

Transforming Kansas' Medicaid Program: Comprehensive Program Review and Updated Staff Recommendations

August 15, 2008

The Medicaid Transformation Committee. *The role of the staff and Board of the KHPA in transforming Medicaid during FY 2009 will include administrative actions, budget and statutory proposals for consideration in the 2009 legislature, and a review of options for health-related sources of revenue to support reform and guard against the impact of declining state revenues on critical health programs. As recommended by the KHPA Board at its annual retreat June 18-19, 2008, KHPA convened a Medicaid Transformation Committee comprised of KHPA Board members and staffed by KHPA for the purpose of crafting a package of changes and improvements reflecting the ongoing transformation of Medicaid to meet the state's greatest health needs. The Committee met three times in July and August to review a set of staff proposals. At their last meeting, the Committee agreed to convey the staff proposals to the full Board for their consideration. The Committee is conveying these staff proposals in draft for continued review by the full Board: given the nature of these proposals as a working document, the Committee did not vote to recommend the package, but rather agreed to convey the package to the Board for final consideration. Components of the plan will require additional work and are not ready for Board consideration. KHPA staff continue to work with external consultants and stakeholders to review options for generating additional Medicaid-related financing to support recommended expansions in Medicaid coverage and eligibility. These revenue-generating options and the revenue-dependent expansions that would accompany them remain a work in progress, and are not recommended for inclusion in KHPA's FY 2009-2010 budget recommendations to the Governor. These proposals will require further review and action by the Board prior to the 2009 legislative session.*

DRAFT

MEDICAID TRANSFORMATION PROCESS EXECUTIVE SUMMARY

CONTEXT FOR MEDICAID TRANSFORMATION IN 2008

The Kansas Health Policy Authority (KHPA) is committed to continuous improvement of its programs. KHPA has implemented a number of changes to Medicaid, SCHIP and the other public insurance programs it operates since it took responsibility for the programs on July 1, 2006. The agency has transitioned to a new, more comprehensive program of managed care, adding about 50,000 members and additional choice within HealthWave. KHPA has engaged in a number of innovative pilot programs to investigate the potential for health information exchange to improve coordination of care, and to identify successful approaches in care management for high-cost beneficiaries. KHPA has also proposed innovative uses of the Medicaid program to support broad health reform efforts, including proposals to simplify administrative costs, increase coverage, and implement a medical home concept in Kansas. The Transformation process represents the next step forward in KHPA's management and oversight of the Medicaid program.

The process itself is motivated by a desire to improve KHPA's public insurance programs themselves, and to transform the management and policy leadership of these programs, and comes at a time when the program is under increasing scrutiny due to increasing costs and lagging state revenues. Medicaid costs have grown at nearly 10% per year over the last decade, and totaled \$2.2 billion across all Kansas Medicaid services in state fiscal year (FY) 2007 (see Table 12). KHPA public insurance programs accounted for about \$1.2 billion. Spending on public insurance programs (i.e., including medical service costs and excluding long-term care) is projected to grow at the rate of about 5.5% per year in FY 2008 and FY 2009 without significant change in coverage, rates, or other program rules. Over the FY 2007-2009 period, cost growth is expected to be split fairly evenly between low-income families and the state's low-income aged and disabled populations. Over the longer term, a greater percentage of growth in expenditures is attributable to the aged and disabled populations.

Compared to other programs around the country, overall Medicaid spending per beneficiary is relatively high: \$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), and ranks highest for the aged and disabled. Medicaid spending in Kansas is somewhat concentrated among the aged and disabled populations. Kansas ranks above-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. Also, while the level of coverage of children is typical, at 200% of the poverty level, coverage for non-disabled adults is relatively low. Kansas ranks 39th in the percentage of Medicaid eligibles who are low-income, non-disabled, working-age adults, and ranks between the 41st and 46th in its eligibility income threshold for adults in this category. Partly as a result, Kansas ranks 43rd in the percentage of its population covered by Medicaid.

Kansas' economic strength ranks near the middle for its region (Colorado, Oklahoma, Missouri, Iowa and Nebraska), as does its overall level of health insurance coverage (see Table 5). Compared to other states in the region, Kansas Medicaid also ranks near the middle in terms of Medicaid spending as a percentage of total health spending (see Table 4), but has experienced relatively low levels of growth in Medicaid expenditures since 1991 (Table 1). Coverage of children represents a relatively high percentage of target low-income uninsured children, but coverage of working-age adults is in the middle when measured on that basis (see Table 7). Income eligibility thresholds for children are middle (coverage expansion for SCHIP to 250% of poverty is not yet reflected in this comparison given

the dependence of this expansion of potential Congressional actions), but rank at the bottom of the region (with Missouri) for coverage of adult parents.

