2008
Medicaid Transformation

Kansas Medicaid Program Reviews Plan
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KHPA has been engaged for the past two years in a comprehensive effort to review and improve each major component of Medicaid and SCHIP. The agency completed fourteen program reviews as the first step in the KHPA Medicaid Transformation Plan, including fee-for-service Medicaid (HealthConnect) and HealthWave, two special populations (the aged and disabled), eight health care services, eligibility, and quality improvement. The eight health care services reviewed were dental, durable medical equipment (DME), home health, hospice, hospital, lab and radiology, pharmacy, and transportation. These reviews covered 77 percent of Medicaid and SCHIP medical care expenditures and 40 percent of the almost $2.5 billion cost of Medicaid and SCHIP.

Background

In 2006, the Kansas Health Policy Authority (KHPA) was designated as the single state agency responsible for Medicaid and SCHIP. The KHPA, however, only directly administers public insurance programs that provide medical care services. This portion of Medicaid and SCHIP spending totaled approximately $1.2 billion of the 2.2 billion spent on Medicaid/SCHIP in fiscal year 2007. The Kansas Department of Social and Rehabilitation Services (SRS) and the Kansas Department on Aging (KDOA) primarily administer programs that provide long-term care and mental health services, accounting for the remaining $1 billion in FY2007 Medicaid/SCHIP spending.

HealthWave and HealthConnect are the primary public health insurance programs for which KHPA is responsible. HealthConnect providers are paid on a fee-for-service basis but they also receive $2 per beneficiary per month to provide managed care services. HealthWave is a managed care program that covers beneficiaries from both traditional Medicaid and SCHIP. KHPA contracts with two managed care organizations to provide services to HealthWave beneficiaries. Medical services for about half of Medicaid and SCHIP beneficiaries are capitated - the set rate KHPA pays the managed care organizations to reimburse their providers - while the rest are reimbursed directly by KHPA on a fee-for-service basis.

Key Findings

The program reviews completed by KHPA provide an overall picture of Medicaid in Kansas. They show that while children and families account for most of Medicaid enrollment, much of the increase in expenditures is driven by aged and disabled beneficiaries. The reviews show increases in spending for hospital and hospice services, durable medical equipment, and pharmaceuticals. The reviews also indicate that efforts by the KHPA to reduce costs are meeting with some success. For example, changes initiated by the agency have resulted in a significant slowdown in the escalation of costs for transportation services. KHPA also had success in reducing the cost of home health services, saving over $16 million. Following is a summary of the findings produced by these reviews.
Medicaid fee-for-service expenditures in 2007 were approximately $250 million, with the aged and disabled population responsible for more than half. In January 2007, KHPA moved 50,000 low-income children and families from the fee-for-service HealthConnect program to the managed care HealthWave program. The remaining 105,000 beneficiaries were primarily members of the aged and disabled population. Although there was a slight reduction in the number of aged and disabled Kansans enrolled in HealthConnect, expenditures still increased. From 2005 to 2007, the top two expenditures were for general hospital-inpatient and prescription drugs. In 2007, prescription drugs became the top expenditure.

In 2007, HealthWave expenditures totaled more than $300 million, covering over 100,000 more beneficiaries than fee-for-service Medicaid. The approximately 230,000 Kansans enrolled in HealthWave during 2007 were primarily low-income children and families. This population tends to cost less to cover because they are generally healthier than the aged and disabled population. Increased enrollment in HealthWave-Medicaid caused dramatic increases in expenditures, while decreased enrollment in HealthWave-SCHIP caused a drop in expenditures. In 2007, average expenditures per member decreased in both HealthWave-Medicaid and HealthWave-SCHIP. The capitated rate in HealthWave covers the majority of health care services; however, $35 million was spent on fee-for-service mental health and dental reimbursements in 2008.

The aged and disabled population account for 67 percent of all Medicaid expenditures, but only constitute 33 percent of beneficiaries. In 2007, medical care expenditures for the aged and disabled population were more than $540 million. In addition to medical care, approximately $860 million was spent on long-term care services (i.e., home- and community-based and nursing facility care). Combined medical and long-term care expenditures for the aged and disabled totaled $1.4 billion. In terms of growth in program spending, this population accounted for 47 percent compared to other populations. A 2007-2008 study of Kansas Medicaid data showed that the aged and disabled population was primarily female, caucasian, and with the mean age of 52. It found that providers often missed opportunities to provide care for beneficiaries with chronic conditions. In addition, the study showed that most beneficiaries also did not receive preventive care, such as cancer screening and cardiac-event prevention.
Medicaid spending increased in six of the eight health care services reviewed. Although Medicaid spending increased, the number of beneficiaries receiving services decreased in hospice care, durable medical equipment (DME), and acute care hospitals. Expenditures in pharmacy, DME, and transportation were driven by a specific type of medication, supply, or service. KHPA has taken steps to address expenditures in many of the services reviewed.

Medicaid Spending on Health Care Services Reviewed in 2008 Transformation Plan

Hospice expenditures grew 139 percent from FY 2003-2007, outpacing consumer growth. From 2003 to 2007, hospice expenditures increased by more than $4 million even though the number of Medicaid-eligible Kansans receiving services decreased slightly. Longer stays are a potential cause of this cost increase. Although the majority of patients stay in hospice for less than 90 days, some have exceeded 300 days. The KHPA review of this program also identified retroactive eligibility as a potential issue, because retroactive coverage extends stays and because the state sometimes ends up paying for pharmaceuticals that normally would not be covered for hospice patients.

Pharmacy expenditures increased by $5.2 million in 2008, with mental health drugs accounting for more than 40% of the growth in total spending. The state spent about $159 million in 2008 to provide medication for more than 113,000 Medicaid beneficiaries. This followed a decrease in pharmacy spending in 2007 due to the introduction of Medicare Part D in 2006. However, costs per prescription increased 20 percent from 2006 to 2008. The top five therapeutic classes of pharmaceuticals were psychotherapeutic, central nervous system, anti-infective, gastrointestinal, and anti-asthmatics. Spending on mental health medications grew by more than 10% in 2008, as all five therapeutic classes of medication increased in total expenditures.

Over the past several years, Medicaid officials have attempted to manage growth in pharmacy expenditures by instituting a preferred drug list (PDL) and prior authorization (PA) requirements for some medications. Working with panels of medical experts, the Medicaid program has initiated safety measures and competitive pricing to decrease pharmacy expenditures, with one exception. Kansas law currently prohibits the use of direct management techniques and competitive pricing for psychotherapeutic medications, which are an increasing source of both safety concerns and cost increases.
Durable medical equipment (DME) expenditures increased by $3 million from FY 2004-2007, but the growth slowed in 2007. Reimbursements for oxygen concentrators were the highest at $5 million, accounting for the largest categorical expenditure of the almost $14 million in total DME spending. Although DME expenditures continue to increase, the number of Kansans receiving services has decreased since 2005. KHPA has instituted programs to address DME costs. The Kansas wheelchair seating clinics and the Kansas Equipment Exchange Program (KEE) have been identified as best practices by outside observers. The KEE program, in which donated equipment is reassigned to new users, saved $1.3 million since 2004. Cost savings will also be achieved through nursing facilities negotiating better rates for DME supplies and using contracted suppliers through the CMS bidding process. Other issues regarding DME include the use of “miscellaneous payment codes” and documentation requirements for DME suppliers.

Dental expenditures increased in 2008 by approximately $600,000 but utilization remains low. Dental expenditures totaled more than $36 million. The percent of children receiving dental services increased in 2008 but utilization remained below levels recommended by the American Academy of Pediatric Dentistry. In May 2009, pregnant women enrolled in Medicaid are scheduled to begin receiving coverage of dental services. Non-pregnant adults remain uncovered.

Kansas continues to have a dental provider shortage, ranking 33rd in the nation for number of dentists per capita. Reimbursement rates and administrative burden are critical factors in attracting and retaining providers. To simplify reimbursement for dental providers, KHPA removed 24 billing codes from prior authorization requirements. Also, more than 75 percent of providers use electronic claims forms to simplify the reimbursement process. Kansas providers receive about 60 percent of the average private reimbursement for this region. Although the percent of enrolled dental providers actually providing services increased to 60 percent, up from 53 percent in FY2007, access continues to be a significant concern.

Inpatient and outpatient hospital expenditures increased in 2007, though the number of people receiving services decreased. Acute care hospital expenditures in 2007 totaled more than $354 million, an increase of $112 million in 2006. However, consumers receiving hospital services in 2007 decreased by more than 27,000. The top reimbursements were related to emergency room visits and births. In 2006, reimbursements to hospitals increased using funds from hospital provider taxes.

Hospitals are reimbursed through different approaches depending on whether services are inpatient, emergency room, or outpatient. Hospitals are paid using diagnosis-related groups (DRG) reimbursements for inpatient services, which are based on Medicare payment methodologies and calculated specifically for Kansas. These calculations change with every Medicare update. Reimbursements for emergency room services have not changed since 1996 and are discordant with standard rates. For outpatient services, Kansas does not follow the Medicare reimbursement approach. These services are reimbursed consistent with Ambulatory Surgical Centers, a method used in Kansas for decades. Medicare uses an Outpatient Prospective Payment System (OPPS) that treats outpatient hospitals as unique facilities and increases reimbursement to represent the cost of services. KHPA has considered changing this methodology and since 2004 has used OPPS guidelines and rates to establish coverage for new procedure codes.

The growth in transportation expenditures slowed significantly in 2007, after a 22 percent increase in 2006. Expenditures for 2007 totaled approximately $9 million and have been increas-
ing over the 4-year period reviewed. The number of consumers receiving transportation services also has increased. Commercial non-emergency medical transportation is by far the highest expenditure accounting for more than $5 million in 2007. Expenditures for the disabled population are about $6 million compared to half a million for low-income families. A federal review of the transportation program found that the state’s oversight controls were not sufficient to ensure that payments were necessary and reasonable. In response, KHPA revised transportation policies including its provider-eligibility criteria and provider reimbursement. However, internal audits reveal continuing concerns regarding provider compliance with transportation billing requirements and sufficient staff resources to ensure program integrity.

Medicaid spending decreased or remained flat in laboratory, radiology, and home health services, however, concerns about cost remain. The decrease in expenditures is due to a decline in beneficiaries receiving services and the efforts KHPA has taken to provide additional oversight.

Home health expenditures have decreased by more than $16 million since 2002, however concerns remain. In 2008, home health expenditures were $12 million, down from almost $15 million the previous year. The number of beneficiaries receiving home health services also decreased. Enhancing the prior authorization requirements for some populations and increasing the use of community resources and waivers are likely contributors to the decline. KHPA program managers are more closely reviewing prior-authorization requests for beneficiaries receiving services with Home and Community Based Services (HCBS) waivers, as well as those receiving services for an extensive period of time without changes in their care plan. In 2007, program changes were implemented for telehealth services (home health services provided by a nurse located at the agency through interactive audio and video telecommunications systems) resulting in a more than 50 percent reduction in telehealth expenditures.

Even with the decrease in expenditures, concerns remain. A large number of beneficiaries receive services daily and the state has no process for ensuring that each visit is necessary and appropriate. Unlike many other states, Kansas does not limit the number of visits and has allowed up to 730 in a year. Kansas reimburses home health providers on a fee-for-service basis while the federal Medicare program uses a prospective payment system to incentivize the provision of only necessary services.

After increases in 2005, expenditures for independent (non-hospital) laboratory have flattened and radiology decreased. Laboratory and radiology expenditures in 2007 were approximately $4.5 million. During this same period, the number of persons receiving laboratory and radiology services decreased by more than 10,000. Although expenditure and consumer trends are decreasing, per capita expenditures have been increasing since 2002, with the most growth occurring between 2005 and 2007. Average expenditures for each consumer of laboratory services were $85.64 in 2007, up from $68.97 in 2005. Radiology per capita expenditures increased by 16.8 percent between 2002-2007 and beneficiaries receiving radiology tests increased by 34.5 percent. Reimbursement rates have been held steady over this period. The main cause of the rise in per-user costs is increasing use by the fee-for-service population, primarily the aged and disabled, especially for tests associated with the treatment of chronic illness. This trend will likely push laboratory and radiology expenditures higher in future years.

Since 2006, KHPA has expanded coverage to include more than 50 laboratory and radiology procedure codes and increased reimbursement rates for some laboratory services. Even with these changes, provider reimbursement concerns remain. Exploring whether to utilize Medicare approaches to reimbursement may assist KHPA in addressing these concerns.
The majority of expenditures for emergency health care for undocumented persons were for labor and delivery. According to federal law, Medicaid must cover services for life threatening emergencies and labor and delivery for (non-U.S. citizens). Whether or not Medicaid pays for services provided to undocumented individuals is determined after-the-fact on a case-by-case basis. In 2007, KHPA approved only 281 out of 576 requests for non-labor and delivery of medical services. Expenditures for this program increased from approximately $9.5 million in 2006 to a little more than $10 million in 2007, with labor and delivery services accounting for $8.4 million of that cost. Because spending in this federally defined program is tied primarily to the number of undocumented persons in Kansas, keeping an eye on border states’ immigration policies may be important in predicting an influx of persons seeking services.

Eligibility guidelines for Medicaid differ between 35 eligibility groups. KHPA has developed Medicaid outreach strategies with the formation of the statewide Outreach Advisory Council to identify and enroll eligible Kansans. Nevertheless, parents and caretakers in Kansas must be very poor to be eligible for Medicaid. To be eligible, a caretaker with two children can earn no more than a gross monthly salary of about $400. This eligibility standard continues to decline because it is based on a fixed dollar amount versus a percentage of poverty.

The eligibility threshold for medically needy populations is tied to the amount of income left after medical bills are paid, i.e., the “protected income limit.” The protected income limit is expressed as a dollar amount rather than a percentage of income. Therefore, inflation can negatively affect a family’s protected income. Some Kansans are eligible for both Medicaid and Medicare. If a Medicaid recipient is also eligible for Medicare, their primary medical care and prescription medications are provided through Medicare, while Medicaid pays the beneficiaries’ portion of Medicare bills. Some low-income seniors cannot take full advantage of Medicare because they are not also eligible for Medicaid.

KHPA is engaged in a number of quality improvement efforts in its health care programs. Its structured efforts to improve health care quality are primarily focused on HealthWave, HealthConnect, and the State employee health plan. KHPA lacks a systematic way to evaluate the quality of services provided through traditional fee-for-service Medicaid.

Recommendations:

The following recommendations are based on the findings from the 14 program reviews. These recommendations address issues related to decreasing expenditures, addressing reimbursement, expanding coverage, and enhancing program oversight.

HealthConnect - Review this program’s model as a primary care gatekeeper and work with stakeholders to develop plans to implement a medical home in order to reduce the rising costs of chronic disease.

HealthWave - In order to increase transparency, make comparative health plan performance and health status quality data available for consumers, policymakers, and other stakeholders in 2009. Highlight wellness and prevention efforts for families.

Medical Services for the Aged and Disabled - Convene stakeholders to help evaluate and design a statewide care management program for the aged and disabled aimed at slowing the growth of
health care costs through improved health status.

**Emergency Health Care for Undocumented Persons** - Monitor changes in border state policies regarding immigrants and assess the impact on Kansas.

**Dental** - Extend prevention and restorative coverage to adults enrolled in Medicaid.

**Durable Medical Equipment** - Require DME suppliers to show actual costs of all manually priced DME items, ensuring reimbursement is no greater than 135% of cost. Review potential overpayments and coverage usage issues, specifically for oxygen services.

**Home Health** - 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.

**Hospital** - Adopt severity adjustment payment system for inpatient services (MS-DRG), review outpatient reimbursement, and emergency room use. Follow Medicare rules on refusing to pay for “never-events” in order to improve patient safety.

**Hospice** - Enhance scrutiny of retroactive authorizations for hospice services. Review concurrent Home and Community Based Service (HCBS) stays. Increase scrutiny of pharmaceutical coverage and spending. Review extended patient stays.

**Lab/Radiology** - Review coverage of new procedures and explore adoption of the Medicare payment system as a starting point for reimbursement of all new procedures, and to ensure appropriate payment over time.

**Pharmacy** - Revise Kansas law to allow for the use of direct management techniques, such as safety edits and the Medicaid Preferred Drug List (PDL) and Prior Authorization (PA) lists, for selected mental health medications. To inform these decisions, use a newly established, specialized mental health advisory committee. Purchase an automated PA system to ease and expand use of PA, and to ensure timely dispensing of medications.

**Transportation** - Issue a request for proposal 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 for the state.

**Eligibility** - Promote community-based outreach by placing state eligibility workers on-site at high-volume community health clinics around the state. Expand access to care for needy parents by increasing the income limit to 100 percent FPL ($1,467 per month for a family of three). Increase eligibility limits for the medically needy (primarily elderly and disabled people who do not yet qualify the Medicare) so that it is tied to the federal poverty level. Increase the number of people who have access to full Medicare coverage.

**Quality Improvement** - Publish quality and performance information that is already collected for the HealthWave and HealthConnect programs to increase transparency. Obtain funding for the new collection of data from beneficiaries and providers in fee-for-service programs to evaluate performance, identify opportunities for improvements, and facilitate comparability across programs.
Chapter 2: Background, Motivation and Methodology

The overall purpose of the Medicaid program reviews is to provide a regular and transparent format to monitor, assess, diagnose, and address policy issues in each major program area within Medicaid. The preparation of these reviews is designed to serve as the basis for KHPA budget initiatives in the Medicaid program on an ongoing basis. This will provide a concrete mechanism for professional Medicaid staff within the KHPA to recommend new policies that improve the program so that well-founded, data-driven, and operationally sound proposals may be advanced to the KHPA board, the Governor, and the Legislature. Publication of these reviews provides accountability and a record of progress in managing the Medicaid program, serves as a central source of plain-language program information, and creates a transparent means to describe and share KHPA policies and plans with participants, providers, and policymakers. Feedback from readers and those who make use of the reviews’ conclusions and recommendations will be an important checkpoint for KHPA staff, and will enhance the quality of KHPA’s management of the Medicaid program.

Background and Motivation

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 of health plans 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 spearheaded the resolution of significant liabilities with the federal government, settling in 2007 a number of outstanding audits with potential financial deferrals and/or disallowances of Federal Medicaid payments totaling potentially hundreds of millions of dollars. KHPA initiated a successful reform of the disproportionate share hospital (DSH) program to target these supplemental Medicaid payments towards hospitals across Kansas with the greatest proportionate burden of uncompensated care.

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. These successes indicate the potential for KHPA staff, and the KHPA model of governance, to identify and achieve significant improvement in the Medicaid program. The agency’s challenge going forward is to intensify the search for program improvements and reforms to support state policy goals and fiscal circumstances on an ongoing basis. This challenge requires a more systematic approach. The KHPA Medicaid Transformation process is designed to meet that challenge and represents a significant step in achieving optimal management and oversight of the Medicaid program.
Evaluating Medicaid by examining total spending

The Transformation process is motivated by a desire to improve KHPA’s public insurance programs and to transform the management and policy leadership of these programs. Medicaid costs have grown at an average rate of about 9% per year over the last decade, and will total about $2.5 billion across all Kansas Medicaid services in state fiscal year (FY) 2009. KHPA public insurance programs accounted for about $1.3 billion of that total (paying for the provision of health care services or “regular Medicaid’’). The sheer size and growth of the program alone, though, does not give us any indication of the value of the services provided, its efficiency and effectiveness in securing and reimbursing health care services for needy Kansans. Neither does the size of the program alone recommend itself to any particular strategy for long-run management, e.g., whether the state should pursue expansion, reduction, or reform of the program.

Comparisons with other state Medicaid programs

Comparisons to other states help establish some context for an evaluation of Kansas’ Medicaid program. A comparison of Kansas’ Medicaid program to other states’ on three key indicators reveals:

- **Total spending.** Overall Medicaid spending per beneficiary is relatively high in Kansas: $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), with the aged and disabled ranking highest among those three populations.

- **Population that benefits most from Medicaid spending.** Compared to other states, 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.

- **Insurance coverage through Medicaid.** While coverage of children is typical at 200% of the poverty level, coverage for non-disabled adults is very low. Kansas ranks 39th in the percentage of Medicaid eligibles who are low-income, non-disabled, working-age adults, and is ranked between the 41st and 46th in income threshold for adults in this category. Partly as a result, Kansas ranks near the bottom (43rd) in the percentage of its population covered by Medicaid (13%).

Comparison with the private sector

Other comparisons also help place Medicaid spending in context, in particular a comparison of Medicaid coverage with private insurance alternatives. Medicaid remains a good bargain compared to private sector coverage, although total spending on Medicaid is growing faster as coverage has shifted over time from private to public insurance, especially among children. Per-capita growth in Medicaid costs has been lower than per-capita growth in private health insurance costs over the long term, contributing to a significant cost advantage for public health insurance on an actuarially-adjusted basis. The cost advantage can be partially attributed to the fact that provider payment rates are typically much lower in Medicaid and other public programs.

Need for specific evaluation of Kansas’ Medicaid program

High-level comparisons to other states and private insurance are helpful, and may help guide the KHPA board, the Governor and the Legislature in their policy choices. However, these compari-
sons do not lead directly to the development of specific options for improving the Kansas’ program. For example, if Kansas Medicaid spends more than the average state on the disabled, but also achieves a high rate of community placement for disabled Kansans in need of long-term care, then Kansas policymakers may view this spending as both efficient and effective given the state’s goal of providing long term care services in the least restrictive environment. While it may be helpful to describe Kansas’ Medicaid program in relation to other state Medicaid programs around the country, rankings do not provide an absolute answer to the question of whether Kansas’ program is efficient, effective, or in need of reform.

Having established its vision for health policy in the state, and having applied that vision in the development of specific health reform recommendations, the KHPA board has selected an overarching set of objectives to guide its management of the Kansas Medicaid program. In comparison to the historical focus of program management, substantial changes in focus and process are needed to address:

- the fiscal burden of steadily rising costs
- strained relationships with providers
- major gaps in coverage
- the need for a broader focus:
  - historic focus on health care - need to also focus on prevention and wellness
  - historic focus on paying bills - need to also focus on quality of care
  - historic focus on program survival - need to also focus on market impact
  - historic focus on responsive management - need for data-driven management

Addressing these basic objectives requires more than a high-level comparison with other states or the private sector - it requires a specific examination of Kansas’ program to identify opportunities for improvement, and this is the goal of the Medicaid Transformation process.

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 two years the Medicaid program has undertaken a new and increasingly comprehensive effort to utilize available data and program management experience to review each major component of the program. The reviews also identify areas for improvement, increased efficiency, savings, and improved quality. The 2007 review process began internally; in 2008 the review process was publicly discussed at KHPA board meetings, in stakeholder meetings, and with various interested policymakers.

Developing a comprehensive process

A key question in evaluating a program as large as the Kansas Medicaid program is how to structure the analysis in a meaningful way. The Medicaid program consists of a very diverse set of services, covered populations, and provider groups. For example, Medicaid funding is used to operate at least three distinct health insurance programs, Medicaid fee-for-service, HealthConnect, and HealthWave, each with a unique design for reimbursing and delivering medical services to
beneficiaries. These three programs operate across a wide range of smaller health care markets, ranging from the provision of basic health care assistance in the home to the performance of complex surgeries in one of the state’s large, urban hospitals. Some Medicaid services are delivered in competitive provider markets, such as the transportation of beneficiaries to and from medical appointments in urban areas, while others operate in highly regulated markets, as is the case with medical professionals operating under restrictive state licenses. This diversity is compounded by the breadth of health needs among beneficiaries, who range in age from birth to the extremely old, and whose needs range from the routine to the extremely complex. This complexity makes it very difficult to meaningfully evaluate the program.

To achieve a comprehensive evaluation of the Medicaid program, we have broken the program into approximately 20-30 major component parts, and will plan to evaluate each component on a regular basis. Reviews completed in 2008 cover fourteen separate but often overlapping “programs” that are organized into four broad categories: health care services and programs, special populations, eligibility, and quality improvement. The fourteen reviews included in the 2008 Medicaid Transformation plan 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, and so the process is intended to be comprehensive over time. Reviews of some 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, and reviews of selected Medicaid-funded programs administered by other state agencies. 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). 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 global 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.
Methodology

The basic approach in completing each program review is to describe each program in detail, describe the population that each program area serves, and highlight key trends in spending, utilization of services, and, where available, the quality or effective delivery of care. In many cases, these descriptions represent the creation of the first (known) resource for a plain-language explanation of the program component. Program managers also included descriptions of significant programmatic activity in each area. The types of questions to be addressed in each review include:

- What are the trends in spending, utilization, and quality?
- Why have expenditures increased/decreased/remained constant?
- What program changes have been implemented and how have they affected spending, participation, and utilization?
- Are these trends consistent with trends in the health care marketplace?
- What program improvements does the analysis suggest?
  - What are the opportunities for potential savings in each area?
  - What gaps in service, payment, or other policies exist in the program area?
  - What questions will remain unanswered that may be addressed in future years, or with additional data?

In many reviews, there are additional analyses, or gaps in available data, that would have supported a more complete explanation of program trends. However, all of the reviews establish an important baseline for routine evaluation and cyclical improvement in the program areas. The agency’s strategic plan includes a focus on developing agency capacity in data collection and analysis which is designed, in part, to support more complete evaluation of KHPA’s programs. Nevertheless, this year’s process identified a number of meaningful program improvements that will generate both savings and improved quality of care in the Medicaid program. In many cases, the specific policy changes recommended as a result of the 2008 Medicaid Transformation process are incremental. In some 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 should both 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. The transformation is to the Medicaid policy process itself, using data and transparent goals to motivate program improvements and avoid speculative change based on anecdote.

KHPA Board Review

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 KHPA board for their consideration. The KHPA board met in August and September 2008 to review and approve the Transformation plan, and to adopt selected
recommendations from the Transformation plan to be included in its recommendations for the FY 2009-10 budget.
Acknowledgements

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Chapter 3: Dental Services

Executive Summary

Description

Kansas Medicaid and State Children’s Health Insurance Program (SCHIP) provide a comprehensive dental benefit package for children, some developmentally disabled adults, and adults receiving services through Home and Community-Based Services (HCBS) waivers. In state fiscal year (FY) 2007, approximately 24,000 SCHIP beneficiaries received dental services totaling $7,330,140 with an average payment per beneficiary of $305.42. Approximately 70,500 Medicaid beneficiaries received dental services in FY 2007 totaling $27,115,769 with an average payment per beneficiary of $384.20.

Key Points

- **Lack of Adult Dental Coverage**

  As a result of health reforms included in Senate Bill 81, a comprehensive dental benefit will be offered to pregnant women beginning May 2009, pending confirmation of full funding through the consensus caseload appropriations process. However, other non-disabled adults on Medicaid (e.g., parents) continue to have access only to emergency dental services.

- **Need for Increased Rates**

  Kansas, like most other states, is facing a significant dental provider shortage and ranks 29th in the nation in the number of dentists per capita. Kansas has a dentist to population ratio of 1 to 2,127 compared to the national average of 1 to 1,888 residents. Reimbursement rates and administrative simplification are commonly thought to be critical factors in attracting and retaining Medicaid-participating dentists.

  - Kansas providers receive just over 60% of the average private reimbursement for our region. Participating dentists frequently raise the issue of reimbursement as a potential barrier to continuing to serve Medicaid and SCHIP beneficiaries

- **Need for Increased Access**

  Although in May 2008 the number of dental providers actively billing Medicaid increased, access remains a significant concern, especially in the context of the pending coverage expansion for pregnant women.
Kansas Health Policy Authority (KHPA) Staff Recommendation

- Expand more comprehensive dental coverage to adults enrolled in Medicaid. Non-emergent preventive and restorative care is not available under the current policy, creating more serious health issues and lower oral health status for poverty-level Kansans.
- Engage medical practitioners in addressing the oral health status of poverty-level Kansans.
- Explore potential options to expand the dental workforce.
  - Recruit dentists to Kansas.
  - Promote changes to increase the dental workforce with hygienists, mid-level practitioners and/or graduating dentists.
  - Continue support of dental hub model.

Additional Option Identified by KHPA Staff

- Increase dental reimbursement from the current level of 60% of usual and customary reimbursement to help increase dental service access for existing beneficiaries.

Program Overview

The dental program provides dental access to eligible Medicaid and State Children’s Health Insurance Plan members. A variety of dental benefit packages are available to different Medicaid populations based on eligibility criteria.

Comprehensive dental coverage is available to:
- Medicaid eligible children under age 21
- SCHIP eligible children under age 19
- Adults with development disabilities, who reside in Intermediate Care Facilities (ICF/MR), age 21 or older
- Home and Community Based Waiver Services (HCBS) members age 21 or older
  - A. Mental Retardation/Developmental Disabilities
  - B. Traumatic Head Injury
  - C. Physical Disability
  - D. Frail Elderly (FE)-including dentures
- Pregnant women, target implementation of May 2009

Emergency services (only) are available to:
- Medicaid eligible adults age 21 or older

For populations with comprehensive coverage, the dental benefit packages are designed to be as similar as possible to ease provider burden. However some differences in prior authorizations and current dental terminology (CDT) codes exist between the benefit packages.

The children’s benefit package provides most dental services; however, orthodontia is limited to children with genetic abnormalities or severe trauma. The benefit package for ICF/MR members provides most dental services but does not include coverage for dentures. The benefit package for the waiver programs covers most dental services; but only the FE waiver includes coverage for dentures.

Adults with Medicaid coverage receive emergency services only, such as, extractions for infected
teeth and the related diagnostic services, removal of oral lesions, and treatment of facial fractures. The benefit package for pregnant women is in development and will be comprehensive in nature.

The following providers are allowed to submit claims for dental services subject to applicable laws and regulations:

- Dentists (including all dental specialists)
- Intermediate Care Facilities for the Mentally Retarded
- Indian Health Clinics (IHC)
- Federally Qualified Health Centers (FQHC)
- Head Start
- Local Health Departments (LHD)

Unlike the medical profession, mid-level dental professionals are not allowed to practice independently and cannot submit claims to Medicaid directly for their services. Mid-level practitioners must bill through a supervising dentist. Claims can be filed up to a year after the service has been provided, for that reason FY 2007 data is not complete.

Recent Program Improvements

Several improvements have recently been made to increase access to dental care in Kansas. In response to provider complaints and difficulty with the claims process, the Kansas Health Policy Authority (KHPA) changed fiscal agents for the Medicaid and SCHIP dental program in July of 2006. Electronic Data Systems (EDS) began processing dental claims on July 1, 2006 which provided the opportunity for administrative changes. EDS provided a dental services team which was comprised of a dental assistant and three other trained personnel to focus solely on dental provider outreach and inquiries. The state web site was enhanced to give dental providers a five year client history of dental services that had been provided. It also has drop down boxes on the electronic claim form so providers need not submit additional documentation with claims.

Other changes have occurred in the dental program over the years to streamline the claims process for providers. On December 1, 2004, four dental codes for all populations had prior authorization (PA) status removed. On October 1, 2005, 20 dental codes for adults, six dental codes for children and all dental codes for members in ICF/MR facilities had their PA status removed. These PA status removals were prompted when a review showed that over 95% of the PAs submitted were being approved. The change of fiscal agent and administrative simplifications were made to increase access and provider participation, the programs’ principle challenge.

Access to Dental Services

There are 561 dental providers enrolled in Medicaid and 348 dental providers enrolled in SCHIP. As of June 2007, the Kansas Dental Board reports 1,367 licensed dentists in Kansas, although some dentists are not active in providing clinical services. EDS contacted non-participating dental providers across the state in the fall of 2007 to recruit additional providers. A letter outlining the dental program was sent to these providers, and followed up with a phone call to the provider. Since July 1, 2007, 43 new dental providers have enrolled in the Medicaid program and 34 new dental providers enrolled in the SCHIP program.
Access issues are a problem for dental programs nationally. Although there has been a modest increase in the number of dental providers enrolled in Kansas Medicaid and SCHIP these issues continue to threaten the viability of our dental program. To advise the agency on matters of dental coverage and policy, KHPA convenes an advisory board on a quarterly basis that consists of KHPA staff, fiscal agent staff, dentists, and Kansas Dental Association staff. Their purpose is to give input on policy formation and relevant dental issues. The board has given recommendations regarding the recommended dental visit schedule, dental claim forms, benefits, and appropriate services to cover and reimbursement.

In Kansas, the Office of Oral Health with the Kansas Department of Health and Environment also collaborates with and provides technical assistance to communities, schools, health professionals, local health departments, professional groups, and various governmental agencies, both state and local. KHPA maintains an active link with the Office of Oral Health. The Office seeks to increase awareness regarding the importance of oral health and improve oral health status by providing education, consultation and training that focuses on health promotion and disease prevention. After consultation with the Association of State and Territorial Dental Directors (ASTDD), as well as meetings statewide with oral health advocates and state and community organizations, the Office of Oral Health issued an oral health plan.

The 2007 Kansas Oral Health plan addresses workforce issues with several strategies (See Attachment A):

- Develop a Statewide Recruitment System for Dentists and Dental Hygienists
- Improve Kansas Loan Re-Payment Programs
- Reduce Barriers to Rural Practice in the Kansas Dental Practice Act
- Explore Options to Assist Students Interested in Kansas Public Health Dentistry to enter Dental School and Finance their Dental Education
- Support and Encourage Community Based Extended Care Permit Hygienists
- Integrate Oral Health into Primary Care
- Evaluate the costs and benefits for a Kansas Dental School and/or more dental Residency Programs
- Support and Monitor the Wichita Advanced Education for General Dentistry program
- Provide Educational Opportunities for Dental and Dental Hygiene Students in underserved areas in Kansas

### Analysis of Performance Data

As noted earlier there has been an increase in the number of providers enrolled in Medicaid and SCHIP. Analysis of claims data reveals that there have been other improvements to measured access to care as well. According to the monthly analysis (below), for both Medicaid and SCHIP, the number of providers actively billing Medicaid has increased. The number of beneficiaries being served has also increased.
### Table 1
**Medicaid Provider Participation**

<table>
<thead>
<tr>
<th></th>
<th>FISCAL YEAR-TO-DATE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008</td>
<td>2007</td>
</tr>
<tr>
<td>Providers Enrolled</td>
<td>550</td>
<td>602</td>
</tr>
<tr>
<td>Providers Participating</td>
<td>332</td>
<td>318</td>
</tr>
<tr>
<td>Percent Enrolled Providers Participating</td>
<td>60.34%</td>
<td>52.94%</td>
</tr>
<tr>
<td>Total Claims Paid</td>
<td>184,714</td>
<td>179,439</td>
</tr>
<tr>
<td>Claims Paid Per Participating Provider</td>
<td>556.52</td>
<td>563.47</td>
</tr>
<tr>
<td>Total Payments</td>
<td>$28,525,387.61</td>
<td>$28,311,945.11</td>
</tr>
<tr>
<td>Average Payment Per Participating Provider</td>
<td>$85,943.38</td>
<td>$88,904.20</td>
</tr>
<tr>
<td>Average Number of Services Per Participating Provider</td>
<td>2,181.96</td>
<td>2,202.28</td>
</tr>
<tr>
<td>Average Payment Per Service</td>
<td>$39.39</td>
<td>$40.37</td>
</tr>
</tbody>
</table>

### Table 2
**SCHIP Provider Participation**

<table>
<thead>
<tr>
<th></th>
<th>FISCAL YEAR-TO-DATE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008</td>
<td>2007</td>
</tr>
<tr>
<td>Providers Enrolled</td>
<td>331</td>
<td>327</td>
</tr>
<tr>
<td>Providers Participating</td>
<td>257</td>
<td>250</td>
</tr>
<tr>
<td>Percent Enrolled Providers Participating</td>
<td>77.84%</td>
<td>76.41%</td>
</tr>
<tr>
<td>Total Claims Paid</td>
<td>51,379</td>
<td>51,926</td>
</tr>
<tr>
<td>Claims Paid Per Participating Provider</td>
<td>200</td>
<td>208</td>
</tr>
<tr>
<td>Total Payments</td>
<td>$7,489,197.63</td>
<td>$7,096,431.06</td>
</tr>
<tr>
<td>Average Payment Per Participating Provider</td>
<td>$29,089.40</td>
<td>$28,427.07</td>
</tr>
<tr>
<td>Average Number of Services Per Participating Provider</td>
<td>795.66</td>
<td>818.89</td>
</tr>
<tr>
<td>Average Payment Per Service</td>
<td>$36.56</td>
<td>$34.71</td>
</tr>
</tbody>
</table>

### Table 3
**Medicaid Beneficiary Participation**

<table>
<thead>
<tr>
<th></th>
<th>FISCAL YEAR-TO-DATE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008</td>
<td>2007</td>
</tr>
<tr>
<td>Total Beneficiaries Served (duplicated)</td>
<td>148,602</td>
<td>143,444</td>
</tr>
<tr>
<td>Average Payment Per Beneficiary</td>
<td>$191.96</td>
<td>$197.37</td>
</tr>
<tr>
<td>Services Rendered</td>
<td>724,211</td>
<td>701,327</td>
</tr>
<tr>
<td>Average Number of Services Per Beneficiary</td>
<td>4.87</td>
<td>4.89</td>
</tr>
</tbody>
</table>

### Table 4
**SCHIP Beneficiary Participation**

<table>
<thead>
<tr>
<th></th>
<th>FISCAL YEAR-TO-DATE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008</td>
<td>2007</td>
</tr>
<tr>
<td>Total Beneficiaries Served (duplicated)</td>
<td>42,600</td>
<td>42,107</td>
</tr>
<tr>
<td>Average Payment Per Beneficiary</td>
<td>$175.80</td>
<td>$168.53</td>
</tr>
<tr>
<td>Services Rendered</td>
<td>204,846</td>
<td>204,424</td>
</tr>
<tr>
<td>Average Number of Services Per Beneficiary</td>
<td>4.81</td>
<td>4.85</td>
</tr>
</tbody>
</table>
Kansas has shown an increase in the percentage of children receiving any dental service over the last two years for both Medicaid and SCHIP. Kansas children receiving any dental service (tables 5 and 6) are above the national average of 33% participation. As the only population with comprehensive preventive and restorative care, counting the number of children in Medicaid who receive dental care gives us the clearest picture of potential access through Medicaid. Despite the welcome increases in FY 2007 and FY 2008, utilization is below levels recommended by the American Academy of Pediatric Dentistry which emphasizes early intervention and continuity of care based on the individual child (see table 7).

**Table 5**
Medicaid-Percentage of Participation

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Total</th>
<th>&lt;1</th>
<th>1-2</th>
<th>3-5</th>
<th>6-9</th>
<th>10-14</th>
<th>15-18</th>
<th>19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 08</td>
<td>41%</td>
<td>3%</td>
<td>21%</td>
<td>54%</td>
<td>57%</td>
<td>52%</td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>FY 07</td>
<td>40%</td>
<td>3%</td>
<td>18%</td>
<td>51%</td>
<td>55%</td>
<td>51%</td>
<td>42%</td>
<td>19%</td>
</tr>
<tr>
<td>FY 06</td>
<td>38%</td>
<td>3%</td>
<td>14%</td>
<td>50%</td>
<td>53%</td>
<td>50%</td>
<td>43%</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Table 6**
SCHIP-Percentage of Participation

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Total</th>
<th>&lt;1</th>
<th>1-2</th>
<th>3-5</th>
<th>6-9</th>
<th>10-14</th>
<th>15-18</th>
<th>19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 08</td>
<td>46%</td>
<td>3%</td>
<td>20%</td>
<td>46%</td>
<td>58%</td>
<td>52%</td>
<td>39%</td>
<td>2%</td>
</tr>
<tr>
<td>FY 07</td>
<td>44%</td>
<td>1%</td>
<td>18%</td>
<td>45%</td>
<td>56%</td>
<td>49%</td>
<td>37%</td>
<td>1%</td>
</tr>
<tr>
<td>FY 06</td>
<td>42%</td>
<td>1%</td>
<td>11%</td>
<td>41%</td>
<td>54%</td>
<td>46%</td>
<td>39%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Table 7**
American Academy of Pediatric Dentistry Recommendations

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>6-12 months</th>
<th>12-24 months</th>
<th>2-6 years</th>
<th>6-12 years</th>
<th>12 years &amp; older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exam</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>X-ray Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Cleaning/topical fluoride</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Analysis of Expenditures

In performing a yearly review of the dental program it is important to examine claims data and expenditures. The data show that expenditures for the dental program have slightly increased over the past three state fiscal years (Graphs 1 and 2).
Analysis of the top five dental services reimbursed over the past fiscal years for Medicaid and SCHIP (Graphs 3 and 4) reveal that those services have remained the same over the review period. There have been some modest changes in utilization patterns over the FY 2005-2007 period however. In general, preventive services appear to have increased slightly while restorative services have either remained constant (crowns) or declined (fillings). Future analysis will help determine whether the data indicates a change or trend in the types of services provided. If trends are established they will be evaluated for potential program implications.

Graph 3

T19 Highest Net Reimbursement by Procedure Codes
FY 2005 - 2007

- D1120  Child prophylaxis (cleaning of teeth)
- D2392  Two-surface resin-based composite (filling)
- D1351  Sealant, per tooth
- D2930  Stainless steel crown, primary tooth
- D2391  One-surface resin-based composite (filling)
Graph 4

SCHIP Highest Net Reimbursement by Procedure Codes
FY 2007

* Encounter data (claims information supplied to our fiscal agent by the managed care organization) issues for SCHIP make the data before 2006 less reliable.

The number of enrolled dental providers as seen in graph 5 suggests a decrease in providers serving SCHIP members in 2007. On July 1, 2006, KHPA changed fiscal agents for the dental program, and a thorough review of providers was conducted. KHPA discovered SCHIP had providers listed who had moved, retired or were no longer active providers. This artificially inflated the number of active SCHIP providers reported for 2006. Medicaid providers decreased slightly in 2008.

Graph 5

Number of Enrolled Dental Providers per SFY

* Medicaid
  * SCHIP
Provider Participation and Satisfaction

As access is an important issue in the Medicaid dental program, this review examined provider distribution. Illustrations 1 and 2 indicate the number of providers who billed for dental services in the first quarter of 2008. The data shows many counties in Kansas with no active billing providers.

**Illustration 1**
*Medicaid Provider Participation – 1st Quarter, 2008*

**Illustration 2**
*SCHIP Provider Participation – 1st Quarter, 2008*

Border State Providers:
- Missouri - 17
- Nebraska - 0
- Oklahoma - 1
- Colorado - 0

Border State Providers:
- Missouri - 13
- Nebraska - 0
- Oklahoma - 1
- Colorado - 0
KHPA has made a number of changes in the dental program to address this access issue for beneficiaries. The fiscal agent change in July 2006 was prompted, in part, by provider dissatisfaction with the claims process. Providers appear more satisfied with the current fiscal agent according to a survey fielded in November 2006 (repeat survey has not yet been conducted). Providers were asked to assess their experience with EDS operating as the dental fiscal agent. One hundred and seventy-nine of the five hundred and twenty surveyed dentists gave input. Eighty-nine percent of responding providers were satisfied with EDS as the dental fiscal agent, indicated by the graph below. Other changes to the dental program are listed below and were aimed at improving access and increasing provider satisfaction.

**Graph 6**

Overall performance of EDS as the dental fiscal agent

- Superior or Good: 75%
- Satisfied: 14%
- Fair or Poor: 6%
- N/A or no opinion: 5%

**Program Improvements**

- Since 2001, the Medicaid and SCHIP dental benefit packages for children have been made as similar as possible for provider ease
- Reimbursement for fluoride application was permitted for medical providers effective August 2005
- Review of all dental payment rules from program inception was accomplished by the dental program manager and master dental policies were written
- Appreciation letters to long-time providers from Governor sent May 2007
- Home and Community Based Services (HCBS) waiver dental program effective April 2007
- Frail and Elderly (FE) dental waiver program effective October 2007
- Provider community is embracing electronic claim filing as over 75% of dental claims are being filed electronically
- In June of 2005 a recommended dental visit schedule from the American Dental Association, American Academy of Pediatrics and the American Academy of Pediatric Dentists was adopted
- Pregnant women dental program targeted to be implemented May 2009
**Key Points**

- A national shortage of dental providers is well-documented. The number of Kansas dental providers is projected to decline without significant policy intervention in the next decade according to a report published in January 2005 by the Kansas Health Institute, “The Declining Supply of Dental Services in Kansas: Implications for Access and Options for Reform.” Most dental providers in Kansas are in the urban areas, with fewer in the rural/frontier counties. Kansas is underserved by the dental workforce, according to the Kansas Oral Health Plan published in November 2007 by the Office of Oral Health at the Kansas Department of Health and Environment.

  ° Kansas’ shortage mirrors national trends and illustrates the need for federal leadership. Kansas is 29th in the nation in the number of dentists per capita, with a statewide Kansas dentist to population ratio of 1 to 2,127. This is under the national average of 1 dentist per 1,888 US residents. This disparity is significantly greater in the more rural areas of Kansas.

  ° States have been attempting to compensate for the dental workforce shortage in various ways. Some states report increased dental access with the use of a managed care approach to dental, while other states report success with a traditional fee for service model. Administrative burdens have been reduced for providers by streamlining the contract/ recredentialing process, reducing the number of prior authorizations, providing electronic verification of eligibility, and providing electronic claim and X-ray submission.

  ° Pilot projects to provide case management, transportation or enhanced reimbursement to providers have shown increased access in some states. Mobile units have been utilized in less populated areas to increase access. Loan forgiveness to dental providers who serve low-income populations can increase dental access.

  ° Medical practitioners have been allowed to provide oral assessments, fluoride applications or other dental services in some states. Extending the scope of practice of dental assistants and hygienists has been allowed in several states; some states allow dental hygienists to be a Medicaid provider and directly bill Medicaid.

- Reimbursement is also thought to be a critical factor in attracting and maintaining dental providers. Providers are receiving just over 60% of the average reimbursement for our region according to the American Dental Association (ADA) 2007 Survey of Dental Fees book. The ADA Survey of Dental Fees book gathers from a random sample of dentists the fee most often charged for commonly performed dental procedures.

- The Centers of Medicare and Medicaid Services (CMS) recently initiated an emphasis on Medicaid dental services nationally. CMS conducted on-site reviews of dental programs in 16 states with the lowest reported rates of dental utilization. All states have been asked to submit information on utilization, rates, recommended dental visit schedules, provider recruitment and beneficiary outreach. All states will receive an on-site audit of their dental program.

- The dental hub model operating in Federally Qualified Health Centers (FQHCs) throughout the state is a strategy to increase access to dental services for beneficiaries in a clinic service area. However FQHCs account for only 2.5% annual Medicaid dental expenditures.
The issue of how Medicaid can support the dental hub model and increase its productivity needs to be addressed. FQHCs are faced with the dental provider shortage and attracting clinicians to their service model. The FQHC model is quite different from the typical dental provider who owns and operates his/her own office.

FQHCs report that providing dental care to a large number of uninsured adults threatens the financial stability of their dental programs. Because of this problem, many clinics try to limit their patient pool to children, and do not provide adults with comprehensive restorative care. Offering an adult Medicaid dental benefit would provide these clinics with a source of payment for what is currently uncompensated care, and would increase access to safety net dental clinics for Medicaid adults.

The long term sustainability of the “dental hub” program relies on Medicaid reimbursement. Without an adult Medicaid benefit plan, dental hubs will continue to reduce the scope of services available to adults in safety net clinics, and continue to perform high levels of uncompensated care.

This review has documented a modest increase in participating dentists and an associated increase in access to dental care for Medicaid beneficiaries. However, levels of use among Medicaid and SCHIP children are inadequate which may suggest that significant barriers to access remain. In the context of a nationwide decline in the availability of dental practitioners, solutions are difficult. KHPA has identified two areas for additional research and planning:

**Recommendations**

1. Pursue dental coverage for all adults in Kansas Medicaid. There are numerous reasons to add dental coverage to the benefit plan for adults. First, good dental health may improve overall health and decrease medical costs related to premature births, heart disease and cancer. Current research has shown a correlation between dental health and these conditions/diseases. For more on the status of the oral-systemic disease link, see the special supplement to the October 1, 2006 *Journal of the American Dental Association* available at [http://jada.ada.org/content/vol137/suppl_2/index.dtl](http://jada.ada.org/content/vol137/suppl_2/index.dtl).

Second, providing dental coverage for adults may improve the dental health of children with Medicaid coverage. Adults with poor dental health may not be able to model good oral health care to their children; therefore the cycle of poor oral health is continued. Also dental caries is an infectious disease, caused by bacteria and exacerbated by bad eating habits and poor oral hygiene. Adults with poor oral health can infect their children with dental caries through their saliva. Providing adults with education about caries prevention and nutrition as well as reducing the amount of bacteria in the parent’s mouth could ultimately result in less dental disease in children as well as adults (based on discussions with Dr. Katherine Weno, Director, Kansas Office of Oral Health).

Third, untreated dental disease results in pain, infection and tooth loss. Uninsured adults often seek dental emergency treatment in the hospital emergency room, often a costly and highly inefficient way to provide dental services.

