The Medicaid Reform Public Input and Stakeholder Consultation process is supported by the following organizations:

• Health Care Foundation of Greater Kansas City,
• Kansas Health Foundation,
• REACH Healthcare Foundation,
• Sunflower Foundation and
• United Methodist Health Ministry Fund.
Welcome

Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

Lt. Governor Jeff Colyer, M.D.
<table>
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<th>Presenter</th>
</tr>
</thead>
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<td>Welcome</td>
<td>Lt. Governor Jeff Colyer, M.D.</td>
</tr>
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<td>Opening Thoughts</td>
<td>Secretary Pat George</td>
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<td>Kansas Department of Commerce</td>
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<td>Public Input Process</td>
<td>Secretary Robert Moser, M.D.</td>
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<td></td>
<td>Kansas Department of Health and Environment</td>
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<td>Medicaid Reform Principals</td>
<td>Lt. Governor Jeff Colyer, M.D.</td>
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<td>Medicaid Costs and Key Facts</td>
<td>Theresa Shireman, PhD, RPh</td>
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<td>University of Kansas Medical Medical Center</td>
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<td>Roundtable Discussions</td>
<td>Michelle Raleigh, Deloitte Consulting</td>
</tr>
<tr>
<td>Closing</td>
<td>Lt. Governor Jeff Colyer, M.D.</td>
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Opening Thoughts

Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

Secretary Pat George
Kansas Department of Commerce
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The Challenge

• Improve Outcomes

• Reduce Costs
How We Got Here

• Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person.

• It is not “just the economy” – Kansas is in the midst of a sustained period of accelerated growth as baby boomers reach age of acquired disability.

• Enhanced federal match rate partially – and temporarily – disguised the scale of the deficit.
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The Crowd-Out Effect

Expenses as % of State General Fund

FY 2010 - FY 2016 projected; illustrates impact on other programs if Medicaid spending growth continues unabated. Assumes projected deficits would be offset in other programs.

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Stakeholder Involvement So Far

• Solicited ideas for reforms or pilots to curb growth, achieve long-term reform, and improve the quality of services in Medicaid
• 60+ submissions with more than 100 proposals submitted in February 2011
• Three public forums this summer with 1,000 participants and more than 1,600 individual ideas
• Web survey generated about 200 additional responses
• Stakeholder web conferences helped define issues and key concerns with emerging themes
Parallel Initiatives

• Medicaid Reform Data Workgroup

• Pharmacy Services Workgroup

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Population Focus/Key Concerns

- Children, Families and Pregnant Women: Mobile population; moves in and out of eligibility
- Aged: Higher-than-average proportion of Kansas seniors in institutions
- Disabled: Fragmented service provision

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Type of Service By Population

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>SFY 2010, in $millions</th>
<th>Children/Families</th>
<th>Disabled</th>
<th>Aged</th>
<th>MediKan/Other</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>555</td>
<td>450</td>
<td>107</td>
<td>76</td>
<td></td>
<td>1187</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>37</td>
<td>102</td>
<td>12</td>
<td>32</td>
<td></td>
<td>184</td>
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<tr>
<td>Substance Abuse</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>NA</td>
<td>111</td>
<td>312</td>
<td>1</td>
<td></td>
<td>424</td>
</tr>
<tr>
<td>Home and Community Based Services</td>
<td>NA</td>
<td>479</td>
<td>121</td>
<td>8</td>
<td></td>
<td>608</td>
</tr>
<tr>
<td>TOTAL</td>
<td>600</td>
<td>1149</td>
<td>552</td>
<td>124</td>
<td></td>
<td>2425</td>
</tr>
</tbody>
</table>

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Fragmentation

- Spending is spread widely across service types, funding streams, state agencies, and providers.

- There is no uniform set of outcomes or measures for programs or providers.
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**Emerging, Cross-Cutting Themes**

**Integrated, whole-person care**

- Aligning financing around care for whole person
- Patient-centered medical homes
- Enhancing health literacy and personal stake in care
Emerging, Cross-Cutting Themes

Preserving independence/creating a path to independence

• Removing barriers to work
• Aligning incentives among providers and beneficiaries
• Delaying or preventing institutionalization
Emerging, Cross-Cutting Themes

Alternative access models

• Utilizing technology and nontraditional settings
• Thinking creatively about who can deliver care
Medicaid Transformation: Serving Kansans

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Lt. Governor Jeff Colyer, M.D.
The Challenges

