

Testimony on:
Updates on Medicaid and Other KHPA Programs

presented to:
Joint Committee on Health Policy Oversight

by:

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**Joint Committee on Health Policy Oversight
May 31, 2007**

Updates on Medicaid and Other KHPA Programs

Good afternoon Mr. Chairman and members of the Committee. I am Dr. Andrew Allison, KHPA Deputy Director and Director of the Medicaid Program. I appreciate this opportunity to provide an update to the Joint Committee on Health Policy Oversight on several major initiatives and issues in Medicaid, the State Employee Health Benefits Plan (SEHBP), and other KHPA programs.

State Children's Health Insurance Program (SCHIP)

I want to provide a brief update related to the ongoing efforts by Congress to reauthorize and potentially redesign the State Children's Health Insurance Program (SCHIP). As you know, Congressional authorization and Federal funding for SCHIP will end September 30, 2007 without Congressional action, and Congress has made reauthorization a top priority. Kansas intends to have a strong voice in this discussion to advocate for sufficient, fair, and flexible funding for this important program. We are currently analyzing the most prominent legislation under consideration by Congress and will be sharing thoughts and concerns with our own delegation and other national policy leaders on an ongoing basis. We look forward to providing additional updates to this Committee as the Congressional debate proceeds.

State Medicaid Plan Agreements, Contracts, and Plan Requirements

CMS Audits/Deferrals/Disallowances

An agreement has been reached between the State of Kansas and the Centers for Medicare and Medicaid Services (CMS) that Kansas has resolved all outstanding administrative and payment issues identified by CMS and the Office of Inspector General (OIG). The resolution of these issues, and agreement with CMS to release claims on additional liabilities, is contingent upon implementation of the agreed-to reforms on July 1, 2007 which will bring the State into full compliance with all Federal regulations and State Plan provisions.

- Local Education Agencies (LEAs). The audit findings and subsequent corrective actions had a fiscal impact due to the combined effects of the required federal dollar repayments and the reduction in federal support received by Kansas when payment methodology was changed from a bundled rate to a fee for service payment as reflected in an approved \$37,487,770 Governor's Budget Amendment for FY 2007.
- Targeted Case Management (TCM). These corrective actions had a fiscal impact due to the reduction of federal funding which will be replaced by State General Funds for case management services provided by Community Development Disability Organizations (CDDOs) as reflected in an approved \$8,975,141 Governor's Budget Amendment for FY 2008.
- Mental Health/Child Welfare. These corrective actions had a fiscal impact due to the combined effects of a reduction of federal funding for the FY 2007 child welfare Medicaid deferrals, the FY 2008 change to a managed care contract for mental health services and substance abuse services, and the replacement of certified public match for community mental health centers and CDDOs as reflected in an approved \$35,387,663 Governor's Budget Amendment for FY 2007 and 2008.
- Strengthen Internal Control Processes. CMS stipulated that KHPA correct what they perceived as a lack of internal controls throughout the Kansas Medicaid program which contributed to the financial issues the state experienced. KHPA has put in place a rigorous internal control plan to ensure that

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implementation of the new State plans, waivers, and system changes will proceed smoothly and on schedule. Key aspects of the internal control plan include:

- Creation of the Program Integrity Manager within KHPA who is responsible for monitoring all implementation activities related to any program changes which span across agencies and involve Medicaid funding.
 - Establishment of a monthly meeting of Medicaid agency Secretaries to discuss Medicaid policy issues.
 - Initiation of substantially-revised interagency agreements delineating individual agency responsibilities related to programs receiving Medicaid funding, including explicit responsibilities for oversight, auditing, and program implementation monitoring.
 - Development of a detailed audit plan for the mental health, school-based services, and TCM program changes.
- With these changes, the CMS Regional Office and the CMS Central Office have agreed that Kansas has resolved all outstanding payment and administrative issues, and contingent upon successful implementation in July 2007, the State of Kansas is released from further liabilities associated with these issues.