Finally, dental disease and tooth loss can undermine an individual’s self-esteem making social interaction difficult and specifically creating another barrier to meaningful employ-
program for beneficiaries with poor oral health. Providing Medicaid adults with a dental home will reduce costly dental emergency room visits and provide adults with options for tooth replacement to enhance self esteem through social interaction and self sufficiency.

2. Promote the application of fluoride by medical practitioners. Fluoride gel was found effective in preventing caries in school-aged children according to several studies cited in the August 2006 *Journal of the American Dental Association*.

3. KHPA will continue to support the expansion of the dental workforce through multiple avenues. This includes the promotion of the dental hub model and its expanded use of dental hygienists as a way to reach dentists practicing in Kansas. The dental workforce of Kansas is below the national average and shrinking. Additional options to consider should the dental workforce continue to shrink include a review of the pros and cons of the licensure and reimbursement of mid-level practitioners.

4. Pursue an increase in dental reimbursement greater than the current level of 60% of usual and customary reimbursement to help increase dental service access for existing beneficiaries. KHPA is aware that improving access is dependent upon addressing multiple barriers to care including reimbursement for services. Kansas has already made administrative changes to make the billing process more streamlined and less cumbersome. The next step may be an increase in reimbursement. Other states have increased rates and had an increase in access to dental services. Michigan increased Medicaid rates close to commercial rates noted in the November 2003 *Journal of the American Dental Association*. Alabama increased rates to 100 percent of Blue Cross/Blue Shield regional rates noted in the 2003, 19 supplement, *Journal of Rural Health*. Both of these states saw an increase in access.

See Appendix A
Oral Health Plan
Executive Summary

Description

Kansas Health Policy Authority (KHPA) currently maintains a Durable Medical Equipment Program for Medicaid beneficiaries. Durable Medical Equipment (DME) is defined as equipment that meets the following conditions: 1) withstands repeated use; 2) is not generally useful to a person in the absence of an illness or injury; 3) is primarily and customarily used to serve a medical purpose; 4) is appropriate for use in the home; and 5) is rented or purchased as determined by designees of the executive director of the KHPA (K.A.R. 30-5-58). Kansas Medicaid covers a variety of durable medical equipment for adults and children that meet specific conditions defined in Kansas regulation. Examples of DME include the following: canes, crutches, wheelchairs, enteral and parenteral supplies, oxygen, and diabetic supplies. There are 824 DME suppliers in Kansas and 700 are pharmacies. DME equipment can be purchased or rented depending on the item and need.

In an effort to contain DME costs, Kansas developed a re-use program called Kansas Equipment Exchange Program (KEE) that has been nationally recognized as a model that other state Medicaid programs are implementing. This allows for an item that Kansas Medicaid has already purchased to be re-used once it is no longer needed by the original beneficiary. Common items include wheelchairs and hospital beds. In FY 2007, the KEE program saved approximately $2 for every $1 spent to operate the program. In FY 2007, the KHPA spent $13.9 million for DME. DME expenditures for FY 2007, when compared to FY 2004 indicate a steady increase with FY 2005 showing the largest increase of $3 million. This increase might be explained by the increase in consumers and claims, mostly within the aged and disabled population, which represent the highest DME expenditures.

Key Points

- Concerns identified in the DME program review are focused on the fourth highest DME expenditure: services billed under the “Miscellaneous” code. Some DME products do not have specific billing codes with set (or programmed) reimbursement rates. All products billed under the Miscellaneous code are prior authorized and are manually priced, however, cost invoices are not required to be submitted by the provider. Because Kansas Medicaid may be overpaying under the Miscellaneous code, we are converting this code when possible to specific codes provided from the Centers for Medicare and Medicaid Services (CMS). These codes provide for billing at a fixed percentage discount of the Medicare rate. The KHPA will continue to review the Miscellaneous code expenditures.

- In July 2008, DME supplies provided to patients in nursing facilities will be removed from the fee-for-service (FFS) program per direction from CMS. We now reimburse those products
through nursing home rates. Nursing homes are, in turn, allowed to negotiate the best prices for these products, presumably resulting in net savings to the Medicaid program, which may have been over-reimbursing for some DME products.

- There will be a focus in FY 2009 on the continued high costs and anecdotal evidence of over-reimbursement for DME, especially in light of the recent Congressionally mandated delay in the Medicare competitive pricing project for DME products - a project that would have generated savings for Kansas Medicaid.

**Recommendations**

- Review potential overpayments and coverage usage issues, specifically for oxygen service.
- Require DME suppliers to show actual costs of all manually priced DME items, which will ensure reimbursement at no greater than 135% of cost.
- Explore the possibility of joining with other state Medicaid programs on a collaborative manufacturer rebate program for some DME items.

### Cost Savings Due to Policy Changes for Kansas Durable Medical Equipment

<table>
<thead>
<tr>
<th></th>
<th>FY 09</th>
<th>FY 10</th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>5 Year Total</th>
</tr>
</thead>
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<tr>
<td>State General Fund (SGF)</td>
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<td>-$160,000</td>
<td>-$170,000</td>
<td>-$180,000</td>
<td>-$200,000</td>
<td>-$710,000</td>
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<tr>
<td>Total</td>
<td>$0</td>
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<td>-$420,000</td>
<td>-$450,000</td>
<td>-$480,000</td>
<td>-$1,750,000</td>
</tr>
</tbody>
</table>

**Program Overview**

Kansas Health Policy Authority currently maintains a Durable Medical Equipment Program for Medicaid beneficiaries. Durable Medical Equipment (DME) is equipment that meets the following conditions: 1) withstands repeated use; 2) is not generally useful to a person in the absence of an illness or injury; 3) is primarily and customarily used to serve a medical purpose; 4) is appropriate for use in the home; and 5) is rented or purchased as determined by designees of the executive director (K.A.R. 30-5-58).

In FY 2007 KHPA spent $-13,929,271 in the Medicaid DME program. At this time, there are approximately 824 Durable Medical Equipment providers in Kansas. This includes approximately 700 pharmacies which have a DME provider number.

The DME program covers many items for adults and children, for example: canes, crutches, walkers, commodes, wheelchairs, beds, enteral and parenteral supplies, ostomy supplies, dressings, wound vacs, oxygen, respiratory supplies, stockings, nebulizers, urinary supplies, and TENS units. There are also items limited to the KAN Be Healthy program for Medicaid recipients under 21 who are eligible for more comprehensive mandatory benefits under federal law. Some of these items include: diapers, CPAP, BiPAP, and Apnea Monitors. Items that are of higher monetary value or have the potential for high abuse require prior authorization (PA). The PA unit located in Medicaid’s fiscal agent, Electronic Data Systems (EDS), has four staff members dedicated to the DME program.

The DME process begins with a physician writing a prescription for the DME item needed. The beneficiary then takes the prescription to the Kansas Medicaid DME provider of his or her choice.
If no PA is required, the DME provider dispenses the item and bills Medicaid. If PA is required, the DME provider will gather all necessary documentation, fill out the PA request form and submit the PA to the EDS PA unit. Once received at the PA unit, the request process starts within 24 hours. The request will either be approved, denied or more information will be requested. If more information is needed, a letter will be sent to the DME provider requesting the necessary documentation. The provider has a 15 day time limit to submit the requested information. Once the information is received, the request will be completed. Any requests that fall outside of criteria for the particular requested item are submitted by the PA unit to the KHPA Program Manager. These requests are reviewed twice a week. If a request is urgent and must be reviewed by the KHPA program manager, the EDS PA unit will place a phone call to the manager. Once a PA request is completed, a letter is sent to the DME provider and the beneficiary notifying them of the decision. Appeal rights are listed on the PA letters.

The Kansas Equipment Exchange Program (KEE) is another part of the DME program. KEE is a medical equipment re-use program that has been nationally recognized; many other state Medicaid programs are using Kansas as a model for start up of a re-use program. DME purchases are tracked by providers, who place stickers on all equipment intended to either supplement Medicaid services or in some cases to substitute free used equipment in place of Medicaid purchases. These stickers list the telephone number for the re-use program so that the beneficiary may call for pickup once the equipment is no longer needed. Although all DME requests for Medicaid beneficiaries are first evaluated for new equipment, in the case that Medicaid coverage requirements are not met, the requested DME may be accessed from the KEE program. Also DME needs that may be temporary in nature may be met by equipment accessed through the KEE program.

Equipment in the KEE is obtained by donation from multiple entities, cleaned and placed into homes of Kansas Medicaid beneficiaries in need. All beneficiaries must complete an application for equipment and are screened before placement is made. The program recycles bath chairs, beds, wheelchairs, walkers, canes, crutches, commodes, enteral pumps, CPAP devices, speech devices, oxygen tanks and concentrators. The program utilizes many volunteers who transport equipment throughout the state. The most common items donated are wheelchairs and walkers. The most common items requested are wheelchairs and hospital beds.

Approximately two months after purchase of a DME item in KEE’s list of targeted equipment, Medicaid DME recipients are contacted to ensure that they have proper equipment, customer service by provider, timeliness of delivery, etc. After the KEE program collects donated equipment and it is placed through the re-use process, contacts continue to be made with the beneficiary to ensure that their needs are being met with the equipment obtained through the KEE program.

Service Utilization and Expenditures

DME Expenditures

Examination of total DME expenditures from FY 2004 through FY 2007 shows an increase of approximately $3 million in FY 2005 (see Figure 2). This increase was due to a 39% increase in volume of consumers and a corresponding 38% increase in claims. The increases were concentrated among the Aged and Disabled populations. The top two services contributing to this increase were Oxygen Concentrators and Diabetic Test Strips.
Total expenditures fell in FY 2006 and remained steady at about $14 million in FY 2007. Reimbursement policy changes help to explain these trends. In FY 2006 policies adjusting reimbursement rates and limitations on miscellaneous respiratory supplies and ostomy supplies were implemented. Both of these policies took effect January 1, 2006. Also, in FY 2006 the manufacturer’s suggested retail prices (MSRP’s) on manually priced codes began increasing. The majority of manually priced codes are related to wheelchair.

Some DME categories have not had reimbursement adjustments since the late 1980s. Program staff initiated a review of these categories beginning in 2005, focusing on reimbursement and coverage limitations. For example, one review revealed that suction pumps were being rented on an ongoing basis. This practice resulted in Medicaid paying thousands of dollars for a rental fee on a pump that cost $400 to purchase. The coverage policy was updated to allow purchase with prior authorization; renting is only allowed when it is evident that the need will be of short duration. If the need is lifetime, purchase is required.

Policy reviews of DME by staff have resulted in a number of changes over the past several years, consistent with evidence based medical standards. Reviews were completed on respiratory supplies, ostomy supplies, diabetic supplies, and insulin pumps. Policy changes related to these categories of DME were implemented in FY 2006. For example, one policy change related to diabetic supplies allowed for coverage for Type II diabetics, a change consistent with the standards of care for a Type II diabetic. Also, in FY 2006 insulin pump coverage began. Associated cost increases were partially offset by cost containment steps taken. In FY 2006, policy changes based on staff research were made for wheelchair cushions, urinary supplies, crutches, canes, walkers, commodes, lifts, and diabetic supplies. These policies were implemented in FY 2007. These policies increased expenditures on wheelchair cushions and urinary supplies due to reimbursement and revisions of out-of-date coverage limitations. In FY 2007, policy changes based on staff research were made for the following DME categories: beds, support surfaces, enteral supplies, parenteral supplies, dressings, TENS units, wound vacs, and breast pumps. The enteral supplies, parenteral supplies and dressing policies had increases in reimbursement and coverage limitations. These policies were implemented in FY 2008.
Several categories of equipment within the DME program will be reviewed as part of Medicaid transformation. The agency continues to review a few categories each year. Subsequently, rates and limitations are adjusted accordingly to industry standards and standards of care.

Prior Authorizations

Prior Authorization (PA) is an important management tool used by the KHPA to insure medical necessity for services and equipment and deter fraud and abuse. Thirty seven percent of all DME codes (purchase and rental) require prior authorization, according to records kept by the EDS Prior Authorization unit. In 2007, there were approximately 1,682 prior authorizations created for the E1399 (miscellaneous DME) code for 1,161 beneficiaries. Of those, 1,216 were approved, 409 were denied, and 57 were cancelled. The distribution of decision outcomes for PA has been essentially identical for the last 4 years.

Administrative costs increase when a DME code is prior authorized due to increased EDS and KHPA staff time. PA also increases the workload for the provider, who must obtain all necessary documents. Some DME items will have to remain on prior authorization due to concerns about fraud and abuse. As categories are reviewed, KHPA staff take into consideration whether to remove or add a code to the prior authorization requirement.

DME items reimbursed under the “Miscellaneous code” E1399 must remain on prior authorization. When possible, switching items from E1399 to the appropriate codes (called HCPC codes) lowers both administrative costs and the burden on providers. Figure 3 shows the distribution of prior authorization outcomes for E1399 by the number of authorizations and Figure 5 represents this by expenditures. Figure 4 represents prior authorized DME items versus non-prior authorized items for all DME codes by expenditures. Additional information on the Miscellaneous code is provided later in this review.

![Figure 3](image-url)

**Figure 3**

Distribution of Prior Authorization Outcomes for Miscellaneous DME (E1399)

FY 2007

- Approved: 1,216 (73%)
- Denied: 409 (24%)
- Cancelled: 57 (3%)

Legend:
- Approved
- Denied
- Cancelled
Utilization by Beneficiary County of Residence

Seating clinics provide beneficiaries who need wheelchairs with the appropriate equipment and proper seat fittings performed by certified providers. KHPA has four approved wheelchair seating clinics within the state of Kansas. These clinics are located in the counties of Shawnee, Sedgwick, Johnson and Wyandotte. Sedgwick County has a higher utilization rate in comparison with other counties. The clinic in Sedgwick County also serves a large segment of the western Kansas population. Sedgwick County has the highest population rate of DME beneficiaries within the state.

The utilization of seating clinics is deemed a “best practice” by the Medicaid Evidence-based Decisions Project (MED). The MED Project creates a powerful collaboration among state Medicaid programs for the purpose of making high quality evidence available to states to support benefit design and coverage decisions made by state programs. The project includes access to the following decision making tools: 1) high quality systematic reviews of existing evidence; 2) technology assessments of existing and emerging health technologies; 3) web-based clearinghouse; 4) support in designing rapid evaluations of products where no evidence exists; and 5) support of highly qualified research staff to assist members in applying the evidence to their own needs.
Table 1 displays the distribution of DME in the top six counties across the state. Sedgwick County remains the number one county for DME due to the size of the county, the availability of medical care, and use of the DME providers by those that live in surrounding counties.

### Table 1
**Top Six Counties: Use of DME**

<table>
<thead>
<tr>
<th>County</th>
<th>FY</th>
<th>Aged</th>
<th>Disabled</th>
<th>Total DME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEDGWICK</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>$346,563</td>
<td>$1,724,993</td>
<td>$2,487,100</td>
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</tr>
<tr>
<td>2006</td>
<td>$422,533</td>
<td>$1,663,604</td>
<td>$2,554,649</td>
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<tr>
<td>2005</td>
<td>$424,630</td>
<td>$1,788,396</td>
<td>$2,793,325</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>$301,584</td>
<td>$1,545,724</td>
<td>$2,291,319</td>
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<tr>
<td><strong>WYANDOTTE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>$121,905</td>
<td>$734,132</td>
<td>$1,028,771</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>$115,543</td>
<td>$687,419</td>
<td>$996,534</td>
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</tr>
<tr>
<td>2005</td>
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<td>$702,695</td>
<td>$1,052,063</td>
<td></td>
</tr>
<tr>
<td>2004</td>
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<tr>
<td><strong>JOHNSON</strong></td>
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<tr>
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<tr>
<td><strong>SHAWNEE</strong></td>
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<td>2007</td>
<td>$164,020</td>
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<td><strong>MONTGOMERY</strong></td>
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<td>2006</td>
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<td>2005</td>
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<td>2004</td>
<td>$91,765</td>
<td>$203,553</td>
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</table>

### Expenditures by Population

The SSI Blind and Disabled population have the highest amount of DME expenditures, as would be expected. This population includes the majority of people who are wheelchair bound, ventilator dependent, or have other medical needs that increase DME expenditures. Figure 5 represents DME expenditures by population code.
Expenditures per Member per Fiscal Year

Figure 6 presents the average expenditures per member by population code. The category “Adoption Support” is the population code with the greatest expenditures per member. This population includes a few very high cost medically fragile children.

Highest Expenditures by Procedure Code

As determined by an analysis of paid claims from the Medicaid Management Information System (MMIS), oxygen is the most commonly utilized category within the DME program. Currently oxygen is used in the home setting and in skilled nursing facilities. Approximately $2 million was spent on oxygen within the skilled nursing facility settings. A policy taking effect in FY 2009 requires DME as part of the per diem rate for facilities. This is represented in Figure 7.
Also, represented in Figure 7 is an increase in Blood Glucose Supplies during FY 2005. This is a direct result of policy E2004-040 implemented October 1, 2005 adding coverage of blood glucose supplies for non-insulin dependent diabetics. In Figure 8, procedure code expenditures less than $800,000, a significant drop occurred in code B4150 (Enteral Formula) as a result of CMS reconfiguring the Enteral HCPC codes. The number of beneficiaries utilizing B4150 dropped from 554 to 421, which caused a decrease in expenditures for this particular code, spreading the difference in utilization over the remainder of the Enteral codes. This is represented in Figure 8.

![Figure 7](image)

### Table 2

**Annual Expenditures by Procedure Code**

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
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</thead>
<tbody>
<tr>
<td>Oxygen Concentrator</td>
<td>E1390</td>
<td>$3,967,954</td>
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<td>$4,871,021</td>
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<td>Blood Glucose Test Strips</td>
<td>A4253</td>
<td>868,100</td>
<td>1,468,023</td>
<td>997,111</td>
<td>1,051,337</td>
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<tr>
<td>Enteral Formula</td>
<td>B4150</td>
<td>617,184</td>
<td>662,006</td>
<td>425,544</td>
<td>394,281</td>
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<td>Miscellaneous</td>
<td>E1399</td>
<td>459,228</td>
<td>606,418</td>
<td>549,540</td>
<td>470,457</td>
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<tr>
<td>Nebulizers</td>
<td>E0570</td>
<td>435,797</td>
<td>623,381</td>
<td>550,464</td>
<td>412,355</td>
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<tr>
<td>Home Infusion Supplies</td>
<td>A4222</td>
<td>356,016</td>
<td>477,557</td>
<td>332,043</td>
<td>429,682</td>
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<tr>
<td>Ventilators</td>
<td>E0450</td>
<td>319,699</td>
<td>239,971</td>
<td>280,886</td>
<td>250,049</td>
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<td>Portable Oxygen</td>
<td>E0431</td>
<td>292,033</td>
<td>367,355</td>
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<td>Enteral Formula</td>
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<td>280,313</td>
<td>353,405</td>
<td>381,181</td>
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<tr>
<td>Disposable Underpads (chux)</td>
<td>A4554</td>
<td>145,846</td>
<td>181,084</td>
<td>173,655</td>
<td>160,479</td>
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</table>
Expenditures by Provider

DME providers with the largest number of clients are located in Wichita and Lenexa. These companies have multiple sites throughout the state and maintain a large selection of DME items. Figure 9 represents DME expenditures by the top eight providers. Significant changes are observed in reimbursements to a number of high volume Medicaid providers. However, no patterns were identified that raised concerns over current Medicaid policies.
Expenditures and Utilization by Age Group

Figure 10 and 11 represent the distribution of use and expenditures between adults and children. These expenditures have remained stable relative to each other and over time. Patterns in overall DME spending observed in Figure 2 are mirrored in both overall spending and the number of consumers for both adults and children, suggesting the prominent role of overall payment and coverage policies in explaining these changes, rather than an explanation specific to a particular population or piece of equipment.

![Figure 10](image)

**Figure 10**

**DME Expenditures by Children/Adults by FY**

Expenditures in $ Millions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$4</td>
<td>$6</td>
<td>$6</td>
<td>$5</td>
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<tr>
<td>Adults</td>
<td>$8</td>
<td>$10</td>
<td>$10</td>
<td>$9</td>
</tr>
</tbody>
</table>

![Figure 11](image)

**Figure 11**

**# of DME Beneficiaries by Children/Adult by FY**

# Served in Thousands

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
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<td>10,000</td>
<td>15,000</td>
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<tr>
<td>Adults</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
</tr>
</tbody>
</table>

Kansas Equipment Exchange (KEE) Program Expenditures/Savings

In FY 2007 there were 551 reassignments through the Kansas Equipment Exchange Program valued at $594,852 and 566 donations valued at $653,717. This program has continued to grow due to increased beneficiary awareness through beneficiary ID card stuffers, word of mouth, and provider cooperation. As noted earlier, this program was noticed as a “best practice” by the MED Project. Figure 12 represents the KEE program operation costs and donated value of equipment.
Program Evaluation

As mentioned briefly earlier, one issue within the DME program is the utilization of the E1399 (Miscellaneous) billing code. From 1995 through 2002, there were many DME items that were not assigned a specific DME code. Over that time period, the only way to bill for these items was to use the Miscellaneous code, which is manually priced. Current DME policy for manually priced items is to pay at the lesser of: 1) Medicaid rate 2) Provider cost plus 35% or 3) Manufacturer’s Suggested Retail Price (MSRP) minus 15-20% (depending on the item). However, DME suppliers are not currently required to provide both cost and MSRP information, leaving suppliers with an implicit choice between the two methods based on the information they choose to provide. This leaves open the possibility that KHPA could be paying the greater of these two amounts in some cases. The lack of available DME codes and recommended prices from the Centers for Medicare and Medicaid Services (CMS) caused an over-utilization of the Miscellaneous code and its ambiguous and potential generous pricing policy. In 2004, CMS began assigning specific codes to some of these items. At that time, efforts began within Kansas Medicaid to write policies to cover the appropriate codes for DME items, and decrease the over-utilization of the Miscellaneous code.

Due to the increased possibility of fraud and abuse, the Miscellaneous code E1399 must be prior authorized. DME providers within this unstructured billing code could utilize this code to obtain higher reimbursement and by-pass limitations. All requests for E1399 are reviewed by the PA unit. If an appropriate code is covered the provider is directed to make his request using the appropriate CMS billing code (“HCPCs”). Several HCPC codes lack a corresponding coverage policy within Kansas Medicaid and instead are covered within the E1399 Miscellaneous code.

The DME program has several categories of equipment that remain manually priced on the pure HCPC codes. For example, wheelchairs are priced either by cost plus 35% or 80% of the MSRP. Providers are not required to submit their cost invoices. Some providers do submit these invoices and try to provide Medicaid with an appropriate cost request. Currently there is no regulation that states a provider must submit his cost invoice with the prior authorization request.

Another issue within this program is the upcoming DME Bidding Project being instituted by CMS. The Durable Medical Equipment Prosthetic Orthotic Supplies (DMEPOS) bidding project is a new bidding program for certain DME as required by section 302 of the Medicare Modernization Act of
2003. This program will change the way Medicare pays for these items under Part B of the Medicare program by using bids submitted by DMEPOS suppliers to establish payment amounts. The only area that will be affected in the initial implementation is the Kansas City area. Medicare beneficiaries who reside within the project area will be required to utilize a CMS contracted bidder. KHPA will also require Medicare beneficiaries to obtain their equipment and supplies from a contracted bidder (if required by Medicare). Reimbursement for DME equipment and supplies that are included in the bidding project have been announced by Medicare. KHPA will adjust its rates to, at or below the Medicare rate for these items.

In FY 2008, the CMS bidding project was postponed by the United States Congress for 18 months. Work is ongoing to continue improving this project, making changes that synchronize with Medicare, and prepare for the implementation of this program. The initial implementation, or “round one”, may occur in 2009. This is expected to be an ongoing project over several years under the direction of CMS.

A new policy regarding DME supplies in nursing facilities was implemented in FY 2008. CMS recently referred KHPA back to a previous federal regulation (C.F.R. 42-440.70) which states that DME equipment and supplies can only be supplied to beneficiaries in their home. The regulation states that nursing facilities, hospitals, and ICF/MR’s are not classified as a beneficiary’s home. Both the Medicaid state plan and state regulations are being updated for this change. KHPA has been working closely with Kansas Department on Aging (KDOA) and the Kansas Department of Social and Rehabilitation Services (SRS) on this issue. Expenditures related to DME in these have been calculated and are being transferred to KDOA and SRS. These agencies have made per diem rate adjustments to include these additional expenses. All DME equipment and supplies for beneficiaries within these facilities will now be considered part of the per diem rate and will not be billed separately to KHPA. This policy was implemented July 1, 2008, and is expected to reduce overall state Medicaid expenditures on DME, since nursing homes are likely to negotiate better rates on average than are currently paid through Medicaid’s Fee For Service (FFS) price schedule.

**Recommendations**

1. Review the home use Oxygen category within DME.

Oxygen expenditures will decrease due to the DME nursing facility policy that was implemented July 1, 2008. However, even apart from the CMS mandated shift in DME for nursing homes, KHPA is aware of a number of potential overpayments and coverage issues for Oxygen DME.

2. Require providers to show the actual cost of all manually priced DME items.

As stated previously, current Medicaid policy regarding reimbursement for DME items is to pay the established Medicaid rate when one exists, or to manually price the equipment at the lesser of: 1) Medicaid rate 2) cost plus 35% or 3) MSRP minus 15-20%. At this time providers are not required to show their actual cost, nor in every case are they required to provide the MSRP, leaving open the possibility that KHPA may be reimbursing at the greater of the two levels. Cost-plus pricing may not be a sustainable approach for any significant number of products, however it seems a prudent and administratively straightforward interim step.

3. Continue to decrease the over utilization of E1399 (miscellaneous) billing code.
As each category of DME is reviewed, old policies are replaced, rates are being updated, and appropriate HCPC codes are being covered. This allows KHPA to more accurately track use of each item and maintain the quality of the program by reducing or eliminating fraud and abuse.

4. As new DME “pure” codes have been identified by CMS, continue to cover the new codes and remove items from PA.

DME use is regulated through the establishment of limitations and restrictions. The trend is to utilize PA for items that are high cost, high use and have greater tendency for abuse. The PA process is provider driven. All PA requests start with a physician order and a provider request. Criteria for the DME program are also being added to the DME provider manual, to assist providers to be more successful in the PA process. This practice follows Medicare standards.

5. Work collaboratively with other state Medicaid programs on a rebate program for specific DME items.

This program would work directly with manufacturers, increasing purchasing power to reduce overall expenditures.
Chapter 5: Home Health Benefits

Executive Summary

Description

Home health services include skilled nursing care, home health aide service, and other therapeutic skilled services. Home health services are provided at a patient’s place of residence. An average of 145 agencies provide home health services to approximately 5,000 Kansas Medicaid beneficiaries. Due to increased program scrutiny and management since 2004, the number of consumers receiving home health services has declined. Expenditures also have decreased through FY 2007, and preliminary data for FY 2008 indicates further declines in total home health spending.

Analysis of expenditures for FY 2005 to FY 2007, based on the top 10 diagnoses for home health services, indicates that unspecified essential hypertension was the most frequently billed diagnosis with expenditures exceeding $4 million. During FY 2005 to FY 2007 Medicaid paid home health agencies a little over $14 million for diabetic management services. During that same period, expenditures for beneficiaries with diagnoses related to mental health were almost $9 million.

Key Points

- In an effort to improve efficiency many states have established limits on the number of visits a beneficiary may receive in a year. Many states allow only 50 to 100 visits per year, compared to limits of 730 visits per year in Kansas. Prior authorization for home health services is currently only required for individuals receiving services through waivers and beneficiaries requiring multiple visits per day.

- A number of concerns regarding home health services were identified in this year’s comprehensive program review:
  - Provision of multiple skilled nursing visits per day for oral medications administered for beneficiaries with psychiatric conditions that could receive this service through the community mental health centers
  - Extended duration of services with a lack of evidence of attempts to promote beneficiary/family independence
  - Providers billing Medicaid for daily home health aide visits that may include services like housekeeping that are not considered to be home health care for purposes of Medicaid reimbursement

- Given the high-level of routine interaction between providers and patients, there may be significant opportunities to implement core elements of a medical home in the context of home health services.
KHPA Staff Recommendations

- In light of the recent launch by Kansas Department of Health and Environment (KDHE) of a five-year state diabetes plan, the KHPA will consider sponsoring a forum to address home health diabetic services, and consider applying the medical home concept by developing a tool for Medicaid home health providers to address best practices in the care of other chronic disease processes.
- Limit home health aide visits to two per week, with additional visits through prior authorization to demonstrate medical necessity.
- Develop separate acute and long-term home health care benefits with differential rates that reflect the changing intensity of services over time.
- Increase some acute home health reimbursement rates for skilled nursing visits to reflect increasing costs.
- Work with the Department of Social and Rehabilitation Services to improve coordination of services with community mental health centers.

Projected fiscal impact:

<table>
<thead>
<tr>
<th></th>
<th>FY 09</th>
<th>FY 10</th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>5 Year Total</th>
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<td>State General Fund (SGF)</td>
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<td>$-230,000</td>
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<td>$-530,000</td>
<td>$-560,000</td>
<td>$-590,000</td>
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Program Overview

Program Description

Home health agencies provide skilled nursing care, home health aide services and other therapeutic skilled services to beneficiaries in the home following illness or debilitation. Home health services are provided in accordance with Medicare requirements in the Code of Federal Regulations (CFR), 42 CFR 440.70. Services available under a home health plan of care include skilled nursing services in combination with at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services).

Home health services are available on a visiting basis in the patient’s place of residence. A place of residence is defined as where the person regularly makes his or her home, for example, a house or apartment. It does not include nursing facilities, hospitals, or intermediate care facilities for mental retardation (ICF/MRs).

Skilled nursing services must be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Skilled nursing services are those services requiring the substantial and specialized knowledge and skill of a licensed professional nurse. Skilled nursing services require a physician’s order. The home health agency care team communicates with the physician in an effort to coordinate appropriate, adequate, effective and efficient care for the consumer.

Home health aide services must be performed by a home health aide under the supervision of a registered nurse.
A nursing care plan outlining specific duties of the aide is required. These plans are also returned to the physicians for their approval. Home health aide services need not be related to skilled nursing visits. A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care.

Home health services are reimbursed fee-for-service through Kansas Medicaid and are not provided through HealthWave, nor through the home and community based service (HCBS) waivers with the exception of the Technology Assisted (TA) waiver for medically fragile children. HCBS waivers that serve other targeted populations are designed to supplement fee for service options such as home health. Providers are reimbursed a specified payment for home health visits. The payment is based upon the service provided and the amount of time typically required to complete the tasks. Medicaid reimburses home health agencies in 15 minute increments for nursing services. Rehabilitative therapy services are reimbursed per visit.

Definitions

A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under state or local law, or be approved by the state or local licensing agency as meeting the licensing conditions of participation.

A home health visit is an episode of personal contact with the beneficiary by staff of the home health agency or others under arrangements with the home health agency, for the purpose of providing a covered service.

A home telehealth visit is made via interactive audio and video telecommunications systems by a registered nurse or licensed practical nurse. Home telehealth services are delivered as a supplement to enhance home health services, and not as a substitute for face-to-face visits.

Program Management

In an effort to improve the efficiency of their home health programs, many states have established limitations on the number of home health aide visits, skilled nursing visits and rehabilitative therapy visits that a beneficiary may receive per year. The Kaiser Family Foundation compiled a state comparison of limitations to the home health benefit. This reference is available at web site: http://www.kff.org/medicaid/benefits/service.jsp?yr=2&cat=1&nt=on&sv=12&so=0&tg=0.

Many states allow a total of 50 to 100 visits per year for home health services including skilled nursing visits, home health aide visits and therapy visits. The state of Kansas allows a maximum total of at least 730 visits per year for these services without prior authorization. The Kansas Medicaid home health benefit has comparatively few limitations on the provision of home health services. For example, Kansas allows one home health aide visit per day and one skilled nursing visit per day without prior authorization. Currently prior authorization for home health services is only required for individuals on waivers and for those who receive multiple skilled nursing visits per day. The implementation of prior authorization for these two populations has allowed Medicaid to more closely monitor services rendered. There remains a large group of individuals who received home health visits daily without a method in place (other than post pay reviews) to ensure that these visits are necessary and appropriate. The analysis below suggests the need to consider limitations to the home health benefit to monitor those services that do not currently require prior authorization.
Service Utilization and Expenditures

When data for the past seven years was reviewed it was apparent that the total expenditures on home health services and average expenditure per beneficiary both decreased significantly (over 50% in both cases). Table 1 illustrates this information.

Table 1
Trends in Home Health Services

<table>
<thead>
<tr>
<th>FY</th>
<th># Home Health Agencies</th>
<th># Unduplicated Beneficiaries</th>
<th>Total Medicaid Reimbursed</th>
<th>Average Expenditure per Beneficiary</th>
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<tr>
<td>2008</td>
<td>135</td>
<td>4145</td>
<td>$12,085,293</td>
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<td>153</td>
<td>4888</td>
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<td>5364</td>
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<tr>
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<tr>
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<td>147</td>
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<td>2003</td>
<td>164</td>
<td>4750</td>
<td>$16,077,318</td>
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<tr>
<td>2002</td>
<td>179</td>
<td>5227</td>
<td>$28,220,999</td>
<td>$5,399</td>
</tr>
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</table>

Total Home Health Expenditures

As shown in Figure 1, during fiscal years 2005-2007, there was a slight increase in the number of home health agencies enrolled to participate in Medicaid fee-for-service. An average of 145 agencies provided home health services for Medicaid beneficiaries during this time frame.

During that same time period, however, the number of beneficiaries and the total home health expenditures decreased as noted in Figures 2 and 3. The number of unduplicated home health beneficiaries decreased from a high of approximately 6,000 in 2005 to a low of approximately 4,000 in 2008. With respect to total expenditures, the decrease cannot be totally attributed to fewer beneficiaries served by the program.
The number of unduplicated home health beneficiaries decreased from a high of approximately 6,000 in 2005 to a low of approximately 4000 in 2008. However, the corresponding decline in total expenditures cannot be totally attributed to fewer beneficiaries served by the program. The data indicate a slight decline in expenditures per beneficiary per year during the last two fiscal years, as indicated in Figure 4. This reduction coincides with closer reviews of prior authorization requests for home health services which began in 2005. The reduction in expenditures may also be attributed to exploration and utilization of other community resources to meet the needs of high cost beneficiaries. A slight reduction can be attributed to HCBS waiver beneficiaries that self direct their care. For some of the most expensive cases, a few providers were able to obtain assistance from the primary caregivers of self directed beneficiaries, and thereby decrease the frequency of skilled nursing visits provided by home health agencies. For example, the cost of four skilled nursing visits per day is $43,800 per year per beneficiary. If a self directed caregiver is able to provide two of the visits as allowed by K.S.A. 65-6201 for HCBS beneficiaries, this would reduce the fee for service cost to $21,900 per beneficiary per year.
Homebound vs. Non-Homebound Recipients

Figure 5 illustrates the number of home health beneficiaries who were homebound versus those beneficiaries who were not homebound. The number of beneficiaries who were not homebound revealed a sharp increase from fiscal year 2004 through fiscal year 2005. In fiscal years 2006 and 2007 the number of homebound beneficiaries has shown a decline. According to Medicare requirements, homebound status is granted for beneficiaries when leaving home requires taxing effort and the beneficiary is normally unable to leave home unassisted either by a person or an assistive device. Medicare does allow beneficiaries to maintain this status even if they leave home to receive medical care, to attend religious services or attend adult day care. Homebound status is not a requirement for Medicaid home health services, but is required for Medicare covered services.

The decline in the number of homebound Medicaid beneficiaries is reflective of Medicare trends, as the homebound status requirement is not as stringently enforced by Medicare; provided the individual’s condition requires intermittent skilled services. However, analysis of homebound status could prove useful in exploring the possibility of substituting a home health visit with alternative community services, depending on the beneficiaries’ ability to access those services. An example of this would be using Community Mental Health Centers for medication administration and medication management for individuals with mental health diagnoses.
HCBS Compared to Non-HCBS Recipients

Figure 6 compares the number of beneficiaries who received home health services in addition to Home and Community Based Services (HCBS) waiver program services with the number of non-HCBS beneficiaries who receive home health services. As mentioned previously, prior authorization is required for home health services provided to individuals on an HCBS waiver. This requirement promotes effective utilization of home health expenditures, and decreases the potential for duplication of services. Beneficiaries who are not on an HCBS waiver are limited to one skilled nursing visit and one home health aide visit per day without prior authorization. The number of HCBS waiver beneficiaries who receive home health services has remained relatively stable, which demonstrates consistent management or a stable HCBS population and reflects the fact that these individuals’ medical conditions require skilled nursing services in the home to remain in the community. HCBS waiver services and fee for service home health expenditures complement each other to serve the needs of long-term care beneficiaries living independently in the community.

The decline in the number of non-HCBS beneficiaries has been a consistent trend over the last two years. This decline could be attributed to home health program changes that were implemented as a result of the home health special project completed several years ago. The results of that project revealed that 83% of the skilled nursing visits reviewed were not medically necessary for a skilled nurse to provide. The prior authorization process has also been a contributing factor in the decline in the number of home health beneficiaries. The prior authorization criterion was published in the home health manual to provide guidance for home health agencies regarding skilled level of care and program expectations. Attributing the decline in home health service reimbursements since 2002 to a lack of medical necessity is consistent with the intent of the program changes, and appears validated by the lack of consumer complaints and coverage appeals since the program changes (and service declines) occurred.

Recipient Diagnoses

Figure 7 represents the top 10 primary diagnoses for home health beneficiaries (by expenditures) for combined fiscal years 2005 -2007, representing about half of all home health expenditures over this period. Unspecified essential hypertension was the most frequently billed diagnosis, which resulted in an expenditure of more than $4,043,665. During this same reporting period, diabetes related diagnoses ranked 2nd through 6th among the top 10 home health primary diagnoses, with expenditures of more than $11,839,376. The prevalence of diabetes is increasing both on the state level and nationally and appears to be headed for epidemic proportions.
Congestive heart failure ranked 8th in the top 10 most frequently billed primary diagnoses for home health services, and represents an expenditure of more than $1,113,569.

Mental health diagnoses which include unspecified schizophrenia, depressive disorder, and paranoid schizophrenia ranked 7th, 9th and 10th of the top 10 most frequently billed primary home health diagnoses. The expenditure for these three mental health diagnoses was more than $3,140,273 during this reporting period.

Aggregating specific diagnoses into larger groups helps to explain the primary medical needs for the home health population. Figure 8 represents the top five diagnostic groups for home health services, representing about three quarters of spending in this period. The data collection involved review of ICD-9 (International Classification of Diseases, ninth edition) groupings. During fiscal years 2005-2007, Kansas Medicaid paid home health agencies fee for service $14,303,883.00 for diabetic management services. This represents an average per year expenditure of $4,767,791 for diabetic management. The expenditures for 2005-2007 for beneficiaries with diagnoses related to mental health were $8,694,177. This represents an average expenditure of $2,898,059 per year.
Conditions of the circulatory system including hypertension and cardiac related illnesses representing an expenditure of $6,432,929. The diagnostic group of respiratory or airway conditions represent an expenditure of $2,923,314. Number five of the top five home health diagnostic groups represents diagnoses related to skin ulcerations and wounds. The expenditure for beneficiaries with skin/wound care was $2,507,366.

**Figure 8**

<table>
<thead>
<tr>
<th>ICD - 9 Diagnostic Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Mental</td>
</tr>
<tr>
<td>Circulatory</td>
</tr>
<tr>
<td>Air/Lung</td>
</tr>
<tr>
<td>Skin</td>
</tr>
</tbody>
</table>

Diabetes (ICD 250-25093 and Insulin V5867)
Mental Disorders (ICD 290-319)
Hypertension/cardiology (ICD 3911-4599)
Airway/lungs (ICD 4610-5199)
Skin ulcers/wounds (ICD 707-7099  8737-8917)

Figure 9 represents the number of home health beneficiaries with diagnoses of diabetes and diagnoses related to mental health, or with both diagnoses, two of the most frequently billed home health diagnoses. It is quite likely that a beneficiary could be counted in both categories for mental health and diabetes, as there are a number of beneficiaries with mental illness who also have a diagnosis of diabetes. These individuals are often prescribed multiple psychoactive medications to manage their mental illness. Potential adverse reactions or side effects of some of the medications used to treat mental illness include weight gain and an increase in blood glucose levels. Skilled nursing visits may be indicated for these individuals with both diabetes and a mental health diagnosis as they may have a limited ability to manage their diabetes due to their mental illness. Further, multiple skilled nursing visits are more likely to be approved for diabetic management visits compared to visits for administration of oral psychoactive medications. Oral medication administration does not require the skill of a licensed nurse and as a stand alone task does not meet medical necessity for skilled nursing services.
Figure 10 represents expenditures for the most frequently billed home health diabetes diagnoses. In 2005, a total of $4,147,714 was spent for diabetic management in the home health setting. The cost of serving diabetic clients peaked in 2006, with a total expenditure of $4,531,344, although close to 100 fewer beneficiaries were served. An explanation for this finding could be that many providers obtained prior authorization for multiple daily visits for diabetic management instead of billing the daily limitation, which is $45 more per day per beneficiary. This information is of significance, as these individuals often require multiple skilled nursing visits each day for blood glucose monitoring and insulin administration. The expenditures for diabetes management decreased in 2007, as only $4,243,244 was reimbursed for the top diabetes diagnoses. This decline coincides with the initiation of reviews by the Home Health Program Manager of home health prior authorization requests on a weekly basis. Many of the requests are for multiple daily visits for blood glucose monitoring and insulin administration.

The data for mental health diagnoses show that there has been a steady increase in expenditures for management of mental illness in the home health setting during the past three fiscal years. In fiscal year 2007, $1,955,110 was reimbursed for beneficiaries with a primary mental health diagnosis. This amount has increased from $1,367,797 paid in fiscal year 2005. KHPA will continue to monitor trends and expenditures of home health services to assist Medicaid beneficiaries with mental health diagnoses. A straight line projection suggests the cost of serving these individuals will continue to rise. Further, many of these individuals are so chronically mentally ill that the home health benefit is one of the few non-institutional options available to meet their needs. The Pre-paid Ambulatory Health Plan (PAHP) was implemented on July 1, 2007 (the beginning of FY 2008), but it is likely that those individuals served by home health agencies will not seek assistance through the Community Mental Health Centers, as their needs are being met through the home health agencies.
Figure 11 represents the top home health providers by expenditures and shows that most providers maximized home health expenditures in fiscal year 2005, and remained fairly stable or had a slight decline in Medicaid revenue in fiscal year 2006. Home Health Agency B surpassed all other providers of home care services, and continued to experience an increase in Medicaid revenue in 2006. Kansas Medicaid will conduct utilization reviews of home health agencies that are outpacing other home health agencies in the provision of services. In fiscal year 2007, most of the top home health providers by expenditure experienced some decline in Medicaid revenue. The decline in home health expenditures is likely the result of state program manager review of prior authorization requests for beneficiaries who have received home health services for an extended period of time. These requests were once approved every six months without question regarding medical necessity or appropriateness for continuation of services. There has also been close review of prior authorization requests for beneficiaries on HCBS waivers to ensure that services that should be provided through the waiver are not provided through home health fee for service. This further decreases the potential of duplication of services for those health maintenance tasks that are self directed.
Telehealth

Figure 12 represents expenditures for home telehealth services for fiscal years 2005-2008. Telehealth visits are provided via interactive audio and video telecommunications systems by a registered nurse or licensed practical nurse located at the home health agency while the beneficiary remains in his or her home. These visits were previously provided to assist beneficiaries in the home setting to monitor medications, vital signs, and consumer administered injections. Program changes were implemented on November 1, 2007, and telehealth visits are now used only to monitor beneficiaries for significant changes in health status, provide timely assessment of chronic conditions and provide other skilled nursing services. The changes have already resulted in a cost savings.
Figure 13 represents monthly expenditures for home telehealth visits for fiscal year 2008. The figure shows a significant decline in expenditures with the implementation of the program changes. The changes were implemented to ensure that telehealth visits provide a skilled service or provide frequent monitoring of unstable chronic conditions. The home telehealth policy was implemented on November 1, 2007. Figure 13 reveals a decline of telehealth expenditures during the month prior to the policy change. Before November, prior authorization was not a requirement for home telehealth services. In anticipation of program changes the provider re-evaluated telehealth clients to ensure that services rendered met the prior authorization requirement for skilled nursing services. The provider discontinued home telehealth services for several beneficiaries as some of the visits were not medically necessary. Home telehealth expenditures continued to decline as the documentation submitted with prior authorization requests did not support the need for skilled telehealth visits.

Figure 13

![Home Telehealth Expenditures July 2007- June 2008](chart)

Program Evaluation

A number of opportunities for potential savings or more efficient use of home health services have been identified, including:

1. **Address the provision of multiple skilled nursing visits per day for oral medication administration for beneficiaries with a psychiatric illness as the primary diagnosis.** Often the physician orders specify that medications should be stored in a locked box and administered by the home health agency. Many of these beneficiaries are not homebound and could be served by Community Mental Health Centers, rather than home health skilled nurses. The home health program manager met with the KHPA Mental Health Liaison and SRS mental health managers to discuss this specified population of beneficiaries and how they may be served through the PAHP and Community Mental Health Centers. During FY 2009 KHPA and SRS will conduct extensive reviews of beneficiary data, including diagnoses, geographic location, and involve other agencies and organizations as appropriate to most effectively and efficiently meet the needs of these beneficiaries.
beneficiaries in the community setting without a duplication of services.

2. **Address the provision of intensive home health services for an excessive duration, with lack of evidence of attempts to promote beneficiary/family independence.** In many cases, home health services should be of limited duration and intensity, and should empower and educate beneficiaries and caregivers to be more active participants in their care. Many states limit the intensity of home health services by regulating the total number of visits in a year. Medicare utilizes a PPS (prospective payment system) reimbursement methodology to provide incentives for the provision of only necessary services. Under the prospective payment, Medicare pays home health agencies (HHAs) a predetermined base payment. The payment is adjusted for the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages for HHAs across the country. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS provides HHAs with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin; there are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. Each episode is adjusted to reflect the beneficiary’s health condition and needs - which acts as a kind of pre-authorization or screening criteria for continuing benefits each 60 days. A special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs.

The home health PPS is composed of six main features:

- Payment for the 60-day episode
- Case-mix adjustment - Adjusting payment for a beneficiary’s condition and needs
- Outlier payments - Paying more for the care of the costliest beneficiaries
- Adjusting for beneficiaries who require only a few visits during the 60-day episode
- Adjusting for beneficiaries who experience a significant change in their condition
- Adjustment for the beneficiaries who change HHAs

For details, go to web site [http://www.cms.hhs.gov/HomeHealthPPS/](http://www.cms.hhs.gov/HomeHealthPPS/).

KHAP will continue to review the effectiveness of the Medicare pre-payment and periodic review methodology, but recommends interim steps below to address the concerns raised regarding provision of indefinite and intensive home health services.

3. **Address the provision of services through home health agencies that are considered content of service for HCBS waiver recipients, including health maintenance tasks such as blood glucose monitoring, insulin administration, administration tube feedings, and simple dressing changes.** The program manager will continue to monitor home health prior authorizations for HCBS beneficiaries to ensure that services are appropriate and that beneficiaries’ needs are met through the appropriate provider and without duplication. There are instances in which an HCBS waiver beneficiary’s condition would require intermittent skilled nursing visits. HCBS beneficiaries are entitled to Medicaid state plan services that are not duplicative of services offered through the waiver. Further, special allowances have been made through the waiver programs that allow self directed personal care attendants to perform health maintenance tasks that may be considered outside of the scope of practice for home health aides or agency directed personal care attendants. The program manager has on-going contact with SRS HCBS program managers as needed regarding home health prior authorization requests for waiver beneficiaries. Beneficiary choice regarding self direction of care is respected, but exploration of other resources available to assist with health maintenance activities is considered on a
4. **Provision of multiple visits per day for the sole purpose of blood glucose monitoring and insulin administration.** Diabetic management and insulin administration are tasks that many diabetic clients are able to safely perform themselves with proper training and diabetic education. In keeping with KHPA’s vision principles of promoting health and wellness, education and engagement, identification of methods to encourage appropriate self-management of diabetic conditions will continue to be a priority.

5. **On-going review of the home health plans of care and assessments required for prior authorizations suggest opportunities for diabetic management services to more comprehensively address beneficiaries’ needs and associated co-morbidities.** Currently Medicaid does not reimburse for DSMT (Diabetic Self Management Training). Instead, Medicaid approves 15 minute visits for diabetic management, which includes blood glucose monitoring and insulin administration. Emphasis could be placed on training and education to facilitate beneficiary and caregiver empowerment, participation and independence.

6. **Provision of excessive home health aide services for beneficiaries that are not on an HCBS waiver.** The current limitation allows a one hour home health aide visit per day without prior authorization. Home health aide tasks include but are not limited to the following: personal hygiene, linen change, maintenance exercises, medication assistance, vital signs, bowel/bladder procedures, and non-sterile stressing changes. On-going review of records has revealed that some providers are billing Medicaid for daily home health aide visits for the provision of home maker services which include housekeeping and meal preparation. These are not home health aide tasks and are consistent with homemaker and chore services which fall under HCBS waivers.