Medicaid remains a good bargain compared to private sector coverage (see Tables 2 and 3), although total spending on Medicaid is growing faster as coverage has shifted nationally from private to public insurance, especially with Federally-mandated Medicaid expansions and introduction of the new SCHIP program (Table 1). Per-capita growth in Medicaid costs has been lower than per-capita growth in private health insurance costs over the long term (Table 3), contributing to a significant cost advantage for public health insurance on an actuarially-adjusted basis. Provider payment rates are typically much lower in Medicaid and other public programs, helping to explain the cost advantage.

THE PROCESS OF TRANSFORMING MEDICAID: COMPREHENSIVE, DATA-DRIVEN PROGRAMMATIC REVIEWS

As the agency has led a very public effort to engage stakeholders and to reform health policy in the state, it has also engaged in the process of reorganizing and refocusing the agency to expand capacity for data analysis and management, and to adopt data-driven processes in the management of its programs. To this end, for the past 2 years the Medicaid program has initiated in a new and increasingly comprehensive endeavor to utilize available data to review each major component of the program and to identify areas for improvement, cost-effectiveness, program integrity, improved quality, health promotion and access. Reviews to be completed in 2008 cover fourteen separate but often overlapping topics that are organized into four broad categories: health care services and programs, special populations, eligibility, and quality improvement. Included in this document are brief summaries of each individual review, along with recommendations for policy changes in FY 2009, FY 2010 and beyond. The full reviews remain in draft form, but will be made available for the Board as they are completed this year: they total nearly 300 pages of description, data, analysis, and recommendations. The fourteen reviews to be completed in 2008 are:

- Health care services and programs:
 - Dental
 - Durable Medical Equipment
 - Home Health
 - Hospice
 - Hospital (inpatient and outpatient)
 - Lab/Radiology
 - Pharmacy
 - Transportation
 - HealthWave program (capitated managed care)
 - HealthConnect program (primary care case management)
- Populations
 - Medical Services for the Aged and Disabled
 - Emergency services for undocumented persons
- Eligibility for public health insurance
- Quality improvement for KHPA programs

Staffing and resource constraints prevent an exhaustive review of every Medicaid program each year, but the process is intended to be comprehensive over time. Reviews of most program areas will be repeated on an annual basis, providing accountability to both the policy process and the programs themselves. Additional reviews will be

added in 2009, including a review of Medicaid operations and contract oversight. The ten 2008 program reviews that address specific health care services or programs cover about three quarters (77%) of Medicaid and SCHIP medical expenditures, and about 40% of total Medicaid expenditures (after including long-term care, waiver, and mental health programs operated by the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services -See Figure 1). The two 2008 program reviews for specific populations cover approximately 25% of the Medicaid and SCHIP population, and these populations account for approximately 45% of all medical service costs. The two remaining reviews are more comprehensive in nature: the eligibility review assesses coverage, policy and enrollment operations for all Medicaid and SCHIP beneficiaries; and the quality improvement review examines quality measurement and improvement efforts for all KHPA medical service programs, including the state employee health plan and the state employee workers compensation program.

In many cases, the specific policy changes recommended as a result of the 2008 Medicaid Transformation process are incremental. In other cases, significant change is anticipated. Engaging in this annual evaluation and laying out for public scrutiny the policies and plans for each area of KHPA's public insurance programs will accelerate and better inform program improvements. The process is KHPA's effort to implement transparent, data-driven policies throughout its public health insurance programs, and represents a significant advance in participatory public policy-making. It is the process itself which is designed to transform Medicaid, using data and transparent goals to motivate program improvements and avoid speculative change based on anecdote.