Reference Material: Tab 8

- 1) Audits/Deferrals Summary Report
- 2) Letter to Dennis Smith

Medicaid Managed Care

As of January 1st of this year, the Kansas Health Policy Authority (KHPA) contracts with two private health plans, Children's Mercy Family Health Partners and UniCare Health Plan of Kansas, to provide capitated managed care for physician health services for our Title 19 Medicaid and Title 21 SCHIP families. UniCare Health Plan of Kansas serves Title 19 and Title 21 beneficiaries statewide, while Children's Mercy Family Health Partners serves Title 19 and Title 21 families in 74 Kansas counties throughout Central and Eastern Kansas. These managed care organizations (MCO) are tasked with caring for over 150,000 Kansas citizens.

Some highlights from the transition to these two health plans:

- These two plans have combined to amass over 3,300 primary care locations.
- Both companies have continual provider recruitment and have been focusing on the recruitment of specialty providers.
- KHPA met weekly with key stakeholders during the transition to hear concerns and resolve issues timely.
- Stakeholders in attendance were KHPA, the Kansas Hospital Association, the Kansas Medical Society, Stormont Vail/Cotton O'Neil, both managed care organizations, and EDS, fiscal agent. Following the "transition", KHPA has continued to convene this group every other week to identify and address any ongoing operational issues.
- While we do not yet have comprehensive data indicating beneficiary satisfaction with the two new health plans, we are pleased to offer a choice of plans, and note that we have received very few complaints from beneficiaries during this transition. We strive, of course, to not only avoid complaints, but to provide exceptional service to beneficiaries that improve access and address health needs. As the period of transition ends, we are turning our attention to the active and ongoing oversight and review of health plan performance.
- An issue of concern during the first five months of operation for the new MCOs, and in particular UniCare Health Plan of Kansas, has been the timely and complete payment of hospital claims for HealthWave beneficiaries. The introduction of a new payer into the Kansas hospital market has generated a number of payment processing issues that have required intensive intervention by the MCO

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and hospitals alike. KHPA appreciates the assistance of staff from the Kansas Hospital Association in the identification of these issues. The health plan has made advance payments available to hospitals expecting significant payment delays, and some hospitals have taken advantage of these payment plans. UniCare has been communicating directly with KHPA and KHA on a weekly basis, providing an update on the status of these and other transition issues. We continue to monitor their progress and look forward to their resolution.

- Both MCOs present a claims report for professional, institutional and pharmaceutical claims. Within this report can be found the number of claims received, paid, denied and suspended for the last 30 calendar days. The managed care organizations also provide an updated issues log. Each MCO maintains an issue log specific to their company and provides all providers access to this log via their respective websites. KHPA has found this to be an efficient means of disseminating the identification of issues, the proposed resolution, and when resolution is expected to be reached.
- UniCare Health Plan of Kansas and Children's Mercy Family Health Partners have placed education and outreach to the Kansas provider community at a premium. These two companies recently traveled with their EDS counterparts and participated in the KMAP provider workshops.
- Both have also completed their own provider workshops specific to their companies and routinely mail provider bulletins, newsletters and announcements within their networks.
- The medical MCOs and the Title 21 mental health MCO, Cenpatico, have participated in the response to the disaster in Greensburg, KS, providing supplies for the providers, making monetary donations to area hospitals, giving gift cards to beneficiaries, and being present at the command center site.

Medicaid Eligibility Clearinghouse and Federal Citizenship/Identification Requirement

A top priority for the Medicaid program and the KHPA this year has been the damaging backlog of applications for Medicaid and SCHIP that has accumulated since the implementation of new documentation requirements for citizenship and identity last July. We are very pleased with the Legislature's and Governor's support for the resources required to address this backlog, and are now in the process of hiring additional staff required to eliminate the backlog by next January. KHPA's budget request was intended to address the increased workload issue at the Kansas Family Medical Clearinghouse, as well as the additional costs KHPA assumed to respond to the family applications backlog and the new federal requirement to verify citizenship. Included in the request are costs related to overtime, costs for additional fax and telephone lines, costs of additional calls received by the "800" toll free line, paper, scanner capacity and the cost to develop new data matches with Vital Statistics and school records.