**Recent Changes**

The following changes have been implemented recently in the home health program to address identified concerns regarding skilled nursing visits for HCBS waiver recipients, home telehealth services, and home health plans of care. Close monitoring of home health services and the prior authorization process has resulted in significant decreases in overall home health expenditures over the past five years.

1. In October 2007 the state program manager and prior authorization nurses began requesting additional information upon receipt of prior authorization requests for HCBS beneficiaries. This process provided the opportunity for home health agencies to identify beneficiary supports and explore ways by which to decrease beneficiary dependence on home health services. The prior authorization request form was modified in January 2008 to include information regarding HCBS waiver services and the beneficiary’s choice of self directed or agency directed personal care attendant services. This change resulted in home health agencies having a greater awareness of other more appropriate resources available to recipients of home health services. Self direction of care permits the beneficiary or caregiver to make important decisions regarding his or her care and delivery of services. Self directed HCBS beneficiaries are able to choose who they would like to provide their attendant care service which has the potential to increase continuity of care. The option of self direction of HCBS services is also a potential area of cost savings, as the self directed caregivers are able to provide an expanded range of services that agency directed caregivers cannot provide. K.S.A 65-6201 permits self directed caregivers to perform health maintenance activities that the beneficiaries could safely perform for them-
Chapter 5 — Home Health Benefits

selves if not for their disability. Utilization of self directed caregivers according to K.S.A 65-6201 has the potential to decrease the need for skilled nursing visits to perform these tasks.

2. A telehealth policy was implemented in November 2007 that requires prior authorization of home telehealth visits for HCBS beneficiaries, and for non-HCBS beneficiaries who receive more than two telehealth visits per week. The policy included the assignment of a new provider type and specialty for home telehealth providers and the use of procedure codes that are specific to nursing services. The reimbursement for this service was decreased to the equivalent reimbursement of a 15 minute in home skilled nursing visit. Plans of care are reviewed by the program manager and only those that require a skilled level of care or warrant more frequent monitoring of an unstable chronic condition are approved. This change has resulted in a significant reduction of expenditures for home telehealth services as noted by Figure 12 and Figure 13. Home telehealth visits are no longer approved for non-skilled services. Review of home telehealth data pre- and post- policy implementation revealed that there has not been an increase in hospitalizations or reports of adverse outcomes for this population. With the implementation of the telehealth policy in November 2007, prior authorizations were requested for 18 beneficiaries. Only two of these beneficiaries required hospitalizations during the period of January to November 2007. Only 1 beneficiary of the 18 has had a hospitalization since the implementation of the telehealth changes in November of 2007.

3. In May 2007 the state program manager and prior authorization nurses began more closely monitoring prior authorization requests for services of an excessive duration that had minimal to no changes in the associated plans of care or level of service. The prior authorization nurses requested additional information regarding beneficiary need, health status and resources available to promote beneficiary and caregiver independence. This change provided opportunities for home health agencies to evaluate the plans of care to ensure that home health services are appropriate, adequate, effective and efficient. Program management has identified and prevented unnecessary and inappropriate utilization of home health services, and has contributed to a decline in the overall use and expenditures in fiscal year 2008.

Conclusions

More careful review of home health prior authorization requests for both HCBS and non-HCBS beneficiaries has resulted in a decrease in overall expenditures for fiscal years 2007 and 2008. While we do not anticipate that this trend will continue indefinitely, we may see continued decreases in expenditures with the increased examination of prior authorization requests. The combination of proposed changes described below is expected to result in modest additional savings in home health expenditures. Realigning benefits to more appropriately align greater payments for more intensive, short-term benefits, and providing incentives and support for beneficiaries to transition to self-care is expected to offset the recommended rate increases intended to maintain access for beneficiaries.

Recommendations

1. The expenditures for home health beneficiaries with a diagnosis of diabetes represent a large portion of the home health budget. This issue will be addressed through a diabetic management forum. A home health provider survey was developed to establish a consistent and comprehensive method of determining the needs of beneficiaries with diabetes. The survey was
shared with board members of the Kansas Home Care Association. The data obtained through the survey results will be analyzed and then used to develop a comprehensive diabetic management program to educate and encourage beneficiary and caregiver participation in self care. The preliminary goals for the diabetic management forum are to:

a. Develop a tool to assess the beneficiary’s knowledge of their disease and provide education and training to increase knowledge and independence.

b. Assess what is currently the best practices in the care of beneficiaries with diabetes in the home health setting, and provide a comprehensive assessment of the beneficiary’s strengths and needs.

c. Address quality indicators to be completed by physicians who refer diabetic beneficiaries to home health for diabetic management services. This tool will require evaluation of the beneficiary’s Hemoglobin A1C, LDL (low density lipoprotein), blood pressure and associated co-morbidities.

2. Implement mechanisms limiting overuse of home health services and distinguishing between intense acute and long-term maintenance and support needs of home health consumers. Proposals include:

a. **Implement prior authorization for all home health services.** Currently only HCBS and other selected services are reviewed in advance to ensure medical necessity. In conjunction with the creation of separate acute and long-term home health benefits, KHPA plans to implement universal prior authorization for home health benefits. Prior authorization will be required for all waiver and non-waiver beneficiaries needing acute care home health services and criteria will be developed to determine if skilled nursing visits are truly for an acute condition. Prior authorization will also be required for long-term care home health services in accordance with criteria that identify the service as health maintenance and provide evidence that other resources have been explored and exhausted.

b. **Limit acute care home health services to 120 visits.** Should beneficiaries require home health services beyond 120 visits, they will receive services through a long-term care benefit. Consultation with other state Medicaid agencies revealed a variety of mechanisms to distinguish between acute and long term home health benefits. Colorado utilizes revenue codes to reimburse home health services and multiple daily visits are paid descending rates. Several states utilize disease management or chronic care management programs. Iowa Medicaid coverage of home health is similar to Kansas Medicaid coverage, but Iowa is also exploring avenues by which to more efficiently meet the needs of diabetic beneficiaries.

c. **Place a limit on acute care home health aide visits.** Currently Medicaid beneficiaries may receive up to 365 home health aide visits and 365 skilled nursing visits per year without prior authorization for those individuals not on an HCBS waiver. Beneficiaries will be allowed only two home health aide visits per week without express prior authorization. Home Health aide visits are for the purpose of assisting with activities of daily living such as bathing, toileting and grooming. It does not include homemaker tasks such as house keeping and meal preparation. Implementation of this program change could result in a cost savings, as services will require prior authorization which will address medical necessity, frequency of visits and duration of home health episodes of care.

d. **Reimburse acute home health benefits at a higher rate than the long-term care home health benefit.** Providers will bill acute care services utilizing the G codes and T codes currently used for skilled nursing visits. The long-term care benefit will re-
imburse at a lower rate and providers will utilize a code to be designated for the long-term care home health benefit. The long-term care benefit would address the needs of beneficiaries with chronic diagnoses that require more frequent monitoring or skilled nursing assistance for health maintenance activities that the beneficiaries and care givers cannot perform themselves. This will allow the beneficiaries to receive supportive services to remain in their homes instead of placement in an institution.

e. **Work with stakeholders.** KHPA will work with stakeholders and our sister agencies to establish needed criteria for the long-term care home health benefit and to review the proposed transition to an acute care and long-term care (health maintenance) home health Medicaid benefit.

3. Develop comprehensive tools to address the best practices in the care of other chronic disease processes. These tools will address education and training that will facilitate increased beneficiary participation in self monitoring and self care. The goal is to empower beneficiaries to obtain a knowledge base that facilitates management of their chronic illness and knowledge of changes that warrant notification of their health care provider. The home health provider will become an extension of the primary care medical home. The home health skilled nursing visit is a perfect opportunity to address the on-going education and training needs of home health beneficiaries, as the providers are frequently in the homes. Since the medical provider may not be able to visit the beneficiaries in their homes, the home health visit becomes an opportunity to reinforce and evaluate training efforts that may be prescribed by the provider. Other disease processes for which comprehensive tools will be established include but are not limited to congestive heart failure, chronic obstructive pulmonary disease, and asthma.

4. The Medical Home Model emphasizes coordination of care throughout the health care continuum. KHPA is convening a group of stakeholders to define medical home in state statute. This definition will be incorporated into the management and administration of Medicaid. Home health providers will be an integral part of the patient centered medical home. Home health providers will serve as an extension of the medical home that seeks to keep the beneficiary at the most cost effective level of care by assessing the beneficiary in their home, educating them on their medical disease and maintaining close contact with the primary care provider. This will be especially important as we develop the medical home model for our beneficiaries with chronic diseases.

5. Expenditures for home health beneficiaries with a mental health diagnosis represent a significant proportion of the home health budget. Improved coordination of services through the Community Mental Health Centers has the potential to benefit home health recipients, facilitating contact with outside resources, decreasing dependency on home health services, and promoting participation in groups and therapeutic activities, and increasing the beneficiaries’ quality of life in many ways. KHPA will work with SRS to identify ways to better coordinate services for these beneficiaries. Reports have been generated to identify beneficiaries who receive home health services that have a SPMI (Severe and Persistent Mental Illness). The data will be analyzed to explore how PAHP (Prepaid Ambulatory Health Plan) services might be utilized to serve these beneficiaries. These beneficiaries could also be served through an ECM (Enhanced Care Management) assignment where available. If these efforts are successful, the beneficiaries will have assistance not only to manage their mental health diagnosis, but will have somewhat of a medical home to address other needs and concerns.
6. There has not been a rate increase in Medicaid reimbursement for home health services since program changes were implemented in 2002. Providers have expressed that low Medicaid reimbursement has made it difficult to stay in business. Some have expressed that they cannot afford to continue serving Medicaid beneficiaries. Increasing gasoline prices are putting additional cost pressure on home health providers. In conjunction with the cost-control measures described above, including the added distinction of acute and long-term home health benefits, KHPA proposes to increase Medicaid reimbursement for the first 15-minute code of the acute home health visit (G0154) from $30 to $35.
Chapter 6: Hospice Services

Executive Summary

Description

Hospice services provide an integrated program of palliative non-curative home and hospital care for those who are terminally ill. Hospice consists of a set of enhanced services available on a fee for service basis to terminally ill patients who elect to receive these services in exchange for limitations on curative care. These services include a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. Hospice services provide personal and supportive medical care for terminally ill individuals and supportive care to the families through medical social workers, chaplain services, nutritionists and other needed service providers. Central to hospice philosophy is self-determination by the patient in choice of medical treatment and manner of death.

To be eligible for hospice services, a Medicaid beneficiary must be certified as terminally ill by the medical director or physician member of hospice as well as by the patient’s attending physician. The beneficiary also must have filed an “election statement” that is completed by the attending physician and signed by the beneficiary indicating that his or her condition is terminal and that life expectancy is six months or less. Hospice services can be provided in a hospital setting, in a nursing home, skilled nursing facility, or the patient’s home.

There are 68 hospice providers serving Kansas Medicaid beneficiaries. In 2007, they provided care to 3,172 Medicaid beneficiaries, resulting in 12,070 paid claims which totaled approximately $25.8 million. The largest provider accounted for $8 million of the $25.8 million of expenditures for 2007.

Key Points

- From FY 2003 to FY 2007, hospice was the fastest growing service in Medicaid, as measured by annual percentage growth through FY 2007. Although program growth slowed in FY 2008, long run growth appears unsustainable and earlier program trends reveal areas that warrant further study:
  - Hospice services volume increases from 2003 to 2006 in terms of providers, consumers, claims and expenditures.
  - In 2007, the number of consumers receiving services decreased while the number of claims and expenditures continued to rise.
  - From FY 2003 to FY 2007, expenditures grew a total of 139%.
The largest expenditure category and most frequently diagnosed condition for hospice services was “unspecified general debility.”

- One source of increased expenditure was an increase in the average time that patients spent in hospice care, or “lengths of stay” (LOS). Between 2005 and 2007, the percentage of stays that were below 30 days declined while the total number of stays above 30 days increased significantly. Other potential sources of growth included pharmaceutical expenditures in the hospice setting (which are billed through the hospice, not separately through the state’s prescription drug program).

- Increased scrutiny of hospice claims and requests for Prior Authorization may have helped slow growth in FY2008.

- Based on historical trends prior to 2008, trends for hospice costs and length of stay were continuing to increase. The KHPA will continue to evaluate whether the slowed growth that occurred in 2008 continues in 2009 and beyond.

Kansas Health Policy Authority (KHPA) Staff Recommendations

- KHPA staff will work to further analyze hospice expenditures and will confer with KHPA’s hospice task force to further evaluate the program, identify sources of growth, and opportunities to improve cost-effective care.

- An initial list of policy options includes:
  - Enhance scrutiny of retroactive authorizations for hospice services to ensure appropriate eligibility and medical necessity;
  - Review of services that are provided through Home and Community-Based Services (HCBS) and hospice care concurrently;
  - Increased scrutiny of pharmaceutical coverage and spending; and
  - Potential reviews for extended patient stays.

Hospice program savings related to proposed policy changes:

<table>
<thead>
<tr>
<th>State General Fund (SGF)</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>5 Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2009</td>
<td>$0</td>
<td>$-700,000</td>
<td>$-790,000</td>
<td>$-830,000</td>
<td>$-880,000</td>
<td>$-3,250,000</td>
</tr>
</tbody>
</table>

Program Overview

Definition

A hospice is a public agency or private organization (or a subdivision of either) that is primarily engaged in providing care to terminally ill individuals. Hospice care must meet the “Medicare conditions of participation” and the Kansas Medicaid Hospice Provider Manual outlines the details for how hospice services are provided. Hospice services are available to Kansas Medicaid beneficiaries who:
• Have been certified terminally ill by the medical director of the hospice or the physician member of the hospice interdisciplinary team; and
• Have been certified terminally ill by the consumer’s attending physician; and
• Have filed an “election statement” with a hospice which meets Medicare Conditions of Participation for Hospices. The election statement is completed by the attending physician and signed by the beneficiary indicating that his or her condition is terminal and that the life expectancy is six months or less. The notice is then submitted to KHPA’s fiscal agent, who then switches their Medicaid payment status to hospice.

Kansas Medicaid provides hospice services to terminally ill beneficiaries as an optional service under federal Medicaid rules. Hospice services provide an integrated program of appropriate home and hospital care for the terminally ill patient and are provided in accordance with 42 CFR 418. This set of Federal Regulations was originally promulgated in 1983 and has only recently been updated. Those updates will go into effect December 2008, and are not integrated fully into this report. Several major changes in the newly approved CFR include mandatory hospice participation in Quality Performance; mandatory provider qualifications required in order to provide certain services and defined time and content requirement for all hospice patients, weekly updates, monthly updates and continued stay reviews.

Hospice is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. Hospice services provide personal and supportive medical care for terminally ill individuals and supportive care to the families. Emphasis is on home care with inpatient beds being available for acute pain control or symptom management for the Home Care Program. Central to hospice philosophy is self-determination by the patient in choice of medical treatment and manner of death.

Hospice offers beneficiaries and their families’ supportive care during the dying process and offers the family bereavement services for up to one year after the patient dies. The provision of hospice services is expected to result in lower expenditures for curative treatments, including curative drugs, acute care hospitalizations and, emergency room usage.

**Coordination with Other Services**

Because of the extended set of services provided, when a beneficiary elects hospice care, many other Medicaid benefits are waived. The waived benefits are those Medicaid services that are considered preventive, curative, or restorative. Hospice, in contrast, provides comfort care, palliation of symptoms, and support during the dying process.

Hospice services can be offered in a number of different settings and in collaboration with other services. During the time that a beneficiary is in hospice care, a prior authorization is required for all other Medicaid services in order to ensure that Medicaid reimburses for medically appropriate, non-duplicated services. Hospice may be delivered in a hospital setting if the hospitalization is required for acute pain or symptom management. Hospice may also be provided in a Nursing Home, Skilled Nursing Facility or in the patient’s residence. Hospice and the HCBS Waiver Services may co-exist, but hospice is the coordinator of all benefits, as well as the individually designed treatment and program plan for the patient. Contracted services may be provided to the patient, such as Home Health Care and Durable Medical Equipment. Additionally, many clients have Medi-
care benefits available for hospice services. Medicare is the primary payer in these situations; however Medicare does not cover room and board in a Nursing Facility.

Review of Program Expenditures

From 2004 to 2007, the number of Kansas hospice providers grew from 55 to 95, and then dipped in 2008 to 76 providers. However, the number of hospice providers accepting Medicaid over this time period grew slightly from 52 to 71. The number of beneficiaries using hospice grew substantially, from 1,707 in 2003 to 3,423 in 2008, a 49.8% increase. This growth trend is continuing to increase, even with a slight decrease in the number of Medicaid hospice paid claims in FY 2008.

Table 1
Hospice Services Summary

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Hospice Providers</th>
<th>Number of Hospices Participating in KS Medicaid</th>
<th>Rate of Participation in Kansas Medicaid</th>
<th>Number of Consumers Receiving Hospice Services</th>
<th>Number of Claims Paid</th>
<th>Amount of Claims Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>76</td>
<td>71</td>
<td>93.42%</td>
<td>3,423</td>
<td>11,140</td>
<td>$25,162,876</td>
</tr>
<tr>
<td>2007</td>
<td>95</td>
<td>68</td>
<td>91.6%</td>
<td>3,172</td>
<td>12,070</td>
<td>$25,784,602</td>
</tr>
<tr>
<td>2006</td>
<td>88</td>
<td>63</td>
<td>91.6%</td>
<td>3,297</td>
<td>10,969</td>
<td>$21,197,357</td>
</tr>
<tr>
<td>2005</td>
<td>86</td>
<td>63</td>
<td>93.3%</td>
<td>2,901</td>
<td>11,101</td>
<td>$20,227,869</td>
</tr>
<tr>
<td>2004</td>
<td>83</td>
<td>59</td>
<td>91.1%</td>
<td>1,997</td>
<td>6,785</td>
<td>$12,511,597</td>
</tr>
<tr>
<td>2003</td>
<td>55</td>
<td>52</td>
<td>94.5%</td>
<td>1,707</td>
<td>5,859</td>
<td>$10,798,171</td>
</tr>
</tbody>
</table>

The number of claims paid from FY 2003 to FY 2007 grew from 5,859 claims to 12,070 claims, indicating an overall growth of 106%. In one year alone, from FY 2004 to FY 2005, there was a 64% increase in claims paid. Expenditures also grew from FY 2003 to FY 2007, but at a faster rate. There was a total increase of 139% in expenditures with the fastest growth between years FY 2004 and FY 2005, at 62% growth.

Although the overall trends from FY 2003 to FY 2007 represented the fastest growth of any specific service in Medicaid, expenditures in FY 2008 were $25,162,876, 2.4% lower than FY 2007. Long-term growth in hospice expenditures, even including FY2008, still greatly exceeds growth in the Medicaid program since 2003. During the years of 2004 through 2008, the Kansas Medicaid Program experienced 9.2% overall growth. During this same time period, Hospice Services experienced an 18.4% overall growth. KHPA staff have not yet fully analyzed data from FY 2008 to explain the reduced rate of growth. Staff did initiate greater scrutiny over hospice claims beginning late in FY2007. The slight reduction in spending in FY 2008 provides at least a temporary pause in an historic era of growth in hospice expenditures. KHPA staff will continue to investigate the causes of growth over the FY 2003-2008 period as discussed in the conclusion to this review. The historic growth rate in hospice suggests the need for a review of program design and coverage to ensure medically necessary, cost-effective care.
Understanding Hospice Expenditures

Hospice services are paid using a fee for service methodology. Services that are related to the terminal diagnosis/illness are paid directly to the hospice. Expenditures that are NOT related to the terminal illness are paid directly to the non-hospice providers.

Services related to the terminal diagnosis and required ancillary services are paid through specific codes. Each code pays for a bundle of services and includes routine home care, continuous care, respite care, etc. Because each ancillary service that is related to the terminal diagnosis is not billed directly to Medicaid, specific services cannot be tracked and Medicaid does not have a record of the specific hospice service provided. For example, pharmacy services that are “related to terminal diagnosis” are part of the hospice payment code and thus not identified in the MMIS, making it impossible to fully review the medication management of a patient in hospice. Other examples of services related to the terminal diagnosis and included in the hospice payment code are durable medical equipment (DME), laboratory charges, and other services prescribed in the plan of care for the hospice beneficiary.

Generally, services unrelated to the terminal diagnosis are paid by Medicaid if they are covered services and meet program guidelines. These unrelated services are paid on a fee-for-service basis through the Medicaid Management Information System (MMIS).

Most frequent diagnoses

The physician who refers a beneficiary for a Hospice Program must certify that the individual has a prognosis of six months or less to live (assuming that the admitting disease runs its normal course or the beneficiary’s health continues to decline). The admitting physician must continue to certify the patient has a terminal condition if the beneficiary stays longer than one certification period (each certification period is defined by Medicare). There is no restriction on admission diagnoses for the hospice program; many beneficiaries have chronic diseases with long term general regression, rather than abrupt terminal illnesses. Figure 1 shows the diagnoses by expenditure and fiscal year across FY 2005, 2006 and 2007 while Figure 2 shows the top 10 diagnoses by frequency, rather than expenditures.
Figure 1

Top 10 Hospice Diagnoses by Expenditure by SFY

**Legend for Figure 1:**

<table>
<thead>
<tr>
<th>ICD-9 code</th>
<th>Description</th>
<th>Year Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>162.9</td>
<td>Lung Cancer</td>
<td>428</td>
</tr>
<tr>
<td>290</td>
<td>Senile Dementia</td>
<td>436</td>
</tr>
<tr>
<td>294.1</td>
<td>Dementia</td>
<td>496</td>
</tr>
<tr>
<td>294.8</td>
<td>Persistent Mental Disorders</td>
<td>783.7</td>
</tr>
<tr>
<td>331</td>
<td>Alzheimer’s</td>
<td>799.3</td>
</tr>
<tr>
<td>331.2</td>
<td>Senile Degeneration of the Brain</td>
<td>799.3</td>
</tr>
</tbody>
</table>

* ICD-9 code 294.1 includes just two years of data. The diagnosis, Dementia in Conditions Classified Elsewhere, was available in 2006 and 2007, but did not appear in 2005. However, diagnosis code 331.2, Senile Degeneration of the Brain, was only provided in year 2005. They are similar diagnoses so it may be that the 2005 diagnosis was replaced in the medical community with the Dementia in Conditions Classified Elsewhere diagnosis.

** Descriptions for ICD-9 diseases have been simplified.

In Figure 1, the most expensive conditions in this population for this timeframe were: Debility, Congestive Heart Failure, Chronic Airway Obstruction (such as emphysema), and Alzheimer’s. The expenditures described here do not include medications.

The most frequent diagnosis (Figure 2) and the largest expenditure per diagnosis is Unspecified Debility. Patients with this diagnosis have a slowly worsening condition and the program data suggests that they frequently remain in the program for a year or more.
**Medications in Hospice**

According to program guidelines, medications related to the terminal illness or are comfort related medications are a hospice’s responsibility to provide. Further, if a beneficiary is receiving hospice services in a Nursing Facility, there are also certain medications that the per diem cost is expected to cover, such as Milk of Magnesia, Tylenol, Aspirin etc. These medications are tracked separately by the Nursing Facility and are not included in this analysis.

**Legend for Figure 2:**

<table>
<thead>
<tr>
<th>ICD-9 code</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>162.9</td>
<td>Lung Cancer</td>
<td>428</td>
</tr>
<tr>
<td>290</td>
<td>Senile Dementia</td>
<td>436</td>
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<td>294.1</td>
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</tr>
<tr>
<td>294.8</td>
<td>Persistent Mental Disorders</td>
<td>783.7</td>
</tr>
<tr>
<td>331</td>
<td>Alzheimer’s</td>
<td>799.3</td>
</tr>
<tr>
<td>799.3</td>
<td>Debility</td>
<td></td>
</tr>
</tbody>
</table>

**Descriptions for ICD-9 diseases have been simplified.**
Figure 3 indicates the most frequently prescribed medications for hospice beneficiaries during Fiscal Year 2007.

<table>
<thead>
<tr>
<th>Use</th>
<th>Class</th>
<th>Use</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactulose Enulose</td>
<td>Encephalopathy</td>
<td>Risperidal</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Hepatic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valproic Acid</td>
<td>Bipolar Disorder, Epilepsy</td>
<td>Furosemide</td>
<td>Treatment of Chronic Heart Failure (CHF)</td>
</tr>
<tr>
<td>Metroprol Tartrazine</td>
<td>Treatment of Hypertension</td>
<td>Duoneb</td>
<td>Treatment of Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>Fluphenazine HC</td>
<td>Treatment of Schizophrenia</td>
<td>Hydrocodone</td>
<td>Narcotic analgesic</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Treatment of Epilepsy</td>
<td>Ipratropium Bromide</td>
<td>Treatment of COPD</td>
</tr>
</tbody>
</table>

Because ancillary services are included in the hospice payment and not identified and paid for separately, it is not possible to link the use of medication to the terminal diagnosis. Hospice pays for medications related to the terminal illness and comfort of the dying patient, including pain medication, or anti-anxiety medication. With increased numbers of patients with chronic health problems and multiple morbidities, Kansas Medicaid is paying for more medications not related to the terminal diagnosis (through the MMIS). However, the analysis here does not link medications used to treat the terminal diagnosis at the individual level (seen in Figure 1) to the MMIS system. With enhanced data analytic capacity, KHPSA will plan to examine the overall experience of hospice recipients at the individual level, including length of stay and expenditures.

The Fiscal Agent, EDS, reviews every submitted list of requested medications and has strict guidelines for approval. They follow the Preferred Drug List (PDL) guidelines, Medicare D guidelines and Hospice Program guidelines. However, Kansas Medicaid through the MMIS system appears to be reimbursing pharmacies for narcotic analgesics when pain control is clearly a responsibility of hospice. The most likely cause for this remains the issue of retroactive eligibility (to be described later), but this is an area for further review in the coming year.

Figure 4
The prescription drug expenditures reviewed here do not include medications related to the terminal diagnosis, but rather for co-morbid conditions (non-terminal diagnosis related) that are paid for through the MMIS system. Of note, five of the top 10 medications by expenditure are psychiatric medications. The most costly drugs may not necessarily be medications related to chronic conditions and they may not match in order of frequency compared to the diagnoses.

An examination of payment for some pharmaceuticals for hospice patients has revealed some concerns. Medicaid coverage can have a retroactive date of eligibility. Once eligibility for hospice is determined to be retroactive, pharmaceutical claims from earlier dates of service have been paid through MMIS. This allows drugs to be reimbursed that Medicaid would not normally pay for during a hospice stay, such as medications that are curative in nature.

To partially address this concern, a policy was implemented in January 2006 that established a timeframe for hospice providers to submit the original election for hospice services and the initial drug requests. Requests not entered into the MMIS customer website within 10 days undergo increased scrutiny to determine an appropriate effective date for hospice services to begin, since the submission was not within the allowed timeframe. Missouri has a similar policy but it only allows five days for the hospice to provide this information. While Kansas Medicaid’s policy potentially limits the number of unauthorized hospice claims, it also potentially limits unauthorized drug requests (i.e., prescription drugs that are curative in nature).

At this time, a policy clarification is being pursued that will also limit the time allowed for retroactive eligibility notifications to be made, which will impact duration and medical necessity.

**Beneficiary Length of Stay**

Results displayed in Figure 5 indicate that the majority of beneficiaries were in the hospice program for less than 90 days. However, the number of longer stays in hospice, those exceeding 30 days in length, has increased each year. The growth in length of stay (LOS) is greatest (proportionally) among those with the longest stays, e.g., those exceeding 300 days. This growth in extended stays may help explain the overall growth in costs (see Table 1).
Chapter 6 — Hospice Services

Figure 5

Length of Stay for Hospice Recipients by FY by Range of Days

Medicare certification periods are at admission, 60 days after admission and then at repeating 90 day intervals.

Figure 6

Hospice Skilled Nursing Length of Stay by FY by Range of Days

Medicare certification periods are at admission, 60 days after admission and then at repeating 90 day intervals.
Figure 7 summarizes the comparison between length of stay at skilled nursing (SN) facilities and hospice facilities, suggesting overall growth in average length of stay in both. However, most hospice services are provided in a skilled nursing setting, which helps to explain overall programmatic trends.

**Hospice Services Provided in Skilled Nursing Facilities**

Figure 8 displays the number of Medicaid beneficiaries living in a Skilled Nursing Facility (SNF) who are receiving hospice. Hospice may be provided to SNF residents in two ways. A beneficiary may move to a SNF after receiving a terminal diagnosis or a beneficiary who is already in residence at a SNF may receive a terminal diagnosis and elect to remain there while receiving hospice. The percentage of hospice beneficiaries served in a SNF remained steady at about 72% during this three year period. The number of SNF hospice beneficiaries dropped slightly in 2007, yet based on data shown in Figure 6, the length of stay continued to rise. Consistent with this rise in length of stay, total expenditures also rose sharply in FY 2007. Figure 9 displays expenditures for hospice beneficiaries living in SNF for the past three fiscal years. The growth is steady, helping to explain a rise in the proportion of hospice expenditures attributable to beneficiaries residing in a skilled nursing facility (to more than 80% in FY 2007).
Hospice Expenditures by Provider

In 2007, there were 68 Medicaid participating Hospice Providers in Kansas. Of these 68 providers, the top 10 by reimbursement are displayed in Figure 10.
In reviewing Figure 10, Hospice Care of Kansas is the largest hospice with $8 million in reimbursement in FY 2007. The next largest provider received $2.5 million in reimbursement. Hospice Care of Kansas has 13 locations across the state whereas Harry Hynes Memorial Hospice has five locations in one city.

Figure 11 identifies expenditures for procedure code “Routine Home Care” (T2042) which includes routine nursing care, social services, DME, supplies, drugs, home health personnel, personal care attendants, physical therapy, occupational therapy and speech language PT, included in the treatment plan and prior authorized.
Figure 12 identifies the procedure code “Continuous Home Care” (T2043) which is a level of care provided under extreme circumstances only, due to the level of staffing and cost that this level represents. This is provided during periods of acute medical crisis, when 24-hr/day nursing care is provided in the home.

Figure 13 indicates a level referred to as “Respite Care” (T2044). The top three hospice providers are not among the top providers of this hospice code. This is predominantly used in rural areas and is defined as, “Respite care in a licensed nursing facility or an acute care hospital which has contracted with the hospice.” The reimbursement from Kansas Medicaid is in the thousands rather than millions for this measure.
Figure 14 demonstrates the General Inpatient Care Hospital Level (T2045), in which a patient may be hospitalized for palliative care in periods of acute medical crisis. The reimbursement is less than other services associated with hospice. Patients can also be admitted for reasons not related to their terminal illness, for example if they fall and suffer from a broken leg. Those lengths of stay are not measured here.

Figure 15 shows the final procedure code for Hospice care (T2046), which is room and board, nursing facility. Hospice bills Medicaid for room and board, Kansas Medicaid reimburses the Hospice 95% of the room and board rate as determined by the Kansas Department on Aging. This 95% reimbursement is based on federal law. The Hospice then pays the Nursing facility at a rate they have contracted for. This analysis reinforces the leading role skilled nursing facilities play in providing hospice services.
Hospice Task Force

In 2007 a Hospice Task Force was convened by KHPA that includes representatives from pharmacies, Nursing Facilities, Hospices, EDS and representatives from the Department on Aging. This Task Force has provided numerous comments, suggestions and recommendations to KHPA and to other State of Kansas programs. For example, the Task Force heard concerns from nursing facilities in Kansas that Medicaid residents receiving hospice services are not counted in the “acuity rating scale” component of the Medicaid payment rate. The nursing facility industry raised concerns about the lack of accounting for hospices’ impact on costs, contending that these patients also require staff time and supplies. As a result of this discussion, this practice was changed by the Kansas Department on Aging and nursing facilities are now able to count the Kansas Medicaid hospice patients into their case mix on acuity levels.

Conclusions

1. Exceptional growth in costs and lengths of stay in the Hospice program, particularly prior to FY 2008, has become an area of significant focus for KHPA program staff and the Hospice Task Force. KHPA program staff is working with the task force to understand the trends in Hospice and address concerns about cost growth.

2. There are concerns about pharmacy expenditures for hospice beneficiaries. The Hospice Task Force has already devoted several sessions to medication usage, including discussions about which entity should be responsible for the costs. Over the next year, the goal is to develop and implement clarifications and/or changes to hospice policy in order to reduce or contain medication costs.

3. Admission criteria for hospice services, including the diagnoses, needs to be reviewed. There are currently no restrictions. Although Medicare does not restrict by diagnosis, Medicare does employ the use of audits in determining whether or not a patient meets admission criteria or length of stay criteria.

4. Length of stay (LOS) also needs to be reviewed in the coming year, including a review of FY 2008 data to determine program trends.

5. Another key area for improvement is in the area of retroactive eligibility and identifying beneficiaries with a current hospice benefit. At this time, KHPA has no mechanism in place to prevent reimbursement of services that would be inappropriate for hospice following the eligibility determination (when claims are subjected to the complete set of edits and audits in the Medicaid payment system). As a result, Kansas Medicaid may have paid for hospitalizations and other treatment services that might be non-reimbursable under Medicaid for a hospice patient (hospital care, psychotherapy, Targeted Case Management, etc.). Kansas Medicaid may have also paid claims at a different rate than would be paid if the beneficiary was properly identified as a hospice beneficiary, such as per diem rates at nursing facilities. These are paid at 95% to the hospice when a beneficiary is appropriately enrolled in hospice. In a case where MMIS has not been flagged for hospice, nursing facilities per diem is paid at 100% directly to the facility. Another example is that
Medicaid may have reimbursed pharmacy claims including curative chemotherapy, osteoporosis treatment, psychotherapeutic medications, narcotic analgesics, and other medications that either should have been paid by the hospice or that should never have been paid at all for hospice patients.

At this time, if a hospice patient is found to have retroactive eligibility, those claims are sent to the state program manager, who reviews the retroactive eligibility, and the reason for the delay in sending the authorization and Notice of Election (NOE) to EDS. The program manager can do one of three things: approve all services, in which case numerous claims which might not be appropriate for hospice care will pay; approve a portion of the retroactive eligibility request and deny the remainder for not meeting program guidelines; and finally the entire claim can be denied. In any case, all pharmacy claims will have been paid. Further review of this system is an issue the Hospice Task Force is continuing to examine in order to ensure both appropriate provision of services and appropriate cost controls.

**Recommendations**

1. The Kansas Medicaid Hospice Provider Manual is being reviewed and redeveloped to include many clarifications that are currently vague and/or to specify currently uncertain provisions of covered services and reimbursement. One option is the re-drafting of the manual; another option, which providers have requested, would be to incorporate the Medicare Conditions of Participation (COP’s) in their entirety in the Kansas Medicaid Provider Manual. The revised 42 CFR 418 was published in June 2008 and is effective for Medicare coverage and reimbursement in December 2008. A number of potential policy items will likely be developed including medication monitoring for payment, prior and retrospective authorization review guidelines, admission and length of stay reviews, HCBS concurrent stay reviews, as examples.

2. Implement the Hospice Task Force’s idea to develop categories of medications and assign responsibility for cost within those categories. Those categories and responsibility for payment are:

   - **Medications never appropriate for hospice** - includes items such as unapproved drugs or therapy, such as Laetrile treatments and chelation therapy. These may also include commonly used medications that are not appropriate for terminal patients such as hormonal therapy, preventive medications such as the statin drugs used to help lower cholesterol, treatments for osteoporosis and so forth.

   - **Medications not covered by the hospice or by Kansas Medicaid** - includes vitamins, health additives such as Bee Pollen or patient personal choice items considered not medically necessary by treatment providers (this category would be patient or family paid).

   - **Medications that are the responsibility of hospice** - analgesics for pain control, anti-anxiety medications, oxygen. Any non-curative medications directly related to terminal disease process would be a hospice responsibility.

   - **Medications that are the responsibility of Kansas Medicaid** - medically necessary medications, not related to the terminal diagnosis such as prescription eye drops, insulin and other anti-diabetic medications, hormonal therapy such as Synthroid® for hypothyroidism.
3. Place some restrictions on admission to Hospice. The KHPA could include hospice admissions criteria that relate to specific diagnosis through the Surveillance Utilization Review System (SURS) or Prior Authorization (PA) units at EDS.

4. Length of Stay (LOS) should be examined by diagnosis, days in hospice and/or certain medications still in use after designated time frames. The practice of reviewing individual hospice stays after a certain period of time (e.g., 90 days or 6 months) may help to identify patterns and may also identify inappropriate medication administration.

5. Implement the Hospice Task Force plan which includes training for hospice and pharmacy providers as well as education aimed at referral sources to hospice. This will not resolve all issues related to retroactive eligibility, but it may relieve the strain on the system until we are able to determine how to identify retroactive approvals more quickly.

Other recommendations to address retroactive eligibility include more elaborate data queries and analysis to measure length of stay and diagnoses with expenditures and medications paid for by hospice. A short term solution will be to request that the hospice furnish this information as part of admission/election process.
Chapter 7: Acute Care Inpatient/Outpatient Hospital Services

Executive Summary

Description

Acute care hospitals are the largest group of enrolled hospital providers. Kansas Medicaid has 144 acute care hospitals, 5 state institutions, 5 rehabilitation hospitals, and 3 psychiatric hospitals enrolled within the state. Over 540 similar out-of-state hospitals are also enrolled. All but nine of Kansas 105 counties have an acute care hospital: two-thirds of those (68) have just one. Most inpatient hospitals are reimbursed based on diagnosis related groups (DRG) with rates that vary as a proportion of Medicare. Outpatient hospitals are reimbursed as fee-for-service.

Key Points

- In 2005, legislation funded a DRG rate increase through a hospital provider assessment.
- Overall spending on inpatient services has increased each year.
- The majority of top DRGs by reimbursement are related to births and the majority of reimbursements based on procedure codes are related to the emergency room visits.
- KHPA updates the DRGs and realigns (but does not increase overall) payment rates each year with the annual Medicare DRG updates. However, KHPA frequently receives the DRG updates late in the year making it difficult to implement them by January 1, resulting in administrative challenges.
- In 2007, Medicare’s payment update included a significant adjustment in many DRG rates, along with the addition of many new DRGs, to better reflect the true costs of care in general versus specialty hospitals. KHPA was not able to make these changes in 2007, but is planning to incorporate these more significant changes in January 2009. Currently, Medicaid sets rates for new outpatient service codes at 65% of the Medicare Outpatient Prospective Payment (OPPS) amount. However, over time Medicaid’s fixed prices erode and leave wide variability in rates.
- In 2008, Medicare’s payment update includes adjustments to remove payment for so-called “never events” or hospital acquired conditions, where the hospital itself is the cause of an illness or expenditure. The changes are intended to better align payment with appropriate incentives for high quality outcomes and patient safety. Kansas Medicaid will follow Medicare’s lead.
In 2008, the Legislature created the Physician Workforce and Accreditation Task Force in part to examine the role that enhanced funding for graduate medical education (GME) could play in expanding the supply of primary care physicians in Kansas. Medicaid provides a percentage add-on to inpatient reimbursements to help cover the costs of GME in the state’s training institutions. KHPA has concerns about the regulatory integrity of the existing Medicaid GME program, and has identified opportunities for program enhancements to support the Task Force’s overall goals. KHPA is a statutory member of the Task Force.

Recommendations

- A number of administrative changes for acute care services are being implemented in FY 2009.
  - Switching to the new “MS-DRG” system implemented by Medicare in 2007
  - Implementing the 2008 Medicare payment methodology and stop paying for “never events”
  - Shifting to a cost-based payment methodology for critical access hospitals
  - Updating reimbursements for high-cost cases at Children’s Mercy Hospital

The fiscal impact of these changes is already reflected in baseline Medicaid spending (caseload)

- Review outpatient reimbursement to investigate the possibility of adopting Medicare’s prospective payment methodology
- Conduct focused review of emergency room use
- Support the activities of the legislative Task Force in improving the GME program to ensure regulatory compliance and better meet the physician training needs of the state.

Program Overview

The Kansas Medicaid fee-for-service program reimburses for health care services in a number of different types of hospitals including: acute care, psychiatric, rehabilitative, and state institutions. Acute care hospital providers represent the largest group of enrolled hospital providers in Kansas Medicaid and receive the highest amount of reimbursement. The hospital program is composed of two service categories: inpatient and outpatient. In most settings the inpatient and outpatient hospitals are located within the same facility, but in distinct sections of the hospital.

Most inpatient hospitals are paid on a per-admission basis using diagnosis related group (DRG) reimbursement. Rates are determined using the federal Medicare program’s payment methodology. Within that methodology, Kansas specific rates are calculated by Kansas Health Policy Authority’s (KHPA) Actuarial Consultant for institutional reimbursements (Myers and Stauffer). These rates are set to ensure overall budget neutrality from one year to the next. Outpatient hospitals are reimbursed on a per-procedure basis using a fee-for-service methodology, which uses specific reimbursement rates set by KHPA.

A facility becomes a Kansas Medicaid provider by requesting provider status and enrolling. Hospitals can enroll in one of several provider types and specialties. Currently Kansas Medicaid has:

- 144 Acute Care Hospitals, five State Institutions, five Rehabilitation Hospitals, and three Psychiatric Hospitals enrolled as in-state hospital providers.
  - 96 out of 105 Kansas counties have acute care hospitals: 68 counties have only one
hospital.

- 541 Acute Care Hospitals, three Rehabilitation Hospitals, and nine Psychiatric Hospitals enrolled as out-of-state hospital providers.

Kansas only pays for out-of-state services that are emergencies or services not available in state. Those services must be prior authorized and approved by the KHPA program manager before they are rendered. Hospitals are required to enroll as Kansas Medicaid providers in order to receive payment for services. Some hospitals enroll to receive reimbursement for as few as one Kansas Medicaid beneficiary. The hospital becomes inactive 18 months after the last claim submission however they are not removed from the rolls. This accounts for the high number of out-of-state hospital providers in the program.

The purpose of this report is to review policy decisions, fiscal trends, and other activities that have occurred in the fee-for-service hospital program during the last year in order to inform the budgetary and strategic planning process for fiscal year FY 2009 and beyond. Services reviewed include those provided to beneficiaries on a fee-for-service basis, including those enrolled in the Health Connect PCCM, but do not include hospital services provided through HealthWave, KHPA’s capitated managed care program.

Analysis of Program Expenditures

Figure 1

Reimbursed Claims by Year by Acute Hospital Type of Payment

- Inpatient
- Outpatient
- Lump-sum payments

* In 2006, a large adjustment was paid out to providers. This graphic presents the fiscal expenditures that would be expected had the adjustment payment not been made.

Figure 1 shows the overall changes in inpatient reimbursements each year. KHPA updates the DRG payment rates each year with the newest Medicare approved DRGs. This update involves a complex formula that takes into account Kansas hospital-specific costs and severity of illness. The update is keyed to the new Medicare Severity (MS) DRGs and uses total provider costs in a manner that targets budget neutrality. This is done to ensure that the overall total Medicaid inpatient expenditure does not increase from year to year. In 2004, the Legislature approved an increase in reimbursements for inpatient rates, outpatient rates and access payments to hospitals. Other
lump-sum payments include targeted Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) payments. Broad based “access payments” total about $24 million per year and are funded by a new assessment (tax) on cost and utilization measures in inpatient and outpatient hospitals, which was implemented in 2006. The graph shows, for the purposes of trends, reimbursement amounts adjusted to what they would have been without the large one-time lump sum payment made in FY 2006. The actual numbers are presented in Table A.

The expected increase in expenditures in FY2006 due to the implementation of the provider assessment and access payment program appears to come one year early, but the increase in hospital reimbursements in FY 2005 is an artifact of two one-time events. First, as the calendar fell that year, FY 2005 included 53 weeks of payment rather than the normal 52. In addition, due to state budget concerns, claims from one week in June 2004 were pended into state fiscal year 2005, resulting in an additional week of payments in FY 2005.

Figure 2 shows totals for hospital reimbursements for the top six providers and includes inpatient reimbursements, fiscal expenditures (lump sum payments), outpatient reimbursements, and also the provider assessment that was implemented in FY 2006. In FY 2006, KHPA made double payments to hospital providers as part of the implementation of provider assessment. The Legislature approved the use of the provider assessment to fund a rate increase starting in 2005 and the increases were implemented in 2006. As a result, Medicaid paid providers for the 2005 and 2006 increases in 2006.

Unlike Figure 1, these double payments are shown in Figure 2, resulting in apparent declines in spending in FY 2007. Another explanation for this apparent decline is the departure of approximately 50,000 beneficiaries from the FFS Medicaid which are reflected in these costs. The beneficiaries moved to the HealthWave program, which is not reflected in the costs. The two HealthWave MCOs, Children’s Mercy Family Health Partners, and Unicare, contract independently with providers at privately negotiated rates. They then reimburse providers directly using a fixed monthly payment from KHPA for each member that must cover all health care costs.
Despite this independent process, there is a relationship between hospital spending in the FFS and HealthWave programs. In recognition of the Access Payment program, which pre-dates KHPA’s contracts with the two health plans, the MCOs have committed to pay each physician and hospital in their network at least the rate available through FFS. The trending also shows a lot of variation in the changes in reimbursements from year to year. DSH payments were substantially reformed in 2008 and with these changes the hospitals should receive more consistent reimbursements.

Reimbursements to the University of Kansas hospital (KU) do not follow the overall pattern of spending in other large hospitals. KU is paid on a cost basis using a Medicare-based formula. This ensures that the state receives federal Medicaid matching funds for all Medicaid expenses, and results in a higher overall reimbursement for KU in comparison to other large private community hospitals. Because of its unique payment arrangement as Kansas’ only public community hospital, KU does not participate in the provider assessment program, and receives a reduced amount of supplemental lump-sum payments for uncompensated care (see discussion of the disproportionate share hospital program below) beginning in FY 2008. KU provides the state share of Medicaid payments above the level of payment they would receive as a private hospital. These funds are made available to KHPA in the form of an intergovernmental transfer. The level of reimbursement and the amount of the transfer are re-evaluated each year based on updated cost information from the hospital.

Figure 3

Figure 3 shows the top 10 outpatient procedure codes by the total level of reimbursement. The majority of these procedure codes represent services received in the emergency room. Procedure codes representing evaluation and management (E & M) procedure codes are usually billed...
whenever a service is performed in an emergency room. Emergency room services are often the most frequently billed services since the emergency department is a major entry into an inpatient hospital and a source of usual care for some beneficiaries. The emergency room visits represent procedures of increasing complexity from non-emergent to severe complexity. Moderate intensity visits are more frequent than any other visit intensity. Overall expenditures for emergency room services are tempered by unusually low rates of reimbursement, which have not been raised since 1996 and average about 33% of Medicare’s rates.

KHPA has considered a policy to increase reimbursement for emergency room services that have remained at the same rate since 1996. However, moving all of these reimbursements to the agency’s standard for new outpatient codes of 65% of the Medicare rate would require an increase in reimbursement of 195% on average. In addition, the policy impact of increased ER reimbursement is unclear, given the high rates of use at existing levels. We have no indication that access to ER services is limited by reimbursement. A more pressing question is how to address the use of the ER for non-emergent or preventable conditions.

Unlisted dental procedure represents the code used to reimburse a facility for dental procedures that can not be performed in an office setting, such as special needs children and adults with acute dental conditions. FY 2005 was the first year we allowed reimbursement for this code. The large number of claims processed that year represents a backlog of claims from the previous year. Since 2005 the Medicaid program has placed restrictions on the use of the unlisted dental procedure code, requiring prior authorization and approval before it is reimbursed.

Figure 4 shows the top 10 DRGs by reimbursement. The majority of the DRGs represented on these tables represent billings for births. Births usually result in at least a minimal stay for the mother and the infant even if both have no complications. The downward trending of the birth DRGs
represents the expansion of HealthWave. As mentioned earlier, this is because 50,000 low-income families, including children and pregnant women, were enrolled in a HealthWave MCO rather than the Medicaid fee-for-service or HealthConnect programs. The spikes in reimbursements seen in FY 2005 can be attributed to: FY2005 being 53 weeks long vs. the standard 52 weeks; a large amount of claims delayed from FY 2004 for payment in FY 2005; and an increase in users of inpatient hospital services. The increases in reimbursements seen in FY 2006 are most likely due to the provider assessment. The downward trend from FY 2006 to FY 2007 in the Psychosis DRG is noteworthy, but not well-understood.

Ongoing Issues

Outpatient Reimbursement Rates

Kansas Medicaid reimburses outpatient hospital services using the same payment reimbursement rates as Ambulatory Surgical Centers (ASC). This has been the payment methodology used by Kansas Medicaid for decades. Medicare introduced a new payment methodology for outpatient hospitals called Outpatient Prospective Payment System (OPPS) in August 2000. Medicare OPPS treats outpatient hospitals as unique facilities and does not use the same coverage and reimbursement rates as they do for Medicare ASCs. This new payment system increased the reimbursement rates received by outpatient hospitals and was designed to better represent the cost of the services provided in an outpatient hospital setting.

