresponding with increased out-of-state hospital expenditures.

Figure 7: Individual Out-of-State PA Expenditures by Fiscal Year

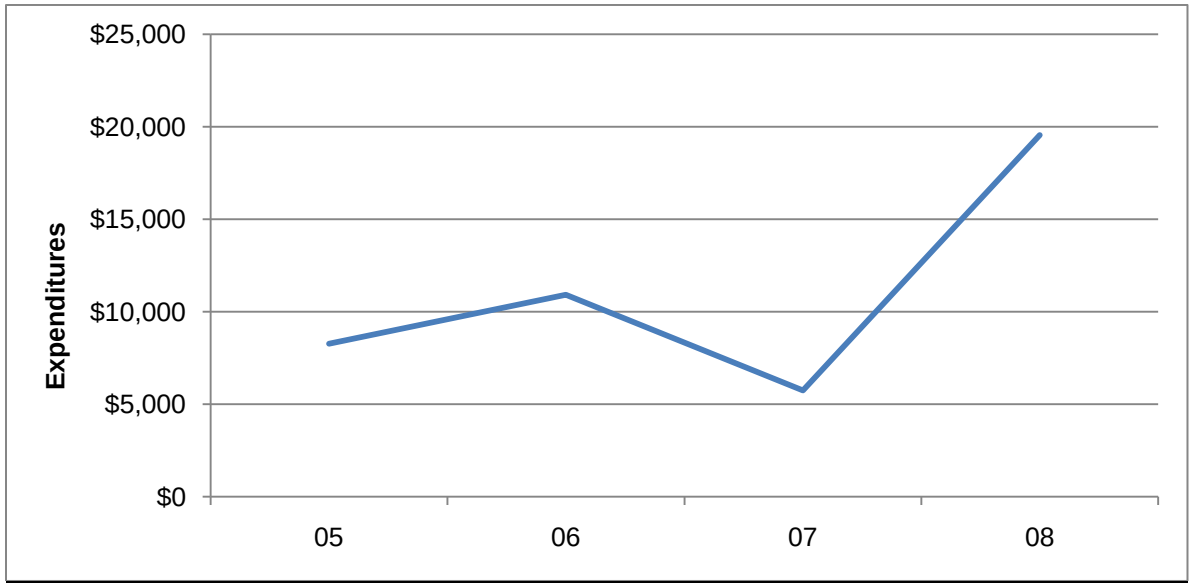

Figure 7 provides the individual out-of-state PA expenditures for FY 2005 - 2008. In FY 2008 the increase in out-of-state hospital expenditures influenced the upward trend in individual PA expenditures.

Program Evaluation

Out-of-state services are usually provided to beneficiaries with high medical needs or beneficiaries who have limited access to services. Out-of-state and in state services are primarily reimbursed using the same rates and methods. For those out-of-state services, no additional oversight is required since the only additional costs incurred relate to transportation and lodging, which are monitored on a case by case basis by KHPA or EDS staff.

Nevertheless, there have been questions about whether payments to some out-of-state providers should be lower since they do not participate in the provider assessment program. .In 2006 KHPA fully implemented a provider assessment tax on Kansas hospital providers. The assessment program levies a 1.83% tax on Kansas hospitals. These revenues were used to increase inpatient hospital and outpatient hospital reimbursement rates. The increases to inpatient hospital rates were limited to in state providers; however, the increase in outpatient hospital rates were not limited to in state providers. The out-of-state and border city outpatient hospital providers receive their reimbursement rate increase through an outpatient adjustment factor that adds a 25.8% increase to the current KHPA procedure code reimbursement. Since no physician pays into the program, there is no inequity in an out-of-state physician receiving the enhanced payments: it is a matter of access to raise payments to both. Out-of-state hospitals, though, receive the benefits of enhanced reimbursement but cannot be taxed by the state of Kansas and therefore to not contribute to the program.

From FY 2005 to FY 2007 there was a decrease in overall out-of-state expenditures. In FY 2008 the increase in overall and hospital expenditures was attributed to an increase in services performed at the Nebraska Medical Center which specializes in organ transplants. Payment for those services is set at a percentage of billed charges and therefore a small increase in beneficiaries requiring transplants can lead to a large increase in expenditures.

In FY 2007 KHPA had an increase in out-of-state independent laboratory expenditures, with 58% of the increase attributed to Laboratory Corporation of America. This provider performed an increased number of drug screens for all Medicaid populations.

Out-of-state hospital expenditures fluctuate from year to year depending on the specific services being provided such as organ transplants, which are reimbursed using a percent of billed charges methodology. In FY 2007 KHPA had a $2,000,000 increase in expenditures for one provider who specializes in transplants.

KHPA spent approximately $1,421,898 from FY 2005 to FY 2008 on special contracts for increased reimbursements with Madonna Rehabilitation Hospital (MRH) at substantially higher rates than the standard reimbursement rate. MRH has a Kansas Medicaid provider number, but does not accept standard Kansas Medicaid reimbursement for any services. Other providers, such as Lucile Packard, may request a contract for an increased reimbursement rate on some of their specialized treatments, but they accept standard Kansas Medicaid reimbursement rates for other services. KHPA has already initiated the following limitations:

- KHPA will only contract for rehabilitation services for beneficiaries with high cervical neck fracture requiring ventilator support. All other services will only be reimbursed using Regular Medicaid reimbursement rates (fee for service).
- KHPA has reduced the contracted rate with MRH by 10%. This change would have saved KHPA $75,878 in FY 2008.

There is concern that additional contract limitations with providers such as MRH may result in their refusal to treat Kansas Medicaid beneficiaries.

Recommendation

1. Evaluate additional limitations on contracts with Madonna Rehabilitation Hospital.
    - Limiting the number of contract extensions at the initiating rate to two. A new reduced rate would be negotiated for any contract extensions past two.
    - Limiting the length of contract extensions to one month.

Additional option

2. Remove the provider assessment reimbursement increases on outpatient services provided out-of-state.
    - Since the out-of-state and border city hospitals did not contribute to the provider assessment, it may be inequitable for them to receive the reimbursement rate increase from the provider assessment, similar to the inpatient hospital rate increase.
    - This option would require a review by KHPA staff of the provider assessment program to ensure continued compliance with CMS rules for provider tax programs, i.e., rules requiring taxes to be broad based and generally redistributive.
    - Upon implementation, outpatient utilization would need to be monitored to ensure that access to services was maintained.