KHPA STAFF RECOMMENDATIONS FOR MEDICAID TRANSFORMATION

There are a total of twenty recommendations and options emerging from the Transformation process (see Table 8), including fourteen that have an expected impact on state Medicaid spending. Examples include:

(A3) Issue a request for proposal (RFP) to outsource management and direct contracting for Medicaid transportation benefits to a private broker, increasing scrutiny, right-sizing reimbursement, and generating modest net savings to the state. *\$.9 million savings to the state over five years.*

(B1) Purchase and implement an automated prior authorization (PA) system for pharmacy services to increase the efficiency of the PA unit in reviewing requests, reduce the burden of PA on participating pharmacists, and achieve savings through the expanded use of PA, which facilitates more intensive utilization management and targeted purchasing through the preferred drug list (PDL). *\$.6.8 million savings to the state over five years.*

(N5) Convene a workgroup of stakeholders to use existing information to effectively evaluate and design a care management program for aged and disabled Medicaid beneficiaries. The recommendation would be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget. *No fiscal impact.*

(RD1) Expand access to care for needy parents by increasing the income limit to 100% of poverty (\$1,467 per month for a family of 3). Current coverage levels are no greater than 30% of poverty (\$440 per month for a family of 3), and fall each year as inflation eats away at the fixed dollar threshold for eligibility. *\$. [TBA]*

The net impact of all Transformation recommendations – not including those dependent on additional revenue sources – represents a savings to the state of approximately \$1 million in state fiscal year (SFY) 2010, and a cumulative savings of approximately \$10 million over the SFY 2009-2013 period (see Table 9). Transformation initiatives that would expand coverage or services should not be included in the state's budgeting process in a year in which budget reductions have been required. Expansions will need to be addressed outside the normal budget process and packaged with sources of new revenue for later presentation to the Governor and legislature.

HEALTH CARE EXPENDITURES¹ Regional and National Comparisons

Growth in Regional Health Care Expenditures

Table 1.

	Kansas	Colorado	Iowa	Missouri	Nebraska	Oklahoma
Personal Health Care All Payers 1991-2004 Avg. Annual Growth	6.6%	7.7%	6.4%	7.0%	7.6%	6.7%
Personal Health Care Medicaid 1991-2004 Avg. Annual Growth	7.8%	9.6%	7.6%	12.8%	9.8%	8.1%

Sources: Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released September 2007; available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts

Health Expenditure Projections

Table 2.

	Kansas Medicaid	U.S. Medicaid	U.S. Private
Average Annual Percent Change by source of funds 2005-2006	4.7%	8.2%	5.4%
Projected Percent Change by Source of Funds			
2007	-1.4%	8.9%	6.4%
2008	10.5%	6.8%	6.8%
2009	2.5%	7.4%	7.0%
2010	2.9%	7.7%	6.5%

¹ In order to compare Kansas and other states to national figures, several national sources of data are used in these tables. The figures may not total to figures provided in the KHPA Medical Assistance Report (MAR).

Increase in Health Insurance Costs

Table 3.

	2005	2006	2007
Health Insurance Premiums ²	9.2%	7.7%	6.1%
Medicaid Per Capita Spending Growth ³	2.5% (medical only and LTC) 3.8% (medical only)	2.8% (medical only and LTC) 3.0% (medical only)	Not yet available

Surrounding States Comparison

Health Care Expenditures

Table 4.

	Kansas	Colorado	Iowa	Missouri	Nebraska	Oklahoma
State Health Expenditures 2003 (Millions)*	\$ 2,761	\$3,303	\$2,733	\$7,706	\$2,154	\$3,439
Total Health Expenditures 2004 (Millions)**	\$14,736	\$21,691	\$15,892	\$31,317	\$9,782	\$17,323
Total Medicaid Spending 2006	\$2.1 B	\$2.2 B	\$2.2 B	\$6.5 B	\$1.5 B	\$3 B

*Includes state-funded health care expenditures for Medicaid, the State Children's Health Insurance Program, state employees' health benefits, corrections, higher education, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services. Sources of state expenditures include general funds, other state funds, and federal funds.

Sources: Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released September 2007

** Health Care Expenditures measure spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence. Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total.

Sources: Milbank Memorial Fund, National Association of State Budget Officers, and The Reforming States Group. 2002-2003 State Health Care Expenditure Report, Table 14, Milbank Memorial Fund, Copyright 2005

² Data on premium increases reflect the cost of insurance premiums for a family of four. Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2007

³ Kaiser commission on Medicaid and the Uninsured. (October 2007). *Medicaid Enrollment and Spending Trends*. Medical services include typical Medicaid medical services, long term care (LTC) services include home and community based care services and nursing home services.

Demographics

Table 5.