KHPA has taken initial steps toward implementing OPPS reimbursement rates to better mirror Medicare’s payment methodology for outpatient hospitals. The first step is to give outpatient hospitals their own rate type and “coverage windows” instead of having them as part of the ASC rate type and coverage windows. Coverage windows are sections of the KHPA payment system where benefit plan coverage and payment rate types are defined. There are some major differences between Medicare OPPS reimbursements and coverage compared to Medicare ASC reimbursements and coverage. By implementing a Medicaid version of OPPS, KHPA would not only better mirror Medicare, but would also give the providers more comprehensive coverage and more consistent reimbursement for the services they offer.

While KHPA has considered recommending OPPS for all outpatient services to mirror Medicare, the agency has not yet decided to implement a Medicaid version of OPPS. This is because of the fiscal impact that would result if facilities were to be “held harmless” in the transition. However, for new procedure codes in outpatient hospitals, KHPA since 2004 has been using Medicare’s OPPS guidelines and rates instead of Medicare’s ASC guidelines and rates to establish coverage and reimbursement.

The next step for KHPA will be to compare Medicare coverage to Medicaid coverage and analyze the differences. Ultimately this could lead to proposals to bring the outpatient reimbursements up to a standard percentage of Medicare OPPS.

Covered Procedure Codes

Each year Medicare releases quarterly “procedure code updates” and the Kansas Medicaid program managers review these new procedure codes for possible coverage. Many of the new procedure codes replace existing codes, or represent more detailed descriptions of currently covered services. In addition, new procedure codes are researched by the program managers for possible
coverage for Kansas Medicaid consistent with evidence based medicine. The program managers review the list of codes along with any information that is available (e.g. other insurance coverage, requests from providers), then recommend which new procedure codes receive coverage and at what reimbursement rate. Coverage is approved or denied by a reviewing team of program managers and then by agency leadership. Reimbursement rates are determined based on a percentage (65%) of proposed Medicare reimbursement rates.

CMS mandates specific procedure codes for coverage. For those codes not mandated each individual state decides to either cover or not cover a given service. Kansas has tried to balance adequate coverage of procedures deemed medically necessary with budgetary constraints. Coverage research for new procedures and currently non-covered procedures is ongoing. Providers contact KHPA program managers and request that they research new coverage, changes in coverage, and reimbursement changes on a daily basis. This demand-driven process is intended to be responsive to changes in medical care, but may also lead to inconsistency in the reimbursement policy. An alternative approach would be to adopt Medicare coverage policies in whole at a set percentage of the Federal reimbursement rate. This would bring Medicaid coverage in line with Medicare and private coverage, which typically follows Medicare, but would most likely be more expensive.

Recent Changes

KHPA has made several recent improvements to the acute care hospital program. A number of other changes are planned in the future.

End-stage Renal Disease Rates

KHPA is currently implementing an increase in End Stage Renal Dialysis (ESRD) facility reimbursement rates. This policy is intended to increase the reimbursement rates to better reflect national trends and preserve access for beneficiaries. Prior to this policy, Kansas’ reimbursement rate was the lowest of 35 known states, and with these changes Kansas will rank 17th out of 35 states. This policy will also provide ESRD facilities their own provider type and specialty in the billing system. Currently ESRDs are assigned physician provider types and specialties. By providing the ESRDs with their own provider type and specialty, KHPA will be able to clearly track ESRD usage and reimbursements. This information will provide KHPA with more accurate data to make better policy in the future.

Because of the growth and high level of emergency room usage, KHPA is researching the possibility of doing a special project to review appropriate emergency room usage among our beneficiaries. Currently KHPA “down codes” instead of denying emergency room services that are billed with a “non-emergent” primary or secondary diagnosis code. KHPA has classified every covered diagnosis code as always emergent, sometimes emergent, or never emergent. These codes are used to determine if the service that was provided was emergent. If the service has been determined to be non-emergent the procedure code billed by the provider is automatically down coded to a lower-paying non-emergent emergency room service code.

Some state Medicaid programs have already begun to implement changes in emergency room program coverage and reimbursement for inappropriate emergency room services. Some states deny emergency room services if not considered to be emergent. Other states have increased or added co-pays for non-emergent emergency room services. Currently KHPA does not charge a co-pay for non-emergent emergency room services.
Disproportionate Share Hospital (DSH)

The federal government provides special matching funds to states through the Disproportionate Share Hospital (DSH) program. These funds provide added payments to hospitals that treat significant populations of indigent patients (Medicaid and the uninsured) through the DSH program.

DSH payments in Kansas have fluctuated drastically in the past due to large hospitals that may not participate in the program equally from year to year. Therefore, the years that these large hospitals have large uncompensated care costs there will be less available monies for other hospitals. In addition, the full DSH allotment has not always been used.

During FY 2007, KHPA worked with consultants, accountants, several Kansas hospitals, and the Kansas Hospital Association to create a new DSH payment methodology. The new methodology better represents hospital losses for uncompensated care and Medicaid costs, and ensures that KHPA uses all available Federal DSH funds. The updated methodology also better targets payments to community hospitals that provide critical care to their patients.

On May 16, 2008, KHPA received approval from the Centers for Medicare and Medicaid Services (CMS) for a new DSH methodology. The new DSH methodology amended the state plan and was effective for FY 2008. In order to determine DSH payments, the amount of uncompensated care (as a percentage of total costs) is calculated for each hospital. This provides a clear picture of the actual burden of uncompensated care provided in each hospital relative to its size. Similar to the Medicare program, the new methodology formula ensures that smaller rural hospitals receive their “fair share” by paying them “cost based reimbursement.”

Critical Access Hospitals (CAH) Cost Reimbursement

On March 5, 2008, KHPA received approval from the Centers for Medicare and Medicaid Services (CMS) for a new Critical Access Hospitals (CAH) cost reimbursement methodology. The new CAH cost reimbursement methodology amended the state plan and was effective October 5, 2007.

Under this new methodology, CAHs will continue to receive initial inpatient and outpatient reimbursements using the standard reimbursement methods. Currently inpatient stays are reimbursed using a DRG reimbursement model and outpatient services are paid using a fee-for-service (FFS) reimbursement model. CAHs will then be issued a Kansas Medicaid cost settlement for hospital inpatient and outpatient services, based on filing of the Medicaid FFS claims data on the Title XIX sections of the Medicare cost report. These cost settlements will reimburse the CAH for 100% of their reasonable costs of providing inpatient and outpatient services as determined under applicable Medicare principles of reimbursement.

By using this new cost reimbursement methodology, KHPA will provide the CAHs with more accurate reimbursements to represent their specific costs. Since the CAHs will have less uncompensated care balance under this new cost reimbursement model, they will qualify for less, if any, DSH reimbursements. The DSH funds not used by the CAHs will be available for distribution to other hospitals serving a disproportionate number of Medicaid beneficiaries and the uninsured.

Health Reform Act of 2008 (Senate Bill 81)

The bill amends two statutes in the Primary Care Safety Net Clinic Capital Loan Guarantee Act to
create a definition of "provider-based indigent care clinic." Such a clinic would have to be located in a Medicare-certified hospital, nursing facility, or home health agency and would be included within the definition of a “primary care safety net clinic.” Additionally, the Secretary of the Kansas Department of Health and Environment would be allowed to enter into agreements with provider-based indigent care clinics to allow such clinics to act as primary care safety net clinics.

This law is intended to fund more safety net clinics in order to decrease hospital emergency room usage for services that can be provided in a safety net clinic setting.

**Border City Children’s Hospital Reimbursement**

Children’s Mercy Hospital of Kansas City, Missouri, is the largest safety net and tertiary care children’s hospital in the region, serving children throughout Kansas. Because of the types of cases referred to Children’s Mercy, the hospital experiences greater lengths of stay and greater costs than other hospitals serving Kansas Medicaid children. Because of the severity of patients they serve, Children’s Mercy has relied increasingly on DSH payments and cost outliers to reimburse for its costs.

In March 2008, KHPA submitted a new state plan to CMS proposing to provide these providers with a modified cost outlier methodology. CMS has not finalized their review of these changes, which take effect in FY 2009.

Recognizing that Children’s Mercy incurs a relatively high loss ratio in terms of outlier claims, the modified outlier payment formula will target reimbursement toward higher cost cases. Increasing the outlier recovery percentage will generate additional reimbursement and permit improved cost recovery while at the same time freeing up limited DSH funds for Kansas hospitals.

The estimated increase in changing the outlier recovery percentage will allow Children’s Mercy to recover approximately 86% of the cost of providing care for Kansas children, a rate just below the largest Kansas hospitals serving Medicaid beneficiaries.

**Recommendations for FY 2009**

KHPA is committed to ensuring access to quality care for Medicaid beneficiaries. In this report we review current and planned policies for hospital reimbursement. Ensuring equitable yet fiscally responsible reimbursement for all our providers is a key strategy for maintaining access for our beneficiaries. Recent or pending changes in hospital reimbursement have both increased reimbursements and improved equity in those payments. Recommendations for FY 2009 include a more focused review of ER reimbursements to identify opportunities for improved efficiency and quality care, and adoption of Medicare impatient rates that further improve equity by better targeting high cost cases.

**Emergency Room Usage**

Because of the growth and high level of emergency room usage, KHPA has begun to plan a special project to review the appropriateness of emergency room usage by the Medicaid population. KHPA would use this information to determine if any program changes would be appropriate.
DRG Reimbursements

Currently Kansas Medicaid uses a DRG payment methodology provided by CMS and rates specific to Kansas prepared by an outside actuary. These calculations are modified with every Medicare update. Kansas Medicaid tries to implement DRG updates in a timely manner in accordance with Medicare; however, due to the timing of the release of the Medicare Inpatient final rule, it is difficult for KHPA to update concurrent with Medicare.

In FY 2008, Medicare implemented a new MS-DRG payment methodology for inpatient hospitals. The new DRG system recognizes severity of illness and resource use and is based on the complexity of both. These changes will provide the ability to identify groups of patients with varying levels of severity using secondary diagnoses. The MS-DRG methodology increased the number of reimbursable DRG’s from 335 to 745.

KHPA implemented a system “crosswalk” from the current DRG version 24 to the new Medicare MS-DRG. KHPA will use this crosswalk until KHPA can successfully implement the new MS-DRG methodology which is scheduled for January 23, 2009. With the new MS-DRG implementation, KHPA will mirror Medicare’s payment updates that includes adjustments to reduce payments for so-called “hospital acquired conditions,” where the hospital itself is the cause of an illness or expenditure. The changes are intended to better align payment with appropriate incentives for high quality outcomes and patient safety. If and when Medicare changes its policies to deny payment entirely for “never events,” KHPA would plan to follow suit adjusting Medicaid payments as well.

See Table A

Next Page
### Table A

**Annual trends for Acute Hospital indicators**

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<td>Number of consumers</td>
<td>36,400</td>
<td>43,664</td>
<td>52,203</td>
<td>69,500</td>
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<td>$231,321,607</td>
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<td>$3,321</td>
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<tr>
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<td>Number of claims</td>
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<td></td>
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<tr>
<td>Avg. payment per claim</td>
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<td>$25</td>
<td>$24</td>
<td>$29</td>
<td>$29</td>
<td></td>
</tr>
<tr>
<td><strong>Financial (lump-sum) expenditures</strong></td>
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<tr>
<td>Total payments</td>
<td>$5,350,638</td>
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<td>$69,093,920</td>
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<tr>
<td>Number of claims</td>
<td>75</td>
<td>228</td>
<td>341</td>
<td>622</td>
<td>622</td>
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<td>$76,736</td>
<td>$92,662</td>
<td>$222,167</td>
<td>$111,083</td>
<td>$188,166</td>
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(a) reflects adjusted totals that exclude one-time catch-up access payments in 2006.
Chapter 8: Laboratory and Radiology

Executive Summary

Description

Independent laboratory and radiology service expenditures remained relatively flat over the FY 2005-2007 period. The principle explanation is the movement of 50,000 beneficiaries out of the fee-for-service (and HealthConnect) program due to the expansion of HealthWave in 2007. However, population-specific analysis indicates an increasing number of users, and a corresponding increase in total expenditures among the remaining aged, disabled, and other populations. The highest-cost services in this category are MRIs, CT scans, and lab tests for sexually transmitted diseases. Kansas Medicaid usually ties coverage and payment decisions to federal Medicare policies.

Key Points

- Maintaining consistency, equity, and efficiency in Medicaid coverage of laboratory and radiology services is difficult given the high rate of innovation in laboratory and radiological procedures.

- New coverage is based on comparisons with Medicare and other insurers, but over time, both pricing and coverage restrictions (e.g., diagnosis restrictions) become dated.

- Costs for the population remaining in fee-for-service, the aged and disabled, are increasing even though reimbursement to providers is not.

Recommendations

- Consider adopting Medicare coverage criteria in order to stay current with federal determinations of technology and appropriate use.

- Explore the development of a universal pricing methodology linked to the Medicare program as a systematic approach to maintaining an up-to-date program.

Program Description

Laboratory and radiology services are mandatory services that must be provided through Medicaid. KHPA reimburses providers for over one thousand laboratory procedures and six hundred radiological procedures. As a result of constant advances in technology, new procedures are developed every year and KHPA program staff use the best available evidence to determine which proce-
Program Review of Laboratory and Radiology

dures will be reimbursed by Medicaid. The purpose of this report is to evaluate trends in utilization and expenditures for independent lab and radiology services reimbursed through the Kansas Medicaid fee-for-service program.

Kansas Medicaid defines independent lab and radiology providers as stand-alone entities not directly attached to or affiliated with a hospital. Laboratory and radiology services provided for patients in the inpatient hospital setting are covered under the diagnosis related group (DRG) payment for inpatient services. Lab and radiology services provided by hospitals, but not associated with an inpatient stay, are reimbursed through a fee-for-service (FFS) payment mechanism. All procedures performed at a hospital were grouped together in this year’s Medicaid Transformation process and are included in the hospital program review. As a result, procedures analyzed in this review represent the subset of all laboratory and radiology procedures, i.e. those performed outside of an inpatient stay.

Program Management

There are three main objectives for the management and oversight of independent laboratory and radiological services: 1) evaluating and adopting a consistent stream of new technologies, 2) reviewing and updating coverage criteria for currently reimbursed tests, and 3) evaluating and updating reimbursement rates for diagnostic tests and procedures. KHPA uses an internal medical work group consisting of nurse and non-nurse program managers, the medical director, and a physician consultant to evaluate new technology and coverage criteria. The Medical Care Advisory Committee (an external advisory board made up of consumers, providers, and other stakeholders) provides additional input on coverage decisions as needed.

Coverage of new tests

KHPA continues to review new technology for the feasibility of coverage. The agency program staff review Medicare coverage rules, information from other insurance carriers and peer-reviewed literature when determining coverage for both radiology and laboratory codes and procedures. In addition, KHPA uses this information to help determine whether a diagnosis restriction and/or prior authorization are necessary.

When a new service is covered, it may be placed on prior authorization (PA). By putting the new service on prior authorization, the KHPA program manager can review the appropriateness of every potential use and monitor the utilization and total cost of the new service. The program manager designs specific criteria for each service placed on PA. These criteria use medical conditions, diagnoses, and medical necessity statements to help determine the appropriateness of the service for each individual. As the service coverage continues, KHPA continues to revise its PA criteria as needed. KHPA may occasionally remove services from PA, but will usually maintain a diagnosis restriction to help maintain program integrity.

One radiological procedure currently under review is the positron emission tomography (PET) scan. KHPA does not reimburse for PET scan, computer-based functional radiological imaging used in the diagnosis and treatment of cancer. PET scans cost approximately $1800 per procedure and their utility in diagnosis and treatment is still being evaluated. KHPA continues to review this service for possible future coverage. It may be more feasible to cover these services if they are provided through a prior authorization process.
Reviewing and updating coverage criteria

For laboratory and radiology codes that are already covered, KHPA uses an ad hoc review process. The program manager and the medical workgroup review criteria on a case-by-case basis. Prior authorization criteria and diagnosis restrictions remain in place once initially adopted and are updated as needed. With limited staff resources and nearly two thousand lab and radiology codes, regular review of each individual code is not feasible.

In contrast, the Medicare program and other large insurers, who are able to devote more resources to program management conduct comprehensive coverage reviews and update their coverage criteria on a quarterly or annual basis. KHPA’s current ad-hoc process has the potential to leave the agency with procedure and diagnosis restrictions that are in some cases outdated and/or inconsistent with current medical practice. These differences may cause reimbursement difficulties for providers when a Medicaid beneficiary has both Medicare and Medicaid.

By implementing an annual procedure and diagnosis code review process, KHPA could better mirror Medicare’s coverage and restriction changes and therefore reduce reimbursement problems. Adopting this annual review process would also provide KHPA with the means to stay current and comprehensive in its coverage criteria, likely increasing the cost-effectiveness of care reimbursed through the fee-for-service Medicaid program. KHPA is reviewing the fiscal impact of implementing an annual procedure and diagnosis code review process.

Reimbursement

Reimbursement issues are brought to the attention of program staff by providers or discovered through the research of program managers. Several reimbursement and billing issues have been identified for the independent laboratory and radiology program.

When a policy is implemented, KHPA prices the new procedure code at a percentage of Medicare-85% for laboratory codes and 80% for radiology codes. This rate stays the same until a new policy is implemented to change the rate. Medicare, however, changes their reimbursement rates every year which means that each year the Medicaid reimbursement varies as a percentage of Medicare. Medicaid reimbursement could fall below the initial 85 or 80% of Medicare or in some cases rise above the initial percentage.

One example of a billing issue is when providers bill for a service with both a technical and professional component. Under Medicare rules, each such service has a base code that a provider uses when they bill for both components of a service. If the provider only bills for one component (technical or professional) of the service, a modifier is used to identify the component they provided.

The modifier TC (technical component) is used when billing for the technical portion of a service. The TC includes the provision of equipment, supplies and technical personnel. The modifier 26 is used when billing for the professional portion of a service. The professional component encompasses all of the physician’s work in providing the service, including interpretation and reporting of the procedure. In the Medicare program, when the reimbursement rates for the technical and professional components are added together, the result equals the base code reimbursement. However, KHPA’s current separate component reimbursement rates (TC, 26) do not always equal the base code reimbursement. Current Medicaid reimbursement for the base code is usually greater than the sum of the reimbursements for the components. This discrepancy has caused dif-
KHPA continues to review the radiology procedure codes that use contrast material for appropriate reimbursement. Contrast material is currently considered by KHPA and several other insurance providers to be part of the service. The reimbursement rate has been set accordingly. Occasionally KHPA receives requests to review specific contrast materials for additional reimbursement because the provider feels that the current reimbursement does not adequately cover the cost of some of the more expensive contrast materials. A random sample of radiology codes were reviewed by the KHPA program manager and the current reimbursement is consistent with Medicare’s current reimbursement. Medicare currently considers the contrast material as content of service to the radiological procedure code.

Finally, the KHPA hospital manual does not allow independent laboratories to bill for services while a beneficiary is in a hospital. KHPA policy considers independent laboratory services provided during a hospital stay to be content of service of the hospital (drug related grouper) DRG payment. KHPA plans to research and implement an edit in its payment system to deny any independent laboratory claims billed during an inpatient hospital stay.

### Recent Program Changes

Over the past few years KHPA has implemented many changes within the Medicaid fee-for-service program to improve reimbursement and coverage for laboratory and radiology services. These changes were developed in response to provider feedback and as a result of reviewing the literature and the policies of other insurance companies. The most recent and prominent changes are described below.

#### Radiology code coverage

In October 2006 program staff wrote a policy that added 20 previously uncovered radiology codes to all Medicaid benefit plans. Agency staff determined that these additional procedures were necessary for effective diagnosis and treatment of Medicaid beneficiaries.

#### Expansion of procedures billable by radiologists

Medicaid began allowing radiologists to bill for codes for interventional radiology in November 2006. Prior to this change radiologists were not reimbursed for these services; however, they could dispute denied claims and request a medical review. As a result of the medical review of several disputed claims and a subsequent review of the literature, KHPA decided to expand coverage to include interventional radiology services. Since the majority of the disputed claims were paid after the medical review process, this change was determined to have no fiscal impact.

Many radiologists have expanded their practices to include services other than traditional radiological procedures. Some laryngoscopy procedures allowing providers to look at the back of the patient’s throat fall under these expanded services. In April 2008, a Medicaid policy was implemented which allowed radiologists to be reimbursed for 28 laryngoscopy procedure codes. These two policies updated Medicaid’s reimbursement for radiological procedures and made it consistent with current radiology practice.
Obstetrical Sonograms

In June 2008, a Medicaid policy was implemented to expand the covered diagnosis list for obstetrical (OB) sonograms to better mirror Medicare and other insurance providers. Several providers requested KHPA to review the covered diagnosis list for OB sonograms and to consider using the same diagnoses as Medicare. After reviewing the medical literature and other insurers’ policies, KHPA approved a new list of covered diagnosis codes for OB sonograms. This new list is more comprehensive and consistent with current medical practice. The policy was calculated to have no fiscal impact because the diagnosis codes were previously manually reviewed and approved through the medical review process.

KHPA has also written a policy to change the chest X-Ray diagnosis restrictions to mirror Medicare and other insurance providers. KHPA has decided to use the previously referenced OB sonogram policy as a guide for the implementation of the X-Ray policy. However, the X-Ray policy encompasses a much larger group of diagnoses compared to the OB sonogram policy.

Trofile testing

KHPA implemented a policy in June, 2008, to expand independent laboratory coverage to include Trofile testing. This test assists prescribing providers to determine which medication(s) will best treat multi-drug resistant AIDS.

Analysis of Program Expenditures

This section reviews independent laboratory and radiological spending in detail in order to identify trends and explain changes in spending and utilization. The two types of services are examined separately.

Independent laboratory Expenditures

Figure I depicts total independent lab expenditures by fiscal year. In fiscal year (FY) 2005 KHPA experienced an increase in independent laboratory expenditures from approximately $2.5 million to $3.2 million dollars. During this same time period there was an increase in the number of bene-
ficiaries using independent laboratory services and an increased number of independent laboratory procedure codes covered. In FY 2005, KHPA experienced two one-time events. First, because of the way the calendar fell in relationship to the fiscal year, FY 2005 included 53 weeks of payment rather than the normal 52. In addition, due to state budget concerns, claims from one week in June 2004 were pended into state fiscal year 2005, resulting in an additional week of payments in FY 2005.

From FY 2005 to FY 2007, independent laboratory expenditures did not change substantially despite a transfer of approximately 50,000 beneficiaries to the managed care plans (HealthWave) in FY 2007. Program staff may have anticipated a decrease in expenditures with the decrease in beneficiaries. However, those who transferred out of the program tended to be healthy families and low users of the services.

**Figure II**

<table>
<thead>
<tr>
<th>Independent Laboratory - Users by FY</th>
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<tbody>
<tr>
<td>#Users</td>
</tr>
<tr>
<td>'02</td>
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<tr>
<td>'03</td>
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<tr>
<td>'04</td>
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</tr>
<tr>
<td>'06</td>
</tr>
<tr>
<td>'07</td>
</tr>
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</table>

Figure II represents the number of beneficiaries actually receiving independent laboratory tests. From FY 2002 to FY 2007, KHPA saw an overall 14.3% increase in the number of users of independent laboratory services. However, from FY 2005 to FY 2007, there was a decline in users (46,701 to 38,361). As previously mentioned, KHPA moved beneficiaries from HealthConnect into HealthWave in FY 2007, which increased the number of beneficiaries eligible for managed care and decreased the number of beneficiaries eligible for fee for service Medicaid.

The decline in users illustrated in Figure II from 2005 through 2007, coupled with the stable expenditures illustrated in Figure I, indicates a rise in overall per-user independent laboratory expenditures in FY 2006 and 2007. Expenditures per user are illustrated in Figure III.
Expenditures per user have steadily increased from FY 2002 to FY 2007. Over the five year time-frame, there was a 43.9% increase in per-user expenditures. Increases in per-user spending have continued despite the decrease in the total number of independent laboratory users from FY 2005 to FY 2007. This trend suggests that either beneficiaries are using services in greater amounts, more expensive services are being ordered, or reimbursements are increasing.

Figures IV shows the top 5 independent laboratory procedure codes billed by year. These tests are routine procedures that are used to determine medical conditions and guide treatment options. Independent laboratory procedures show a large growth in the last 3 years. These laboratory procedure codes are high volume, high turnover codes. As the technology and new laboratory standards change, use of existing laboratory procedure codes change accordingly. The individual growth rates for some tests are higher than the overall growth rate of the independent laboratory program.
There was a decrease in expenditures for some lab tests (for example, the obstetric panel) in FY 2007 because of the shift of families to managed care. The top two procedure codes billed continue to be those used for testing for sexually transmitted diseases. However in 2007, expenditures for those codes did not increase. Expenditures for metabolic panels and Thyroid Stimulating Hormone (TSH), associated with diagnosis and treatment of chronic diseases, continue to increase because of the continued presence of the aged and disabled population in the Medicaid fee-for-services (FFS) programs.

Table A

Table A shows the number of claims and average reimbursement per claim for the top 5 procedure codes listed in Figure IV. The average reimbursement from FY 2004 to FY 2007 remains fairly constant. This further suggests that the per-user increase in expenditures is related to an increase in utilization.

Figure V

Figure V shows the independent laboratory expenditures per user by population groups. From FY 2002 to FY 2007, there was an increase in expenditures in each population group. In FY 2007, there was a greater increase in user expenditures in the MediKan and disabled populations than in other groups. This increase was likely associated with an increased level of disability in the Medi-
Kan population with the implementation of the Presumptive Medical Disability program (PMD). The PMD program tightened eligibility criteria for MediKan which may have raised the overall level of disability and medical need, leading to increased utilization in this group relative to other beneficiaries.

**Figure VI**

Figures VI shows the top 5 independent laboratory procedure codes billed each year for the aged and disabled population. This figure illustrates that expenditures for four out of five top procedures continue to increase for this population. This increase is occurring despite the fact that reimbursement rates per procedures illustrated in Table A have remained steady. The increases are also consistent with a high and increasing rate of chronic disease in the aged and disabled population.

**Figure VII**
Figure VII illustrates the continued increase in per user expense for the aged and disabled population. From FY 2005 to FY 2007, KHPA has seen an increase in expenditures from $83.89 to $102.31 (22%). Based on this analysis, it is likely that expenditures for the independent laboratory program will begin to increase over the next few fiscal years. Analysis of expenditures in the aged and disabled population supports the need for increased management of chronic disease in this group.

Radiology Expenditures

Figure VIII illustrates the total independent radiology expenditures by fiscal year. In FY 2005, KHPA experienced an increase in radiology expenditures from approximately $816 thousand to $1.29 million dollars. During this same time period, KHPA had an increase in the number of beneficiaries receiving radiological tests and increased coverage in radiology procedure codes. Fiscal year 2005 was also the year in which we processed a larger number of pended claims from the previous year and had 53 rather than 52 weeks. From FY 2005 to FY 2007, overall radiology expenditures declined.
Figure IX shows the number of beneficiaries using radiological tests. There was an increase in radiology users from FY 2004 to FY 2005 (7,798 to 12,373) associated with the increase in expenditures noted above. However, from FY 2006 to FY 2007, KHPA saw a decline in radiology users (11,704 to 10,443). This decline coincides with the previously mentioned transition of families to HealthWave in FY 2007.

**Figure X**

KHPA had a gradual increase in per user expenditures from FY 2002 to FY 2007 as illustrated in Figure X. This increase has occurred even though KHPA has seen a slight decrease in the total number of beneficiaries using radiology services. The increase in FY 2006 may have been associated with the provider assessment tax implemented that year, a portion of which was used to raise the reimbursement rate of some radiology procedure codes. Overall from FY 2002 to FY 2007, KHPA has seen a 16.8% increase in per user expenditures. To further examine the cause of the increase in per user expenditures, we analyze the expenditures by procedure.

**Figure XI**

Figure XI shows the top four types of radiology services that make up approximately 90% of the total radiology expenditures. The average individual percentages of total radiological expenditures per service are: MRI 62%, CT 11%, X-Ray 10%, and Ultrasound 7%. This graph illustrates that
Expenditure patterns are consistent across technologies, suggesting that no particular type of test is driving the changes in spending but rather that widespread changes in overall utilization and/or reimbursement are driving the increase.

The analysis below focuses on the predominant populations remaining in the fee-for-service population, the aged and disabled, to identify any consistent trends in the program.

**Figure XII**

Examination of radiology expenditures for the aged and disabled population illustrates a continued increase. Figure XII shows an increase in FY 2005 from approximately $395,000 to $623,000. During this period, KHPA had an increase in the number of beneficiaries receiving radiological tests and increased coverage in radiology procedure codes. Apart from the deviation in FY 2004 and FY 2005, likely due to cash-flow and payment issues, there has been a steady increase in radiology spending in this population.

**Figure XIII**

Examination of radiology expenditures for the aged and disabled population illustrates a continued increase. Figure XII shows an increase in FY 2005 from approximately $395,000 to $623,000. During this period, KHPA had an increase in the number of beneficiaries receiving radiological tests and increased coverage in radiology procedure codes. Apart from the deviation in FY 2004 and FY 2005, likely due to cash-flow and payment issues, there has been a steady increase in radiology spending in this population.
Data illustrated in Figure XIII indicates that the rise in radiology expenditures (seen in the previous Figure XII) tracks very closely with the rise in users. In FY 2005 KHPA saw a 50.2% increase in aged and disabled users and in FY 2007 KHPA saw another 8.1% increase.

**Figure XIV**

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<th>FY</th>
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<td>'02</td>
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</table>

Figure XIV shows the per user expenditures for aged and disabled beneficiaries remained fairly stable from FY 2004 to FY 2007 with only a 1.6% increase. Together, the last three analyses indicate that the upward trend in spending in the independent radiology program is most likely associated with the increase in the number of aged and disabled beneficiaries in Medicaid FFS and/or an increase in the rate of chronic disease in this population.

**Figure XV**

Figure XV shows the top 4 types of radiology services that make up approximately 88% of the total radiology expenditures for the aged and disabled population. This graph illustrates that expenditure patterns are consistent across technologies. As with the analysis of laboratory tests, this analysis suggests that no particular type of radiological test is driving the changes in spending, but...
rather changes in the number of aged and disabled beneficiaries and/or the rate of chronic disease, which is causing the use of radiology services to go up.

Conclusion

Independent laboratory program:
- Costs for the remaining population (aged and disabled, MediKan) are increasing even though reimbursement has not
- Reimbursement in relationship to Medicare varies across test over time
- Limited staff resources make it difficult to conduct a regular and systematic review of existing prior authorization and coverage criteria, which may lead to outdated criteria over time

Independent radiology program:
- The number of aged and disabled users of radiology services is increasing
- Expenditures for the aged and disabled population are increasing even though reimbursement has not
- Program staff continues to assess new, expensive technology for possible coverage.
- The program continues to have reimbursement issues which must be addressed

Recommendations

Systematic application of Medicare coverage criteria
KHPA and Medicare may have different coverage or restrictions, such as diagnoses, for the same service code. These differences may cause providers difficulty in accessing coverage and reimbursement for their services when a Medicaid beneficiary has both Medicare and Medicaid. Several providers have requested that KHPA mirror Medicare’s coverage and restrictions on services. These differences also imply that KHPA is not taking advantage of the investments the Medicare program has made in determining appropriate coverage criteria. By implementing a global methodology, KHPA may better mirror Medicare’s coverage and restriction changes and therefore reduce the number of provider reimbursement issues. A decision to adopt Medicare coverage criteria will require further analysis for feasibility and cost-effectiveness.

Systematic application of Medicare reimbursement
Payment rates are set when technologies are initially presented, and they typically follow a coverage decision by Medicare. Initial payment is tied to a percentage of Medicare’s rate, but staff resources do not allow for frequent updates of rates for the large number of lab and radiology codes covered. Over time, the appropriate relationship between the costs of the tests and KHPA’s reimbursement weakens. One option to remain current is to routinely take advantage of Medicare payment information, and benchmark all radiology rates to a fixed (budget-neutral) percentage of Medicare’s rates. This is the process used to keep pace with Medicaid hospital rates. KHPA will explore adoption of a Medicare payment standard to support routine and budget neutral updates for independent laboratory and radiology services.
Chapter 9: Pharmacy Services

Executive Summary

Description

In Fiscal Year 2008, Medicaid fee-for-service pharmacy services were provided to 113,446 unique beneficiaries through 745 contracted pharmacies, with nearly 2 million prescriptions dispensed.

Pharmacy program management is aided by a federally mandated Drug Utilization Review (DUR) program to provide education to physicians, mid-level practitioners and pharmacists. In addition to the guidance provided by the DUR board, the Kansas Medicaid Prescription Drug List (PDL) Advisory Board provides direction for the implementation of a PDL, which is a compilation of drugs that are most cost-effective for the State. Of note, medications used for mental health are statutorily excluded from inclusion on the Medicaid PDL in Kansas. The pharmacy prior authorization process operates using a manual prior authorization (PA) system.

Key Points

- Changes in drug spending and population served changed dramatically between FY 2006 and 2007 due, in part, to implementation of Medicare Part D which now covers prescription drugs for low-income seniors eligible for both Medicaid and Medicare. The second significant shift in the fee-for-service (FFS) prescription drug program occurred in January 2007, with the transition of approximately 50,000 beneficiaries from Medicaid fee-for-service to the HealthWave managed care program.

- Significant increases in costs-per-prescription exceed consumer and medical price inflation rates, as well as long-run rates of increases in state revenue. This raises questions about the sustainability of Medicaid prescription drug spending.

- Psychotherapeutic medications comprise a notably higher percentage of expenditures than the next largest classes of medications combined, including central nervous system (CNS) drugs, anti-infectives, gastrointestinal drugs, and anti-asthmatic drugs, in order of expenditures.

- Nearly half of all of the growth in Medicaid prescription drug spending in FY 2008 is attributable to increases in the cost-per-prescription and in the utilization of mental health drugs.
the last few years, an increasing number of scientific studies have identified serious adverse events associated with use of mental health drugs. In Kansas, two thirds (63%) of mental health drugs are prescribed by general practitioners and other non-psychiatrists. This raises questions as whether beneficiaries have full access to best practices and the current body of knowledge regarding the safety and effectiveness of mental health medications.

These findings indicate the need for increased oversight and active management of the Medicaid pharmacy program, including more aggressive pursuit of market-based price discounts and focused attention on the management of mental health indications. Given the emerging data regarding the use of mental health medications in children, KHPA is especially concerned about the safety of young Kansans. Prior authorization (PA) is the standard tool used by pharmacy benefits management (PBM) and Medicaid programs to improve safety and ensure appropriate dispensing of drugs that are commonly mis-used.

Recommendations

1. Update drug pricing formulas and reimbursement limits for Medicaid fee-for-service (FFS) drugs.
2. Implement an automated prior authorization (PA) system.
3. Remove the statutory limitation on management of mental health prescriptions.
4. Establish a Mental Health Prescription Drug Advisory Committee.

Overview and Background

This review examines trends and activities in the Medicaid fee-for-service (FFS) pharmacy program. The goal of the review is to identify opportunities for program improvements that improve safety and quality of care, generate efficiencies in program administration and yield savings for the state. The Medicaid fee-for-service pharmacy program includes all prescribed medications that are offered to beneficiaries and provided through community pharmacies and physicians’ offices. Medications administered in an institutional or inpatient setting are not included in the fee-for-service pharmacy program. Instead, these medications are reimbursed through payment to the facility. Prescription drugs dispensed to Medicaid beneficiaries participating in the HealthWave managed care program are also not specifically addressed in this review since these medications are reimbursed through the HealthWave program, rather than fee-for-service pharmacy.
Program Description

Under the federal rules governing the administration of Medicaid, pharmacy programs are an optional benefit that states may choose to offer. Given the central role of pharmacy in medical care, all states have chosen to provide this service to their beneficiaries. There are many federal requirements for Medicaid pharmacy programs. These include a requirement that all Food and Drug Administration (FDA) approved prescription drugs are available to Medicaid beneficiaries (specifically, those prescription drugs whose manufacturers have a pricing contract with the Centers for Medicare and Medicaid Services; this is essentially all prescription drugs in the U.S.).

In Fiscal Year (FY) 2008, pharmacy services were provided to 113,446 unique beneficiaries through 745 contracted pharmacies, with nearly 2 million prescriptions dispensed. Most of the contracting pharmacies are located in Kansas, but Medicaid also contracts with a small number of additional pharmacies in Colorado, Nebraska, Oklahoma, and Missouri to help serve Kansas Medicaid beneficiaries who live close to state borders. The Kansas Board of Pharmacy reports 836 licensed pharmacies in Kansas. Kansas Medicaid has successfully contracted with a significant majority (89%) of Kansas pharmacies to ensure pharmacy access for Medicaid beneficiaries.

Medicaid rules allow pharmacies to dispense a sufficient quantity of medication for up to 30 days of therapy. Pharmacies are reimbursed for the cost of the drug plus a $3.40 “professional service fee” for each prescription. Billing by pharmacies is unique in comparison to other medical services because pharmacies bill electronically before the drugs are dispensed. In contrast, hospitals, physician offices and other providers file claims after the service has been provided. This pharmacy billing mechanism provides an opportunity for public and private insurers to interact with beneficiaries when the medication is dispensed. Medicaid reimbursement to pharmacies for the cost of the drug is set at 27% below the average wholesale price (AWP) for “multi-source” (generically available) drugs. Medicaid reimbursement is set at 13% below AWP for single source (brand name) drugs. Reimbursement may be further limited by KHPA’s maximum allowable cost (MAC) list., a set of prices established by the state through periodic examination of wholesale prices for generically-available drugs. A MAC is established when current reimbursement is greater than actual acquisition cost.

To offset pharmacy costs, states also receive a rebate from prescription drug manufacturers for each prescription dispensed to a Medicaid beneficiary. The federal government secures a substantial rebate on behalf of states from drug manufacturers who have agreed to participate in the Medicaid program (at least 15% of the average price at the manufacturer’s level). In addition, states can separately negotiate additional rebates from manufacturers in exchange for listing a drug as “preferred”. This means that the state has agreed to a “listed preference” in dispensing that specific drug rather than other therapeutically equivalent drugs. In Kansas, the process of determining therapeutic equivalence is transparent and publicly regulated. That process is described in more detail below.
Pharmacy services for Medicaid beneficiaries enrolled in the two HealthWave managed care organizations (MCOs) are reimbursed through the capitated rate paid to the MCO for each beneficiary. The HealthWave MCOs manage their pharmacy program independently, developing separate agreements with pharmacies and manufacturers to determine reimbursement rates and rebate agreements. The MCOs are allowed to subcontract with a pharmacy benefit management firm for medication management services. For instance, Unicare utilizes WellPoint for management of their pharmacy benefits and Children’s Mercy Family Health Partners employs CVS/Caremark. WellPoint and CVS/Caremark use standard formulary management techniques and both operate under the same stipulations required for the fee-for-service pharmacy benefit. This includes requiring coverage of every drug included in the federal rebate program. The pharmacy benefit management programs also adhere to Kansas law which does not allow for any restrictions or “management” of mental health drugs (Kansas Statute 39-7, 121b). Costly medications used to treat hemophilia and acquired immunodeficiency syndrome (AIDS) are carved out of the managed care organization (MCO) capitation rate and are covered under the fee-for-service benefit.

The Medicaid pharmacy program provides administrative support for two additional programs, the AIDS Drug Assistance Program (ADAP) and MediKan. ADAP is jointly administered by KHPA and the Kansas Department of Health and Environment (KDHE). It is funded by a Health Resources and Services Administration (HRSA) grant and state general funds. The program provides coverage of HIV/AIDS treatment medications for program enrollees. These medications can be purchased at the Medicaid price and take advantage of federal rebates. MediKan is a public health insurance program financed entirely by the state of Kansas to provide coverage to citizens applying for federal disability. The MediKan pharmacy benefit package is more limited than Medicaid, but it includes most maintenance medications and other life-sustaining drugs. In the MediKan program, prescription drugs are reimbursed using Medicaid prices. However, no rebates are collected.

**Program Management**

**Drug Utilization Review**

The Omnibus Budget Reconciliation Act of 1990 (OBRA ’90) required each state Medicaid Program to establish a Drug Utilization Review (DUR) program to provide education to physicians, mid-level practitioners and pharmacists. This education is provided through patient profile reviews, population-based interventions, academic detailing visits and a quarterly newsletter. KHPA contracts for academic detailing services, which include visits to approximately 60 providers each year. Visits in FY 2008 covered such topics as hypertension and diabetes. The DUR program is supervised by the DUR Board, which also determines appropriate criteria for medications on prior authorization (as referenced below). By law, the DUR Board is composed of four physicians, four pharmacists, and one Advanced Registered Nurse Practitioner or Physician’s Assistant. The Kansas DUR Board convenes every other month in a public meeting.

**Preferred Drug List**

In addition to the guidance provided by the DUR board, the Kansas Medicaid Preferred Drug List
(PDL) Advisory Board provides direction for the implementation of a preferred drug list. Established in 2002 and authorized by K.S.A. 39-7, 121a, the PDL Advisory Board advises KHPA on the implementation of the Kansas PDL. The PDL is based on safety, effectiveness, and clinical outcome data in order to promote clinically appropriate utilization of pharmaceuticals for high quality, cost-effective treatment. The PDL Advisory Board is composed of practicing physicians and pharmacists who carefully evaluate evidence-based clinical information to determine the relative uniqueness of individual medications within a class of medications. If their evaluation of the evidence allows them to determine that agents in the drug class are therapeutically equivalent, KHPA ascertains which agent is most cost-effective for placement as a PDL preferred drug. The use of a PDL is a standard pharmacy management tool used in both the public and private sectors. However, per Kansas statute, medications used for mental health are excluded from inclusion on the Medicaid PDL. The PDL is established in Kansas regulations and is published on KHPA’s website.

Prior Authorization
Prescription drugs that are non-preferred (not on the PDL) are still available to beneficiaries through a process known as prior authorization. Prior authorization (PA) is a tool used widely by public and private purchasers of health care, including KHPA. Reasons for the use of a non-preferred agent must be provided by the prescribing physician before the drug can be dispensed to a beneficiary. Reasons justifying the use of a non-preferred drug through prior authorization are established by the DUR Board. All PA criteria are reviewed and approved by the DUR Board, the KHPA Board and the Legislative Rules and Regulations Committee prior to implementation.

The current pharmacy prior authorization process is manual. All PA requests are submitted by mail or fax and nurses in the KHPA fiscal agent’s PA unit compare submitted documentation against the PA criteria established by the DUR Advisory Board. Requests that fall outside of established criteria are reviewed by a nurse or pharmacist at KHPA. Nearly 6,000, approximately 23 per working day, PA requests are processed annually, making it a labor intensive process. Automated PA systems are available that allow programming of established criteria into a computer database. Using the power of information technology, pharmacy claims can then be screened against the beneficiary’s prescription and medication history. Since pharmacies submit claims electronically, this process can be conducted electronically during the transaction at the pharmacy counter. Claims that do not meet criteria are intercepted by the automated PA system at the point of sale, which prompts the pharmacist to begin the manual PA process by contacting the prescriber, while claims that meet evidence-based guidelines are processed instantaneously.

Over the last several years, the Medicaid program has focused on prescription drug spending in several therapeutic classes with the highest expenditures and/or volume. Accordingly, most cardiovascular, gastrointestinal and anti-asthmatic therapeutic classes have been evaluated by the PDL Committee and subsequently placed on the PDL. Several medications in other therapeutic classes, such as the analgesics Actiq and Fentora and anti-infectives Zyvox and Synagis, have been placed on PA due to safety or cost concerns.
Analyses of drugs placed on the PDL or on PA reveal significant decreases in inappropriate use and significant savings to the state whether for an entire drug class or an individual drug. For example, the addition of PA requirements for Byetta an injectable medication for diabetes that is sometimes used off-label for weight loss since February 2007 has resulted in an expenditure decrease from $180,000 to $100,000 and a drop in paid claims from 990 to 515. This illustrates the ability of the PA process to reduce off-label drug use determined to be inappropriate by the Kansas DUR Board.

Provider Education: Behavioral Pharmacy Management System

The Behavioral Pharmacy Management System (BPMS), provided by Comprehensive NeuroScience (CNS) is utilized by KHPA and several other state Medicaid programs to enhance its physician education efforts. The program is a retrospective educational effort focused on mental health drugs. This means that the BPMS project tries to educate prescribers after they have already prescribed a mental health medication/s. BPMS utilizes quality indicators, which are based on clinical evidence and expert input, to identify potentially inappropriate drug therapy. Examples of quality indicators (QIs) utilized by Kansas Medicaid include the use of two or more atypical antipsychotics within 45 days and use of five or more psychotropic medications within a 90 day period.

Prescription claims are collected by Kansas Medicaid on a quarterly basis and submitted to CNS for analysis. Prescribers (physicians or mid-level practitioners) who are found to exceed a threshold of the QI are mailed letters which outline which quality indicators their prescribing behavior has triggered and provides clinical evidence to suggest alternate therapies. These mailings occur four to six months after the triggered prescriptions were written and filled. Prescribers are encouraged to re-evaluate the therapy that triggered the QI. Prescribers targeted by BPMS mailings may request a consultation from one of the program’s clinical consultants. Both adult and child psychiatrists are used as consultants. In 2007, BPMS distributed more than 4,000 mailings. However, less than ten prescribers requested a consultation.

Despite consistent and detailed monitoring of prescribing patterns since the program’s inception in 2005, data from the BPMS project are inclusive. Prevalence of prescribing behavior triggering some of the Kansas QIs does appear to have fallen over time. However, declines in potentially problematic prescribing behavior were observed for only a portion of the quality indicators. In addition, the timing of BPMS interventions and the observed decline in prescribing behavior is not consistent across quality indicators. Accordingly, it is unclear whether the BPMS project actually caused the changes in prescriber behavior.

A principle focus of the BPMS is a reduction in Kansas polypharmacy — the simultaneous use of multiple drugs in a single class, such as atypical antipsychotics. The BPMS educational efforts are designed to reduce polypharmacy, and to encourage the recommended, clinically appropriate use of a single drug within each class, known as monotherapy. Quarterly reports provided by the Comprehensive NeuroScience staff in support of BPMS projects do suggest a decrease in polyphar-
macy rates. However, the data also demonstrate a drop in the overall number of children in the Kansas Medicaid program using (atypical) antipsychotics, which is not a goal of the BPMS project. This inconsistency suggests that either: (1) other factors are behind the decline in antipsychotic use, such as the publication of new research raising safety concerns in this drug class, or (2) that the BPMS intervention itself was having the unintended effect of reducing overall use of antipsychotics. The questionable effectiveness of the Kansas BPMS and similar retrospective education efforts in other states strongly suggests the need to identify alternative tools to address the significant safety and cost concerns identified in the analysis below. Available studies of such retrospective educational efforts have shown only modest impact (Rascati, Okano and Burch, 1996; Grimshaw, Thomas and MacLennan, 2004; Jamtvedt, Young, Kristoffersen, O’Brien and Oxman, 2006; Lu, Ross-Degnan, Soumari and Pearson, 2008).

Changes in the Program in Fiscal Years 2007 and 2008

In calendar years 2007 and 2008, the pharmacy program implemented several program modifications as a result of new federal and state legislation.

Reimbursement

The 2005 Deficit Reduction Act (DRA) included a provision to change Medicaid prescription drug reimbursement. The change was motivated by long-standing concerns that Medicaid pays too much for pharmaceuticals. Specifically, the law focused on the mechanism used to determine Medicaid price indices, referred to as the Average Whole Price (AWP). The AWP is supposed to represent the manufacturers’ average sale price at the wholesale level. These prices form the basis of payment for state Medicaid programs, including Kansas. Kansas reimburses pharmacies at 87% of AWP for brand name drugs and 73% for generically-available drugs. Successful state legal actions against manufacturers demonstrate that the AWP overstates costs, which has undermined the credibility of using AWP as the mechanism for Medicaid payment. The Kansas’ Attorney General filed suit in 2008 against dozens of manufacturers to recover Medicaid overpayments caused by mis-reporting of manufacturers’ average sale price at the wholesale level.

In the DRA, Congress sought to establish a new basis for Medicaid payments to pharmacies, establishing a statutorily-defined average manufacturer’s price (AMP) for this purpose. National studies reveal that the AWP reimbursement exceeds pharmacy costs. Many stakeholders became concerned that the proposed change from AWP to the new AMP would reimburse pharmacists less than the actual cost to purchase pharmaceuticals. Kansas pharmacists and the pharmacy association voiced their concerns to KHPA and the legislature. As a result, the Kansas legislature imposed a temporary measure to protect existing levels of reimbursement and asked KHPA to survey pharmacies to find out their actual inventory costs.

In the Fall of 2007, KHPA surveyed pharmacies to determine their pharmaceutical acquisition costs. Staff analyzed the data to determine the potential impact of the pricing change on Kansas pharmacies. The survey confirmed that Kansas Medicaid often over-compensated pharmacies for
the cost of prescription drugs. A total of 50 surveys were returned which included data on 24,980 paid claims totaling $375,549. On average, pharmacies had a gross profit on ingredient costs of $6.76 per claim. (The largest potential “loss” on a pharmacy claim was $18.87 and the largest potential “gain” was $87.23.) Using the survey data, KHPA examined strategies to ensure that pharmacies would not incur a significant financial loss while providing services to Medicaid beneficiaries. The goal was to maintain the current level of pharmacy access.