- For citizenship and Clearinghouse funding requests, KHPA requested \$1,067,632 SGF and \$2,196,797 All Funds in total for FY 07 and FY 08. The funding approved by the Legislature in total for both years amounted to \$704,836 SGF and \$1,435,373 All Funds. Essentially, KHPA received 66 percent of the funding requested to address issues at the Clearinghouse.
- At the current level of funding approved by the Legislature, KHPA again has to make the difficult decision of having to redirect marketing funds to ensure the timely resolution of the applications backlog and to address the increases in workload volume and associated operational costs.
- After the initial spike in the backlog of family applications at the HealthWave Clearinghouse, the backlog of family applications has stabilized at about 11,000, each representing a distinct family and, on the whole, representing between eighteen and twenty thousand eligible Kansans.
- The original KHPA funding request reflected a timetable of six months to eliminate this backlog. Given the decision to shift funding from marketing, the target date for the backlog resolution will remain January 2008.
- KHPA has begun the contract amendment process with the Clearinghouse vendor to add resources to the

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contract and the hiring process for the additional state staff to ensure everything is in place by July 2007.

I look forward to future reports of our progress in eliminating this backlog and returning application wait-times to reasonable levels.

Ongoing Programs, Pilot Projects, and Annual Report Items

Disproportionate Share for Hospitals (DSH) Program Reform

Congress established the Medicaid DSH program in 1981 to help states support hospitals serving a significant number of low-income patients with special needs, i.e., safety net hospitals. DSH payments are nothing more than supplemental payments to a targeted set of hospitals that go beyond the basic fee-for-service Medicaid rate. Kansas has made DSH payments to hospitals for many years. Some early payments were designed primarily to generate additional Federal matching payments. Since the early nineties, Kansas has operated a DSH program of modest size in comparison to other states, representing only about 4% of total Medicaid service payments. The total amount of funding available for supplemental hospital payments through the DSH program is capped, or allotted, by the Federal government. Kansas' cap is approximately \$64 million, of which about \$21 million is dedicated to the state's public psychiatric facilities, leaving approximately \$43 million for community hospitals.

DSH payments are made strictly according to the qualifications and payment formulas set out in the state's Medicaid plan. These formulaic payments have been subject to large fluctuations due to recent changes in Medicaid financing, including the implementation of the provider assessment and access payment programs, changes in reimbursement for Medicaid services provided by the University of Kansas Hospital, and the shift of additional Medicaid beneficiaries to managed care. In fiscal year 2007, these formulas did not result in the state expending all Federal matching available through the DSH program. This is also expected to be the case in FY 2008. In addition to under-spending Kansas' Federal DSH allotment, the current formulas result in large fluctuations in payments to hospitals from one year to the next, limiting the effectiveness of the program in encouraging and compensating hospitals for services provided to Medicaid beneficiaries and the uninsured. In addition, a hospital-by-hospital review of DSH payments demonstrates on the whole a weak relationship to the amount of uncompensated care and Medicaid services provided. For these and other reasons, in September 2006 KHPA invited hospitals to join in a collaborative effort to review the disproportionate share hospital (DSH) payment program with the goal of revising and modernizing the payment formulas to reflect public policy objectives. KHPA has met in two open meetings with hospitals, and formed an advisory working group consisting of a small number of finance and accounting experts from Kansas hospitals and the Kansas Hospital Association, as well as KHPA staff and contracted actuaries. This working group has met several times in 2007 to provide technical assistance and to provide an initial sounding board for new payment formulas.

KHPA's objectives in working with hospitals to revise the DSH payment methodology are to:

- Ensure that reimbursement through the DSH program is targeted to facilities that, relative to their size, incur a greater share of the burden for caring for Medicaid beneficiaries and the uninsured.
- Ensure that the payment methodology results in spending up to Kansas' full DSH allotment each year.
- Provide a more stable and predictable source of supplemental payments for Kansas hospitals serving a disproportionate share of Medicaid beneficiaries and the uninsured.

The working group has considered a number of different methodologies, but has come to focus on a small number of options with the following characteristics:

- Provides a three-year transition period to allow hospitals that currently receive DSH funds to plan for

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any changes in reimbursement brought about by the new methodology.

- The percentage of losses incurred by hospitals for treating Medicaid and the uninsured that are met by DSH payments is higher for hospitals that bear a proportionally heavier burden for the uninsured. In particular, DSH payments vary by *both* the total amount of losses incurred in treating Medicaid and the uninsured *and* the percentage these losses comprise of total hospital costs.
- The new methodology combines two existing disbursement formulas within the DSH program, formulas that compensate losses in otherwise similar hospitals at remarkably different rates. Under the current methodology, a hospital can qualify for one formula in one year, and another formula in another year, with more than a 100% difference in DSH payments as a result.