- 100,000 Kansans out of work
- School Funding
- KPERS Underwater
- Medicaid Transformation
- Large Budget Deficits
Major Issues in Medicaid

• Medicaid is 45 years old
• Assure stable healthcare for Kansans
• Assure better health outcomes
• Complex Federal/State/Patient/Insurer/Provider relationship
• Current Costs will overwhelm Kansas

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Medicaid Transformation Principle: Holistic Care focused on Outcomes

• A Surgeon’s Perspective: Care for the Whole Person focused on Outcomes

• Quality results improve lives

• Need to look at ALL programs, agencies, tax policy, jobs, lifestyle of the person

• Respect and account for the connection between physical and mental health. Kansans do not live in silos.
Medicaid Transformation Principle:
Create a Strong, Dignified Safety Net for our Most Vulnerable Kansans

• Target Those Most in Need
• Home is Best
• Make sure the Safety Net is stable
Medicaid Transformation Principle:
Economically Rational

• Medicaid Pricing/planning structures are very similar to Soviet military economics
• Need to align health decisions, costs, and quality in the same direction
• Quality/Outcomes need to be linked to Price
• Eliminate needless paperwork
• Economic Rationality means everyone needs to feel the link between outcomes and costs

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Medicaid Transformation Principle: Assist people from Medicaid to the workplace

• Nearly 20% of Medicaid recipients leave/enter annually
• Wherever possible, Medicaid should bridge and transition to work and private financing. Avoid cliff effect.
• Need to create incentives for the private sector to employ people with disabilities
• Eliminate the disincentives to employment for people with disabilities

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Medicaid Transformation Principle:
Reward Personal Responsibility for Health Outcomes

- Personal Health Decisions have the biggest impact on quality of life
- Need to align Medicaid to reward personal responsibility—just as private insurers do
- Example: Reward patients who quit smoking, improve obesity, etc.
- Example: Reward patients who actively manage their own healthcare, take their medications, etc.

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Medicaid Costs and Key Facts

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Theresa Shireman, PhD, RPh
University of Kansas Medical Center
Medicaid Reform Data Workgroup

• Identify and use data to help the Administration better define the challenge, address the challenge, and communicate with stakeholders
• Asked for volunteers to use claims data and KDHE’s Data Analytic Interface to help answer questions
The Questions

- How does utilization vary by region?
- Who are the high-cost patients?
- How can spending on the dually eligible (Medicare – Medicaid) be explained?
- How can hospital readmissions and avoidable spending be explained?
The Volunteers

• Cheng-Chung Huang, MPH, KHI
• Ivan Williams, MBA, KHI
• Theresa Shireman, PhD, KUMC
• Amanda Reichard, PhD, University of Kansas
• Suzanne Hunt, MS, KUMC
• Niaman Nazir, MBBS, MPH, KUMC
• Robert Lee, PhD, KUMC
• Chuck Anderson, KU Hospital
• Jean Hall, PhD, University of Kansas

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# Kansas Medicaid Costs Across Populations

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Regional Variation for the Medicaid Aged Population

- Regions with more licensed Long-Term Care beds per capita (per 1,000 adults 65+) tend to spend more per member than regions with a smaller number of LTC beds per capita
- Regions that spend more on HCBS services may spend somewhat less on health care overall
- While HCBS increases spending initially, eventually long-term savings come from reduced institutional spending (Kaye, et al., 2009)
- AARP ranks Kansas as having the 6th highest nursing facility utilization per capita and the 4th highest HCBS utilization per capita for adults over 65.
Regional Variation for the Medicaid Adult Blind/Disabled Population

• Regions that spent more on HCBS services for the Blind/Disabled tended to spend more overall.
• Spending a greater proportion on HCBS services was also associated with higher overall costs.
• Regions that spent a higher proportion of their overall spending on physician services tended to spend less overall.
• Same relationship doesn’t exist for actual dollars spent.

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State fiscal years 2006-2010
Regional Variation in Acute Hospital Cost & Utilization

• Acute hospital payments per member per month ranged from $37.94 in the McPherson area to $101.81 in the Kansas City North Area (WY and LV counties).
• Aged acute hospital days per 1,000 members ranged from 1,499 in McPherson to 5,099 in Coffeyville.
• Blind/Disabled adult acute hospital days per 1,000 members ranged from 1,328 in Hays to 3,848 in KC North (WY and LV counties).
• Non-Disabled children and adult acute hospital days per 1,000 members ranged from 351 in Winfield to 630 in Hays
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N = 100,397
Adults in Medicaid ABD
(FY2009)