Federal action delayed the pricing change implementation so no change in state policy was undertaken. Currently the change to average manufacturer’s price (AMP) pricing is still being examined, and implementation is planned for October 2009. As a result of the Congressional delay, the policy issue of pharmacy overpayments has fallen back to the states. KPHA is currently exploring strategies to bring prices back in line with an appropriate standard.

**Tamper-resistant Prescriptions**

A new federal law (The U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007) requires that prescriptions written for Medicaid recipients be provided on tamper-resistant paper. This upcoming change in requirements was announced to Medicaid providers through bulletins distributed to all providers in September 2007, October 2007, February 2008 and September 2008, as well as via a posting on the KHPA website. Final implementation of the tamper-resistant requirements took place on October 1, 2008. Pharmacies are no longer allowed to fill prescriptions for Medicaid beneficiaries written on prescription pads that do not meet all federal requirements.

**National Provider Identifier**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard “unique identifiers” for health care providers and health plans. The goal was to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) developed the National Provider Identifier (NPI) to accomplish this mandate. The original implementation date for universal use of the NPI was May 2007, but in April 2007 CMS delayed implementation to May 23, 2008. The Kansas legislature passed a law during the 2006 session requiring all pharmacy claims to be submitted with the prescribing providers’ NPI. This law was also to become effective in May of 2007, however, it was delayed consistent with the federal change.

Per legislative directive, KHPA began requiring NPIs on all claims submitted as of April 1, 2008, approximately seven weeks prior to the federally required date. Between April 1 and May 23, KHPA’s fiscal agent, EDS, proactively contacted pharmacies who were receiving a high number of claim denials due to NPI submission issues and provided education. KHPA plans to use the prescriber information related to the NPI, incorporating it into the agency’s new data management system, the Data Analytic Interface. One application of this information is an analysis of mental health providers’ prescribing patterns by type and specialty. The analysis successfully identified providers for about 90% of prescriptions using the NPI.
National Drug Code

Another requirement of the DRA was aimed at data collection related to drug rebates. The law instructed states to obtain the National Drug Code (NDC), quantity used, and other pieces of data for the purpose of collecting drug rebates, specifically for physician administered medications. This data was required if states wanted to ensure availability of Federal Financial Participation (FFP) funds for physician-administered medications. KHPA began collecting and submitting of utilization data in January 2007. As of January 1, 2008 claims submitted with NDCs that are not rebate eligible are denied. Due to the recent implementation of these policies, the physician-administered drug category was not included in this program review.

Service Utilization and Expenditures

Total spending on fee-for-service pharmacy benefits was $154 million in Fiscal Year (FY) 2007 and $159 million in FY 2008, an increase of 3% (see Table 1). This increase is historically low. In addition, there was a 22% decrease in the number of persons receiving fee-for-serve pharmacy. The reasons for the decrease in fee-for-service pharmacy are described after Table 1.

<table>
<thead>
<tr>
<th>Table 1- Summary of Medicaid FFS Drug Spending</th>
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<tbody>
<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Prescription Expenditures</td>
</tr>
<tr>
<td>Prescription Claims</td>
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<tr>
<td>Cost per Prescription</td>
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<tr>
<td>Persons Served</td>
</tr>
<tr>
<td>Claims per person</td>
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<tr>
<td>Cost per person</td>
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</tbody>
</table>

Changes in the Population Served

Over the last three years there were several policy changes impacting the number of individuals served by the Medicaid fee-for-service pharmacy program. The most significant change occurred on January 1, 2006 when Congress expanded drug coverage to seniors through the new Medicare Part D program. Prior to that time, State Medicaid programs had been the primary source of payment for prescription drugs for low-income seniors eligible for both Medicaid and Medicare. Beginning in the middle of FY 2007, the number of dual-eligible persons served, claims and total expenditures all dropped significantly. As a result, total fee-for-service (FFS) drug costs dropped by more than $100 million in FY 2007, making it very difficult to compare summary totals from FY 2006 with FY 2007-2008.

The second major population shift in the FFS prescription drug program occurred in January 2007 with the transition of approximately 50,000 beneficiaries from Medicaid fee-for-service to the
HealthWave managed care program. The beneficiaries who were transitioned into HealthWave were primarily low income young women and children in comparatively good health. This resulted in the FFS prescription drug program having a population with a higher proportion of ill, more costly beneficiaries.

Enactment of another federal policy through the Deficit Reduction Act (DRA), was the imposition of a federal requirement for proof of identity and citizenship in order to become, or remain, eligible for Medicaid services. The policy change was implemented by the Federal government on July 1, 2006. The quick implementation and the resulting backlog of paperwork produced a loss of 20,000 beneficiaries at the beginning of fiscal year 2007. This change primarily impacted low income young women and children. The Kansas legislature provided additional resources to the KHPA to hire temporary and some permanent, staff for the KHPA eligibility clearinghouse and the backlog was resolved by the beginning of January 2008.

An additional population shift occurred in FY 2007 with the implementation of the presumptive medical disability (PMD) program. The PMD program screens those applying for federal disability and presumptively enrolls those most likely to become eligible into Medicaid. This program partially replaced the MediKan program, a state-only program that provides limited medical services, as well as general assistance cash benefits, to individuals with disabilities who are applying for federal disability. With the introduction of PMD benefits, many who would otherwise be covered by the state-only MediKan program are now enrolled in Medicaid.

**Spending by Population Group**

Examination of expenditures by specific populations from FY 2006 - 2008 in Table 2 below reveals diverse spending patterns because of the population shifts mentioned above. This has resulted in large declines in total spending in some groups.
### Table 2 - Expenditures by Population: Detailed Eligibility Groups

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Aged and Disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) - Aged; 65 and over</td>
<td>5,740</td>
<td>2,361</td>
<td>2,324</td>
<td>$11,157,023</td>
<td>$2,408,535</td>
<td>$2,575,467</td>
<td>$85.01</td>
</tr>
<tr>
<td>SSI - Disabled; under age 65</td>
<td>28,794</td>
<td>24,705</td>
<td>26,226</td>
<td>$90,650,673</td>
<td>$76,207,830</td>
<td>$87,257,767</td>
<td>$257.06</td>
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<tr>
<td>Medically Needy - Aged (SSI)</td>
<td>17,827</td>
<td>10,152</td>
<td>9,886</td>
<td>$39,254,632</td>
<td>$1,341,316</td>
<td>$1,291,451</td>
<td>$11.01</td>
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<tr>
<td>Medically Needy - Disabled (SSI)</td>
<td>12,501</td>
<td>9,014</td>
<td>9,890</td>
<td>$38,798,507</td>
<td>$13,503,873</td>
<td>$16,617,335</td>
<td>$124.84</td>
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<tr>
<td>HealthWave-eligible (beg. Jan 2007)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Temporary Aid to Needy Families - Transitional Medical</td>
<td>3,593</td>
<td>3,368</td>
<td>1,304</td>
<td>$795,250</td>
<td>$602,334</td>
<td>$177,805</td>
<td>$14.90</td>
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<tr>
<td>Low income families with children</td>
<td>35,454</td>
<td>28,040</td>
<td>14,983</td>
<td>$15,453,123</td>
<td>$9,354,246</td>
<td>$3,961,448</td>
<td>$27.80</td>
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<tr>
<td>Pregnant Women under 150% of poverty</td>
<td>9,133</td>
<td>7,714</td>
<td>6,076</td>
<td>$1,590,444</td>
<td>$1,136,933</td>
<td>$706,356</td>
<td>$12.28</td>
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<tr>
<td>Children under 1 below 150% of poverty</td>
<td>9,540</td>
<td>7,704</td>
<td>4,083</td>
<td>$2,470,476</td>
<td>$1,924,495</td>
<td>$941,414</td>
<td>$20.82</td>
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<td>Children 1 - 5 under 133% of poverty</td>
<td>17,549</td>
<td>14,763</td>
<td>8,823</td>
<td>$3,506,816</td>
<td>$3,293,540</td>
<td>$2,244,516</td>
<td>$18.59</td>
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<tr>
<td>Children 6 - 18 under 133% of poverty</td>
<td>20,844</td>
<td>17,190</td>
<td>10,060</td>
<td>$8,400,694</td>
<td>$6,407,919</td>
<td>$3,068,848</td>
<td>$31.06</td>
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<tr>
<td>MediKan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Assistance/ MediKan</td>
<td>5,776</td>
<td>4,779</td>
<td>3,964</td>
<td>$9,708,975</td>
<td>$9,128,059</td>
<td>$7,596,511</td>
<td>$159.17</td>
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<tr>
<td>Other Populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Care up to 21</td>
<td>5,853</td>
<td>6,246</td>
<td>6,494</td>
<td>$9,736,583</td>
<td>$9,600,467</td>
<td>$10,804,162</td>
<td>$128.09</td>
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<tr>
<td>Foster Care-Juvenile Justice Authority custody</td>
<td>1,515</td>
<td>1,307</td>
<td>1,255</td>
<td>$2,700,463</td>
<td>$2,269,902</td>
<td>$2,075,980</td>
<td>$144.73</td>
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<tr>
<td>Children adopted with special needs</td>
<td>3,676</td>
<td>4,035</td>
<td>4,295</td>
<td>$5,316,746</td>
<td>$6,654,622</td>
<td>$7,557,216</td>
<td>$137.44</td>
</tr>
</tbody>
</table>

**Note:** Populations groups with fewer than 1,000 beneficiaries are not included in this analysis.

Expenditures for the Aged and Disabled populations, many of whom are also eligible for Medicare, declined significantly in FY 2007, the year after implementation of Medicare Part D, and resumed growth in FY 2008. Per-capita expenditures, expressed in terms of an average expenditure per member per month (PMPM), grew significantly in FY 2008 in all but the disabled elderly category.

Expenditures for the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) populations declined significantly in both FY 2007 and 2008. This decline reflects the mid-FY 2007 transfer of 50,000 beneficiaries to HealthWave (and out of fee-for-serve pharmacy). Average spending per person (the PMPM) declined in FY 2008, reflecting the short-term and retroactive na-
ture of enrollment in the category following the expansion of HealthWave.

The shift in population out of MediKan beginning in FY 2007 resulted in substantial decreases in volume of that group in both FY 2007 and FY 2008. This is because an increasing percentage of MediKan enrollees were screened for presumptive Medicaid enrollment, resulting in a corresponding increase in the Medicaid Social Security Income Under-65 population. Those individuals moved into Medicaid were those with the clearest indication of disability.

Other populations, which include foster children and children with special health care needs, were not affected by any of the major population shifts described above and show more consistent enrollment and expenditures over time.

**Focused Review of Fee-for-Service Population**

In order to interpret the underlying trends in prescription drug spending and utilization, the previously described population shifts must be considered. The impact of Medicare Part D is addressed by focusing on changes that occurred post implementation. The tables and figures below include data from 2006, but the analysis focuses on FY 2007 and FY 2008. The impact of the transition of 50,000 beneficiaries from the fee-for-service (FFS) population to Healthwave (HW) is addressed by excluding this population from the remaining analysis. The resulting population expenditures and trends are re-stated in Table 3 and displayed in Figure 1 below. The non-HealthWave population presented in Table 3 represents more than 85% of Kansas Medicaid drug expenditures in FY 2007 and more than 92% in FY 2008.

**Table 3 - Summary of FFS Drug Spending Excluding HealthWave Populations**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Expenditures</td>
<td>$222,131,005</td>
<td>$131,537,003</td>
<td>$147,455,386</td>
<td>12%</td>
</tr>
<tr>
<td>Prescription Claims</td>
<td>3,059,522</td>
<td>1,622,392</td>
<td>1,719,269</td>
<td>6%</td>
</tr>
<tr>
<td>Cost per Prescription</td>
<td>$72.60</td>
<td>$81.08</td>
<td>$85.77</td>
<td>6%</td>
</tr>
<tr>
<td>Persons Served</td>
<td>86,030</td>
<td>66,605</td>
<td>68,520</td>
<td>3%</td>
</tr>
<tr>
<td>Claims per person</td>
<td>35.56</td>
<td>24.36</td>
<td>25.09</td>
<td>3%</td>
</tr>
<tr>
<td>Cost per person</td>
<td>$2,582.02</td>
<td>$1,974.88</td>
<td>$2,152.01</td>
<td>9%</td>
</tr>
</tbody>
</table>
Results in Table 3 and Figure 1 indicate a 12% increase in non-HealthWave pharmacy costs in FY 2008, comprised of nearly equal increases in the total number of prescriptions (6%) and the costs per prescription (6%). Further analysis, also shown in Table 3, indicates that the increase in the number of prescriptions was due to both an increase in number of persons receiving pharmacy services (3%) and an increase in the average number of prescriptions dispensed per person (3%), resulting in a total pharmacy costs per person increase of 9%.

This trend in costs-per-prescription exceed consumer and medical price inflation rates, raising concern about the sustainability of Medicaid prescription drug spending. This analysis does not reveal whether the increase is due to both price inflation as well as shifts in utilization towards more costly drugs, or if the health needs of the population served shifted utilization towards more costly drug categories. Additional analyses below attempt to identify the primary sources of growth in the FFS prescription drug program.

Spending by Type of Medication

Figure 2, and the accompanying Table 4, illustrate trends in spending for the five most expensive drug classes. Psychotherapeutic medications comprise a notably higher percentage of expenditures than the next largest classes of medications combined, including central nervous system (CNS) drugs, anti-infectives, gastrointestinal drugs, and anti-asthmatic drugs. Table 4 also reveals that mental health drugs (psychotherapeutic drugs plus Central Nervous System drugs) comprise 42% of the growth in total non-HealthWave spending on prescription drugs in the Medicaid program in FY 2008.
The percentage of spending among these five categories has remained consistent over the three year period, with the exception of a drop in the percentage of spending attributable to gastrointestinal medications. Psychotherapeutic medications were the dominant drug class as measured by spending in each of the three years.

![Expenditures by therapeutic class](image)

**Figure 2**

**Table 4 - Drug Class Expenditure Trends**

<table>
<thead>
<tr>
<th>Therapeutic Drug Class</th>
<th>FY 2006</th>
<th>FY 2007</th>
<th>FY 2008</th>
<th>Increased Spending in Drug Class from 2007 to 2008</th>
<th>Percent of Total Increased Spending 2007-2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapeutic Drugs</td>
<td>$69,415,638</td>
<td>$46,887,670</td>
<td>$51,572,772</td>
<td>$4,685,102</td>
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<td>$13,909,624</td>
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<td>Gastrointestinal</td>
<td>$18,834,959</td>
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<td>All other drugs</td>
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<td><strong>Total</strong></td>
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Figure 3 below examines the top five most utilized drug classes in FY 2008. Trends reveal patterns similar to those observed in expenditures, except that the rate of increase is slightly lower. The pattern suggests widespread increases in utilization by drug class.

KHPA data indicates that expenditure increases are due not only to an increased number of beneficiaries served but also to increased cost of the medications utilized. This could be due either to
an overall increase in drug cost or a shift in utilization from less costly medications to more costly. Further examination of this trend will occur in FY 2010.

![Figure 3](image_url)

Figure 3 displays costs per prescription by therapeutic class, and indicates that costs rose consistently across each major class of drug prescribed, with the exception of a small rate of growth in gastrointestinal drugs. The growth rate reduction is attributed to recent program management activities. The Proton Pump Inhibitor class, which as class of drugs generally taken once daily to treat gastroesophageal reflux disease, has been on the PDL for several years. An additional PA edit added in February 2008 related to twice-daily dosing. Although clinically appropriate in some cases, twice-daily dosing is frequently used without sufficient evidence of necessity. Using criteria developed by the DUR board, unnecessary twice-daily use was reduced over 75 percent, with an estimated $1.2 million of associated savings. The restrictions are thought to have produced a nearly flat cost-per-prescription curve from FY 2007 to FY 2008 in the gastrointestinal class (see Figure 4).

Except for gastrointestinal drugs, spending in each class grew by the overall average, 12% (plus or minus 2%). The consistency between FY 2007 and FY 2008 in the growth of both drug spending and utilization across major drug classes suggests that changes in the health needs of the population
were not a factor. Possible explanations for increased costs-per-prescription include broad increases in drug prices and/or a broad trend towards prescribing of more expensive drugs within each therapeutic class. The anti-infective drug class provides an example of increased cost per claim due to increased drug prices. The anti-infective cost per claim trend has been on a steady, fairly steep increase for the last decade as the prices of newly discovered antibiotics have been set at higher costs by their manufacturers. Due to factors such as antibiotic resistance, the relatively small utilization of antibiotics, generally used only for a short period of time while other medications such as those that treat high blood pressure are used continuously and stiff regulatory challenges imposed by the Federal Drug Administration (FDA), the profitability of producing new anti-infectives is limited and therefore prices of new antibiotics are set high to offset the expense of new drug discovery and approval.

Factors potentially contributing to the increased costs per prescription can be examined through trend comparisons of the Medicaid program and the privately-insured population, whose drug purchases are conducted at more competitive market rates. Figure 5 below includes information for the past three years from the Medicaid FFS pharmacy program and the state employee health plan (SEHP). The SEHP provides health insurance to approximately 90,000 state and other public employees and their dependents across the state of Kansas. The SEHP contracts with private insurance companies who secure competitive market prices through networks of pharmacies. Pharmacy benefits in the SEHP are managed by a private pharmacy benefits management (PBM) firm, currently CVS Caremark. The comparison in Figure 5 presents trends in total expenditures, numbers of claims and costs per claim. The comparison includes data on all pharmacy costs — the left
most columns in the figure - and information on expenditures for the most costly class of drugs in Medicaid, mental health (MH) drugs.

Contrasting the Medicaid FFS pharmacy program and the SEHP reveals conflicting trends in total spending and costs per claim for both the full pharmacy program and for mental health (MH) drugs.

Costs increased for Medicaid in 2008, while overall use, spending, and costs per claim have remained flat or declined in the state employee health plan over the last three years. During this time, the pharmacy benefits management (PBM) contract was re-bid and the state negotiated a new, lower-cost contract price for prescription drugs on behalf of employees and their dependents. This comparison demonstrates that the cost trends affecting the Medicaid program are not driven by similar trends in the Kansas health care marketplace. Increasing costs per prescription in Medicaid appear to be driven by: (1) an increase in the Medicaid price index, an increase that does not appear to be in line with prices charged to Kansas state employees in the private marketplace, or (2) a Medicaid-specific trend towards the prescribing of more expensive drugs within each drug class. Both of these explanations may be correct. In order to help identify underlying
trends in the use and costs of prescription drugs, below we further examine the largest class of drugs prescribed in Medicaid, psychotherapeutic and central nervous system (CNS) drugs.

**Mental Health Medications**

KHPA data indicates that psychotherapeutic drugs account for both the largest expenditure and the greatest volume of prescription medications utilized by the Medicaid fee-for-service (FFS) population. They are also responsible for the largest percentage of growth in the fee-for-serve pharmacy program. For the non-HealthWave population, FY 2008 expenditures for Psychotherapeutic and Central Nervous System Drugs (together frequently referred to as “mental health drugs”) were $69 million; representing 47% of total spending on drugs. Atypical antipsychotics are the largest unit of spending in this category at $37.5 million, accounting for over 50% of spending in this category. Addressing the costs and growth of mental health medications is a central issue in reducing the rate of growth in the Medicaid FFS prescription drug program.

This analysis has focused solely on cost and utilization of prescription drugs and has not included an examination of the impact of medications on beneficiary health or total medical spending. Mental health professionals and research literature emphasize significant advances in mental health treatments over the past decades, as psychotherapeutic medications have improved patient functioning and replaced more restrictive treatments. However, over the past few years, there have been increasing numbers of news reports of serious adverse events associated with the use of some mental health drugs. Use of antidepressants in adolescents received attention in 2004 when the FDA added a black box warning to antidepressants. The FDA cautioned prescribers and consumers that adolescents may be at higher risk of suicide while taking an antidepressant (FDA, 2004). An Archives of General Psychiatry study reports that those warnings resulted in a 9.6% decrease in antidepressant prescribing to children and adolescents - a sharp contrast to the previous trend of a 36% per year increase (Olfson, Marcus and Druss, 2008).

More recently, there has been a focus on atypical antipsychotics and potential health risks of psychotherapeutic drugs. Advances produced by this broad class of antipsychotic drugs include improved function, reduced inpatient hospitalization and reduced use of outpatient treatments for individuals with schizophrenia and other psychoses. Newer generation antipsychotics have demonstrated a reduction in some side-effects associated with older classes of antipsychotics. However, evidence of long-term safety and efficacy has lagged behind the increasingly common use of these medications. Recent studies have raised questions about the effectiveness of the newer antipsychotics over the older generations of antipsychotics (Sikich, Frazier and McClellan, 2008). There is also mounting safety concerns related to atypical antipsychotics. These drugs, frequently used off-label in children, have repeatedly been associated with significant weight gain as well as negative changes in cholesterol, insulin, and liver enzymes. New long-term studies of atypical antipsychotic use in adolescents and children are showing higher incidence of obesity, type II diabetes, cardiovascular conditions and cholesterol disorders among children prescribed an atypical antipsychotic versus a similar population of children not prescribed an atypical antipsychotic. In chil-

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Dren prescribed multiple psychotropic medications, the incidence is even greater (McIntyre and Jerrell, 2008).

Analysis of KHPA claims data reveals that 6,197 unique Medicaid fee-for-service beneficiaries under the age of 18 received a prescription for an atypical antipsychotic in FY 2008, which is 12% of the roughly 50,000 eligible beneficiaries under the age of 18. Aggregate use of atypical antipsychotics increased by 6% from FY 2007 to FY 2008 in children less than 18 years of age, with an alarming increase in 3-6 year olds, where there was a nearly 2.5 fold increase in beneficiaries prescribed an atypical antipsychotic. This increase does not reflect use among children enrolled in HealthWave managed care plans, and occurred despite a decline in the number of children participating in the fee-for-service program between FY 2007 and FY 2008.

Analysis of the entire Medicaid and SCHIP population - which includes roughly 160,000 beneficiaries enrolled in the HealthWave managed care system - shows that approximately 4% of beneficiaries under age 18 were prescribed a psychotherapeutic medication in SFY 2008. That includes 1.2% of beneficiaries under age 5, some less than 1 year old. Additionally, 0.5% of beneficiaries under age 5 were prescribed an atypical antipsychotic, even though no such drugs are FDA approved for use in children under age 5 for any indication.

Only one atypical antipsychotic, risperidone (Risperdal®), is FDA approved for use in young children and adolescents (ages 5-17). Approved pediatric indications for taking risperidone are schizophrenia, short-term treatment of acute manic or mixed episodes associated with Bipolar I Disorder, and irritability associated with autistic disorder. Aripiprazole (Abilify®) is also approved for treatment of schizophrenia in adolescents (ages 13-17). The National Institutes of Mental Health (NIMH) reports the incidence of schizophrenia in children to be 1 in 40,000 (0.0025%). An NIMH sponsored study reports that the incidence of bi-polar disorder in children is 1%, and the American Academy of Pediatrics reports the incidence of autism spectrum disorders to be 1 in 150 (0.06%) (Nicolson and Rapoport, 1999; Lewinsohn, Klein and Seely, 1995; American Academy of Pediatrics, 2008). It is expected that Medicaid would be the primary insurer of a greater proportion of children with these conditions than is found in the general population because severe mental disability can itself be a qualification for Medicaid services. However, the greater percentage (17% vs. 0.0025-1%) of children receiving atypical antipsychotics cannot be explained by this population characteristic alone.

Additional analyses of KHPA fee-for-service data indicates that use of multiple psychotropic medications is common among children enrolled in Kansas Medicaid. From April to June of 2008, 214 children under 18 years of age were prescribed 5 or more different psychotropic medications within a 90 day period. In the same time period, 201 children under 18 years of age were prescribed two atypical antipsychotics simultaneously. Scientific evidence supporting the use of multiple psychotropic medications simultaneously is lacking. Reasons for these potentially inappropriate prescribing patterns have not been isolated.
These concerns have also received attention from the federal government. Starting in FY 2009, the US Health and Human Service (HHS) Office of Inspector General (OIG) will be placing a larger focus on prescribing patterns that do not follow approved uses. The FY 2009 OIG Work Plan lists “Medicaid payments for drugs not approved for use by children” as a category that will be reviewed. The Social Security Act states Medicaid will pay for outpatient drugs if prescribed for indications approved by the FDA or if supported by official drug compendia, such as DrugDex, as standard-of-care therapy. The OIG plans to review paid claims from 2007. The OIG does not specifically mention psychotherapeutic drugs, but high-profile news reports of off-label use of these drugs in other states suggest that this may be one motive for their new focus on off-label use.

Off-label use and potential misprescribing of atypical anti-psychotics among children has garnered increasing attention in the press, in the scientific literature and among medical experts. An external panel of experts convened to review the oversight practices of the FDA recently chastised the agency for acting too slowly to improve prescribing patterns for these drugs among children. The New York Times reported that

“The committee’s concerns are part of a growing chorus of complaints about the increasing use of antipsychotic medicines in children and teenagers. Prescription rates for the drugs have increased more than fivefold for children in the past decade and a half, and doctors now use the drugs to settle outbursts and aggression in children with a wide variety of diagnoses, even though children are especially susceptible to their side effects.” (Harris, 2008)

Safety concerns are reinforced by recent reports of the marginal value of the newer anti-psychotics. A large-scale meta-analysis of 150 scientific (double-blind) trials conducted by a team of experts working on a grant from the National Institutes of Mental Health concluded that the newer generation of anti-psychotics as a group carried no clear advantage in effectiveness in the treatment of schizophrenia, were associated with significant new risks, and in comparison to most of the older anti-psychotic drugs, did not improve on the pattern of side effects observed in the older drugs (Leucht, 2008).

Concerns have been raised in a number of states about the high rate of use of mental health medications among children in the foster care system. Children in foster care are eligible for Medicaid services in all 50 states. In FY 2008, over half of children in the Kansas foster care system (52%) were on mental health medications. Overall use has fallen from 71% in 2004, when the FDA’s black-box warning was placed on antidepressants for children. Among children in the state’s foster care system, 20% are on an atypical antipsychotic medication, and 20% are on an antidepressant with some children on both. The use of anti-psychotic medications has fallen slightly from a high of 24% of foster care children in FY 2005, but payments for antipsychotics have increased from $2 million in FY 2002 to $4.2 million in FY 2004 and $5.5 million in FY 2008. This increase coincides with an increased use of the newer generation of atypical anti-psychotics.
One factor that may be contributing to the potential misuse of psychotherapeutic medications in Kansas is the relatively small and unevenly distributed supply of psychiatrists and other trained mental health professionals across the state. The Medicaid population is served by Kansas Health Solution (KHS), a unified network of mental health professionals organized under a managed care entity owned and operated by the state’s community mental health centers. Mapping KHS’s network of mental health providers to KHPA Medicaid fee-for-service (FFS) beneficiary demographic information reveals that there is one mental health provider for each 175 FFS beneficiaries. That number drops significantly when examining mental health providers that have prescriptive authority. There is only one prescriber for approximately 2,000 FFS beneficiaries.

When coverage is broken down by county, 43 Kansas counties (41%) have no mental health providers, and in Pratt, Jackson, Wilson and Osage counties, the ratio of beneficiaries to providers is greater than 1000 to one. However, Community Mental Health Centers (CMHCs) in Kansas are by statute required to serve all Kansans, regardless of ability to pay for services and CMHC catchment areas include all 105 Kansas counties. Sixty-five Kansas counties (62%) have no mental health professionals that can prescribe medication, and an additional 11 counties have a prescriber to beneficiary ratio of greater than 1000 to one. Figures 6 and 7 are graphical representations of the breakdown of mental health professionals to beneficiaries by county. Figure 6 is the ratio of mental health providers (i.e. psychiatrists, psychologists, psychiatric nurse practitioners, social workers, counselors, marriage, and family therapists) to each FFS beneficiary. Figure 7 is the ratio of mental health providers who can prescribe medications (i.e. psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants) to each FFS beneficiary.

Figure 6

![Mental Health Providers to Each One Beneficiary](image-url)
With the uneven statewide distribution of specifically trained mental health prescribers, anecdotal and claims information suggests that families seek services from primary care physicians, advanced registered nurse practitioners and physician assistants for treatment of mental health conditions. Statewide, most prescriptions for psychotherapeutic medications for Medicaid fee-for-service beneficiaries are written by primary care providers, not mental health professionals. An analysis of Medicaid FFS drug claims in FY 2008 using the newly required NPIs to identify prescribers revealed that just over one-third (37%) of mental health prescriptions were written by a psychiatrist, while a combination of general practitioners (35%), nurse practitioners (14%), and physician assistants (3%) wrote half.

A significant concern, given the increasing safety issues raised for several mental health drugs, is how to assure high-quality mental health treatment statewide. As mentioned previously, KHPA has engaged in physician education through the BPMS program, but with unknown results. Another strategy would be to apply electronic mechanisms to ensure that prescriptions dispensed for Medicaid beneficiaries are consistent with quality guidelines established by mental health professionals.
Conclusions

This review of the Medicaid FFS pharmacy program has documented substantial changes over the past three years, has identified an unsustainable pattern of increases in utilization and spending and has raised a number of safety concerns in the use of mental health medications, especially among children. Key findings include:

- Expenditures on fee-for-service pharmacy benefits totaled $154 million in FY 2007. This total increased to $159 million in FY 2008, an increase of 3.4% despite a 22% decrease in the number of persons served.
- Costs per prescription rose 6% in FY 2008, a rate that significantly exceeds consumer and medical inflation. In addition, a recent comparison of reimbursements and costs at the pharmacy level suggests that Medicaid over-compensates pharmacies, on average, for the ingredient costs of Medicaid drugs.
- Increasing costs per prescription in Medicaid appear to be driven by either an increase in the Medicaid price index, an increase that does not appear to be in line with prices charged to Kansas state employees in the private marketplace, or a Medicaid-specific trend towards the prescribing of more expensive drugs within each drug class.
- Over 40 percent of the growth in Medicaid prescription drug spending in FY 2008 is attributable to increases in the cost-per-prescription and in the total utilization of mental health drugs, as illustrated in Figure 3 and Figure 4.
- In the last few years, an increasing number of scientific studies have identified serious adverse events associated with use of mental health drugs.
  - Atypical antipsychotics, frequently used off-label in children, have repeatedly been associated with significant weight gain, as well as negative changes in cholesterol, insulin, and liver enzymes.
  - New studies with more long-term data of atypical antipsychotic use in adolescents and children are showing higher incidence of obesity, type II diabetes, cardiovascular conditions, and cholesterol disorders among children.
  - Federal panels of experts have questioned whether existing labels provide sufficient warning of these safety concerns.
  - In Kansas, two thirds (63%) of mental health drugs are prescribed by general practitioners and other non-psychiatrists, raising questions as to whether beneficiaries have full access to best practices and the current body of knowledge regarding the safety and effectiveness of mental health medications.

These findings indicate the need for increased oversight and active management of the Medicaid pharmacy program, including more aggressive pursuit of market-based price discounts and focused attention on the management of mental health medications.
Given the emerging data regarding use of mental health medications in children, KHPA is especially concerned about the safety of young Kansans. However, at this time safety precautions commonly employed by insurance plans and other state Medicaid agencies are prohibited by Kansas Statute 39-7, 121b which states that:

"no requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder may be imposed on Medicaid recipients."

This statute prevents KHPA from employing pharmacy management tools that could identify excessively high doses or the combination of multiple drugs, prevent the inappropriate dispensation of medications to young children and alert pharmacists and prescribers that the therapy prescribed may be inappropriate. Given the scale of potential misuse of mental health medications identified in this review, the statutory restriction on the direct management of those medications requires examination. Current management tools have been ineffective and more direct measures merit review.

Direct, point-of-sale management is the standard approach in both the public and private marketplace to address safety issues and introduce market forces in drug pricing.

- Pharmacy edits are commonly used to place limits on the number or combination of drugs dispensed to prevent misuse, fraud, and abuse.
- Prior authorization (PA) is the standard tool used by Pharmacy Benefit Management firms and Medicaid programs to improve safety and ensure appropriate dispensing of drugs that are commonly misused.
- Prior authorization is also the most effective tool in public insurance programs (where limits on cost-sharing prevent the use of financial incentives) to direct beneficiaries towards less expensive drugs that are considered by mental health experts to be therapeutically equivalent, or even preferable to more expensive alternatives.

Concerns over the potential misuse of such direct management tools for prescription drugs led to the exemption of mental health drugs when Kansas first authorized the use of these tools in 2002. Kansas Statute 39-7, 121a provides for the establishment of a preferred drug list in the Medicaid program, and establishes a PDL committee to advise the Medicaid program in the determination of appropriate edits and therapeutic equivalency. Based on the PDL committee’s recommendations, the federally mandated DUR committee then uses these recommendations to determine prior authorization criteria for certain drugs. The DUR committee is comprised of physicians, pharmacists and an advance practice nurse practitioner and is currently chaired by a practicing psychiatrist. The PDL committee’s recommendations also facilitate competitive pricing within classes of drugs by confirming that the drugs are indeed therapeutically equivalent. KHPA staff use the PDL committee’s recommendations to negotiate with drug makers within an established therapeutic class and, based on that competition, place the least cost-effective drugs on prior authorization. In
this way, the clinical decisions regarding medical edits and therapeutic equivalence are made by experts on the PDL committee before the specific economic impact is known. The criteria used for prior authorization is approved by the DUR committee based on the medical judgment of the PDL committee and their own medical evaluation of the evidence. The PDL and DUR committees’ recommendations for the establishment of therapeutic equivalence and prior authorization criteria is then reviewed and approved by both the KHPA Board and the Legislative Rules and Regulations Committee before being recorded in the Kansas Regulation 129-5-1 and implemented.

Despite the multiple protections and transparency offered by this established process, if prior authorization and a PDL are to be applied to classes of mental health drugs as well, there are concerns that the expertise and clinical approaches required to treat mental illnesses will not be addressed. These concerns led to the establishment by KHPA of a new Mental Health Prescription Drug Advisory committee. This committee is to be used foremost to advise KHPA and the DUR committee in establishing a PDL for the MediKan program.

The motivation behind the establishment of a new advisory committee is two-fold: to recognize the unique expertise and clinical strategies prevalent in the treatment of mental illness, and to establish a mechanism to extend mental health professional expertise to all Medicaid beneficiaries. With limited access to mental health professionals, guidance from a panel of experts, using the tools available with the removal of the statutory restrictions established in 2002, will help assure that patients with mental health conditions are treated according to best practice guidelines.

Another concern in the application of standard tools of pharmaceutical management to the dispensing of mental health medications is the potential delays for critical medications at the point of sale. Current methods for obtaining a prior authorization entail the pharmacist notifying the prescriber of the prior authorization requirement, the prescriber completing the necessary documentation, EDS staff reviewing of submitted documentation and, finally, notifying of the pharmacy/prescriber of the determination. Delays caused by these administrative hurdles could, in some cases, cause a several day lag between the presentation of the prescription at the pharmacy and the actual dispensation of the medication. However, federal Medicaid rules protect beneficiaries from some such delays, allowing the dispensation of a 72-hour supply of drugs when the pharmacy is unable to confirm or reject the request for a prior authorization. Even with these protections, delays could disrupt treatment and undermine the motivation for direct management.

To address concerns about timely dispensing of mental health and other medications, many insurers and some states employ a system of electronic guidelines that are applied at the point of sale to ensure compliance with dispensing criteria established by the PDL and DUR committees. These systems, referred to as “electronic prior authorization,” enable real-time management at the point of sale, thus providing a potential technologic solution to concerns over delays, and offering the promise of a reduction in administrative costs for pharmacies already burdened with manual prior authorizations for non-mental health drugs reimbursed through Medicaid.
**Recommendations**

To address the concerns over the unsustainable rise in the use and cost of Medicaid FFS drugs, KHPA recommends the following:

1. **Update drug pricing formulas and reimbursement limits for Medicaid FFS drugs.**

   This program review has identified costs-per-prescription as a key contributor to the 12% increase in pharmacy costs in FY 2008. Based on recent data, Kansas Medicaid often overcompensates pharmacies for the costs of prescription drugs and a comparison to trends in the private marketplace in Kansas indicates that per-prescription costs are rising much faster in Medicaid. Mechanisms to be explored and addressed in FY 2009 include a review of the maximum allowable cost (MAC) established by KHPA to limit reimbursement for generically-available drugs to observed market prices.

2. **Implement an automated prior authorization (PA) system.**

   Approximately 80% of submitted prior authorization requests are approved, many of which could be achieved through point of sale screening against a guideline database by an automated PA system. Time saved by clinical pharmacists and nurses could allow for expansion of the current PDL, and results in greater savings and efficiency within the Medicaid program, without an increased administrative burden. Currently, all PA requests are submitted on paper, reviewed by a nurse and/or pharmacist and notification provided to the pharmacy via phone if the PA is approved. With the implementation of an automated PA system, prescriptions will be screened at the point of sale against prescription and medical claims history to quickly determine if the claim is appropriate. Streamlining of the PA process will allow for:

   - Nearly instantaneous approval of appropriate therapies based on guidelines.
   - Enhanced real-time application of drug use protocols to improve patient access and safety.
   - Increased efficiency of the PA unit in reviewing requests.
   - Reduced burden of completing the documentation required for PAs on pharmacists and physicians.
   - Savings through the expanded use of PA and PDL, which facilitates more intensive utilization management and targeted purchasing.

3. **Remove the statutory limitation on management of mental health prescriptions**

   Current language prohibits management of mental health prescriptions at the point of sale, which limits KHPA’s ability to protect beneficiaries and to take advantage of market pricing, where appropriate. Concerns about direct management of mental health management, raised in 2002,
when the statutory limits were put in place, can be addressed by protecting beneficiaries with established drug regimens, by convening a group of experts to guide the management of mental health drugs, and by ensuring timely access to mental health drugs at the pharmacy. In conjunction with the other recommendations in this review, KHPA is recommending a new and transparent approach to the administration of the pharmacy program that brings mental health expertise to each beneficiary across the state, but these tools will not be effective without a change in the state law which bars their application.

4. Establish a Mental Health Prescription Drug Advisory Committee.

KHPA firmly believes that the treatment of mental illness is vitally important, allowing the mentally ill to lead more mentally and physically healthy, socially integrated, and productive lives. Recent developments in medical research have suggested that some mental health medications are over-used, particularly in young children and adolescents, sometimes with grave adverse health effects. Currently the only mechanism available to Medicaid designed to influence prescribing patterns for mental health drugs is the BPMS program. However, the BPMS program is retrospective, educating prescribers often months after the medication has been provided to the beneficiary. Moreover, the impact of the program is inconclusive at best. More direct mechanisms for changing physician prescribing practices and addressing current deviations from the QI targets for specific beneficiaries are prohibited by the Kansas statute restricting direct management of mental health drugs. These facts, combined the concern that current expenditure trends on mental health drugs is growing at an unsustainable rate, has led KHPA to the proposition of developing a mental health PDL. Guidance from mental health experts about appropriate utilization of mental health drugs will allow for improved treatment of mentally ill Kansans, as well as provide significant reductions in expenditures of tax payer dollars on therapy that is not appropriate. KHPA recommends:

a. Convening a Mental Health Prescription Drug Advisory Board that is composed of experts in the mental health field such as Psychiatrists, Psychologists, Psychiatric Pharmacists, and other stakeholders, including consumers, who have extensive experience in understanding the health care needs of the mentally ill and understand the complex picture of a mentally ill individual.

b. The Mental Health Prescription Drug Advisory Committee would work to ensure the safe use of medications across the state. Serious concerns about the safety and efficacy of atypical antipsychotic use in children requires a more direct approach to management of mental health drugs. Many Kansans receive prescriptions for mental health medications from primary care providers and mid-level practitioners. The Advisory Committee would work to identify new clinical edits to address the most serious safety issues, bringing mental health expertise directly to all beneficiaries across the state through point-of-sale management.

c. The advisory board will have the sole ability to determine which medications should be placed on the preferred drug list, which should require PA (if any), and
what limits should be incorporated into the billing system in order to flag usage that may be inappropriate.

d. Beneficiaries would maintain the ability to access all medically necessary medications; only inappropriate therapy would be limited through the application of pharmacy edits and PAs.

e. Beneficiaries already stable on a medication regimen would be grandfathered into the new PDL, ensuring that no disruption of therapy occurs.

f. Access to mental health professionals, particularly those who can prescribe medications, is limited in some parts of Kansas. Guidance from the advisory panel of experts will help assure that patients are treated according to best practice guidelines in all areas of Kansas, including the rural and underserved.
References


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Chapter 9—Pharmacy Services


Chapter 10: Transportation Services

Executive Summary

Description

Kansas Medicaid provides transportation services for beneficiaries who need emergency transport or lack transportation services to access routine health care. In 2007, approximately 37,500 consumers utilized Medicaid transportation services resulting in expenditures of $9.6 million. Medicaid reimburses five different types of transportation: commercial non-emergency medical transportation (CNEMT), non-commercial and non-emergency medical transportation (NEMT), emergent ground ambulance (EGA), non-emergent ground ambulance (NEGA) and air ambulance (AA). For transportation providers to be reimbursed, they must adhere to specific criteria for the specific type of transportation. Payment for transportation services is paid for on a fee-for-service (FFS) basis.

Key Points

- The total number of transportation providers participating in Medicaid was lower in fiscal year (FY) 2007 than in 2005 and 2006.

- The limited growth in expenditures for transportation services may be attributable to: (1) more stringent participation rules for providers; (2) increased program scrutiny and management; (3) and a shift of approximately 50,000 low-income families from the fee-for-service HealthConnect program to the capitated managed care Medicaid program HealthWave.

- Transportation service expenditures for the aged and disabled populations continue to increase. The Social Security Income (SSI) disabled population account for the majority of Medicaid expenditures and costs for this population have increased significantly since 2005.

- Due to the large volume of transportation services, growing documentation requirements from the federal government, and participation by numerous small-scale providers (including beneficiaries themselves) the Kansas Health Policy Authority (KHPA) recognizes the need to expand oversight of transportation services. The increased oversight activity will ensure appropriate and cost-effective use of transportation services.

- Although rising gasoline prices are a major concern for transportation providers, gas comprises only a portion of transportation service costs. Absent a competitive process for reimbursing providers, KHPA lacks a mechanism to directly link increased gas prices to service costs and reimbursement rates.
Other states have engaged transportation brokers to outsource transportation services in order to increase competition and promote program efficiencies.

- KHPA dedicates approximately one full time staff member for transportation program management.
- A private transportation broker would apply additional personnel resources and achieve program efficiencies through economies of scale.

**Recommendation**

- Issue a request for proposal (RFP) to outsource management and contracting for Medicaid transportation benefits to a private broker. This would generate modest net savings to the state.

**Five year savings associated with outsourcing transportation services**

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**Overview and Background**

**Program Description**

Transportation is a critical access to care issue for low-income and/or disabled populations. Medicaid is one of the few health insurance programs that provide reimbursement for transportation services. Because Medicaid beneficiaries are by definition low-income, providing transportation for beneficiaries to medical appointments and for emergency services is essential to ensure appropriate access to care. Medicaid beneficiaries often have inadequate access to private vehicles and many beneficiaries live in areas with limited public transportation. This program review examines transportation services reimbursed on a fee-for-service basis. Both HealthWave capitated managed health plans, UniCare and Children’s Mercy Family Health Partners, sub-contract transportation services to a broker, who then contracts with individual providers and reimburses for services. Those services are not a part of this review.

**Definitions**

Five types of transportation services are provided to Medicaid beneficiaries in Kansas. These five types of transportation, described in more detail below, are:

- Commercial Non-Emergency Medical Transportation
- Non-Commercial, Non-Emergency Medical Transportation
- Ground Ambulance, Emergent
- Ground Ambulance, Non-Emergent
- Air Ambulance
For transportation providers to be reimbursed, they must adhere to specific criteria for the specific type of transport, outlined below:

**Commercial Non-Emergency Medical Transportation (C-NEMT)** is covered when:
- The beneficiary is transported to a Medicaid enrolled provider in order to receive Medicaid covered medical service.
- The Medicaid beneficiary is present in the vehicle. For example, Medicaid does not reimburse the transportation provider for the cost of driving to pick up the beneficiary.

**Non-Commercial, Non-Emergency Medical Transportation (NEMT)** is covered when:
- Prior authorization has been given
- The Medicaid beneficiary is present in the vehicle
- The beneficiary is transported to a Medicaid enrolled provider in order to receive a Medicaid covered medical service.
- Only those consumers who are enrolled as an active Non-Commercial, Non-Emergency Medical Transportation provider will be considered for transportation related reimbursement.
- Transportation is not covered for MediKan consumers.

**Ground Ambulance, Emergent (EGA)** is covered when:
- The medical condition of the consumer necessitates ambulance transportation.
  - If the beneficiary’s health is in serious jeopardy.
  - If the beneficiary’s accident/injury/illness could cause serious impairment to bodily functions.
  - If the beneficiary’s accident/injury/illness could result in serious dysfunction of any bodily organ or part.

**Ground Ambulance, Non-Emergent (NEGA)** is covered when:
- The beneficiary’s condition is such that a car or regular van cannot be used.
  - If the beneficiary is unconscious.
  - If the beneficiary cannot sit up.
  - If oxygen or other life support is required.
  - If the beneficiary is extremely obese or position of cast(s) or restraints are required.

**Air Ambulance (AA)** is covered when:
- The beneficiary’s medical condition requires immediate and rapid ambulance transportation.
- Medically necessary documentation is provided.

**Service Utilization and Expenditures**

Transportation service expenditures in the fee-for-service program increased 13.1% in FY 2005 and 22.1% in FY 2006. In contrast, expenditures increased only 1.0% in FY 2007 (see Figure I and Table 6). Low growth in expenditures for transportation services in FY 2007 are likely to be attributable to increased program oversight and a transfer of approximately 50,000 beneficiaries from the fee-for-service HealthConnect program to the capitated managed care programs (HealthWave) in January 2007.
Figure 1 depicts the total fee-for-service expenditures for transportation claims for FY 2004 through FY 2007.

Figure 2 depicts fee-for-service transportation expenditures for FY 2004 through FY 2007. Payments for commercial transportation are routinely higher than any other type, and command most of the attention in this year’s transportation program review.

Commercial transportation providers transport Level I and Level II beneficiaries. Level I beneficiaries are those who are ambulatory or able to walk. Level II beneficiaries are those who are non-ambulatory or need wheelchairs. Changes in spending differ markedly by provider type, with noticeable increases in the air and emergency ambulance categories. The increase in expenditures in FY 2006 of $1.7 million corresponds to increases in reimbursements for both air and emergency ground ambulances.
Figure 2

Transportation Expenditures by Provider Type

KEY
C-NEMT - Commercial non-emergent medical transportation
NEMT - Non-emergent medical transportation
EGA - Emergency ground ambulance
NEGA - Non-emergent ground ambulance
AA - Air ambulance

Figure 3 delineates the number of providers by type of transportation services for FY 2004 through FY 2007. The number of non-emergent medical transportation providers decreased in 2007 by (.96%).

Figure 3

Total Transportation Providers
Figure 4 depicts the number of Non-Emergency Medical Transportation (NEMT) beneficiaries by provider type during FY 2004 through FY 2007. There has been steady growth in the number of beneficiaries receiving transportation services, despite the shift of 50,000 beneficiaries from the FFS to the HealthWave transportation program.

Figure 4

Figure 5 illustrates the transportation use by population. During FY 2004 through 2007 three populations used NEMT services the most and accounted for approximately three-fourths of Medicaid fee-for-service transportation costs.

Figure 5

Population refers to the Medicaid eligibility category:
SSI Dis: Social Security Income disabled population
MN Dis: Medically Needy Disabled
Low Income Families
This breakout of expenditures by population type indicates that FFS transportation costs increased in FY 2007 for the Social Security Income (SSI) disabled population and the MS disabled population. As explained previously, expenditures for low-income families decreased as this population was transferred into HealthWave which uses subcontractors to provide transportation services.

Program Evaluation

In 2006, Center for Medicare and Medicaid Services (CMS) conducted a review of Kansas’ Non-emergency Medical Transportation (NEMT) program. This Financial Management Review (FMR) concluded that the oversight controls in place may not be sufficient to assure that payments for NEMT services are necessary and reasonable. This review was part of a nationwide emphasis on improving program integrity in this service area. In response to increased federal oversight, Kansas made a number of program improvements to the transportation program.

Revisions to Transportation Forms

Several revisions to transportation forms have reduced confusion and improved communication with transportation providers.

- Updates were made to the C-NEMT Provider Manual in the General NEMT Requirements, Covered Services, and Transportation Services Never Covered sections of the manual. These changes will reduce billing errors and over payments which require recoupment of disbursed funds. Additional requirements were added to promote a better understanding by transportation providers of the qualifying requirements for Medicaid-covered services before they transport a Medicaid beneficiary.