	Kansas	Colorado	Iowa	Missouri	Nebraska	Oklahoma
Total Population 2005	2,696,650	4,701,840	2,907,450	5,746,150	1,759,420	3,471,600
Population at or below 100% FPL	16%	14%	14%	15%	12%	20%
% of those under Poverty who are Adults with Children	17%	14%	15%	17%	13%	22%
Median Annual Income	\$44,264	\$54,039	\$47,489	\$44,651	\$48,126	\$40,001
State Minimum Wage	\$2.65	\$7.02	\$7.25	\$6.65	\$6.55	\$6.55
Unemployment	4.6%	4.9%	3.9%	6.0%	3.2%	3.5%
Total Medicaid Enrolled 2005	352,200	535,2000	412,900	1,206,4000	261,200	715,500
Total Uninsured	306,626	798,722	273,812	719,914	201,302	638,220
% of Total Population in Poverty	11%	17%	9%	13%	11%	18%
% of Population Who are Non-elderly and Uninsured with Incomes Under 100% FPL	29%	45%	26%	32%	35%	42%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey.

Income Eligibility and Disregards Children's Medicaid

Table 6.

	Kansas	Colorado	Iowa	Missouri	Nebraska	Oklahoma
Income Eligibility:						
Ages 0-1	\$25,755	\$22,836	\$34,340	\$31,765	\$31,765	\$31,765
Ages 1-5	\$22,836	\$22,836	\$22,836	\$25,755	\$31,765	\$31,765
Ages 6-19	\$17,170	\$17,170	\$22,836	\$25,755	\$31,765	\$31,765
Working Adults w/ Children	\$5,838	\$11,332	\$42,925	\$6,696	\$10,130	\$34,340
Disregards:						
Earnings \$/Worker/Month	\$200	\$90	20% of Earnings	\$90	\$100	\$240
Child Care Expenses	None	\$175-\$200	\$175-\$200	\$175-\$200	Full amount	\$175-\$200
Child Support Received	None	\$50	\$50	None	None	\$50
Child Support Paid	None	None	Full amount	None	None	None

Data as of January 2008 unless otherwise noted. Currency figures based on FPL for a family of three in 2007. Medicaid Eligibility, Department of Health and Human Services, Centers for Medicare and Medicaid Services. NOTE: Disregards represent income not counted in assessing eligibility.

Medicaid Coverage and Uninsured by Type and Age⁴

Table 7.

	Kansas	Colorado	Iowa	Missouri	Nebraska	Oklahoma
Medicaid Children 18 and under	190,420	196,960	181,810	418,250	93,420	312,420
Medicaid Adults 19- 64	84,820	154,410	144,450	246,830	57,540	117,040
Total Medicaid enrollment ⁵	352,200	535,200	412,900	1,206,400	261,200	429,460
Uninsured Children 18 and under	51,040	175,500	43,780	127,480	36,870	113,740
Uninsured Adults 19- 64	251,260	616,280	228,890	588,170	162,240	524,480

⁴ Enrollment estimates are rounded to the nearest 100. Figures may not sum due to rounding.