Divided adult aged & disabled program into subgroups:
• IDD = adults with intellectual & developmental disabilities
• PD = adults with physical disabilities
• SMI = adults with severe mental illness
• Aged = older adults NOT in above groups
• Other = persons not classified

N = 14,236 14.2%
IDD

N = 10,727 10.7%
PD

N = 25,105 25.0%
SMI

N = 27,655 27.5%
Aged

N = 22,674 22.6%
Other
Adults with IDD are younger than other disability groups
Adults with PD or SMI are in their early 50s

<table>
<thead>
<tr>
<th></th>
<th>IDD (%)</th>
<th>PD (%)</th>
<th>SMI (%)</th>
<th>Aged (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (yrs.)</td>
<td>43.6</td>
<td>52.4</td>
<td>52.1</td>
<td>78.5</td>
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<tr>
<td>Distribution</td>
<td></td>
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</tr>
<tr>
<td>18-29 yrs.</td>
<td>25.8</td>
<td>4.7</td>
<td>12.4</td>
<td>0</td>
</tr>
<tr>
<td>30-39 yrs.</td>
<td>16.9</td>
<td>8.3</td>
<td>12.5</td>
<td>0</td>
</tr>
<tr>
<td>40-49 yrs.</td>
<td>21.5</td>
<td>23.0</td>
<td>22.4</td>
<td>0.1</td>
</tr>
<tr>
<td>50-59 yrs.</td>
<td>18.8</td>
<td>35.6</td>
<td>23.4</td>
<td>0.3</td>
</tr>
<tr>
<td>60-69 yrs.</td>
<td>9.9</td>
<td>25.1</td>
<td>10.6</td>
<td>19.2</td>
</tr>
<tr>
<td>70-79 yrs.</td>
<td>4.6</td>
<td>2.3</td>
<td>7.0</td>
<td>35.9</td>
</tr>
<tr>
<td>80 yrs. plus</td>
<td>2.7</td>
<td>1.0</td>
<td>11.7</td>
<td>44.4</td>
</tr>
</tbody>
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Medicaid Expenditures for Aged & Blind/Disabled adults mostly go toward HCBS or LTC (SFY 2009), but vary by group

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51% of 2009 Kansas Medicaid FFS spending was on behalf of Duals (persons covered by Medicaid & Medicare)

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82% of Medicaid FFS spending for Duals was for HCBS and Long-term Care

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HCBS means Home and Community Based Services. These are meant to avoid or delay institutionalization.
Key Findings - Readmissions

- 30-day readmission rates for Kansas Medicaid = 9.9%
- Medicare = 18%
- Psychoses = highest volume DRG with 3,313 readmissions within 30 days of discharge over a five year period (12.9% readmit rate)
- Next highest volume DRG had 1,141 readmissions over a five year period.
- Average cost of a readmission is approximately 50% higher than the average cost of all admissions.
- While readmissions are not a key driver of increased Medicaid expenditures, but there is potential to reduce Medicaid costs (~$40 million/year)

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Readmissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.
Key Findings – Avoidable Admissions

- Avoidable admission rates are 11.8% per year
- 49% of these costs are related to low birth weight
- Only 29% of these costs are related to chronic conditions (Asthma, CHF, COPD, Diabetes and Hypertension)
- While avoidable admissions are not a key driver of Medicaid expenditures, there are opportunities for reducing these costs (~$36-40 million/year)
  - Reducing these admissions would require an improved coordination of care and education in the outpatient setting.

Avoidable admissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.
Promote Work
Reduce Costs

A work incentive program implemented July 1, 2002 designed to help people get or stay competitively employed by providing Medicaid-funded health care.

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Avoidable admissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.
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Source: Kansas MMIS

*Does not include retroactive enrollment and premiums
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Reduced health care costs over time

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*From MMIS claims data*
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Instructions for Roundtable Sessions

- There will be multiple rounds of discussion on many Medicaid reform ideas presented so far in the process. The majority of the ideas cover all populations. There will also be some specific ideas on HCBS and Nursing Facility services.

- Utilize the Feedback forms on your tables to:
  - Discuss recommendations for reforming Medicaid
  - Review pre-populated issues and considerations
  - Add/edit list of issues and considerations (appoint table scribe to take clear notes)

- Report back on selected recommendations (appoint speaker at table)
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To share any additional thoughts or considerations please complete the Public Input Survey located at the following web address:

https://www.dhe.state.ks.us/Community/se.ashx?s=11B9BDC9212F51AF