- The “Certification by Medical Provider for Transportation Services Form” has also been revised. This form allows the physician to classify the beneficiary as Level I (ambulatory; able to walk) or Level II (non-ambulatory; cannot walk). Previously, the billing system allowed a beneficiary to be either Level I or II, but not both. Problems arose when, for example, a beneficiary would go into a dialysis treatment able to walk, but would be weak and need a wheelchair after treatment. Providers using the old form were only able to bill the same level of transportation for both trips, even though a wheelchair was only needed for the return trip. The newly revised form will allow a beneficiary to be classified as both Level I and II during a single trip.

- The “Medical Necessity Form” was revised to clarify what constitutes a referral. The form clarifies that to refer a patient is to “transfer their medical care from one clinician to another.” The clarification will help physicians understand when to use referrals and limit recoupment in audits by ensuring a more accurate referral system from primary care physicians to other physicians.

- An The Provider Manual was amended to clarify billing unit descriptions in all applicable sections. These revisions were necessary to make the billing unit description clear to providers and eliminate payment inconsistencies identified in our review.

- Ongoing review and modifications should continue to improve communication with transportation providers and beneficiaries.
Strengthening C-NEMT Provider Qualifications

In response to the federal review in 2006, Kansas Medicaid also put in place new policies that emphasized enforcement of stricter criteria for new applicants and enrollees, as well as current transportation providers. This new increased enforcement policy will screen and monitor transportation providers and drivers to ensure that beneficiaries are transported in safe, licensed and insured vehicles.

- For applicants and new enrollees, the stricter criteria have allowed Kansas Medicaid to be more discerning when reviewing application forms and information on new drivers as well as terminating some current providers who did not meet the new standards. Greater scrutiny was used in the following areas:
  - Requiring KBI criminal background checks on all drivers.
  - Requiring a valid driver’s license.
  - Requiring proof of insurance and validating it by calling the insurance company.
  - Requiring vehicle inspections.
  - Requiring photos of vehicles enrolled to transport Medicaid beneficiaries.
  - Listing standard driver and vehicles guidelines, along with specific criminal history guidelines in the C-NEMT Provider Manual.

- Enforcing these criteria has prevented former providers who have defaulted on payment to Medicaid to re-enroll under a new business name. In the past, C-NEMT enrollment applicants were not matched up with those providers who defaulted on recoupment payments to re-enroll under a new name. Electronic Data System (EDS), KHPA’s contracted fiscal agent for the Medicaid program, has been asked to develop a spreadsheet that would provide disclosure of ownership of present and terminated C-NEMT providers that would then be used in making enrollment decisions.

- Implementation of these criteria for current providers has proven to be beneficial in ensuring quality and safety for beneficiaries. For example, enforcing the new standards has exposed providers who have not fulfilled their provider agreements. Medicaid was also able to identify providers who employ drivers with criminal records. Administrative reconsiderations, pre-hearings, and fair hearings have all increased in the past year. As well as have the number of recoupments. Trends observed in Figure IV suggest that this increased scrutiny over participation in the transportation program reduced the number of providers in FY 2004-2006, but that the number of C-NEMT providers increased significantly in FY 2007. C-NEMT expenditures increased 9.8% in FY 2005, but decreased 1% in FY 2006 before increasing again in FY 2007. The pattern suggests a substantial reduction in enrollment and spending on C-NEMT services in FY 2006, the year many of the stricter criteria for C-NEMT providers and billing were put in place.

Addressing Transportation Costs through Increased Reimbursement

Transportation program costs have increased for a number of reasons. Some of these increased costs result from improvements made to the program, such as improved access for beneficiaries, and increases in reimbursement when necessary. Targeted rate increases during the previous three years were needed to maintain provider participation in the program and ensure access for beneficiaries.
Observed increases in the number of consumers (see Figure 4) could be due in part to both increased staff outreach and to improved reimbursements. Efforts to replace Medicaid-financed private transportation with lower cost public transportation seem promising, but have not yet shown savings. Van passes for the local transportation authority were made available for Medicaid beneficiaries in the Wichita area, which have the potential to save the program some money, but enlisting participants has been slow and many beneficiaries are reluctant to switch transportation providers.

The costs to providers have also increased with rising gasoline prices. According to the Energy Information Administration, who produces the official energy statistics from the federal government, average regular retail gasoline prices for the Midwest over the last three years were as follows: 2005 gas prices were $2.218; 2006 gas prices were $2.517; 2007 gas prices were $2.785, and; gasoline prices in 2008 have been as much as a dollar per gallon more than they were in 2007. After key C-NEMT providers communicated to KHPA that increases in business expenses threatened their operating and could lead them to possibly pull out of the transportation program, limited rate increases for C-NEMT providers were implemented in January 2008. Code A0130 (Level II, non-ambulatory) for wheelchair van transport increased from $20 per unit to $30 per unit. Two other codes for less complex transportation services did not increase. Additional reimbursement codes will need to be considered for increases this coming year.

Conclusions

Fee-for-service transportation programs are an area of fiscal vulnerability in Medicaid programs across the country. Costs continue to increase and audits routinely identify concerns with the integrity of services and the accuracy of payments. This program review has documented the need for a new direction in the management of Medicaid transportation services in Kansas:

- Enhanced oversight of transportation providers and billing practices has had a significant impact on provider participation and overall expenditures since FY 2005. Nevertheless, the underlying trend in both participation and spending was positive in FY 2007.
- Fuel costs have caused some providers to threaten to exit the program, placing Medicaid beneficiaries at risk.
- Program managers do not have enough time to ensure the program’s integrity, and internal audits continue to reveal concerns about provider compliance with transportation billing requirements.
- KHPA policies place significant demands on transportation providers to serve as both managers and providers of transportation services. A broker for Medicaid transportation services would ease this requirement for providers as the responsibility to collect the required information and verify the legitimacy of transportation services would be streamlined.

Recommendations

1. Reconsideration of Reimbursement Rates
Transportation expenditures for 2009 will be impacted by fuel costs, maintenance, insurance costs and other factors. While rising gasoline prices are a major concern, gasoline comprises only a portion of transportation service costs, and KHPA lacks information enabling a direct translation of increasing gasoline prices into service costs for the purpose of updating reimbursement rates.
Chapter 10 — Transportation Services

Given the emphasis on re-organizing the delivery of transportation services (referenced in the following recommendation), KHPA anticipates that future increases in fuel costs will be addressed through competitive outsourcing rather than direct fee-for-service (FFS) rate increases.

Nevertheless, KHPA is increasingly concerned about maintaining access to transportation services in light of the dramatic increases in the price of gasoline since 2008.

2. Transportation Broker

Over the past year, the KHPA has investigated the possibility of outsourcing the management and provision of transportation services using a broker that would be reimbursed through a risk-based contract. Staff have met with vendors, visited another state’s broker and have begun planning for procurement process. Some of the benefits to hiring a broker include:

- A broker is expected to reduce overall costs by applying pro-active scrutiny to services provided, and by ensuring the minimum rates necessary to maintain access for beneficiaries. Conservative estimates project a 3% reduction in spending, or approximately $287,051 in FY 2010. However, additional savings should be realized by avoiding post pay recoupments. Approximately $400,000 has been identified for recoupments in each of the last two fiscal years.
- The broker is the gate keeper for transportation services and storehouse for all the required transportation forms.
- All trips are verified prior to payment. This should reduce recoupments.
- The broker is responsible for obtaining Kansas Bureau of Investigation (KBI) background checks, vehicle inspections, and other documentation on all providers.
- Access is nearly 24 hours a day, 7 days a week and should improve customer service broadly.
- Brokers facilitate a more competitive market among providers for Medicaid transports by allowing KHPA to have an arms-length relationship with providers.

A broker would also address the administrative burden currently applied to transportation services that is placed on KHPA to increase program integrity and lower costs. The level of administrative oversight is limited by the number of dedicated program staff at KHPA (approximately 1 FTE). Greater oversight is expected to reduce overall expenditures due to the impact on service costs, but additional staff is unavailable for this purpose. Transportation brokers providing services to Medicaid programs in other states would apply approximately 15 FTEs to manage a program of this size.

Data Tables

Table 1
Commercial NEMT

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Provider</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>248</td>
<td>12,289</td>
<td>$4,669,610</td>
<td>--</td>
</tr>
<tr>
<td>2005</td>
<td>207</td>
<td>11,824</td>
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<td>9.8</td>
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<tr>
<td>2006</td>
<td>173</td>
<td>11,854</td>
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<td>2007</td>
<td>238</td>
<td>14,556</td>
<td>$5,169,995</td>
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### Table 2
**Non-Commercial NEMT**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Provider</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
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<td>1,846</td>
<td>$462,821</td>
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<td>2005</td>
<td>1,425</td>
<td>2,343</td>
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<td>2006</td>
<td>1,489</td>
<td>2,428</td>
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<td>2007</td>
<td>1,364</td>
<td>2,274</td>
<td>$574,992</td>
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### Table 3
**Ground Ambulance - Emergent**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Provider</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>170</td>
<td>11,751</td>
<td>$1,075,527</td>
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<tr>
<td>2005</td>
<td>180</td>
<td>14,555</td>
<td>$1,332,053</td>
<td>23.9</td>
</tr>
<tr>
<td>2006</td>
<td>179</td>
<td>15,336</td>
<td>$2,608,924</td>
<td>95.9</td>
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<tr>
<td>2007</td>
<td>175</td>
<td>16,853</td>
<td>$2,679,799</td>
<td>2.7</td>
</tr>
</tbody>
</table>

### Table 4
**Ground Ambulance - Non-Emergent**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Provider</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>85</td>
<td>1,716</td>
<td>$67,344</td>
<td>--</td>
</tr>
<tr>
<td>2005</td>
<td>94</td>
<td>2,825</td>
<td>$71,924</td>
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<tr>
<td>2006</td>
<td>92</td>
<td>2,499</td>
<td>$73,333</td>
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<tr>
<td>2007</td>
<td>98</td>
<td>3,004</td>
<td>$74,785</td>
<td>2.0</td>
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</table>

### Table 5
**Air Ambulance**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Providers</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>16</td>
<td>645</td>
<td>$604,732</td>
<td>--</td>
</tr>
<tr>
<td>2005</td>
<td>16</td>
<td>762</td>
<td>$615,314</td>
<td>1.7</td>
</tr>
<tr>
<td>2006</td>
<td>19</td>
<td>838</td>
<td>$1,066,908</td>
<td>73.4</td>
</tr>
<tr>
<td>2007</td>
<td>19</td>
<td>841</td>
<td>$1,068,807</td>
<td>0.2</td>
</tr>
</tbody>
</table>

### Table 6
**Transportation Summary Table**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. Providers</th>
<th>Consumers</th>
<th>Total Expenditures</th>
<th>% Change in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>1,702</td>
<td>28,247</td>
<td>$6,880,024</td>
<td>--</td>
</tr>
<tr>
<td>2005</td>
<td>1,922</td>
<td>32,309</td>
<td>$7,780,663</td>
<td>13.1</td>
</tr>
<tr>
<td>2006</td>
<td>1,952</td>
<td>32,955</td>
<td>$9,504,078</td>
<td>22.1</td>
</tr>
<tr>
<td>2007</td>
<td>1,894</td>
<td>37,528</td>
<td>$9,568,378</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Table 7
Top 10 C-NEMT Providers of 2007

<table>
<thead>
<tr>
<th>Transportation Company</th>
<th>Total Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Class Transportation</td>
<td>$390,477.50</td>
</tr>
<tr>
<td>Assisted Transportation Services, Inc.</td>
<td>$281,072.50</td>
</tr>
<tr>
<td>A &amp; A Medical Transportation</td>
<td>$242,775.00</td>
</tr>
<tr>
<td>G &amp; B Enterprises, Inc.</td>
<td>$241,830.00</td>
</tr>
<tr>
<td>M Transportation</td>
<td>$157,807.72+</td>
</tr>
<tr>
<td>Gordon Transportation</td>
<td>$112,708.50</td>
</tr>
<tr>
<td>Best Choice Transportation</td>
<td>$104,707.00</td>
</tr>
<tr>
<td>Capitol City Taxi, Inc.</td>
<td>$100,132.76</td>
</tr>
<tr>
<td>GED Specialized Transport</td>
<td>$  89,337.50+</td>
</tr>
<tr>
<td>Coach Transportation</td>
<td>$  81,610.00</td>
</tr>
</tbody>
</table>

+C-NEMT Providers no longer in business.
Chapter 11: HealthWave

Executive Summary

Description

HealthWave is a managed care program through which two populations, HealthWave Title XIX (traditional Medicaid) and HealthWave Title XXI (State Children’s Health Insurance Program [SCHIP]) receive health care services. Approximately 75% of HealthWave participants are in Title XIX component. Although there are subtle differences in coverage, the HealthWave program is seamless to beneficiaries. Prior to January 1, 2007, HealthWave was managed by a single managed care organization (MCO). The HealthWave program now provides capitated managed care through two MCOs: Children’s Mercy Family Health Partners (CMFHP) and UniCare. Mental health services, however, are carved out from physical health services. Medicaid beneficiaries are primarily covered through a Prepaid Ambulatory Health Plan (Kansas Health Solutions) and a Prepaid Inpatient Health Plan (Value Options). Mental health services for SCHIP are covered by Cenpatico, a private MCO providing separately capitated services. Some HealthWave services are still provided through fee-for-service (FFS). For example, dental services, previously provided through a capitated contract, are now fee-for-service.

Analysis

HealthWave XIX enrollment and expenditures increased in 2007 primarily because approximately 50,000 beneficiaries were shifted from the HealthConnect Kansas program to HealthWave. Simultaneously, the Deficit Reduction Act of 2005 (DRA) had a negative affect on Medicaid enrollment due to the paperwork backlog created by the citizenship documentation requirements. This resulted in a year-long decline of 20,000 members. HealthWave also experienced a cost savings through the competitive bidding process that resulted in new HealthWave contracts with CMFHP and UniCare. From state fiscal year (FY) 2004 through FY 2006, average expenditures per member increased. However, a downward trend began in FY 2007.

Key Points

- By contract and federal obligation, the Kansas Health Policy Authority (KHPA) collects a wide range of quality and performance data on the HealthWave program. However, this information has not yet been made public, leaving consumers with little information to select their MCO, and leaving state policymakers without a strong basis for program policy decisions.

- In FY 2009, KHPA expects a reduction of approximately 1% in capitation rates due to formula-driven actuarial adjustments. There are also potential federal funding issues in light of Congress’ failure to reauthorize SCHIP. Federal funding availability for increased participation of
uninsured eligible children in Kansas’ HealthWave XXI program is uncertain, even at the current threshold of 200% Federal Poverty Level (FPL).

- Senate Bill 81 (2008) authorizes an expansion of the SCHIP program up to 250% of the FPL for children 0-18, if federal funding becomes available. However, in FY 2009, federal funding for SCHIP expansion is not expected to become available. KHPA plans to expand the SCHIP program through HealthWave as instructed by Senate Bill 81 when federal funding is assured.

**Recommendation**

- Make performance and quality data available for consumers, policymakers and other stakeholders in FY 2009 in order to assist in beneficiary plan selection and inform program policy changes.

**Overview and Background**

**Program Description**

The HealthWave program of capitated managed care was developed to provide comprehensive health coverage for low income children and families across the state of Kansas. This care is offered through a combination of fee-for-service (FFS) coverage and direct contracts with two physical health managed care organizations (MCOs), Children’s Mercy Family Health Partners (CMFHP) and UniCare Health Plan of Kansas (UniCare) and one mental health managed care organization, Cenpatico Behavioral Health (CBH). These companies join with the Kansas Health Policy Authority (KHPA) to provide children and families a health care delivery system of high quality care with comprehensive coverage that promotes healthy choices for members.

HealthWave provides access to health care for two populations: HealthWave XIX and HealthWave XXI. Although there are subtle differences in coverage, the HealthWave program is seamless to beneficiaries. This is an attribute that is important for enrollees who transition from one population to the other and for families with children enrolled in both HealthWave XIX and HealthWave XXI.

Prior to January 1, 2007, a single HealthWave XIX MCO, FirstGuard Health Plan of Kansas, was offered as the managed care choice to Medicaid members in 62 counties. Within these counties, Medicaid members could choose between FirstGuard and HealthConnect Kansas (HCK), a FFS program.

Following a year long recontracting process in 2006, HealthWave contracts were awarded to CMFHP and UniCare as the managed care organization for “physical health”, effective January 1, 2007. The physical health MCOs are required to provide coverage equal to or greater than the Medicaid FFS program. Mental health coverage for all HealthWave XXI members is provided by Cenpatico Behavioral Health (CBH). The mental health coverage provided by CBH is equivalent to the State Employee Health Plan and adds Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation Group Therapy as value added services. Dental services for both HealthWave XIX and XXI members are reimbursed by FFS and provide full scope coverage for children in both populations and emergent dental care for adults. The majority of Medicaid beneficiaries, including all HealthWave XIX members, receive mental health care from Kansas Health Solutions (KHS) through the Prepaid Ambulatory Health Plan (PAHP) and substance abuse care from Value

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*Chapter 11—HealthWave*

*Program Review of HealthWave—January 2009*
Options (VO) through the Prepaid Inpatient Health Plan (PIHP). Table 1 provides a condensed version of coverage responsibilities.

### Table 1
**Programs and Benefits for HealthWave Families**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Health Plan (Medical)</th>
<th>Benefits Coverage</th>
<th>Method of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Services (Medical)</td>
<td>Children’s Mercy Family Health Partners</td>
<td>HW XIX and XXI equivalent to Medicaid FFS</td>
<td>Risk Based Capitation</td>
</tr>
<tr>
<td></td>
<td>UniCare Health Plan of Kansas</td>
<td>HW XIX and XXI equivalent to Medicaid FFS</td>
<td>Risk Based Capitation</td>
</tr>
<tr>
<td>Dental</td>
<td>Kansas Medicaid Program (EDS)</td>
<td>HW XIX and XXI receive identical coverage</td>
<td>FFS</td>
</tr>
<tr>
<td>Mental Health HealthWave XXI</td>
<td>Cenpatico Behavioral Health</td>
<td>Equivalent to the State Employee Health Plan plus two value added services</td>
<td>Risk Based Capitation</td>
</tr>
<tr>
<td>Mental Health HealthWave XIX</td>
<td>Kansas Health Solutions</td>
<td>SRS-contracted list of covered services</td>
<td>Non-Risk Capitation</td>
</tr>
<tr>
<td>Substance Abuse HealthWave XIX</td>
<td>Value Options</td>
<td>SRS-contracted list of covered services</td>
<td>Risk Based Capitation</td>
</tr>
</tbody>
</table>

With the successful re-contracting for HealthWave MCOs in 2006, the program grew from a single MCO, FirstGuard, to two MCOs, CMFHP and UniCare. Because beneficiaries now have a choice between the two HealthWave MCOs in the two regions representing 94.7% of the HealthWave population, beneficiaries in these two regions no longer have the option of enrolling in the largely unmanaged HealthConnect program, which serves members through the FFS Medicaid program. [Note: Federal rules require that beneficiaries faced with a managed care option must be given a choice of plans.]

Enrollment in the HealthWave program increased in January 2007 by about 60,000 as these individuals and families were transferred from the HealthConnect program. Table 3 documents the increase in HealthWave participation. Each of the Medicaid FFS programs, such as acute care hospitals or prescription drugs, will show a corresponding decline in both participants and expenditures in 2007, a dynamic noted in the 2008 reviews of the programs.

**Service Regions**

To facilitate the implementation of HealthWave throughout Kansas, the state was divided into three distinct service regions. Identified in Illustration 1 are these service regions as well as the managed care plans active in each region.
HealthWave XIX and XXI members in Regions 1 and 2 choose between CMFHP and UniCare. HealthWave XIX members in Region 3 choose between UniCare and HealthConnect Kansas. HealthWave XXI members in Region 3 are assigned to UniCare.

**Population Distribution by Program and Plan**

In the year following the contract-related expansion of the HealthWave population in January 2007, HealthWave XIX increased its enrollment by another 8.7% while HealthWave XXI experienced 9.2% growth. HealthConnect Kansas remained level. The growth experienced in HealthWave is directly related to the increase in staff and resources at the HealthWave Clearinghouse. KHPA received the resources necessary to reduce enrollment barriers created by federal legislation implemented in FY 2007, which required applicants to document both their citizenship and identity. Those efficiencies included:

- Developing a link with the Department of Vital Statistics to verify Kansas births.
- Streamlining imaging processes to allow for quick dissemination of materials with the eligibility clearinghouse.
- Determining appropriate staffing levels and increasing staff to deal with the backlog of applications and to maintain established standards for processing time.

Figure 2 and Table 2 are representations of the HealthWave and HealthConnect Kansas (HCK) population distribution by quarter and indicate the majority of membership has chosen CMFHP as the MCO through which they receive care.
Program Expenditures

HealthWave accounts for approximately 27% of KHPA’s annual combined Medicaid and SCHIP expenditures. These expenditures were calculated by combining reports from the Management and Administrative Reporting (MAR) system, a public report updated monthly and available on the Agency web site. Data in this section will illustrate a summary of overall HealthWave costs, focusing on the capitation and highest FFS expenditures for HealthWave members.

Capitation payments represent the total funds distributed to the MCOs. Payments are made to MCOs on a prospective, per-member per-month basis and are then used by the MCOs to compensate their medical providers for services delivered to Medicaid and SCHIP members. Capitation rates are based on the competitive bids provided by the health plans during the contracting process and updated each year to assure actuarial soundness and maintain approval by the federal government (CMS). HealthWave XIX experienced a cost savings in FY 2008 [not shown] as a result of the new contract with the two competing MCOs. The negotiated capitation rates were effec-
Traditionally, capitation expenditures are the predominant expense for both HealthWave XIX and HealthWave XXI. Data collected for FY 2008 indicates capitation expenditures remain the largest cost drivers and are presently on target to reach KHPA’s prediction by the end of FY 2008. Figure 3 indicates an upward trend from FY 2004 to FY 2007 for the overall HealthWave XIX expenditures.

Non-capitated expenditures are those expenses that are covered benefits under HealthWave; however, they are carved out from the managed care plans. These charges are reimbursed directly to the provider on a fee-for-service basis. Examples of carve-out services include:

- Dental: All dental services are provided fee-for-service following a transition from a dental MC (Doral Health Plan) in July 2006.
- Mental Health
- Substance Abuse
- Local Education Agencies: Reimbursement for therapies and counseling provided to eligible students with individualized education plans has always been reimbursed FFS.
- In-patient hospital
- Prescription drugs

Figure 4 illustrates expenditures by “Category of Service” and those beneficiaries utilizing the specific benefits for FY 2005, 2006, 2007 and 2008 (projected). FY 2007 reflects the beginning of a major shift in several categories of service. First, there is an increase in MCO carved out pharmacy expenditures in 2007 directly relating to factor drugs prescribed for hemophiliacs as that population, which had been concentrated in the HealthConnect program, transitioned to HealthWave in 2007. Second, although incomplete, the FY 2008 data illustrates changes required by CMS to reform payments to Local Education Agencies (LEA). This reduces expenditures by approximately $8 million. Third, during FY 2008, Kansas Department of Social and Rehabilitation Services
(SRS) subsumed Alcohol/Drug Rehabilitation and Community Mental Health Care (CMHC) services for the majority of Medicaid beneficiaries. These services are now provided through the Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) respectively (see descriptions above). This change appears to have caused a net increase in HealthWave population expenditures. Both Figure 4 and Figure 5 exclude capitation payments made to the MCOs for regular (physical) health services.

*Please note, FY 2008 is not a full year’s data. Expenditures by unique (unduplicated) beneficiaries.
Figure 5 represents the top three expenditure categories for HealthWave XXI for FY 2005, 2006, 2007 and 2008. Prescription Drug costs increased even with fewer members utilizing these benefits. The cost increase is a result of growth in the use of factor drugs (used for treatment of patients with hemophilia). Payments outside of dental and factor drugs can be attributed to Presumptive XXI Eligibility. (Presumptive Eligibility is a process that allows low income uninsured children under the age of 19 access health care services from qualified providers while their formal HealthWave applications are being processed.)

Also of note, dental costs appear to drastically increase from FY 2006 to 2007 in both Title XIX and Title XXI. In actuality, this is a transfer of dental costs from a separate capitated contract with Doral Health Plan back into the fee-for-service dental program.

Tables 3 and 4 provide the total number of unduplicated enrollees and consumers of FFS services, as well as the average expense per consumer by category of service by year for HealthWave XIX and XXI (# Cons = number of consumers; Av Exp = average expense).

### Table 3
**Consumers and Average Yearly Expenditure in HealthWave XIX**

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>FY 2005</th>
<th>FY 2006</th>
<th>FY 2007</th>
<th>FY 2008*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cons</td>
<td>Av Exp</td>
<td># Cons</td>
<td>Av Exp</td>
</tr>
<tr>
<td>Managed Care Organizations</td>
<td>103,248</td>
<td>$1,249</td>
<td>117,840</td>
<td>$1,393</td>
</tr>
<tr>
<td>PIHP (Substance Abuse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAHP (Mental Health)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee-for-service Dental</td>
<td>25,782</td>
<td>$314</td>
<td>29,467</td>
<td>$308</td>
</tr>
<tr>
<td>Fee-for-service CMHC</td>
<td>7,040</td>
<td>$1,041</td>
<td>7,245</td>
<td>$985</td>
</tr>
<tr>
<td>LEA/ECI</td>
<td>6,312</td>
<td>$1,116</td>
<td>6,529</td>
<td>$1,090</td>
</tr>
<tr>
<td>Fee-for-service Inpatient Hospital</td>
<td>428</td>
<td>$3,891</td>
<td>645</td>
<td>$1,951</td>
</tr>
</tbody>
</table>

### Table 4
**Consumers and Average Yearly Expenditures in HealthWave XXI**

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>FY 2005</th>
<th>FY 2006</th>
<th>FY 2007</th>
<th>FY 2008*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cons</td>
<td>Av Exp</td>
<td># Cons</td>
<td>Av Exp</td>
</tr>
<tr>
<td>Managed Care Organizations</td>
<td>52,198</td>
<td>$1,055</td>
<td>55,895</td>
<td>$1,085</td>
</tr>
<tr>
<td>Fee-for-service Dental</td>
<td>863</td>
<td>$232</td>
<td>606</td>
<td>$246</td>
</tr>
<tr>
<td>Fee-for-service Prescribed Drugs</td>
<td>7</td>
<td>$39,385</td>
<td>2</td>
<td>$111,353</td>
</tr>
<tr>
<td>FQHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The expenditures for FY 2008 do not represent a complete year.
**The higher average cost per consumer enrolled in HW 19 compared to HW 21 is due to pregnancy related costs.
***This average is based on utilization from members with hemophilia as factor drugs are reimbursed FFS for HW 21.
Chapter 11—HealthWave

HealthWave Program Demographics

All figures in this section were developed from ad-hoc reports obtained through the Decision Support System (DSS). These figures contain demographics information for members in both HealthWave XIX and HealthWave XXI for FY 2007.

Figure 6

HealthWave XIX Gender Distribution Year End 2007

Male - 44.50%
Female - 55.50%

Figure 7

HealthWave XXI Gender Distribution Year End 2007

Male - 51.52%
Female - 48.48%

A comparison of beneficiary gender between HealthWave XIX and XXI reveals there are proportionally more females associated with HealthWave XIX. This variation is directly related to the number of pregnant women who are eligible for services under the HealthWave XIX program.

A comparison of race across HealthWave XIX and HealthWave XXI for FY 2005 to FY 2008 reveals a significantly larger percentage of Black or African-Americans in the HealthWave XIX compared to HealthWave XXI. This data depicts little change in the distribution of race over time for either program. HealthWave XIX experienced an increase in all populations from 2005 to 2008, with the exception of American Indians or Alaskan Natives, which remained very stable. The population percentages within HealthWave XXI remained stable in all categories.
Figure 8

HW XIX Members by Race

- P - Pacific Islander including Native Hawaiian
- A - American Indian or Alaska Native
- S - Asian
- O - Unknown or Blank
- B - Black or African
- W - White

Figure 9

HW XXI Members by Race

- P - Pacific Islander including Native Hawaiian
- A - American Indian or Alaska Native
- S - Asian
- O - Unknown or Blank
- B - Black or African
- W - White

Figure 10

HW XIX Members by Ethnicity

- H - Hispanic
- N - Nonhispanic
A comparison of the distribution of ethnicity across HealthWave XIX and HealthWave XXI shows a larger percentage of Hispanic members in HealthWave XXI. The data depicts a 5% increase of Hispanics in both programs from 2005 to 2008. In 2006 federal citizenship and identification requirements resulted in a backlog of 20,000 HealthWave applications. Separate analysis of the backlog indicated a disproportionate negative impact on African-Americans, but not on Hispanics.

The HealthWave program consists of those members who are eligible for Medicaid (Title XIX) under the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs, or SCHIP (Title XXI). The chart above depicts 75.91% of the HealthWave population as HealthWave XIX members.
Information in this section represents the growth in unduplicated members from FY 2004 - 2007. Both HealthWave XIX and HealthWave XXI experienced positive growth. However, HealthWave XIX grew significantly faster from FY 2005 - 2006. This increase is attributed to removing the cap on the number of Medicaid beneficiaries that the previous Medicaid managed care organization served. There was also an increase in enrollment in HealthWave XIX from FY 2006 - 2007. This represents program growth due to the transition to multiple MCOs. The decline in membership of HealthWave XXI in FY 2007, (shown in Figure 13) is related to the spillover effects of the backlog created by the federal citizenship documentation requirements. The approximately 20,000 person decline in FY 2007 HealthWave XIX due to citizenship documentation is masked in Figure 12 by the larger increase in enrollment that year following the transition to multiple MCOs.

Analysis of Program Expenditures FY 2004 - FY 2007

Information in this section was obtained from the Management and Administrative Reporting (MAR) system, and reflects HealthWave MCO and carve-out expenditures for FY 2004 - 2007.
Both HealthWave XIX and HealthWave XXI experienced population changes during FY 2006 - 2007. There is a direct correlation between the growth in membership (as identified in the previous section) and the total expenses for these populations.
HealthWave XIX and HealthWave XXI both experienced an increase in the average expenditure per member through FY 2006. However, FY 2007 reflects a downward trend. This is directly related to changes in HealthWave XIX and XXI reimbursement rates negotiated with the new managed care organizations (MCOs). It also includes some payment delays to the MCOs associated with the transition.

Quality and Oversight

The Kansas Health Policy Authority, UniCare Health Plan of Kansas and Children’s Mercy Family Health Partners are committed to ensuring quality health care for HealthWave beneficiaries. This is accomplished through a number of means, such as: using industry standard reporting tools; various quality of care projects; onsite oversight of MCO activities; and routine reporting. Table 5 contains a short list of some activities used to assess the quality of services and the care provided to membership. Items 1 - 6 are slated to be completed in 2008, while items 7 - 10 are management reports that KHPA routinely receives. Results will be shared periodically throughout the year on the KHPA website, and will be summarized and evaluated in the 2009 annual Medicaid review.
During 2007 KHPA fielded a pilot provider satisfaction survey for HealthConnect (the Medicaid primary care case management health care program). KHPA also required the HealthWave MCOs to do the same. In the development of these surveys, there were four questions that were required for comparison across programs. They were:

- In comparison to all of your other patients, (HCK/CMFHP/UniCare) patients are just as educated regarding the use of their medical insurance cards.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments they need.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the prescription drugs they need.
- I am satisfied with being a PCP/PCCM in the (HCK/CMFHP/UniCare) program.

Responses to these questions were predominately positive, and reflect an overall satisfaction in these key areas. The most opportunity for improvement was in member education (results in Figures 18 - 21). In this initial pilot, the provider surveys for UniCare and CMFHP were self administered. Response rates (10.9 - 37.5%) and sample sizes (673 - 1,000) were small. We are unable to report statistically significant differences across plans. Next year’s surveys will be administered independently by a third party which will provide more reliable and comparable results.
In comparison to all of your other patients, (HCK/CMFHP/UniCare) patients are just as educated regarding the use of their medical insurance cards.

**Figure 19**

In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments as they need.

**Figure 20**
CMS Review

In April 2008, CMS performed an onsite review of Kansas SCHIP and Medicaid Managed Care programs. During this visit CMS reviewed KHPA adherence to several items: federal laws and regulation; SCHIP eligibility determination process; KHPA contract management practices; internal MCO practices; member notifications processes; and KHPA reporting to CMS. Overall, the CMS response was very positive and productive. CMS identified a number of “noteworthy practices,” presented “recommendations” for improvements, as well as a few “findings” requiring action.
Conclusions

KHPA has contracted with UniCare Health Plan of Kansas and Children’s Mercy Family Health Partners for 18 months. During this time, there have been a number of operational issues which the MCOs responded quickly to correct. This reduced the impact felt by membership and network providers. Now that the MCOs have created stable operational environments, KHPA will shift its focus to assessment of the services being offered. This quality assessment will be accomplished through a number of means, utilizing industry standard tools such as Consumer Assessment of Health Plan Survey (CAHPS), Health Effectiveness Data & Information Set (HEDIS) measures, and Provider Satisfaction Surveys. Onsite audits will be performed to ensure that the MCOs continue to meet their contract requirements. KHPA is currently in the process of validating encounter data (administrative health care records) from the MCOs to ensure accurate reporting, as well as working internally and externally to create better management reports. Results of these assessments will be shared on KHPA’s website as it becomes available, and will be evaluated in the 2009 annual Medicaid review.

Milestones during 2007 and 2008 included:

- The transition to two MCOs offering more choice in health care services to approximately 160,000 HealthWave XIX and XXI beneficiaries.
- Process improvements were implemented to ensure better service and responsiveness from both MCOs.
- Care Management Programs rolled out by the MCOs for pregnant mothers, those with chronic disease, and to promote healthy lifestyles.
- Quality Improvement Projects identified, approved and established by MCOs.
- MCO-sponsored educational opportunities for both members and providers.
- MCOs are developing satellite offices in larger communities across Kansas to create access points for beneficiaries and providers.
- MCOs are up-to-date on submission of encounter data and KHPA has begun assessment of this data for validity.
- The creation of a Kansas Member Care Collaboration between the physical health MCOs, CBH, the PIHP and PAHP, to foster collegial relationships between plans and improve treatment plan development across physical and mental health spectrums.

Expected activities for 2009

Rates in FY 2009 and beyond will be set for the two physical health MCOs using an actuarially sound methodology. KHPA has rebased HealthWave XIX capitation payments for FY 2009. While rooted in the MCOs’ original competitive bids, which helped determine the winning contractors, this change represents an improved and consistent approach to rate development. HealthWave XIX and XXI actuarial rates were developed by an external organization using a HealthWave XIX membership comparison group and HealthWave XIX and XXI historical encounters. As a result of the change to the reimbursement structure for the physical health MCOs, KHPA expects a slight reduction in FY 09 capitation rates of approximately 1%.

As a component of the legislature’s health reform activities in 2008 (SB81), the HealthWave XXI program was authorized to be expanded from an eligibility threshold of 200% of the Federal Poverty Level (FPL) to a threshold of 250% FPL. The expansion is contingent upon the availability of federal matching funds for HealthWave XXI. However, the most notable risk to the HealthWave program has been the inability of Congress to reauthorize SCHIP, the Federal funding source for
HealthWave XXI. Though it was funded through March 2009, neither new funds for increased participation in Kansas' current program, nor funds for expansion to 225% or 250% of poverty were included. The future of SCHIP funding, and the pending expansion of HealthWave XXI in Kansas, will be left to the new president and Congress.

Recommendations

In order to assist in beneficiary plan selection and inform program policy changes, the KHPA will make performance and quality data available for consumers, policymakers and other stakeholders in FY 2009, and will incorporate an evaluation of this performance into the 2009 HealthWave program review.

Definitions

Blended Family—Those families in HealthWave that have members enrolled in both HealthWave XIX and HealthWave XXI.

Category of Service (COS)—Identifier used to report types of service in a consistent manner.

Federal Poverty Level (FPL)—Income level index used to identify eligibility in the HealthWave XIX and HealthWave XXI programs.

Fee-For-Service (FFS)—Coverage methodology in which a provider of service is reimbursed by Kansas directly for services rendered.

HealthWave XIX—The portion of HealthWave comprised of members that receive Medicaid as their source of coverage. These members fall into either the Temporary Assistance to Families (TAF) or Poverty Level Eligible (PLE) aid categories. (See Attachment 1)

HealthWave XXI—The portion of HealthWave comprised of members that receive the State Children’s Health Insurance Program (SCHIP) as their source of coverage. This group is made up solely of children 18 years and younger between 101-200% of the Federal Poverty Level (FPL). (See Attachment 1)

HealthConnect Kansas—The Primary Care Case Management model of managed care in which KHPA contracts directly with primary care providers to act as “gatekeepers” by providing medical homes and referrals to specialty care for certain Medicaid members.

Managed Care Organization—A company through which medical coverage is administered.

PAHP—Prepaid Ambulatory Health Plan offering mental health treatment to Title XIX members. Contract is administered by SRS.

PIHP—Prepaid Inpatient Health Plan offering substance abuse treatment to Title XIX members. Contract is administered by SRS.
Chapter 12: HealthConnect Kansas

Executive Summary

Overview

HealthConnect Kansas (HCK) is a statewide primary care case management program established in 1994 to provide Medicaid beneficiaries with access to quality medical care in an efficient and economical manner. The Kansas Health Policy Authority (KHPA) contracts directly with Primary Care Case Managers (PCCMs) who receive a per member per month (PMPM) fee to provide some components of a medical home. They also act as “gatekeepers” for specialty care referral. Medical services obtained by HCK members are reimbursed on a fee-for-service (FFS) basis. Some of these expenditures are broken down in service-specific Medicaid program reviews (such as the Aged and Disabled program review). This review focuses on aggregate medical service expenditures for the population served in HCK, and the specific role of care management implied by the PCCM model.

Key Points

- In January 2007 approximately 50,000 beneficiaries were transferred from the HealthConnect (HCK) program into our expanded HealthWave capitated managed care program. These beneficiaries were the generally healthy low income mothers and/or children and they resided in the eastern two-thirds of the state (Regions 1 and 2). Because of the large transfer of beneficiaries to HealthWave, the HCK program has been transformed into a much smaller program focused primarily on providing primary care for Social Security Income (SSI) and MediKan disabled beneficiaries. The population remaining in HCK experiences a high prevalence of chronic disease, including diabetes, heart disease and mental illness. Costs for conditions such as heart disease and diabetes are expected to rise in relative importance within HCK, and in the management of Medicaid’s medical services as a whole.

- Through the direction of the department of Social and Rehabilitation Services (SRS), and in response to concerns raised by Centers for Medicare and Medicaid Services (CMS) over funding of the previous system, mental health care funding and management was also restructured, resulting in the transfer from the HCK fee-for-service program into the Prepaid Ambulatory Health Plan (PAHP), a separately-operated mental health managed care program in July 2008. The purpose of the PAHP is to increase beneficiaries access to mental health providers that are willing to meet specified mental health treatment needs.

- Participation of primary care providers in the HCK program remains strong, and the program receives relatively positive ratings by participating providers.

- This program review confirms a strong overall level of access to primary care providers within
HCK, but there is limited evidence of the impact of the PCCM program on beneficiary health care and health outcomes. The PCCM program was initiated to increase access to primary care, but other aspects of the medical home have not yet been applied within HCK, leaving many of KHPA’s highest-cost, highest-need beneficiaries without a coordinated and cost-effective system of care.

- Many HCK beneficiaries report high satisfaction with care received, and a relatively high level of access to care. Lower scores were observed for some of the core outcomes associated with a medical home, such as timeliness of care and effective physician-patient communication.

Recommendations

The HCK program has experienced dramatic changes in both covered populations and services during FY 2007 and FY 2008. The KHPA does not recommend further changes in the HCK program in FY 2009 and FY 2010. However, recommendations from other program reviews may have a direct bearing on the HCK program and its population, and could lead to further transformation of the program in future years:

- An increased focus on the chronic medical conditions of those remaining in HCK is important as the KHPA seeks to improve the delivery of cost-effective care. An emphasis on cost effective care is reflected in the other Medicaid program reviews that directly affect the HCK program such as hospital, pharmacy, home health services and the application of a medical home for the aged and disabled.

- A KHPA quality improvement plan, also addressed in a separate program review, is being implemented in FY 2009 that will create performance and outcomes information which will allow for comparison across health plans, including HealthWave and HealthConnect.

In addition to these Medicaid initiatives, KHPA is part of a large stakeholder process engaged in a comprehensive effort to promote the medical home concept statewide. These efforts will ultimately include payment reforms for specific components of care, for example, increased payment to providers who offer flexible hours of operation, or who use electronic health records. The target outcome in these efforts is an improvement in the quality of care, health outcomes, and long-term medical costs which are expected to decline with a structured, systematic approach to primary care.

Overview and Background

HealthConnect Kansas (HCK) is a statewide primary care case management program established in 1994 to provide Medicaid beneficiaries with access to quality medical care in an efficient and economical manner. The Kansas Health Policy Authority (KHPA) contracts directly with Primary Care Case Managers (PCCMs) who receive a per-member-per month (PMPM) fee to provide some components of a medical home. They also act as “gatekeepers” for specialty care referral. HCK PCCM assignments and referrals are administered by Kansas Medicaid’s fiscal agent, Electronic Data Systems (EDS). Medical services obtained by HCK members are reimbursed on a fee-for-service (FFS) basis. These expenditures are included in other FFS specific program reviews. This review focuses on aggregate medical service expenditures for the population served in HCK, which changed dramatically with the expansion of the HealthWave in January 2007.
The PCCM

The PCCM agrees to provide medical care to a select group of Medicaid members, or when necessary, refer the beneficiary to another provider. The primary care case manager is paid a $2 monthly fee for each beneficiary assigned to their management, plus the Medicaid fee-for-service rate for medical services. Beneficiaries are restricted to their assigned primary care case manager and may not receive medical services from other providers without the case manager’s approval. The two exceptions are emergency services provided in a hospital emergency room and those services exempt from case management referral, such as obstetrical care or family planning. Each HCK primary care case manager may contract to accept and provide services for a minimum of 10 and up to a maximum of 1,800 beneficiaries.

The following provider types are allowed to act as a PCCM within the HCK program:

- Advanced Registered Nurse Practitioners (ARNP)
- Family Practice Physicians
- Federally Qualified Health Centers (FQHC)
- General Practice Physicians
- Indian Health Centers (IHC)
- Physician Assistants (PA)
- Internal Medicine Physicians
- Local Health Departments (LHD)
- Obstetrics/ Gynecology Physicians
- Pediatric Physicians
- Rural Health Clinics (RHC)
- Group practices of the provider types specified

Participation in HealthConnect

HealthConnect Kansas provides a broad array of services to beneficiaries with vastly different health care needs. Populations who receive HCK services qualify for Medicaid based on one or more of the following eligibility categories:

- Supplemental Security Income (SSI), a cash payment program administered by the Social Security Administration that pays benefits to aged and disabled individuals with low income and assets.
- MediKan, also known as General Assistance, provides coverage for individuals who have a severe condition that has not been determined to meet Social Security Administration (SSA) criteria. MediKan recipients also receive General Assistance cash benefits from SRS.
- Temporary Assistance to Families (TAF) Families with children under 30% of federal poverty level.
- Poverty Level Eligible (PLE) Pregnant women and children with family income below 150% of federal poverty level.

In January 2007, approximately 50,000 HCK beneficiaries in Regions 1 and 2 (defined in Graph 1) were transitioned into the HealthWave program and given a choice of enrolling in either Children’s Mercy Family Health Partners (CMFHP) or UniCare Health Plan of Kansas (UniCare). This transition was meant to provide improved access to quality health care by leveraging a competi-
The Managed Care Organizations (MCO’s) that participate in HealthWave offer case management services, educational opportunities and a more robust set of core services. In these regions HCK is made up of SSI and MediKan beneficiaries. Region 3, which is in western Kansas, has fewer beneficiaries and providers. There is only one HealthWave MCO available (UniCare); TAF and PLE beneficiaries are given a choice between HCK and UniCare, while SSI and MediKan beneficiaries are assigned to HCK (see Graph 1).

The expansion of HealthWave in Regions 1 and 2 is demonstrated below in Figure 1 with an increase in the HealthWave population from June 2005 - 2007 (labeled HW 19). Also shown in Figure 1 are the impacts of new federal eligibility requirements for the Medicaid program. Between June 2006 and June 2007, the HCK and HealthWave population declined by about 20,000 persons due to the implementation of new federal citizenship and identity documentation requirements (which took effect July 2006). Implementation of these new eligibility requirements, coupled with the expansion of HealthWave, explains why the HCK population dropped by about 60,000 even though the number of Medicaid beneficiaries enrolled in HealthWave grew by only about 40,000 enrollees.
Given the transition of 50,000 HCK members in Regions 1 and 2 into the HealthWave program, the majority of the remaining beneficiaries in the HCK in June 2007 had SSI or MediKan coverage (referenced in Figure 2 below).

Also evident is a decline in the HCK and MediKan population, which coincides with the implementation of the new Presumptive Medical Disability (PMD) program, which was implemented in 2006. The PMD program screens MediKan applicants for probable eligibility for federal disability benefits and immediately enrolls in Medicaid those who are likely to qualify for full disability. This allows the state to draw down additional federal funds to provide services to this population and allows those who qualify for Medicaid to have a broader set of benefits (Medikan benefits are more limited). As expected, enrollment in MediKan declined by over a thousand following the implementation of Presumptive Medical Disability. Total SSI enrollment, including both the fee-for-service and HCK participants, grew by 4.22% in FY 2007, partly as a result of the enrollees added through the PMD process.
In Kansas, certain beneficiaries are not required to be assigned to a managed care program but are allowed to “Opt-In” if they would like to participate in managed care. Those who do not opt-in are enrolled in the FFS program. Members who default to the FFS program in this fashion, but who are allowed to opt-in to either HCK or HealthWave, are: Children with Special Health Care Needs (CSHCN); members with SSI that are less than 21 years of age; and Native Americans. Members are also allowed to opt-out of managed care at a later date. Table 1 presents a snapshot of the enrollment choices of the total opt-in population in June of each year, 2005-2007, revealing a decline in the percentage selecting managed care.

Though it appears there are fewer opt-in beneficiaries who choose managed care, this decline is somewhat artificial. Prior to November 2003 these groups were mandated into either HCK or HealthWave. When the current Medicaid Management System (MMIS) was implemented in 2003, new logic was developed to allow these subgroups to opt-in to managed care rather than being automatically assigned to managed care. However, if a member was already assigned to managed care in 2003 that assignment was not changed. Over time, with normal turnover in the opt-in population, the number in managed care has declined as fewer new members voluntarily select managed care than were automatically enrolled before 2003. This suggests that the HCK-eligible population is not convinced of the value of the primary care case manager (PCCM) model of care available in HCK. This information may help inform the broader effort to identify opportunities to enhance and re-think the implementation of a medical home in the Medicaid program.

Demographics in HealthConnect Kansas

This section examines the HCK population in more detail. As described above, there was a dramatic decline in HCK participation due to two main factors: the implementation of federal citizenship and identity requirements in July 2006, which made it more difficult for people to enroll in Medicaid, and second the expansion of HealthWave in January 2007. Despite this decline, there appear to be only modest changes in the percentage distribution of the HCK population by age,
gender or race/ethnicity (see Figure 3, Figure 4 and Table 2). These distributions are based on total enrollment during each full fiscal year. The FY 2007 data includes six months of enrollees before the expansion of HealthWave in January 2007 and six months afterwards. The full impact of the reduction in the HCK population on the distribution of enrollees by age, gender and race/ethnicity may not be fully evident until FY 2008, the first complete year under the newly expanded HealthWave program.

*Figure 3*

**HCK Age Category Distribution as % of Total / FY**

*Figure 4*

**Gender Distribution by FY**
Table 2
Race Distribution by FY

<table>
<thead>
<tr>
<th>Race</th>
<th>FY 2005</th>
<th>FY 2006</th>
<th>FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>.97%</td>
<td>.89%</td>
<td>1.77%</td>
</tr>
<tr>
<td>Black or African</td>
<td>16.66%</td>
<td>16.28%</td>
<td>14.09%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.14%</td>
<td>4.19%</td>
<td>2.91%</td>
</tr>
<tr>
<td>Pacific Islander/Hawaii Native</td>
<td>.06%</td>
<td>.08%</td>
<td>.01%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.51%</td>
<td>1.58%</td>
<td>1.80%</td>
</tr>
<tr>
<td>White</td>
<td>75.29%</td>
<td>75.48%</td>
<td>74.10%</td>
</tr>
</tbody>
</table>

Service Utilization and Expenditures

HCK program expenditures, including the $2 per-member/per-month (pm/pm) case management and fee-for-service claims, are displayed below. There was a reduction in both the TAF and PLE population and total expenditures for these populations in SFY 2007 (see Figure 3 above and Figure 5 below). This reduction directly relates to the transition of the 50,000 beneficiaries from HCK to HealthWave in January 2007. Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) also experienced a reduction in average monthly expenditure, which would appear to indicate that average costs for members transferred to HealthWave are lower than costs for those remaining. This implies lower average utilization by TAF and PLE beneficiaries residing in Region 3 in FY 2007 as compared to utilization by beneficiaries residing primarily in Regions 1 and 2 in FY 2006 (Figure 6). The reason for this difference in utilization and spending per person remains unexplained. SSI and MediKan had slight reductions in population size, while experiencing increases in expenditures as well as average yearly cost.