KHPA Program Review Coverage

FIGURE 1. Total Expenditures by Category of Service* - SFY 07

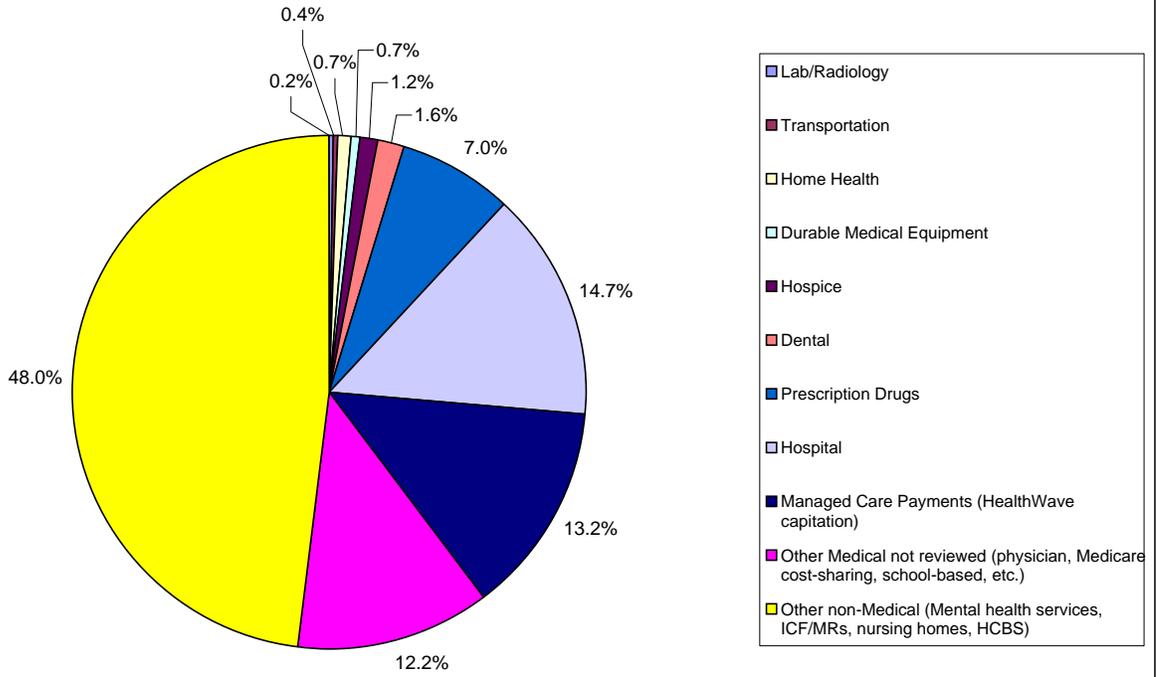


Table 8

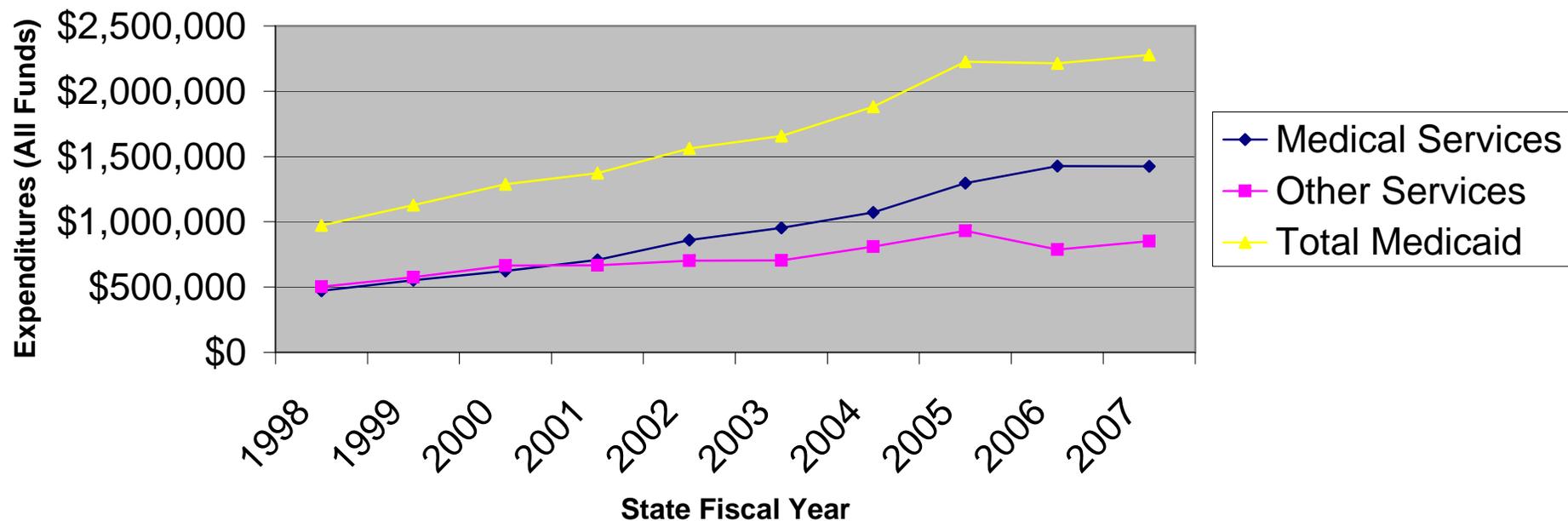
Summary of Staff Recommendations for Medicaid Transformation