The working group will be working over the next month or so to complete its work and to bring to the KHPA Board a fairer, more stable, and more purposeful methodology. Our intention is to complete the task and submit a new methodology to CMS for review, and to make the new methodology effective in the first quarter of FY 2008. Again, this would be with the understanding that there will be a modest transition period for hospitals that could experience significant changes in reimbursement with the new methodology. We look forward to completing our work with hospitals in the very near future.

Community Health Record

The Community Health Record (CHR) Pilot is a program testing the impact of a shared electronic health record on quality of care with Kansas Medicaid providers in Sedgwick County. Working with the Medicaid managed care plans (FirstGuard, then UniCare and Children's Mercy Family Health Partners) and a technology vendor (Cerner Corporation), KHPA developed a network of physicians, clinics and hospitals that access a web-based shared electronic health record containing their Medicaid patient's health information including demographics, diagnoses, office visits, procedures and prescriptions. In addition, the CHR includes a web-based e-prescribing tool. The CHR includes 12 months of aggregated historical health transaction information in person-centric records for Medicaid member's visits, medications, claims data, immunizations, and lead screening laboratory results. All of the data is continually updated, based on the following schedule: weekly updates-member, provider, organization, claim header and detail, and immunizations; and daily updates - medication claims.

- As of April 2007, CHR project statistics include:
 - over 400 trained end-users
 - 82 trained ePrescribing users
 - 20 sites from 7 distinct provider organizations
 - nearly 10,000 charts open
- KHPA is working with an independent contractor (Trajectory Healthcare) to conduct an impartial evaluation of the impact of the CHR on quality of care. Initial feedback from providers has been positive.
- The pilot extends through June 30, 2007, with the evaluation ongoing. If the tool proves effective, the intent is to expand the CHR to the larger Medicaid population through a competitive bidding process.

Reference Material: Tab 10

1) KHPA Annual Report

State Employee Health Benefits Plan Wellness Request For Proposal (RFP)

The State Employee Health Benefits Plan (SEHBP) is in the midst of the process for finalizing an RFP concerning health and wellness for its members. The RFP aims at aligning the SEHBP with KHPA's vision

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principles. KHPA is applying these concepts to the SEHBP in hopes of creating a template that could ultimately be duplicated within other agencies and the private sector. The vendor is to be chosen by the end of June 2008. The purposes of the RFP are to:

- Build a health management program that is both longitudinal and incremental in design and implementation.
- Build in desired outcomes and measurements and track both.
- Build a foundation that includes the ability to allow each program to be transitioned to other agencies so that all citizens of Kansas can benefit.
- Build a program that incentivizes all ‘touchpoints’, e.g. physicians, employees, etc., to improve employee engagement, participation and personal health outcomes.
- Build a robust Health Risk Appraisal, with clinical screenings, and involve employee (dependent) and physician in developing appropriate medical plan with desired outcomes.
- Build in strong mental health support, including health and lifestyle coaching to sustain healthier behaviors.
- Build strong community support.
- Develop outreach resources to help local workplace/community partnerships build “core competencies”.
- Develop and maintain customized internet-based support.
- Aggregate data to ensure effective and appropriate decision making – include transparency wherever possible.
- Programs to be integrated may include the following:
 - Integrated Data Management Program Evaluation and Decision Support
 - HRA/Screening and Screening
 - Incentive Delivery and Design
 - Lifestyle Behavior Change programs
 - Health Coaching
 - Web-based Interactive programming
 - Health Related Web Resources
 - Health Related Education Print Materials
 - Communications
 - Health and prescription benefits management vendors
 - EAP vendor
 - Alternative Medicine
 - Other Programs and Services

Reference Material: Tab 9

1) State Employee Health Benefits Plan - Wellness RFP

Conclusion

I conclude my testimony with a note of optimism. With the successful resolution of potentially overwhelming obligations to the Federal government, we look forward to opportunity we now have to focus on efficient and creative stewardship of the Medicaid program and other KHPA initiatives. Like Dr. Nielsen, I’m keenly aware that that opportunity will remain open to us only to the extent that we use the resources we have to fullest advantage. I look forward to further reports to this Committee demonstrating progress in advancing innovative and data-driven policies.