As noted above, the drop in enrollment of the MediKan population (see Figure 1) is the result of the ongoing transition of disabled applicants to the Presumptive Medical Disability (PMD) program. The residual population appears to have higher overall costs as indicated by the rise in per person spending between SFY 2006 and 2007 (see Figure 6). Data below suggests the increase in spending by MediKan members was concentrated in mental health services (see Figure 7 and 12.) Note that services available to MediKan members are tailored and do not include the full Medicaid service package. MediKan provides limited benefits to adults whose applications for federal disability are being reviewed by the Social Security Administration. Health benefits include the provision of medical care in acute situations and during catastrophic illness. Many inpatient hospital services are excluded from MediKan coverage, which may further concentrate observed health care costs among mental health conditions.
Spending by Diagnoses

The largest fraction of services provided to HCK members fell under the procedure code “lack of physiological development”, followed by procedure codes for various mental health diagnoses. The use of the diagnosis “lack of expected physiological development” was greatly reduced from SFY 2005 – 2007 as providers have more accurately diagnosed members instead of utilizing this non-specific code. Figure 7 illustrates the distribution and expenditure of the top diagnoses for SFY 2006 – 2007. Large reductions in spending are evident in SFY 2007, coinciding with the January 2007 exit of most TAF and PLE enrollees to the expanded HealthWave program.

The highest cost diagnoses in FY 2005 and FY 2006 reflect a younger and healthier HCK population and include attention deficit disorder, routine care for children, and Caesarean deliveries. With
the exit of most parents and children from HCK mid-way through FY 2007, these diagnoses fell in rank and were replaced by care for mental health indications such as schizoaffective disorder and paranoid schizophrenia.

Figure 7

Top HCK Expenditures by Diagnosis FY 2005 - 2007

- 7834 Lack of expected normal physiological development
- 31401 Attention deficit disorder of childhood with hyperactivity
- 29570 Schizoaffective Disorder, unspecified
- V202 Routine infant or child health check
- 78099 Other general symptoms
- 65421 Previous cesarean delivery, delivered, w/wo mention of ante partum condition
- 29530 Paranoid schizophrenia, unspecified condition

To gain a better understanding of the nature of the HCK program going forward, Figures 8 and 9 isolate trends in spending by diagnoses for the two predominant populations that remain in HCK: SSI and MediKan. Spending patterns across these top diagnoses appear to be similar across years, although with a steady increase in rank for the non-specific procedure code “other general symptoms.” Also evident is a general trend towards less common diagnoses such as, a reduction in the concentration of spending among these top diagnoses. The analysis presented above demonstrates rising spending in the Supplemental Security Income (SSI) category, and yet spending within these top diagnoses appears to be falling somewhat. This suggests that spending is more evenly spread across a greater number of diagnoses in later years. It is not known whether this indicates changes in the population’s health status and health care needs, or whether it may reflect a change in the composition of SSI participants in HCK.
Figure 8

Top HCK/SSI Expenditures by Diagnosis
FY 2005 - 2007

- 7834 Lack of expected normal physiological development
- 78099 Other general symptoms
- 29570 Schizoaffective disorder, unspecified
- 29530 Paranoid schizophrenia, unspecified condition
- 41401 Coronary atherosclerosis of native coronary artery
- 31401 Attention Deficit Disorder of childhood with hyperactivity

Analysis of spending by diagnoses among the MediKan population suggests continuity across years in the concentration of spending among mental health conditions, although the rank importance of specific diagnoses does change over the three year period. The transition of MediKan membership into the PMD Medicaid program beginning in FY 2007, is likely to have a growing impact on the health needs of those remaining in the program, and could lead to an increasing concentration of spending among those with a mental health diagnosis. The implementation of the Prepaid Ambulatory Health Plan (PAHP) for mental health services in FY 2008 will have a large impact on the focus of the HCK program, especially for the MediKan population: most of the mental health spending within HCK were shifted into the PAHP on July 1, 2007, with the significant exception of prescription drugs.
Spending by Procedure

Examination of HCK expenditures by the highest-reimbursed procedure codes provides data on the largest cost-drivers for the different populations within HCK. Figure 10 suggests the two primary populations remaining in HCK have very different needs and utilization patterns (SSI and MediKan beneficiaries). The number one individual procedure is school-based services. These services consist of Medicaid-reimbursable expenses provided in a school setting to Medicaid-eligible children. Children with disabilities receive significant therapies in a school setting that qualify for Medicaid reimbursement. Figures 11 and 12 reveal a strikingly different set of services provided to these two groups, with a heavy concentration of spending for mental health procedures within the MediKan population. Spending on mental health by the MediKan population is expected to change significantly in FY 2008 with the implementation of the PAHP for mental health care. This change will shift expenditures from a fee-for-service (FFS) basis to a capitated rate. The PAHP (Prepaid Ambulatory Health Plan) contract is overseen and evaluated by SRS, and will be the subject of a targeted program review in the 2009 Medicaid transformation process.
Figure 10

Top HCK Expenditures by Procedure FY 2005 - 2007

- T1018 School-Based Individualized Education Program Services (IEP)
- H0036 Community Psychiatric Supportive Treatment, face-to-face, per 15 minutes
- 99213 Office or other outpatient visit for the eval/management of established patient
- H2017 Psychosocial Rehabilitation Services, per 15 minutes
- 59400 Routine Obstetric care including ante partum, vaginal delivery
- S9124 Nursing Care, in the home, by LPN per hour

Figure 11

Top HCK/SSI Expenditures by Procedure FY 2005 - 2006

- H0036 Community psychiatric supportive treatment
- T1018 School-based individualized education
- S9124 Nursing care, in the home
- H2017 Psychosocial rehab service, per 15 minutes
- 99213 Office or other outpatient visit
- T1019 Personal care services, per 15 minutes
Examination of spending by type of service illustrates the impact of several policy changes in Medicaid and MediKan during 2005-2007. First, spending on inpatient hospital increased substantially in FY 2006 with the implementation of the health care assessment and access payment program, which increased hospital and physician reimbursement rates significantly. The health care access and improvement program uses an annual assessment on inpatient services provided by hospitals to improve and expand health care in Kansas for low income persons. The assessment paid by hospitals is used as a state match to draw down additional federal funding of approximately 40% state dollars and 60% federal dollars to support rate increases for both hospital and physician services. Secondly, total spending declined in FY 2007 as caseloads fell due to the implementation of federal citizenship and identity documentation requirements. And thirdly, KHPA transferred about 50,000 beneficiaries out of HCK and into HealthWave. Expenditure patterns are expected to change substantially again in FY 2008 as most mental health treatment is transitioned into the separately-funded and operated mental health PAHP.

HCK services are paid for through the Medicaid fee-for-service program. Most of the fee-for-service expenditures shown in aggregate in this program review are examined in more detail in separate program reviews. For example, a separate analysis of the fee-for-service prescription drug program examines trends and opportunities for enhanced safety and cost-effectiveness. Prescription drug spending is also a concern specifically for the MediKan population. The 2008 legislature required KHPA to develop a process to better manage prescribing and dispensing patterns for mental health drugs within the MediKan population. This process is to draw on the advice of mental health experts in Kansas to identify appropriate management interventions to improve
safety and cost-effectiveness in the MediKan population. The importance of this focus on prescribing and dispensing patterns in Medicaid and MediKan will become more apparent as mental health spending is transferred to the PAHP in FY 2008, and the proportion of (remaining) HCK expenditures attributable to hospital, prescription drugs, and physician services increases.

*Figure 13*

**Top HCK Expenditures by COS FY 2005 - 2007**

- 011 General Hospital (Inpatient)
- 071 Prescribed Drugs
- 051 Physician, Osteopath, Physician Group
- 293 Community Mental Health Center (CMHC)
- 061 General Hospital (Outpatient)
- 151 EPSDT Screening Services (KAN Be Healthy)
Chapter 12—HealthConnect Kansas

Figure 14

Top HCK/SSI Expenditures by COS FY 2005 - 2007

- 071 Prescribed Drugs
- 011 General Hospital (Inpatient)
- 051 Physician, Osteopath, Physician Group
- 012 Public Teaching Hospital (Inpatient)
- 293 Community Mental Health Center (CMHC)
- 295 Local Education Agency/Early Childhood Intervention

Figure 15

Top HCK/MediKan Expenditures by COS FY 2005 - 2007

- 071 Prescribed Drugs
- 051 Physician, Osteopath, Physician Group
- 293 Community Mental Health Center (CMHC)
- 061 General Hospital (Outpatient)
- 011 General Hospital (Inpatient)
- 151 EPSDT Screening Services (KAN Be Healthy)
Quality Issues

HealthConnect Kansas Consumer Services and Satisfaction

KHPA receives input from HCK beneficiaries in a variety of ways, providing an indication of beneficiary satisfaction, customer service, and overall program performance.

The Quality Assistance Team (QAT) at KHPA’s fiscal agent, EDS, assists with beneficiary and provider inquiries and grievances for both HCK and Medicaid fee-for-service beneficiaries. The QAT is composed of nurses, billing and reimbursement specialists, as well as social work staff. Provider and consumer issues from the QAT may be referred to EDS staff, KHPA program management staff, the Medicaid and Fraud Control Unit (MFCU) at the Kansas Attorney General’s Office, state licensing boards, or other regulating authorities. Currently, HCK and FFS population grievances are reported in a combined report to the State. The State has requested grievances be broken down into the HCK and FFS populations so that comparisons can be made between the programs.

KHPA also solicits feedback from HCK beneficiaries through annual surveys administered by the agency’s external quality review organization (EQRO), which in 2007 was the Kansas Foundation for Medical Care. In Figures 16 -18 below, results from the 2007 HealthConnect Kansas Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey are compared with the National CAHPS Benchmarking Database. The benchmarks consist of average scores for persons enrolled in public health plans across the Midwest and the nation.

Three rating questions reflect overall satisfaction with the care provided at the physician office level. Survey participants were asked to rate their satisfaction with their personal doctor/health provider, specialist, and all health care on a scale from 0 to 10, where 0 was the worst possible and 10 was the best possible. The scores below represent the percentage of respondents who indicated ratings of either 9 or 10.

Figure 16

High Rating (9 or 10) of Personal Doctor/Provider

<table>
<thead>
<tr>
<th></th>
<th>HCK</th>
<th>Nation</th>
<th>Midwest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>64%</td>
<td>66%</td>
<td>68%</td>
</tr>
<tr>
<td>Child</td>
<td>62%</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>Child</td>
<td>60%</td>
<td>62%</td>
<td>64%</td>
</tr>
<tr>
<td>Child</td>
<td>58%</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Child</td>
<td>56%</td>
<td>58%</td>
<td>60%</td>
</tr>
<tr>
<td>Child</td>
<td>54%</td>
<td>56%</td>
<td>58%</td>
</tr>
</tbody>
</table>

- HCK
- Nation
- Midwest
Overall, these comparisons indicate that many HCK beneficiaries were very satisfied with their personal doctor/provider and specialist as well as with the overall quality of health care. HCK adults were more satisfied than the national and Midwest benchmarks with their personal doctor/provider, specialist and overall health care. Parents of children enrolled in HCK expressed levels of satisfaction with their personal doctor specialist and overall health care /provider that were on par with national and Midwestern benchmarks.

The CAHPS surveys also include measures referred to as composites. Composites are groupings of two or more questions that measure the same dimensions of health care or health plan services, and have the same response options, enabling a comparison of adult and child responses to each
other as well as to national and regional benchmarks. While some of the composite attributes were different in the Adult and Child surveys, they measured the same dimensions of care. Figures 19-21 below display the percentage of surveyed beneficiaries with the most positive responses (e.g., “Not a Problem” or “Always”) to questions contained in the composites.

**Figure 19**

Getting Needed Care (Not a Problem)

![Chart showing percentage of surveyed beneficiaries with the most positive responses to questions contained in the composites for Adult and Child surveys, comparing HCK, Nation, and Midwest.]

**Figure 20**

Getting Care Quickly (Always)

![Chart showing percentage of surveyed beneficiaries with the most positive responses to questions contained in the composites for Adult and Child surveys, comparing HCK, Nation, and Midwest.]

Many HCK beneficiaries reported high scores for Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate. However, some opportunities for improvement were identified based on comparisons to the Midwest. These areas are Getting Care Quickly (Child) and How Well Doctors Communicate (Adult and Child). The composite attribute questions with the lowest scores in these areas involved:

- Getting care as soon as was wanted when care was needed right away (Child)
- Showing respect for what parent or guardian had to say (Child)
- Explaining things in an understandable way (Child)
- Spending enough time with patient (Child)
- Listening carefully (Adult and Child)

A brochure providing an overview of the CAHPS survey results was sent to all HCK providers in spring of 2008. When routine provider workshops are conducted around the state by KHPA’s fiscal agent, emphasis will be placed on the lowest score issues cited above. These opportunities for improvement also correspond with some of the outcomes associated with the implementation of a medical home, a core objective for the KHPA and a specific objective associated with health reform in Kansas.

A KHPA quality improvement plan is being implemented in FY 2009 that seeks to create more comparable performance and outcomes information across health plans, including HealthWave and HealthConnect. KHPA is also proposing to implement new data collection for quality improvement purposes within the fee-for-service program, which would provide additional comparative information across programs. This would create, for example, the opportunity to identify the value added by the HCK program’s PCCM as compared to performance in the less structured fee-for-service program and the more structured HealthWave program.
HealthConnect Kansas Provider Participation and Satisfaction

KHPA engages providers in a number of ways at the agency and program level to assist in identifying policy issues, administrative concerns, coverage levels and other programmatic issues. Two sources of information are of particular relevance in the administration of the HCK PCCM program: the Peer Education and Resource Council (PERC) and provider surveys.

The PERC is composed of KHPA representatives, fiscal agent representatives and at least six enrolled Kansas Medical Assistance Program (KMAP) providers. PERC assists with provider education, development and review of improvement plans for providers, peer review and recommendations for policy change for HCK and Title 19 fee-for-service (FFS) beneficiaries. Coupled with the resolution of individual provider issues, PERC provides feedback for managed care initiatives. For example, input from PERC was instrumental in helping to manage a smooth transition of approximately 50,000 HCK beneficiaries to the HealthWave (HW) program in January 2007, when they were reassigned to their choice of either UniCare Health Plan of Kansas (UniCare) or Children’s Mercy Family Health Partners (CMFHP).

During 2007, KHPA’s External Quality Review Organization (EQRO) fielded a provider satisfaction survey for HCK, while each of the HealthWave MCOs were required to do develop and administer their own provider surveys. KHPA required the HealthWave MCOs to include at least four questions in common with the HCK survey to enable comparisons across plans and managed care programs. They consisted of scaled responses to each of the following statements:

- In comparison to all of your other patients, (HCK/Children’s Mercy Family Health Partners (CMFHP)/UniCare) patients are just as educated regarding the use of their medical insurance cards.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments they need.
- In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the prescription drugs they need.
- I am satisfied with being a PCP/PCCM in the (HCK/CMFHP/UniCare) program.

Responses to these questions were predominately positive, and reflect an overall satisfaction in these key areas, with the most opportunity for improvement being in beneficiary education. The distribution of responses is provided in Figures 22 - 25. In 2008, the administration of provider surveys for both HealthWave and HealthConnect will be consolidated with KHPA’s EQRO. This will allow for significant increases in the number of comparable questions and enhanced uniformity in the selection of providers to be included in the survey.
Figure 22

In comparison to all of your other patients, (HCK/CMFHP/UniCare) patients are just as educated regarding the use of their medical insurance cards.

Figure 23

In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the tests and treatments as they need.
Figure 24

In comparison to your patients in other health plans, (HCK/CMFHP/UniCare) patients have as much access to the prescription drugs they need.

Figure 25

I am satisfied with being a PCP/PCCM in the (HCK/CMFHP/UniCare) program.
Access to Primary Care and a Medical Home

KHPA contracts directly with providers to act as PCCMs. Table 3 represents the capacity of the HCK program by displaying the actual caseload of each type of PCCM and the maximum caseload possible. The table outlines caseloads at a consistent point in time in each of three years examined—June 2005, 2006, and 2007. A provider in HCK may contract for up to 1,800 beneficiaries. Many HCK PCCMs contracted for the maximum allowed caseload; however, some geographic areas may not have enough beneficiaries to support full caseloads.

None of the provider categories are operating close to their contractual maximum for caseload at the statewide level. Overall capacity significantly exceeds enrolled caseload, with enrollees at about 15% of contractual maximum in 2005 and just 4% in 2007, after the transfer of TAF and PLE beneficiaries to HealthWave. Two potential cautions are in order in assessing access to PCCMs for HCK beneficiaries. First, HCK providers also contracting to provide service in the HealthWave program may choose to limit access to HCK (or fee-for-service Medicaid) beneficiaries, a decision that may not be reflected in the 2007 totals for maximum caseloads. Second, the information in Table 3 has not been analyzed at the regional and county level, and does not identify potentially underserved areas around the state. With these cautions in mind, we conclude nonetheless that aggregate capacity for primary care in HCK is sufficient.

### Table 3

<table>
<thead>
<tr>
<th>Focus</th>
<th>Number of Providers</th>
<th>Total Current Caseload</th>
<th>Total Max Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practitioner with Obstetrics</td>
<td>94</td>
<td>95</td>
<td>91</td>
</tr>
<tr>
<td>General Practitioner with Obstetrics</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>53</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>35</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>13</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>81</td>
<td>86</td>
<td>82</td>
</tr>
<tr>
<td>Family Practitioner</td>
<td>197</td>
<td>210</td>
<td>218</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>7</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>FQHC - Federally Qualified Health Clinic</td>
<td>13</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>RHC - Rural Health Clinic</td>
<td>131</td>
<td>138</td>
<td>143</td>
</tr>
<tr>
<td>IHC - Indian Health Clinic</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Local Health Department</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mid-Wife</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pediatrician and Internal Medicine</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Multi-specialty Group (Mixed Specialty)</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>OB/GYN and Primary Care</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Statewide Total</strong></td>
<td><strong>648</strong></td>
<td><strong>675</strong></td>
<td><strong>675</strong></td>
</tr>
</tbody>
</table>

Capacity (% of assigned caseload)  
15% 14% 4%

Average Slots per Provider  
941 930 911
As measured by standard patient-to-provider ratios for the state as a whole, HCK has historically provided good access to medical services for beneficiaries. The $2 monthly fee may induce some level of participation, and reimbursement rates for many physician services were increased in FY 2006. These enhancements haven’t been formally evaluated to assess their impact on participation, but informal feedback from the physician community consistently points to their positive role in securing access to primary care for beneficiaries. However, most rates remain below Medicare, and are even further below privately-negotiated reimbursement with other insurers. As expected, Medicaid is not able to “buy” its way into physician and other primary care offices through competitive reimbursement.

There may be a number of other reasons for continued participation in HealthConnect. Coverage policies support wide participation of health professionals serving as PCCMs: In addition to primary care physicians, nurse practitioners and specialists such as OB/GYNs are also enrolled as PCCMs, and physician assistants were allowed to be enrolled as PCCMs effective August 2004. Still, the vast majority of individually-contracted PCCMs are in family practice or are pediatricians. The majority of PCCMs operate in a clinic setting, headed by physicians with nurse practitioners and physician assistants operating under their purview.

Although difficult to quantify, the State’s primary care providers clearly express a professional obligation to serve the state’s Medicaid and uninsured populations. While rates, coverage and reimbursement policies, and administrative procedures are routinely raised as concerns by participating providers, it is also apparent in their interaction with KHPA public insurance programs that Kansas primary care providers as a whole operate with an ethical commitment to these programs. A number of providers have served for decades. In recognition of their longstanding commitment, in September of 2007, a thank you letter signed by the Governor was sent to 98 HCK PCCM providers and fee-for-service providers that had 30 years or more service to the State.

The information presented in Table 3 suggests that the issue of “access” to primary care is not a significant issue for most HCK beneficiaries (since most beneficiaries reported adequate access). Access to primary care, however, is an important first step in ensuring an effective medical home, an especially critical step for the HCK program. A separate analysis of the health needs of the high-cost populations that now dominate the HCK and fee-for-service programs is included in the review of medical services for the aged and disabled [see Chapter 13]. That analysis provides a number of examples of gaps in the quality of care received by some of the disabled, and identifies a number of alternative systems of care that could be advanced in Kansas to promote additional components of a medical home. One approach is currently being tested by KHPA in Sedgwick County. The Enhanced Care Management Program (ECM), a pilot project in Sedgwick County, is comprised of HCK members. Since March 1, 2006, the ECM project has provided home-based care management services to ECM members. Assessment will continue to determine if more intense management of high cost populations is cost effective. This pilot and several alternatives are discussed in more detail in Chapter 13.

Conclusions

The HCK program has been transformed in the last year from a statewide “managed care alternative” for Medicaid beneficiaries, to a much smaller program focused primarily on providing primary care for SSI and MediKan disabled beneficiaries. The remaining population experiences a high prevalence of chronic disease, including diabetes, heart disease and mental illness. While costs have decreased significantly due to the exit of more than 50,000 beneficiaries, KHPA analy-
sis of Medicaid spending consistently highlights the growing costs of the disabled, and the prominent role these costs play in driving overall Medicaid spending. Costs for conditions such as heart disease and diabetes is expected to rise in relative importance in HCK and in the management of Medicaid’s medical services as the funding and management of mental health services was transferred into the PAHP, a separately-operated mental health managed care program in July 2008. The chronic medical conditions of the SSI and MediKan populations merit an increasing focus as KHPA seeks alternative means of delivering cost-effective care, an emphasis reflected in the separate 2008 program review focused on medical services for the aged and disabled.

The HCK program consists primarily of a primary care provider, a PCCM that receives a small per-member-per-month fee of $2 to serve as manager and gatekeeper for each HCK beneficiary’s care. This program review confirms an overall level of access to primary care providers within HCK, but there is limited evidence of the impact of the PCCM program on beneficiary health care and health outcomes. The PCCM program was initiated to increase access to primary care, but other aspects of the medical home have not yet been applied within HCK, leaving many of KHPA’s highest-cost, highest-need beneficiaries without a coordinated and cost-effective system of care.

This program review summarizes results of beneficiary and provider surveys which indicate a relatively high level of satisfaction with the HCK program. More objective measures of the quality of health care received by this population suggest a number of potential opportunities for improvement. These results are discussed in detail in Chapter 13. The perceived value of the PCCM approach in promoting higher-quality care can also be observed in beneficiaries’ choices. It is apparent from the information presented in this program review that many high needs beneficiaries who have a choice are not selecting HCK, indicating the lack of perceived added value in the PCCM approach. The role of the PCCM system in supporting primary care and a medical home within Medicaid will be a central question in KHPA’s review of care management approaches for the aged and disabled during FY 2009.

**Recommendations**

The HCK program has experienced dramatic changes in both covered populations and services during FY 2007 and 2008. The KHPA does not recommend any further changes in the HCK program in FY 2009. However, recommendations from other program reviews may have a direct bearing on the HCK program and its population that could lead to further transformation of the program in future years:

1. The chronic medical conditions of the SSI and MediKan populations merit an increasing focus as KHPA seeks alternative means of delivering cost-effective care, an emphasis reflected in the separate 2008 program review focused on medical services for the aged and disabled. The role of the PCCM system in supporting primary care and a medical home within Medicaid will be a central question in KHPA’s review of care management approaches for the aged and disabled during FY 2009.

2. A KHPA quality improvement plan is being implemented in FY 2009 that seeks to create more comparable performance and outcomes information across health plans, including HealthWave and HealthConnect. KHPA is also proposing to implement new data collection for quality improvement purposes within the fee-for-service program, which would provide additional comparative information across programs.
3. Develop linkages between HealthConnect PCCMs and the Social and Rehabilitation Services Mental Health and Substance Abuse providers to better coordinate physical care with Mental Health/Substance Abuse.
Chapter 13: Medical Services for the Aged and Disabled

Executive Summary

Description

The aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending. Almost half (47%) of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged. The top Medicaid cost drivers for the aged and disabled include: inpatient services, pharmacy, outpatient services, mental health services, hospice and Medicare premiums and co-pays. Inpatient services represent the highest costs among the Supplemental Security Income disabled category, accounting for 71% of the $183.83 million of inpatient costs. Pharmacy is the second highest cost driver for the disabled.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Caseload (number of people)</td>
<td>32,798</td>
<td>16,591</td>
<td>6,305</td>
<td>17,114</td>
<td>8,156</td>
</tr>
<tr>
<td>Total Medical Costs</td>
<td>$336.51 million</td>
<td>$107.56 million</td>
<td>$29.39 million</td>
<td>$61.58 million</td>
<td>$11.13 million</td>
</tr>
<tr>
<td>Average Monthly Costs (per person) paid by Medicaid</td>
<td>$855</td>
<td>$540</td>
<td>$388</td>
<td>$300</td>
<td>$114</td>
</tr>
</tbody>
</table>

*The Supplemental Security Income (SSI) program pays monthly benefits to disabled adults and children who have limited income and resources.

Key Points

- Medical expenditures for the aged and disabled population are projected to show steady increases in 2008 and 2009.
- Using funds from a Center for Medicare and Medicaid Services (CMS) transformation grant awarded to KHPA, we looked at whether we could improve preventive care to the aged and disabled. Our analysis showed:
  - Preventive care opportunities are being missed for beneficiaries struggling with diabe-
Chapter 13—Medical Services for the Aged and Disabled

- Preventive care opportunities are also being missed for cancer screenings, cardiac event prevention, osteoporosis screening, and pain management.

- The overall trends in expenditures and the implications of chronic health conditions that plague the aged and disabled population suggest the need to more effectively manage and support the needs of this population. KHPA is currently conducting two pilot projects that aim to improve health outcomes for people with disabilities:
  - The “Health Promotion for Kansans with Disabilities” pilot project, the CMS Transformation Grant program to identify and improve primary care needs among the chronically ill, and
  - The “Enhanced Care Management” pilot program targeting high-cost Medicaid beneficiaries in Sedgwick County for intensive care management.

- Given the high incidence of chronic illness and the high level of interaction with the medical system, the need to implement a medical home model of care is significant for the aged and disabled. Goals for improving care in this population mirror closely the established goals of a patient-centered medical home.

KHPA Staff Recommendation

- Develop and utilize a medical home model of care for the aged and disabled population. The development of a medical home model for Kansas is currently underway with the passage of Senate Bill 81 during the 2008 legislative session. Over the next year, a large group of stakeholders will design over the next year a care management model based on existing evidence and the needs of our state. The recommendations will be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget.

Program Overview

Established in 1965, Medicaid has become the largest single source of financing for the long-term care of aged and disabled people who are low-income or who have depleted their income and assets on medical and long-term care expenses (Keenhan, Siska, Truffler, Smith, Cowan, 2008). As succinctly stated in a 1999 Urban Institute report, Medicaid spending for these beneficiaries dominates the program (Bruen, Wiener, Kim, Miazad, 1999). Nationally, while aged and disabled beneficiaries make up only 25% of the population, they account for nearly 70% of all Medicaid spending. In Kansas, during FY 2008, they accounted for about 33% of the population and 67% of Medicaid spending. Partly because long-term care services such as nursing home and community-based are so expensive, the aged and disabled are the costliest groups of people covered under Medicaid (Congressional Research, 2008). However, while long-term care services play a significant role in driving the costs for the aged and disabled, it is important to note that acute care spending for these individuals is also greater than it is for children, pregnant women, and parents.

Kansas’ Medicaid expenditures for the aged and disabled compares with neighboring states both in aggregate and as a percentage of total state Medicaid spending. A 2005-2006 state Medicaid fact sheet developed by the Kaiser Commission shows this comparison.
Chapter 13—Medical Services for the Aged and Disabled

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Note: Medicaid spending for the elderly and disabled includes long-term care costs. A regional breakdown of medical and long-term care costs is currently not available.

Introduction to the Population

There are five major categories of the aged and disabled among Kansas Medicaid beneficiaries. Although Medicaid eligibility is complicated, a simplified explanation of these categories follows.

<table>
<thead>
<tr>
<th>Category</th>
<th>Beneficiary Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Security Income (SSI) - Aged</td>
<td>These are adults, 65 years of age and older, with low income and limited resources who receive SSI payments and are eligible for medical assistance. A large percentage of the individuals also receive Medicare benefits.</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) - Disabled</td>
<td>These are adults, under age 65, and children with disabilities who receive SSI payments and meet income guidelines for Medicaid.</td>
</tr>
<tr>
<td>Medically Needy - Aged (SSI)</td>
<td>People included in this category are over 65 and have incurred medical expenses to the extent that their income has been depleted to levels that make them eligible for Medicaid.</td>
</tr>
<tr>
<td>Medically Needy - Disabled (SSI)</td>
<td>These are people under 65 with disabilities that qualify them for coverage, but who have incomes that require them to spend a certain amount on medical services before Medicaid will cover them.</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>People in this group are certain low-income Medicare recipients, for whom Medicaid pays portions of Medicare premiums, coinsurance, or deductibles.</td>
</tr>
</tbody>
</table>

The monthly caseloads for each eligibility group are shown in Figure 1. These five separate groups comprise approximately 107,742 people served during FY 2007, based on eligibility throughout the fiscal year.
Table 1 depicts the top medical cost drivers, excluding long term-care costs, for each of the five eligibility groups.

<table>
<thead>
<tr>
<th>Type of Service by Agency</th>
<th>Supplemental Security Income - Aged</th>
<th>Supplemental Security Income - Disabled</th>
<th>Medically Needy - Aged (SSI)</th>
<th>Medically Needy - Disabled (SSI)</th>
<th>Qualified Medicare Beneficiary (QMB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health- SRS</td>
<td>$28,510,000</td>
<td>$92,56,000</td>
<td>$33,328,000</td>
<td>$1,123,000</td>
<td>$263,000</td>
</tr>
<tr>
<td>Inpatient - KHPA</td>
<td>$9,055,000</td>
<td>$9,256,000</td>
<td>$33,328,000</td>
<td></td>
<td>$1,123,000</td>
</tr>
<tr>
<td>Outpatient - KHPA</td>
<td>$2,729,000</td>
<td>$80,124,000</td>
<td>$14,378,000</td>
<td></td>
<td>$263,000</td>
</tr>
<tr>
<td>Pharmacy - KHPA</td>
<td>$1,398,000</td>
<td>$19,358,000</td>
<td>$18,429,000</td>
<td>$12,708,000</td>
<td>$9,308,000</td>
</tr>
<tr>
<td>Hospice- KHPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12,708,000</td>
</tr>
<tr>
<td>Medicare Premiums and Co-pays - KHPA</td>
<td>$9,174,000</td>
<td></td>
<td></td>
<td></td>
<td>$9,308,000</td>
</tr>
</tbody>
</table>

Cost drivers for the aged reflects the role that Medicare plays in funding health care services. Medicare not only helps pay for health care benefits such as hospitalizations and physician services but also provides prescription drug coverage through Medicare Part D. Medicare Part D was implemented in 2006 to cover pharmacy costs for Medicare beneficiaries. Prior to that, individuals dually eligible for Medicare and Medicaid received their pharmacy benefit through Medicaid. Pharmacy for the disabled is among the top cost drivers primarily due to the treatment of chronic conditions, as well as the significant use of mental health drugs.

Figure 2, listed below, shows a breakdown of total medical costs, excluding long-term care costs per eligibility group for FY 2007. The total medical expenditures for all five groups is $546,165,000, representing approximately 45% of the total medical expenditures for Kansas Medicaid during that year. When long-term care costs are included, expenditures increase to $1,405,695,000, representing approximately 67% of the total expenditures for Kansas Medicaid.
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during FY 2007.

Figure 2

Long-Term Care Coverage Options in Kansas

People who receive Medicaid long-term care are:

- Individuals with mental retardation and developmental disabilities
- Individuals with mental illness
- Individuals with spinal cord injuries and traumatic brain injuries
- Individuals with Alzheimer’s disease and dementia
- Individuals with neuro-degenerative conditions
- Children with special health care needs

Contributing to the high cost of providing coverage to these beneficiaries is not only the nature of their disabilities and complex needs, but also the fact that many have multiple chronic conditions (Kronick, Bella, Gilmer, Somers, 2007). Data reported by the Center for Health Care Strategies (CHCS) show that beneficiaries with three or more chronic conditions are responsible for a significant portion of the nation’s Medicaid spending, and that for people with disabilities, each additional chronic condition is associated, on average, with an increase in costs of approximately $8,400 per year (Kronick et al, 2007).

In Kansas, there are two options for receiving long-term care services through the Medicaid program: the Home and Community Bases Services (HCBS) waivers and the Nursing Facility Program (KHPA, 2007). These options are managed by Social Rehabilitations Services (SRS) and the Department of Aging (DOA). HCBS waivers currently being implemented in Kansas are:
In addition to long-term care services provided through the waivers, nursing home services and intermediate care facilities for the mentally retarded are available to certain Kansas Medicaid beneficiaries.

Behavioral health and substance abuse services are provided through two waivers (called 1915b): the Prepaid Ambulatory Health Plan (PAHP) and the Prepaid In-Patient Health Plan (PIHP). Both programs are managed by the Kansas Department of Social and Rehabilitation Services.

**Coverage of Medical Services**

Kansas Medicaid coverage of medical services, or acute care, includes services such as physician and hospital care, prescription drugs and laboratory and diagnostic testing. For some aged and disabled beneficiaries, who are dually eligible for Medicaid and Medicare, prescription drugs are now covered by Medicare Part D.

FY 2007 average monthly expenditures for these individuals, according to category of eligibility, are shown in Figure 3.
Differences in average costs across the five eligibility groups reflect the large extent to which Medicare pays for services for the SSI-Aged, the Medically Needy-Aged (SSI), and the Qualified Medicare Beneficiaries (QMBs). It is important to note that the medically needy beneficiaries are comprised of people whose income is too high for regular Medicaid but who become eligible for a medically needy program by spending down their excess income on health care services. Because medically needy beneficiaries enrolled in Medicare receive pharmacy coverage through Part D, eliminating (or postponing) significant out-of-pocket expenses on prescription drugs, they may not be able to spend-down as quickly and experience lapses in their Medicaid eligibility. When these lapses occur, they lose access to health services covered by Medicaid (for example, mental health services or drugs not covered by Medicare).

\[ \text{Figure 3} \]

**FY 07 Average Monthly Medical Cost Per Person**

<table>
<thead>
<tr>
<th></th>
<th>FY 07 Average Monthly Medical Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Security Income - Aged</td>
<td>$388</td>
</tr>
<tr>
<td>Supplemental Security Income - Disabled</td>
<td>$855</td>
</tr>
<tr>
<td>Medically Needy-Aged (SSI)</td>
<td>$300</td>
</tr>
<tr>
<td>Medically Needy-Disabled (SSI)</td>
<td>$540</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>$114</td>
</tr>
</tbody>
</table>

\[ \text{Figure 4} \]

**Figure 4: Aged and Disabled Medical Expenditures**

- **Aged**
- **Disabled**
- **Total Aged & Disabled**

- **Part D**
Chapter 13—Medical Services for the Aged and Disabled

Figure 4 represents the medical expenditures for the aged and disabled across fiscal years 2001 through 2007, with expenditure projections included for 2008 and 2009. Contributing to the peak in spending in FY 2005 was an increase in the number of weeks comprising that year 53 weeks instead of the normal 52 weeks, and pending of claims from FY 2004. In addition, Medicare Part D pharmacy benefits were implemented January 1, 2006, with the first full year of impact reflected in the FY 2007 expenditures.

Further analyses of the contribution of each Kansas Medicaid population to overall growth in Medicaid medical service costs for fiscal years 2007 through 2009 illustrates the importance of the aged and disabled populations in addressing overall Medicaid spending. KHPA analysis presented to the Board in June 2008 was based on each population’s total enrollment and cost per beneficiary. The percentage of growth attributed to the aged and disabled when compared to all other populations was a combined 46.6% (i.e., 6% of the growth was attributed to the aged while 40.6% was attributed to the disabled) from FY 2007 to FY 2009. These findings along with trends in expenditures and our understanding of the implications of chronic health conditions that help define these populations, suggest the need to take a close look at opportunities to more effectively manage and support these high cost groups.

The Impact of Chronic Conditions

National Information

Recently, a number of states have focused health reform efforts on ways to provide better, more cost effective care to Medicaid beneficiaries who are aged or disabled. The Center for Health Care Strategies (CHCS), a nonprofit health policy resource foundation funded by national health care and corporate philanthropies and federal agencies, has served as a resource to states interested in health reform for the aged and disabled. CHCS has collected a wealth of information on the impact multiple chronic conditions have on this population and identified ways to improve quality of care, health outcomes, and better manage health care costs.

In a March 2008 issue brief entitled Medicaid Best Buys: Improving Care Management for High-Need, High Cost Beneficiaries, CHCS reported a number of national key findings on the aged and disabled, including:

- A remarkably small number of Medicaid beneficiaries with significant needs drive the majority of program spending.
- People with more than $5,000 in annual Medicaid costs make up less than 15% of total beneficiaries, but account for over 75% of all spending. Among these high-cost beneficiaries, virtually all have multiple physical and behavioral health conditions, disabilities, and/or frailties associated with aging.
- Within the most expensive 1% of beneficiaries, almost 83% have three or more chronic conditions, and more than 60% have five or more.

CHCS also provides a breakdown of the most common diagnostic pairs, or sets of diseases, experienced by the nation’s highest-cost Medicaid beneficiaries. CHCS indicates that identifying the most commonly occurring co-morbidities within Medicaid’s costliest beneficiaries may serve as a viable option for identifying those who might benefit from care management strategies (Center for Health Care Strategies Inc, March 2008). The medical home model of care in Kansas is anticipated to incorporate this kind of coordinated care management.
Chapter 13 — Medical Services for the Aged and Disabled

Top 10 Diagnostic Pairs Among the Most Costly 5% of Medicaid Beneficiaries

<table>
<thead>
<tr>
<th>Diagnostic Pair</th>
<th>Percent of most costly 5% diagnosed with this pair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular-Pulmonary</td>
<td>30.5%</td>
</tr>
<tr>
<td>Cardiovascular-Gastrointestinal</td>
<td>24.8%</td>
</tr>
<tr>
<td>Cardiovascular-Central Nervous System</td>
<td>24.8%</td>
</tr>
<tr>
<td>Central Nervous System-Pulmonary</td>
<td>23.8%</td>
</tr>
<tr>
<td>Pulmonary-Gastrointestinal</td>
<td>23.8%</td>
</tr>
<tr>
<td>Cardiovascular-Psychiatric</td>
<td>22.0%</td>
</tr>
<tr>
<td>Cardiovascular-Renal</td>
<td>20.8%</td>
</tr>
<tr>
<td>Central Nervous System-Gastrointestinal</td>
<td>20.7%</td>
</tr>
<tr>
<td>Psychiatric-Central Nervous System</td>
<td>20.7%</td>
</tr>
<tr>
<td>Cardiovascular-Diabetes</td>
<td>19.2%</td>
</tr>
</tbody>
</table>


These findings from national analyses illustrate the complex nature of health and disease in Medicaid’s costliest populations, and help explain why health management strategies for the populations lag behind the expansion of managed care for children and younger, healthier families.

The Aged and Disabled (AD) Population in Kansas

Although Kansas is not currently participating in a CHCS sponsored initiative, a recently awarded CMS transformation grant has funded a project which will examine the characteristics of the Kansas aged and disabled populations. Theresa Shireman, PhD from the University of Kansas Medical Center, has recently completed a preliminary analysis of Kansas data using an Ingenix Impact-Pro tool. Baseline data includes all of the Medicaid beneficiaries in the eligibility groups previously described, from September 1, 2006 through August 31, 2007. Demographic and quality of care measures are presented in the tables below.
Table 2
Descriptive Characteristics of Aged and Disabled enrollees: September 2007- August 2008

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Enrollment</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 82,849</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>47,732</td>
<td>57.9</td>
</tr>
<tr>
<td>Caucasian</td>
<td>66,856</td>
<td>81.0</td>
</tr>
<tr>
<td>African-American</td>
<td>11,454</td>
<td>13.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4,343</td>
<td>5.3</td>
</tr>
<tr>
<td>Age, mean in years (range)</td>
<td>52.0 (0-107)</td>
<td></td>
</tr>
</tbody>
</table>

Chronic Conditions (Clinical Indicator)

<table>
<thead>
<tr>
<th>Chronic Conditions (Clinical Indicator)</th>
<th>Number Enrolled</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>12,727</td>
<td>15.4</td>
</tr>
<tr>
<td>Depression</td>
<td>7,524</td>
<td>9.1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>13,018</td>
<td>15.8</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>3,031</td>
<td>3.7</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>2,880</td>
<td>3.5</td>
</tr>
<tr>
<td>Asthma</td>
<td>2,247</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Quality of Care

The Impact-Pro tools identifies instances when beneficiaries need to have preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or monitoring procedures for chronic conditions. All of the 82,849 beneficiaries described above had at least one missed care opportunity. Care opportunity rates for various chronic conditions are presented below.

Table 3
Care Opportunity Rates for Aged and Disabled Enrollees with Diabetes

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose monitoring:</td>
<td></td>
</tr>
<tr>
<td>No evidence of HbA1c testing in 12 months</td>
<td>53.5%</td>
</tr>
<tr>
<td>Follow-up care &amp; monitoring of other lab values:</td>
<td></td>
</tr>
<tr>
<td>No evidence of lipid testing</td>
<td>68.8%</td>
</tr>
<tr>
<td>No evidence of visit to eye specialist</td>
<td>73.9%</td>
</tr>
</tbody>
</table>

Table 4
Care opportunity rates for Aged and Disabled Enrollees with Depression

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>No follow-up to the initiation of prescription therapy</td>
<td>7.3%</td>
</tr>
</tbody>
</table>
### Table 5
*Care Opportunity Rates for Aged and Disabled Enrollees with Coronary Artery Disease (CAD)*

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of lipid testing</td>
<td>71.1%</td>
</tr>
<tr>
<td>No lipid lowering medication</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

### Table 6
*Care Opportunity Rates for Aged and Disabled Enrollees with Hypertension*

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of diuretics while on other hypertension drugs</td>
<td>24.3%</td>
</tr>
</tbody>
</table>

### Table 7
*Care opportunity rates for Aged and Disabled Enrollees with congestive heart failure (CHF)*

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate CHF pharmacotherapy</td>
<td></td>
</tr>
<tr>
<td>No evidence of ACE inhibitors</td>
<td>41.1%</td>
</tr>
<tr>
<td>No beta-blocker</td>
<td>41.7%</td>
</tr>
<tr>
<td>No lipid lowering therapy</td>
<td>41.2%</td>
</tr>
</tbody>
</table>

### Table 8
*Care opportunity rates for Aged and Disabled Enrollees with asthma*

<table>
<thead>
<tr>
<th>Care Opportunity Description</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication related issues:</td>
<td></td>
</tr>
<tr>
<td>No evidence of inhaled steroids for asthma</td>
<td>57.9%</td>
</tr>
<tr>
<td>Asthma-related health care use:</td>
<td></td>
</tr>
<tr>
<td>No evidence of primary care visit in recent 6 months</td>
<td>67.9%</td>
</tr>
</tbody>
</table>
There are several limitations to using Medicaid claims data and the Impact Pro tool. These limitations include using only one year’s worth of claims data and not having access to the pharmacy claims for Medicare Part D beneficiaries. Because access to the claims data is limited to the most current one year period, preventive procedures that are only required on a periodic basis (e.g., a colonoscopy every 10 years) may not be reflected. Additionally, the absence of pharmacy claims for Medicare Part D beneficiaries does not allow the case managers to see what medications have

<table>
<thead>
<tr>
<th>Care Opportunity Type</th>
<th>Population</th>
<th>Aged and Disabled Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence of breast cancer screening</td>
<td>Females, ages 40 up to 65 years</td>
<td>N = 17,569</td>
</tr>
<tr>
<td></td>
<td></td>
<td>73.9%</td>
</tr>
<tr>
<td>No evidence of cervical cancer screening</td>
<td>Females, ages 18 up to 65 years</td>
<td>N = 24,323</td>
</tr>
<tr>
<td></td>
<td></td>
<td>78.9%</td>
</tr>
<tr>
<td>No evidence of colorectal cancer screening</td>
<td>Males &amp; females, ages 50 up to 65 years</td>
<td>N = 18,981</td>
</tr>
<tr>
<td></td>
<td></td>
<td>76.5%</td>
</tr>
<tr>
<td>Cardiac Event Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence lipid testing: adults</td>
<td>Males &amp; females, ages 40 +</td>
<td>58,395</td>
</tr>
<tr>
<td></td>
<td></td>
<td>82.6%</td>
</tr>
<tr>
<td>No evidence of lipid testing: atypical antipsychotic users</td>
<td>Males &amp; females, ages 18 +: min 3 Rxs for atypical</td>
<td>7,287</td>
</tr>
<tr>
<td></td>
<td></td>
<td>79.5%</td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence of osteoporosis screening</td>
<td>Females, ages 50 +</td>
<td>N = 31,094</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95.4%</td>
</tr>
<tr>
<td>Pain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged opioid use, pain management referral indicated</td>
<td>Adults, 18 +</td>
<td>N = 72,519</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.7%</td>
</tr>
</tbody>
</table>
been dispensed and if associated problems or concerns exist. Most of the care opportunity flags associated with medication problems, however, indicate when a medication is not being used when it should (e.g., a person with hypertension not receiving a diuretic or an asthma patient without a rescue medication refill).

Despite these limitations, the data presented in Tables 2-9 indicate a quality of care issue among aged and disabled Medicaid beneficiaries and suggest significant opportunities to help beneficiaries engage in preventive health care. The transformation grant described below is one such opportunity, but the patterns of care illustrated above suggest the need for continued innovation and focused attention to these populations. Properly designed, a medical home model could significantly improve the comprehensive care coordination needed for this population.

**Kansas Projects**

Kansas is currently implementing two pilot projects that aim to improve health outcomes for people with disabilities. These two projects are “Health Promotion for Kansans with Disabilities” and “Enhanced Care Management.” A description of each follows.

**Health Promotion for Kansans with Disabilities**

As mentioned previously, the Kansas Health Policy Authority was awarded a Center for Medicare and Medicaid Services (CMS) transformation grant in February 2007 to improve preventive health care for disabled Kansans enrolled in Medicaid. Integral to achieving the outcomes of the pilot project is the use of the Ingenix ImpactPro information technology tool which allows case managers and independent living counselors to review the history of and the need for preventive health care for adult beneficiaries. Specifically, the tool uses Medicaid claims data to flag instances when beneficiaries need to have best practice preventive age and gender appropriate screenings (such as mammograms and colonoscopies) or other monitoring for chronic conditions. Once the preventive health care opportunities have been identified, case managers and independent living counselors can discuss with beneficiaries and their health care providers the importance and necessity of recommended screenings and monitoring. The overall goal of the project is to improve the provision of quality preventive health care services and quality monitoring for chronic conditions.

Four Community Developmental Disability Organizations (CDDOs) and three Independent Living Centers (ILCs) serve as the project pilot sites. Collectively they provide services to approximately 1,700 people with developmental disabilities and/or physical disabilities. The pilot began in November 2007; preliminary results are expected in early 2009.

**Enhanced Care Management**

The Enhanced Care Management (ECM) pilot project, implemented in March 2006, provides enhanced care services to HealthConnect Kansas members in Sedgwick County who have probable or predictable high future health care costs, usually as a result of multiple chronic health conditions. The project is based on an Enhanced Primary Case Management (E-PCCM) Model which is member centered, provider driven, and based on a successful model in North Carolina. Service is community based and culturally appropriate with the goal of connecting beneficiaries to social and health care services already available in the community. Many of the components of the ECM pro-
ject reflect aspects of the medical home model. Eligible Medicaid beneficiaries are invited to receive services: Participation in the pilot is strictly voluntary. Because this population is socially isolated, ECM staff establishes relationships with members in their homes, using creative outreach techniques. Care managers assist beneficiaries to focus on chronic health conditions, social risk factors and unhealthy lifestyle behaviors that adversely affect their health status. Intervention by ECM staff involves a holistic approach, which focuses on assisting clients in accessing resources in the community, which will improve their health conditions.

“In a Medicaid population, chronic conditions cannot be managed without considering the whole person; the co-morbidities, the mental health of recipients and social conditions that would otherwise prevent one from achieving effective self-care.”

Source: Making Medicaid Work: A Practical Guide for Transforming Medicaid (co-authored by SHPS represented by Rishabh Mehrotra, President and CEO, and the Center for Health Transformation represented by Founder Newt Gingrich).