Budget Initiatives		Recommendation
B1	Pharmacy; Auto/Expanded PA	Purchase an automated prior authorization (PA) system to ease and expand use of PA.
B2	Pharmacy:Expand PDL with mental health	Revise Kansas law to allow for the inclusion of selected mental health medications on the Medicaid PDL and prior authorization lists. Use the newly established specialized Preferred Drug List (PDL) advisory committee for medications used to treat mental health conditions.
B3	Public Insurance Outreach	Promote community based outreach by placing state eligibility workers on-site at high-volume community health clinics around the state.
B4	Quality review for fee-for-service	Obtain funding for new collection of data from beneficiaries and providers participating in its fee-for-service programs to evaluate performance, identify opportunities for improvement, and facilitate comparability across programs.
B5	Program integrity for beneficiaries	Work with the Office of the Attorney General to develop a proposal to expand coordinated efforts to investigate and prosecute beneficiary fraud.
Administrative Initiatives		Recommendation
A1	Home health reforms and increase	Limit home health aide visits; develop separate acute and long term home health care benefits with differential rates that reflect the intensity of services over time.
A2	Durable medical equipment price reforms	Require DME suppliers to show actual costs of all manually priced DME items, ensuring reimbursement no greater than 135% of cost. Review the Oxygen category of service for potential overpayments and coverage usage issues.
A3	Transportation broker	Issue a request for proposal (RFP) to outsource management and direct contracting for Medicaid transportation benefits to a private broker in order to increase scrutiny, right-size reimbursement, and generate modest net savings to the state.
A4	Review of retroactive and long-term hospice stays	Enhance scrutiny of retro-active authorizations for hospice services; review of concurrent Home and Community Based Services (HCBS) stays; increased scrutiny of pharmaceutical coverage and spending, and potential reviews for extended patient stays.
Revenue-Dependent Initiatives		Recommendation
RD1	Eligibility at 50% or 100% FPL for caretakers	Expand access to care for needy parents by standardizing program rules for caretakers and increasing the income limit to 50% FPL. (\$734 per month for a family of 3) or 100% FPL (\$1,467 per month for a family of 3)
RD2	Dental services for adults	Extending preventive and restorative coverage to adults enrolled in Medicaid.
RD3	Expand Medicare buy-in	Increase the Protected Income Limit for medically needy (primarily elderly and disabled people who do not yet qualify for Medicare) so that it is tied to the FPL.
RD4	Raise Medically needy thresholds	Increase the number of people on Medicare who have access to full prescription drug coverage.

Table 8

R5	Financing initiatives (e.g., revenue from cigarette or provider tax)	Develop specific revenue and financing recommendations for presentation to the KHPA Board in fall 2008.
	No Fiscal Impact	
N1	Inpatient and Outpatient Hospital Services	Adopt severity adjusted payment system for inpatient services (MS-DRGs) and review outpatient reimbursement and emergency room use.
N2	Laboratory and Radiology	Review coverage of new procedures and explore adoption of Medicare system as starting point for reimbursement of all lab and radiological services.
N3	HealthWave	Make performance and health status quality data available for consumers, policy makers and other stakeholders in FY2009.
N4	HealthConnect	Examine MediKan expenditures in detail to identify cost-drivers and policy options.
N5	Medical Services for the Aged and Disabled	Convene stakeholders to help evaluate and design a care management program for the aged and disabled to be presented to the board in 2009.
N6	Emergency Health Care for Undocumented Persons (SOBRA)	Monitor changes in border state policies regarding immigrants and assess the impact on Kansas.

Total Spending for Kansas Medicaid Programs (All agencies; All funds)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Growth 1998-2007
Total Expenditures (All Funds)											
Medical Services	\$470,346	\$553,199	\$622,020	\$707,036	\$858,850	\$952,497	\$1,071,871	\$1,294,967	\$1,426,519	\$1,424,546	
Other Services	\$502,129	\$575,228	\$664,329	\$665,524	\$701,694	\$704,164	\$810,224	\$930,952	\$786,421	\$852,297	
Total Medicaid	\$972,475	\$1,128,427	\$1,286,349	\$1,372,560	\$1,560,544	\$1,656,661	\$1,882,095	\$2,225,919	\$2,212,939	\$2,276,843	
Yearly Growth											
Medical Services		15.0%	11.1%	12.0%	17.7%	9.8%	11.1%	17.2%	9.2%	-0.1%	13.1%
Other Medicaid		12.7%	13.4%	0.2%	5.2%	0.4%	13.1%	13.0%	-18.4%	7.7%	6.1%
Total Growth		13.8%	12.3%	6.3%	12.0%	5.8%	12.0%	15.4%	-0.6%	2.8%	9.9%

Source: Actual spending as reported in state accounting system and obtained from Governor's Budgets