The care management team, consisting of a nurse, a social resource care manager, and a physician, provide a broad array of services. Some of these services are: assessing members’ health and social needs; reviewing utilization trends; reconnecting members with their Primary Care Case Manager (PCCM); ensuring members fill and take necessary prescriptions; teaching members how to manage their own health conditions; and assisting members with accessing community resources including safe and affordable housing, food, utility assistance, clothing, mental health and substance abuse services, credit counseling and others. The Enhanced Care Management (ECM) program may also purchase health monitoring equipment including digital blood pressure monitors, weight scales, and pedometers if prescribed by the Primary Care Manager (PCM).

Beginning in August 2006, ECM case managers began using the Community Health Record (CHR), a web-based application that allows authorized providers online access to claims data and health transactions regarding a person’s office visits, hospitalizations, medications, immunizations, and other relevant healthcare information.

An e-prescribing component of the CHR incorporates drug information so that if there is a contraindication to the prescribed therapy, the clinician is alerted at the time of prescribing, rather than after the prescription is received in the pharmacy. ECM staff report that access to the CHR provides them with a more complete picture of the member’s actual utilization of health resources that is often not reported by the member in interview.

As of August 31, 2007, there were 154 beneficiaries enrolled in the program. An internal analysis of the ECM program prepared by the Central Plains Regional Health Care Foundation, analyzing all active clients and clients enrolled since March 1, 2007, yielded the following results:

- The ECM population was predominantly female (69.0%) aged 41 to 64 years (73.2%), and single, divorced or widowed (83.5%).
- The race/ethnicity of participants was White-Non-Hispanic, (48.3%), followed by African American (28.7%), White-Hispanic (7.7%), Asian/Pacific Islander (2.3%) and Native American (3.1%).
- Nearly 80% of the beneficiaries reported a high school education or less (78.1%), and more than 90.0% reported an income of less than $1,000 per month. Additionally, a large percentage of beneficiaries (67.5%) reported receiving food stamps.
- The recorded Body Mass Index (BMI) suggests that the majority of enrolled clients are overweight or obese.
- The mean and median number of state identified chronic conditions per client was 2.8 and 3.0,
respectively. However, 32 clients had four conditions, 33 had five conditions, and 24 had six conditions.

ECM leadership and staff are in the process of adding data fields to the client database to assist with tracking disease management outcomes of beneficiaries with targeted diagnoses. These indicators will be used to track clinical treatment milestones that assess whether clinical treatment guidelines are being followed by the beneficiary. These indicators are: HgbA1c test recorded for beneficiaries with diabetes; using a peak flow meter for beneficiaries with asthma; cholesterol, triglycerides, and LDL checked and recorded for beneficiaries with hyperlipidemia; and monitoring weight daily and salt intake for beneficiaries with congestive heart failure (CHF).

**Steps Being Taken by Other States**

Recently, substantial attention has been focused on how states can better meet the complex needs of people with disabilities. A growing number of states have begun exploring or implementing models of managing care for populations with complex health care needs. Because people with disabilities often experience multiple chronic conditions, models of managed care include traditional full-risk capitation, as well as broader or more inclusive models such as enhanced primary care case management and comprehensive care management. Increasingly, states are moving from single disease management approaches in which only particular diseases are covered one at a time (e.g., diabetes, asthma, congestive heart failure), and instead are focusing on strategies needed to assess and treat people with multiple chronic conditions. This trend underscores the interest and need for the development of the medical home model.

During November 2006, CHCS interviewed staff in 14 selected states to provide a nationwide scan of the current status of Medicaid managed care. The states selected represent variation in Medicaid delivery across the United States, however, all either had a managed care program for their aged and disabled population in place, or had plans to implement an expansion or pilot a program. States included in the scan were: California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin. In addition to these states, there are others such as North Carolina and Indiana that have implemented managed care programs for the Aged and Disabled (AD) and have been cited as being particularly successful and promising. A brief description of these two programs is presented below. Pennsylvania’s program is also described in order to provide an example of a more traditional style managed care program offered to the aged and disabled.

**North Carolina**

North Carolina uses one type of medical-home model that aims to strengthen the connection between Medicaid beneficiaries with complex needs and their providers. Its program, Community Care of North Carolina (CCNC) is an Enhanced Primary Care Case Management Model (EPCCM) program that provides an enhanced level of services to its target high-risk population. It enrolls approximately 35% of the AD/SSI population and includes core care management strategies such as risk assessment, emergency room utilization, disease specific case management, and pharmaceutical management (Bella, Shearer, Llanos, Somers, 2008). Fourteen Community Care networks, consisting of 3,000 physicians and numerous community support services, provide these care management services (Bella et al, 2008). Also being piloted is a Chronic Care Project, which is designed to serve North Carolina’s highest-risk, highest cost AD/SSI beneficiaries.
Indiana

Indiana Care Select is geared towards improving the quality of care provided to Aged and Disabled (AD) beneficiaries, including those receiving services through HCBS waivers. The program, which provides services through two care management organizations (CMOs), was implemented in November 2007 with statewide implementation planned for March 2008. Care Select uses a health assessment screener combined with claims data to identify and prioritize the care requirements of newly enrolled beneficiaries (CHCS, March 2008). Beneficiaries are then stratified into four groups based on the severity of their needs; corresponding care management strategies are then made available based on risk level and needs. One of the unique features of Indiana’s program is the pay-for-performance strategies used: CMO incentive payments and withholds are implemented based on the timeliness and submission rate of the health assessments in addition to increased payments to providers who adopt identified best practices (CHCS, March 2008). Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research, are used to measure care management quality. PQIs capture data on hospital admission rates for conditions such as dehydration, bacterial pneumonia, etc. that are common to people with chronic illnesses but that are recognized as avoidable or preventable if proper care management has been provided (CHCS, March 2008).

Pennsylvania

The HealthChoices Program is a mandatory managed care program, authorized through a 1915(b) waiver, for Medicaid consumers in Pennsylvania. As noted in their program description, the impetus for development of this program was “recognition of a national trend that the Fee-For-Service health care delivery system was neither cost effective nor delivered care with assurance for quality and access” (Health Choices Physical Health Update, 2008). Along with beneficiaries of all age groups and most eligibility groups, the aged and disabled are included in the program. Beneficiaries receive services through two types of Managed Care Organizations (MCOs) health plans. Physical health plans provide and/or authorize physical health services while behavioral health MCOs are responsible for providing and/or authorizing mental health and drug and alcohol services. Currently the program is operational in 25 counties.

Conclusions

- Aged and disabled beneficiaries are driving the costs of the Kansas Medicaid program. They account for only 33% of the Medicaid population, but in FY 2008 were responsible for approximately 67% of the total expenditures for Medicaid when long-term care costs were included.
- The percentage of growth attributed to the aged and disabled when compared to all other populations was a combined 46.6% (i.e., 6% of the growth was attributed to the aged while 40.6% was attributed to the disabled) from FY 2007 to FY 2009.
- Unlike lower-cost populations, health care for the aged and disabled is not adequately managed. Moreover, significant quality of care issues exist, as illustrated in tables 2-9.
- Continuation and more complete evaluation of both of the KHPA pilot projects (i.e., Health Promotion for Kansans with Disabilities and Enhanced Care Management of Sedgwick County) is needed to determine how to make program improvements before statewide implementation is considered. A budget proposal to extend the Health Promotion for Kansans
with Disabilities pilot was presented and approved by the KHPA Board on August 19, 2008. If approved by the Legislature, the proposal will provide care management information to providers across Kansas who serve elderly and Medicaid eligible persons with disabilities.

- Steps are currently being taken by other states to examine ways that coordinated comprehensive care can be used to provide better and more cost effective care to the aged and disabled. Kansas can benefit from the lessons learned by other states.

**Recommendations**

1. Utilize existing information from the KHPA pilot projects and other states to effectively design, implement, and evaluate managed care programs for people with disabilities. Guidelines that have been developed, based on other states’ experience, include:

   a. The necessity of consumer support and involvement in the development, design, implementation and oversight of the program.

   b. Careful identification of the target population (e.g., will the program target high-risk, high-cost individuals? Individuals with specific diseases? Who are the consumers who will benefit most?)

   c. Designing the intervention to ensure services are multi-faceted, improves quality and cost effectiveness, and ensures coordination of care.

   d. Evaluation of the program should include methods for measuring whether or not the interventions are improving quality, efficiency, and effectiveness.

   e. Designing payment reforms that allow both the beneficiary and provider to be incentivized (e.g., case management/medical home payments, etc.)

2. Develop an FY 2011 budget proposal to include payment reforms for a medical home model for Kansas, to include care for the aged and disabled. The development of a medical home model for Kansas is currently underway with the passage of Senate Bill 81 during the 2008 legislative session. A large group of stakeholders will design over the next year a care management model based on existing evidence and the needs of our state. The recommendations will be brought to the KHPA Board in 2009 for consideration in development of the FY 2011 budget.

3. Provide care management information to service providers across Kansas that serve aged and Medicaid eligible persons with disabilities by continuing the model tested through the CMS Transformation Grant “Health Promotion for Kansans with Disabilities.” If approved by the legislature, this project would use the experience gained during the pilot project and expand the program intervention to all aged and disabled Medicaid beneficiaries statewide. Specific quality of care topics would be selected monthly by KHPA and used to query Medicaid claims information, supplemented by other data sets from Medicaid services administered by the Department of Social and Rehabilitation Services. Outreach information on those topics would be targeted to beneficiaries, primary care physicians, pharmacists, and other regular sources of health care. The risk modeling effort also would be continued to identify population groups and subgroups that would benefit from targeted interventions.
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Chapter 14: Emergency Health Care of Undocumented Persons

Executive Summary

Description

For undocumented persons, federal Medicaid funds may only be used to provide health care services for life threatening emergencies or labor and delivery services for pregnant women. The Sixth Omnibus Budget Reconciliation Act (SOBRA) was enacted by Congress in 1986 to provide a funding stream for these services. In Kansas, eligibility for this program is processed through Social and Rehabilitative Services (SRS) area offices. If the medical event is labor and delivery, the case worker can approve SOBRA eligibility. If the event is not labor and delivery, the provider of the service receives a form to fill out and return with the medical record. The Medicaid fiscal agent, EDS, receives this information and works with the SOBRA program manager to approve or deny eligibility. In 2007, there were 576 requests for non-labor and delivery medical expenses of which 295 were denied. The main challenge in administering this program is consistent application of the federal definition of covered services. Although this is a concern, the quarterly review of SOBRA claims for payment errors shows a current error rate of less than one percent.

In 2007, Kansas SOBRA expenditures for almost 6,000 claims were approximately $10 million. Over $7 million was paid for labor and delivery services with the remainder paid for life threatening emergency services such as tracheotomies, trauma OR, trauma of the brain, and coronary events. The expenditures for FY 09 are estimated to be $10-$12 million.

Key Points

- Because this is a federally mandated program, program options are limited.

- Undocumented individuals have been found to use hospital and emergency services at over twice the rate of the overall U.S. population, according to the National Health Foundation, a not-for-profit foundation comprised of several provider and health plan organizations. Given the large number of undocumented individuals who are uninsured, the high use of emergency services is predictable. By federal law (Emergency Medical Treatment and Active Labor Act - EMTALA), all those who seek services in an emergency room must be screened for needed health care services and stabilized.

- Other health programs exist in the state to assist undocumented persons with their health care needs:
  - The Kansas Department of Health and Environment (KDHE) administers the Migrant Seasonal Farm worker program which provides a state-wide voucher case management sys-
tem through which migratory and seasonal farm workers can receive some types of preventive care through Access Point Agencies.

- KDHE and SRS jointly manage a refugee program that is primarily funded by the U.S. Department of Health and Human Service and supports health screenings of refugees.

Recommendations

- Add a category to the current SOBRA Database maintained by EDS, the Kansas Medicaid fiscal agent, to include the medical issue for each reimbursement form submitted for a life threatening medical emergency.
- Focus on monitoring and understanding continued increases in SOBRA costs, including examination of what types of medical issues are occurring within this population.
- Monitor surrounding state and federal immigration law changes to anticipate their impact on the Kansas Medicaid SOBRA program.

Overview and Background

Program Description

The Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA), addressed the general question of how to help hospitals and other providers with the costs of treating undocumented persons in an emergency setting. Earlier federal legislation, the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 required Medicare-participating hospitals to treat and stabilize all emergency medical conditions. SOBRA was enacted by Congress to address the portion of these costs incurred by undocumented persons who are ineligible for Medicaid due to their citizenship status.

SOBRA requires all states to reimburse certain health care services through Medicaid. This act provided a funding stream for services already provided in hospital and physician offices by legal or professional obligation. As a result of this law, effective January 1, 1987, limited reimbursement became available for services provided to eligible non-U.S. citizens. Those services included hospital and physician care for life threatening emergencies and labor and delivery for pregnant women. Medical events covered under SOBRA are reimbursed through the Medicaid fee-for-service program at standard rates of reimbursement. The administration of SOBRA coverage has two components; an eligibility component and a medical necessity component.

The SOBRA process in Kansas begins with the determination of eligibility in the local SRS area office. The non-US citizen (or designee) contacts his or her local SRS area office after an event that she believes may qualify for SOBRA funding. The area office case worker will determine if the non-US citizen meets eligibility requirements (for citizenship).

The case worker will then initiate the Kansas Medicaid reimbursement form (MS-2156) to determine medical necessity. If the medical event was a simple labor and delivery, and the non-US citizen meets all other requirements, the case worker may approve SOBRA eligibility for that particular medical event. If the event was something other than a simple labor and delivery, the case worker will send the MS-2156 form to the provider of the service. The provider then will attach appropriate medical records to the MS-2156 form and send all documents to the Medicaid fiscal agent (EDS).
The Medicaid fiscal agent will check the completeness of pertinent documents and contact the provider if more information is needed. EDS will then review the request and all medical records together with the SOBRA program manager. The program manager may approve, deny, or take the case to the Medical Workgroup committee. Once a decision is made based on the federal regulations, EDS sends the MS-2156 back to the area office with all pertinent information and final decision. The area office will notify the applicant of the decision. The applicant has the right to appeal the decision.

Definitions

In order to qualify for full Medicaid, the individual must be a U.S. citizen or meet specific immigration rules. During the application process all applicants are asked to declare if they are a citizen or non-citizen. Those reporting to be a citizen must provide proof of citizenship and identity. Those indicating they are not a citizen must provide information regarding their immigration status. This information is then verified with the Department of Homeland Security. Full Medicaid coverage for non-citizens is limited to: refugees; veterans; persons who attained Legal Permanent Resident Status more than 5 years ago; and a small number of other individuals with specific immigration statuses. Other non-citizens, including the undocumented, cannot receive Medicaid coverage, but may qualify for SOBRA coverage. Persons who may be covered under SOBRA include undocumented individuals, but also immigrants who fail to meet Medicaid criteria.

Federal regulations outline who is eligible for SOBRA services. These services and general provisions are defined under Federal Regulations in 42 CFR Part 440 Subpart B and Services Sec. 440.255. Citizenship and alienage requirements are defined in Sec. 435.406:

**Definitions under SOBRA**

**42CFR440.255 Limited services available to certain aliens**

(c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—

(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient’s health in serious jeopardy;
(ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part, and

(2) the alien otherwise meets the requirements in secs. 435.406(c) and 436.406(c).

**Alien** is defined as an individual who is not a U.S. citizen or U.S. national.

**U.S. National** is defined as an individual who owes his sole allegiance to the United States, including all U.S. citizens, and including some individuals who are not U.S. citizens. These individuals would include citizens of certain U.S. possessions.

**U.S. Citizen** is defined as:

1. An individual born in the United States
Chapter 14—Emergency Health Care for Undocumented Persons

2. An individual whose parent is a U.S. citizen
3. A former alien who has been naturalized as a U.S. citizen
4. An individual born in Puerto Rico
5. An individual born in Guam
6. An individual born in the U.S. Virgin Islands

Immigrant is defined as an alien who has been granted the right by the U.S. Citizenship and Immigration Services (USCIS) to reside permanently in the United States to work without restrictions in the United States.

Nonimmigrant is defined as an alien who has been granted the right by the USCIS to reside temporarily in the United States.

Illegal Alien (undocumented alien) is defined as an alien who has entered the United States illegally and is deportable if apprehended, or an alien who entered the United States legally but who has fallen “out of status” and is deportable.

Kansas’ SOBRA program operates under strict federal guidelines with very limited flexibility. A key challenge in administering the SOBRA program is consistent application of the federal definition of covered medical claims (other than labor and delivery). Because eligibility, population, and service requirements are strictly defined by the Code of Federal Regulations, SOBRA coverage is also very limited. Using medical records as evidence, caseworkers review SOBRA requests to determine whether treatment provided to an undocumented person qualifies as a life threatening emergency under SOBRA.

National Data

Non-U.S. citizens are often uninsured or underinsured. In 2007, 44% of non-citizens under 65 had no health insurance. There are 9.7 million uninsured non-citizens, a majority of whom are undocumented, representing over 20% of the nation’s uninsured population (U.S. Bureau of the Census, March 2008).

According to the National Health Foundation, non-U.S. citizens establish social connections in their place of origin (and places abroad) using border-crossing social networks. Through these connections or networks, they learn and inform each other about where to go, how to gain employment, and how to find a place to live in the United States. Through these ties they can also maintain families, utilize economic opportunities, keep informed on political interests and maintain cultural practices. Non-U.S. citizens can be found working in multiple areas of employment within the United States. About 3% work in agriculture; 33% have jobs in service industries; and substantial numbers can be found in construction or related occupations (16%), and in production, installation and repair industries (17%) (Vertovec, 2007). Young, unmarried men have been found to have repeat illegal border-crossing episodes; this likelihood falls with marriage, and increases again with children (National Health Foundation, 1993).

There remains controversy regarding undocumented immigrants and their use of social services, including health care. The Western Journal of Medicine completed a survey of undocumented persons residing within the United States which reported that 8.6% of emergency department visits are by undocumented immigrants. Among the undocumented immigrants surveyed, 86% stated they planned to remain within the United States, 80% cited a lack of funding as a reason for seeking emergency department care, and 44% stated that even if care was available elsewhere only
the emergency department was acceptable (Chan, Krishel, Bramwell and Clark, 1996).

The National Health Foundation states undocumented persons commonly use hospital and emergency services rather than seeking preventive medical care. For example, the utilization rate of hospitals and clinics by undocumented aliens (29%) is more than twice the rate of the overall United States population (11%) (U. S. Bureau of the Census, May 2008). In Kansas, there are three sources of care and funding that help address this gap in prevention for undocumented persons, which are described below.

Other Resources for Undocumented Persons

The Kansas Department of Health and Environment (KDHE) administers the Migrant Seasonal Farmworker program. This program coordinates a statewide voucher case management system for migratory and seasonal farmworkers. Vouchers for covered services are obtained from Access Point Agencies made up of state-funded primary care clinics and local health departments. This program allows health care organizations approved as Access Point Agencies or participating as Referral Providers to request payment for the following services: immunizations, screening tests, child and adult physical examinations, office visits, laboratory and X-ray services, vision care, pharmaceuticals, dental, and prenatal care.

The Kansas Department of Health and Environment and the Kansas Department of Social and Rehabilitation Services (SRS) jointly provide the refugee program. When refugees arrive in the United States, they pass through the U.S. Public Health Services Quarantine State at their port of entry. Documents that outline the refugees’ settlement information and medical records are sent to the State Refugee Health program and/or local health department. Local sponsors notify the county health department and arrange for health screenings. These services are funded by the U.S. Department of Health and Human Services Refugee Medical Assistance (RMA), Medicaid, and if appropriate, state grant funds.

Most primary care clinics and Community Health Centers operating in the state are members of the Kansas Association for the Medically Underserved (KAMU), the state’s primary care clinic organization. Members are safety net providers whose primary mission is to assure access to comprehensive health care for underserved populations, including non-citizens. These are State funded primary care clinics, Federally Qualified Health Centers (FQHCs), local health departments and other non-profit clinics established and supported in part by public funds, faith-based organizations, individual volunteers, private foundations, or local donations. One such clinic serving a large number of non-citizens is the United Methodist Mexican-American Ministries clinics located in Garden City, Dodge City, Liberal, and Ulysses. These clinics offer family practice medical clinics, special health programs, AIDS case management and oral health education. They also offer food and clothing banks, Bibles and Christian materials, parenting classes, documentation assistance, and volunteer income tax assistance.

Service Utilization and Program Expenditures

Figure 1 shows the total expenditures for SOBRA claims from FY 2004 through FY 2007. Total SOBRA reimbursements increased substantially in 2005, and dipped in 2006 before rising again in 2007. Expenditure increases in 2005 were likely due to both a substantial increase in claims as well as a significant increase in hospital reimbursement rates by Kansas Medicaid.
Labor and delivery is routinely the largest SOBRA expenditure. Non-U.S. citizens may migrate to the United States before their child is born. If born in the United States, the child is automatically a United States citizen.

Medical services (other than labor and delivery) are limited to those services related to the sudden onset of life-threatening emergencies. Approximately 50% of medical SOBRA requests (non labor and delivery) are denied because they do not meet federal guidelines for coverage. In 2007, there were 576 requests for non-labor and delivery medical services. Of those 576 requests 281 were approved and 295 were denied. It is important to note that in Kansas, SOBRA requests are always made after the event has occurred. Due to the time it may take for a case to completely process, the claims may not be submitted until several months after the event.

Figure 2 depicts the total number of SOBRA claims processed within the MMIS system by fiscal year. An increase in claims was seen in FY 2005, followed by declines in both 2006 and 2007.
Figure 3 depicts the FY dollar per claim for the SOBRA population. This data portrays an 18% increase in expenditures per claim in FY 2007.

![Figure 3: SOBRA Expenditures per claim by FY](image)

Figure 4 provides information about the SOBRA claims volume trends during different times within the fiscal year. This graph shows two drops in January and April of 2005. This decrease coincides with Congressional attention on potential changes to immigration laws.

![Figure 4: SOBRA Claims Per Quarter by FY](image)

Figure 5 depicts the counties with the greatest amount of SOBRA reimbursements: Wyandotte, Sedgwick, Ford, Shawnee, and Finney. Between 2000 and 2006 the Kansas population increased by 2.6% with approximately 5.4% of this increase directly attributable to immigration. Usual sources of employment for immigrants consist of agriculture, service industries, construction, production, and installation and repair. Ford County (Dodge City) has experienced a substantial increase in immigration. Nevertheless, growth in SOBRA reimbursements in FY 2007 is greatest in Wyandotte and Sedgwick counties.
The SOBRA expenditures for Labor and Delivery are greater than other medical services. This is due to the limitations placed on medical services by the Code of Federal Regulations. This information is illustrated in Figure 6.

Figure 7 portrays the top six procedures codes billed by physicians for SOBRA services, which are all associated with labor and delivery services.
Table 1 identifies the six Diagnosis Related Group (DRG) codes (or bundled services provided in an inpatient hospital setting) most frequently billed for SOBRA services. The most frequently billed pregnancy related DRG’s have been grouped together (370 thru 374, 376, 378, 383). The other types of medical services provided frequently within the hospital setting are trauma related. The categories with a zero indicate that the DRG’s included in that category did not exist at that time.

<table>
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<th>FY</th>
<th>Pregnancy</th>
<th>Tracheotomy</th>
<th>Trauma OR</th>
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</table>

**Program Evaluation**

Nine years ago the SOBRA program was managed by non-medical staff; claims were paid based on diagnosis codes automatically through the MMIS system. This process created a large payment and eligibility error rate. In 2000, management of the program was assigned to medical staff. The MS-2156 reimbursement process was also changed to include a manual review of every request. This aligned SOBRA payments more closely with federal regulations. In 2004, a policy was written to allow simple labor and delivery cases to be approved by the area office case worker, and claims to be automated within the MMIS system. This reduced the fiscal agent’s workload for SOBRA requests by 50% and allowed them to focus on more difficult and potentially costly cases. Currently, the simple labor and delivery reimbursements are still received and approved in the local SRS area offices. KHPA’s fiscal agent (EDS) continues to process all non labor and delivery cases. All SOBRA claims are reviewed before payment by the appropriate staff at EDS. Each quar-
ter EDS staff review SOBRA claims for payment errors. The current error rate is less than one percent.

**Payment Error Rate Measurement** was developed by the Center for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002 (Public Law 107-300). This law requires the heads of Federal agencies to review programs on an annual basis that are susceptible to significant erroneous payments and to report estimates to Congress. They are also required to submit actions the agency is taking to reduce the amount of improper payments. The Office of Management and Budget (OMB) identified Medicaid as a program at risk for significant improper payments. CMS now requires state Medicaid programs to participate in a program of reviewing Medicaid and SCHIP eligibility decisions and claims payments to produce state and national error rates.

The SOBRA program is affected by changes made in Congress, the state legislature, political arenas, job availability, farming seasons, etc. For example, Oklahoma recently enacted new state legislation (HB 1804) restricting undocumented immigrants from obtaining government IDs or public assistance. It also gives police the authority to check the immigration status of anyone arrested, which can lead to deportations. The law also makes it a felony for U.S. citizens to knowingly provide shelter, transportation or employment to undocumented immigrants. These changes in Oklahoma could potentially cause migration northward to Kansas for undocumented populations.

**Conclusions**

SOBRA reimbursements for emergency health care for undocumented persons rose by 18% in FY 2007 after a slight decline in 2006, and a near-doubling of expenses in 2005. The number of health claims reimbursed peaked in 2005 and fell in both 2006 and 2007. These changes appear to be explained in large part by known fluctuations in immigration patterns and by reimbursement rate increases by the Kansas Medicaid Program in 2005 and 2006. However, spending in 2007 remains partially unexplained.

**Recommendations**

1. Add a category to the current SOBRA Database maintained by EDS to include the medical issue for each MS-2156 reimbursement form submitted.

2. Focus on monitoring and understanding continued increases in SOBRA costs, including closer views of what types of medical issues are occurring within this population.

3. Monitor surrounding state and federal immigration law changes to anticipate their impact on the Kansas Medicaid SOBRA program.
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Chapter 15: Eligibility Policy and Operations of Public Insurance Programs

Executive Summary

Description

The core purpose of this review is to evaluate eligibility policy and operations and to develop recommendations in both areas for the KHPA Board. This review describes and assesses Medicaid eligibility rules and eligibility policies, as well as the critical components of the eligibility determination process: Operations, Automated Systems and Program Integrity. Since the Medicaid program targets low-income populations, the report also includes information that describes poverty in Kansas, and state and federal minimum wage levels (Appendix C and D). Future reviews will focus on enrollment, with an evaluation of historic changes in enrollment and performance and outcomes for the Medicaid enrollment process.

To participate in the Kansas Health Policy Authority’s (KHPA) public health insurance programs, a person must be determined to be eligible. Staff at the KHPA or Department of Social and Rehabilitation Services (SRS) review a consumer’s application for medical coverage and decide if the person is eligible based on certain criteria. Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons.

Key Points

- Determining who is eligible for our programs is becoming more technically complex based upon changes in state and federal law. Adoption of improved computer technology to increase accuracy and efficiency of eligibility determinations is essential for the future of KHPA programs. A new automated eligibility information system is needed to support program policy and ensure accurate and consistent implementation of that policy.
  - Increased computer automation of the eligibility determination will streamline the processes and result in more timely, accurate, and consistent determinations.
  - Implementation of a more flexible and sophisticated system will facilitate the transition of public medical programs from traditional outdated welfare models to more innovative approaches to provide public health insurance coverage.
  - KHPA and SRS have collaborated for the past year on the design of a web-based eligibilit-
• KHPA is in the process of acquiring and implementing an innovative online application system for consumers to use to apply for public insurance.

• KHPA and its fiscal agent, EDS, recently implemented a multi-functioning web-based tool which gives consumers information about their benefits and processes to be completed for maintenance of their medical assistance.

• A web-based presumptive eligibility (PE) screening tool will be incorporated into the online application, improving accuracy of determinations and increasing the number and location of sites where PE determinations can be completed.

• Although eligibility policy encompasses numerous groups and special categories of individuals, policy gaps remain, leaving many vulnerable and very low-income Kansans without access to public health insurance coverage.

KHPA Staff Recommendations

• Promote community-based outreach by placing state eligibility workers on-site at high-volume community health clinics. Eligibility workers out-stationed at these clinics will be able to do full determinations at sites serving populations most likely to be eligible for public health insurance.

  Cost to provide out-stationed eligibility workers

<table>
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<tr>
<th></th>
<th>FY 09</th>
<th>FY 10</th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>5 Year Total</th>
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<td>$4,582,000</td>
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• Expand access to care for needy parents by increasing the eligibility income limit to 100% Federal Poverty Level (FPL), ($1,467 per month for a family of three). Current coverage levels are no greater than 30% FPL ($440 per month for a family of three), and fall each year as inflation eats away at the fixed dollar threshold for eligibility.

  Cost to expand Medicaid for parents (caretakers) up to the federal poverty level

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Additional Options Identified by KHPA Staff

• Change household composition rules for pregnant women so that they are consistent with those used for other medical populations, which would have the effect of increasing the number of eligible women.
Expand coverage to childless adults from the current age of 19 years of age to the age of 21.

Expand Medically Needy coverage to parents and other caretakers of children to provide catastrophic coverage.

Medicaid’s support for low-income Medicare enrollees through (a) providing access to full prescription drug coverage and (b) paying the Part B premium by eliminating asset tests and increasing the income limit for Medicare Savings Programs (MSPs) up to 185% Federal Poverty Level (FPL).

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. The last increase for this program was in 1994 and it is currently at $475 per month for both single people and couples (55% and 41% FPL respectively).

Overview

The core purpose of this review is to evaluate eligibility policy and operations and to develop recommendations in both areas for the KHPA Board. This review describes and assesses Medicaid eligibility rules and eligibility policies, as well as the critical components of the eligibility determination process: Operations, Automated Systems and Program Integrity. Since the Medicaid program targets low-income populations, the report also includes information that describes poverty in Kansas, and state and federal minimum wage levels (in the Appendix C and D). Future reviews will focus on enrollment, with an evaluation of historic changes in enrollment and performance and outcomes for the Medicaid enrollment process.

To participate in the Kansas Health Policy Authority’s (KHPA) public health insurance programs, a person must be determined to be eligible. Staff at the KHPA or Kansas Department of Social and Rehabilitation Services (SRS) review a consumer’s application for medical coverage and decide if the person is eligible based on certain criteria. Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons.

The Application Process

Medicaid eligibility determinations are made by qualified staff from the Kansas Health Policy Authority (KHPA) and the Kansas Department of Social and Rehabilitation Services (SRS), who are assisted by sub-contractors employed at HealthWave Clearinghouse. These determinations are based on whether an individual fits into a specific Medicaid eligibility group and meets both non-financial and financial criteria. Once determined eligible, beneficiaries are required to report any changes that affect their eligibility and a complete redetermination of eligibility occurs annually. The operation of Kansas Medicaid’s eligibility process is described in greater detail below.
Eligibility Policy

Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons. Often referenced as the payer of last resort, all programs are means-tested (based on level of income or assets), but each program utilizes different eligibility criteria and standards.

Federal rules greatly influence state Medicaid and SCHIP programs, since federal funding for both operating expenses and coverage of medical services is dependent upon adherence to various federal requirements.

Of KHPA’s three major public health insurance groups, Medicaid provides health insurance coverage to the largest number of people and is the most complex. Medicaid also provides the historical and policy foundation underlying the MediKan and SCHIP programs. The Kansas Medicaid program includes 35 separate categories of coverage.

Introduction to Eligibility Groups

In order to qualify for benefits, an individual must fit into a Medicaid eligibility group. This is a fundamental principle of Medicaid eligibility. A Medicaid eligibility group is comprised of persons who share defined common characteristics and meet specific eligibility requirements. Medicaid eligibility groups show great variation, having arisen through 40 years of policy innovation and expansion of Medicaid since its creation in 1966 as Title XIX of the Social Security Act. Eligibility groups range from very broad to narrow and targeted.

As a requirement of its Medicaid program, the state must provide coverage to individuals who meet the eligibility requirements for mandatory eligibility groups. The state has the option to provide Medicaid coverage to other groups of individuals, known as optional groups. Coverage of these optional groups provides states with a mechanism to expand coverage to a subset of an existing population. Regardless of the groups the state chooses to cover, there are federally mandated standards and limitations that the state must follow, even when the group is optional.

Examples of Basic Medicaid eligibility groups include:
- Pregnant Women
- Children Under Age 19
- Persons determined disabled by Social Security Standards
- Seniors age 65 and older

Medicaid eligibility groups can also be quite specific, providing coverage to particular subgroups of individuals. These well-defined groups are usually created by targeted federal expansions of eligibility. Some examples of specific groups include:
- Women diagnosed with breast or cervical cancer by the Early Detection Works program
- Medicare beneficiaries
- Disabled individuals with earned income
- Children receiving Adoption Support or Foster Care payments
Finally, medical eligibility groups can be tied to other programs. These narrow eligibility criteria can complicate eligibility policy implementation in a state. Some examples of very specific groups include:
- Individuals who would be eligible for cash assistance if they were not in a medical institution.
- Individuals receiving only an optional state supplement which is more restrictive than an optional state supplement the individual could receive under SSI.
- Disabled individuals whose earned income exceeds the limits for SSI, but who are still considered SSI recipients under Section 1619(b).

**Eligibility Tests**

Another basic principle of Medicaid eligibility is that an individual must meet both financial and non-financial criteria for the specific Medicaid eligibility group.

**Non-Financial Criteria**

Non-financial eligibility criteria are used for almost all individuals seeking eligibility for public health insurance. Non-financial factors include age, state residency, U.S. citizenship or satisfactory immigration status, verification of citizenship or immigration status and Social Security Number. In addition, individuals must complete an application, cooperate with the agency by supplying necessary information to make a determination, and provide to the agency any third party payments from other sources of medical support and medical insurance. Most non-financial criteria are established at the federal level.

**Financial Criteria**

Financial eligibility requirements consist of income and/or resource limits. Financial eligibility criteria vary significantly among the various eligibility groups. It is helpful to understand the basis for these varying standards.

Originally, eligibility for Medicaid was tied to the receipt of cash assistance - Aid to Families with Dependent Children (AFDC) for children, pregnant women, parents and caretakers or Supplemental Security Income (SSI) for aged, blind and disabled individuals. Over the years, coverage was extended to persons who were not getting cash assistance, for example, poverty level children. After federal welfare reform passed in 1996, Medicaid eligibility was de-linked from cash assistance.

Yet still today, these other means-tested programs are the starting point for the financial eligibility criteria used by Medicaid. Medicaid eligibility groups for families, children and pregnant women use the counting rules for income and resource standards applied in its AFDC program on July 16, 1996. This is the date established as a point of reference in federal welfare reform legislation. These groups are linked and often called family medical programs.

Medicaid eligibility groups for the elderly and disabled are linked to the income and resource standards and methodologies of the SSI program as the benchmark level. These groups are often labeled elderly and disabled medical programs.

Although benchmarks and counting rules for both family medical and elderly and disabled groups
have been established, there is flexibility to make changes to the income and resource levels. Generally, states are allowed to adopt less-restrictive income and resource criteria. States cannot adopt more restrictive criteria than those that exist in the benchmark cash assistance programs.

Individuals who fit into a Medicaid eligibility group and meet all financial and non-financial eligibility criteria for that group are deemed eligible to receive coverage. It is not uncommon for individuals to fit into more than one group, for example, a pregnant woman with a disability. A hierarchy of coverage has been established for these situations, as coverage must be considered for all categories.

**Featured Eligibility Groups**

This section provides in depth reviews of six different eligibility groups, including a brief history and some background information about each specific group. The reviews identify gaps in coverage and other issues related to current eligibility policy. To help illustrate the kinds of families and individuals covered, or not covered, in each of these groups, case examples are described in Appendix A. Some examples are fictional, but representative of actual situations. Others, which are labeled as such, are actual examples of Kansans who have given written permission for their stories to be shared in this way. Finally, suggestions for improvements to the program are included.

**TAF-related Medical Group**

Low income families which include a minor, dependent child are covered under the TAF-related medical groups. Families may be headed by parents, relatives such as grandparents, or other caretakers who have primary responsibility for the child. Both adults and children are potentially eligible for coverage under this program.

**Description**

Three distinct medical groups comprise the Temporary Assistance for Families (TAF) program: Caretaker Medical (MACM), Transitional Medical or TransMed and Extended Medical. These labels reflect the historic linkage to cash assistance programs. Kansas has, for the most part, baseline eligibility requirements and provides coverage only at minimum levels which do not adjust to inflation and do not rise with poverty thresholds.

Families qualify for MACM only if they have a very low income - less than 30% of the Federal Poverty Level (FPL). The eligibility determination is further complicated by the methodology used to determine the income standard. The MACM income standard is not tied to the poverty level or other common standard expected threshold. It is actually based on the TAF (or welfare) need standard where factors such as county of residence (Shelter Groups) and living arrangement (shared vs. non-shared living) are considered. For example, a parent of two children living in Topeka can only receive medical coverage if the family income is less than $403 gross per month. In Garden City, that same family has an income limit of $386. If these families are sharing an apartment with a friend, the income limits fall to $359 for the family in Topeka and $349 for the family in Garden City. Monthly rent for a 1-bedroom apartment in Topeka is about $300, necessitating the sharing of a home with friends, family, or a roommate. When families share homes.
they are subject to the shared living reduction, which reduces the income limit allowed to qualify for medical coverage. Although a small earned income disregard is also considered for families with wages ($90/month), the vast majority of people who qualify initially are not employed.

Once families qualify for MACM, they may be eligible for additional programs when their income increases beyond the MACM income limits. The Transitional Medicaid program (TransMed) assists as a safety-net to families who have been receiving MACM coverage and then gain employment which puts their income over the required limit. Instead of losing medical coverage immediately, the family receives up to 12 additional months of coverage. Although the program provides a necessary transitional benefit to the consumer, it is a difficult program to administer due to various reporting criteria and mandated eligibility checks. For example, all adults in the family are initially approved for a six-month period. At the end of this timeframe, they are expected to complete a review and must submit proof of all income received in their first three months of TransMed coverage. If their income meets additional income guidelines, the adults can then qualify for an additional six months of coverage. The children, however, continue to remain eligible for the entire 12-month period regardless of the adult’s compliance with the reporting requirements.

The Extended Medical program is the second transitional program for families who have received child or spousal support which results in countable income in excess of the limit. The adults in the Extended Medical group receive an additional four months of coverage, while the children receive an additional 12 months.

Any change to eligibility in the basic coverage group, MACM, will also have an effect on the TransMed and Extended Medical groups, as these groups are dependent upon receipt of MACM. When compared to coverage levels in other states, Kansas rates near the bottom. A report from the Kaiser Foundation places Kansas at or near the bottom 10 states when ranking income eligibility levels for parents and caretakers.

Options to Fill Policy Gaps

- **Extend Medicaid to poor working parents.** Eligibility requirements for low income parents are very strict, essentially resulting in a program for the unemployed. Offering health coverage to the working poor will not only help to ensure a healthier work force, but could also help set an example for the next generation by demonstrating the importance of maintaining adequate health insurance. This recommendation is comprised of three complementary policies that further de-link Medicaid from cash assistance programs and allow the program to operate more like modern insurance.

  - Equalize coverage across the state by simplifying eligibility determination for families. Eliminate the complexities in the current determination process, specifically the Shelter Group and shared/non-shared living factors and apply a standard income deduction to all household members equalizing access to the program for all low-income families in Kansas.

  - Expand coverage to families with incomes below the federal poverty level. Adopt a standard, reasonable income level for coverage, helping to eliminate the unemployment incentive. Indexing to the poverty levels, will provide some protection for future generations of very poor Kansans from the effects of inflation.

  - Adopt 12 month Continuous Eligibility for Parents. Because it is tied to cash assistance,
parental eligibility for Medicaid is re-determined each month. As with similar expansion for poverty-level children, these re-determinations would be conducted annually once Medicaid is fully de-linked from welfare. Current policies which require monthly income determinations may restrict a wage earner’s desire to accept a new job or work more hours. Ensuring low income families have access to health care for at least 12 months can encourage advancement in the work force without the fear of losing health insurance. Continuous coverage mimics job-based enrollment cycles and reduces the administrative burden of monthly re-determinations.

- **Simplify TransMed Eligibility Policy and Procedures.** Simplified eligibility processes would encourage those families who achieve slightly higher wages to continue to receive health care coverage. Relaxing the rigid reporting criteria for continued TransMed eligibility will allow eligible individuals to retain insurance. Using interfaces and passive reporting options are possible solutions to reduce program complexity.

### Pregnant Women Group

Pregnant women can receive Medicaid coverage through the term of the pregnancy and two post-partum months.

#### Description

Currently, coverage is provided for women with incomes up to 150% of the Federal Poverty Level (FPL), $1,950 gross monthly income for a single pregnant woman. However, the 2008 Kansas Legislature approved an increase to 200% FPL. KHPA plans to implement the expansion in May 2009.

Pregnant women initially applying for coverage receive an expedited eligibility determination. This means that pregnant women can receive access to medical coverage for a short period of time while they work on obtaining necessary income and pregnancy verification. This prevents any delay in accessing prenatal care while the administrative process continues.

Pregnant women have access to all Medicaid covered benefits, and most are enrolled in the HealthWave managed care program rather than the HealthConnect, or fee-for-service program. At the end of the coverage period, ongoing coverage may be provided to the mother if her income is very low and the family qualifies for the Caretaker Medical (MACM) program.

The household determination for pregnant women coverage is not aligned with the other medical groups. The household size used for the determination includes only the pregnant mother, the father of the child, if he is in the home, and the unborn child, or children. The needs of other children in the family are not considered, although the income of the parents is certainly used to support those children. For example, if the family includes a pregnant woman, her husband and their three children, the household size for the pregnant woman determination is three, as only the mother, the father and the unborn are included. This results in a maximum income threshold of $2,400 gross income per month. Because the income and needs of the entire household are used to determine eligibility for the children, this is often a point of confusion for the family. The effect of this state-optional distinction is that children in the family are more likely to qualify, even apart from the higher income thresholds that apply to children.

### Option to Fill Policy Gaps

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*Program Review of Eligibility Policy and Operations of Public Insurance Programs—January 2009*
Equalize the eligibility threshold for Pregnant Women to reflect a true household determination. Use the income threshold associated with the full household to determine eligibility for the pregnant woman. This would align eligibility calculations for pregnant women and children up to 200% of FPL, effectively raising eligibility thresholds for pregnant women who already have children.

Children’s Medical Group

Children under age 19 are covered in Kansas families with incomes below 200% of FPL.

Description

There are three primary categories of medical coverage provided to children in Kansas. These groups are Medicaid, SCHIP and Presumptive Eligibility for children. All groups are designed for children up to the age of 19 years old and residing in Kansas.

Eligibility determination processes for the Medicaid and SCHIP groups have been combined into a single process, where children in families found to have lower incomes receive Medicaid and those found to have higher incomes receive SCHIP. Because the child’s age is also considered, and the dividing line between eligibility for Medicaid and SCHIP rises with age, income eligibility is frequently referred to as “stairstep eligibility.” For Medicaid, the following levels apply:

- Children under the age of one qualify for Medicaid if the household income does not exceed 150% of the Federal Poverty Level (FPL) ($2,400 per month for a household of three).
- Children ages 1 through 5 qualify if the household income does not exceed 133% of the FPL ($2,151 per month for a household of three).
- Children between 6 and 18 qualify at 100% of the FPL ($1667/month for a family of three).
- For HealthWave 21, children qualify if the household income exceeds the Medicaid threshold and does not exceed 200% of the FPL ($3,334 month for three). To be eligible for HealthWave 21 children must be uninsured and cannot have access to state employee health coverage. Families with incomes over 150% FPL must pay a monthly premium. The amount of the premium is based on the family’s income. One premium covers all of the children in the family. Between 100 and 150% of poverty, children in the same family may qualify for either Medicaid or SCHIP, based on the child’s age. Families with at least one child in each program are called “blended” and require staff to provide additional levels of education to assist members as they navigate through the differing groups and rules required of each of the groups. Previous analysis indicates that about 25% of SCHIP families also have a child in Medicaid.
Program Review of Eligibility Policy and Operations of Public Insurance Programs

Chapter 15—Eligibility Policy and Operations of Public Insurance Programs

Table 1.
*HealthWave Income Eligibility Limits*

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<tr>
<td>≤133% FPL</td>
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Key:
- Medicaid
- HealthWave 21 - No Premium
- HealthWave 21 - Premium

The 2008 Kansas Legislature approved an expansion of SCHIP to 250% of the FPL. However, due to the lack of federal funding currently available, the expansion will not be implemented at this time. The program will to be expanded when federal funding becomes available.

- Presumptive Eligibility for Children began in July 2006. Presumptive Eligibility (PE) allows designated Medicaid providers to enroll children at the time a medical service is provided while the application for coverage is being processed. Three entities are currently authorized to make presumptive determinations. Presumptive eligibility is time-limited and coverage terminates after two months if a follow-up application is not received. Participating Medicaid providers play a critical role by assisting the applicant in completing the eligibility process. The presumptive eligibility program is an essential part of outreach initiatives targeted towards enrolling the children in Kansas. At this time, three providers participate, with services offered at 10 locations. By the end of 2009, our goal is to expand to this program to an additional five providers who may operate at multiple locations.

Options to Fill Policy Gaps

- **Expand Presumptive Eligibility to additional health clinics and provide adequate support to all PE locations.** Allowing additional sites to make Presumptive Eligibility (PE) determinations will permit more children to receive critical health care immediately. KHPA plans to expand to five additional sites within the next year. However, personnel and other support are necessary at the clinics to make quick, accurate determinations. Having a trained staff person from the clinic assist the family with the application process increases the likelihood of a complete application, and therefore increases the likelihood of a positive determination.

- **Expand coverage to young adults under age 21.** Providing health coverage to low-income young adults will not only ensure they have access to care, but can also help the individual realize the importance and value of health insurance at an early age. Uninsurance rates are highest in this group of young adults who earn the least, are often investing time and money in their education, have few assets to protect against financial loss and are the healthiest group of adults. Medicaid coverage for individuals ages 19-21 is currently unavailable except...
Medically Needy Group

Description

The medically needy or spend-down program covers pregnant women, children, the disabled, and elderly who are living independently in the community and have too much income to qualify for regular Medicaid. Persons in the medically needy program have a spend-down. A spend-down mimics the insurance deductible of private health coverage where the individual is responsible for a share of his or her overall medical expenses. Medicaid will pay for covered medical services once the deductible, or spend-down, is met. The amount of the deductible is based on the individual’s or household’s countable income. The amount of that income in excess of the protected income level in a six month base period is the spend-down. The current protected income level is $475/month for both an individual and a couple. There is also an asset limit for an elderly or disabled individual of $2,000 ($3,000 for a couple). Individuals with resources above these amounts are deemed ineligible for benefits. There is no asset limit for pregnant women and children.

It is important to understand how the Medically Needy income standard, or protected income level, relates to the eligibility determination. Unlike other medical groups, where there is a hard income limit, the protected income level (PIL) in the medically needy program allows consumers to keep some of their income. In theory, the PIL is used to meet the non-medical living expenses, such as food and shelter, of the individual or couple. Any income in excess of the protected income level is considered available to pay for medical expenses. The actual non-medical living expenses are not considered in this determination. For example, an individual at poverty level will have income of $847/month. The PIL is $475/month, which is protected, leaving $372/month ($847-$475) to be put toward health care expenses. For a six month base period the individual will have a $2,232 spend down, or deductible. Over the course of a year, the single individual living at poverty level must incur and remain responsible for almost $4,500 of medical bills. Considering the annual income limit is $10,400 - almost 43% of his or her income will be spent on medical expenses.

Although program rules are very similar, the way pregnant women and children use the medically needy program is different than the way the elderly and disabled use the program. Pregnant women and children fail to qualify for regular Medicaid at higher income limits than the elderly and disabled. Because of this, pregnant women and children with higher incomes can use the medically needy program to provide catastrophic coverage. When family income is too high to qualify for Medicaid, a pregnant woman or child may still qualify for medical assistance after a health care spenddown (or deductible) is met. With the income limits currently in place for Medicaid, medically needy coverage for pregnant women and children is actually only used by persons with relatively high incomes. Because people with higher incomes have larger spenddowns, they must also have very high medical bills to actually meet a spenddown. Consider a 10 year-old child in a family at 220% of poverty living with both parents - where income would be about $3227/month. The total spenddown for a six month base for the child will be $16,482, enough to bring the family’s income for the six month period down to the Medicaid threshold of $480/month. It is important to note that the medically needy option may only be applied to the Medicaid eligibility threshold, not the higher SCHIP thresholds. If the family has medical bills to meet this deductible, they can receive Medicaid coverage to help with other expenses.

For the elderly and disabled, the medically needy Medicaid program is often used by those who
have very low incomes that are just above the eligibility threshold but who also have ongoing health care costs. Eligibility is typically long-term and provides primary or critical supplemental coverage to Medicare. As Medicare entitlement begins two years after the individual is eligible for Social Security benefits, the Medically Needy program is often the only coverage the individual may have available. Medicare doesn’t always cover all health care needs, and additional coverage is often needed for services such as mental health and home health care. However, with such low eligibility thresholds for full Medicaid benefits, and with Medicare’s coverage gaps, the neediest individuals are often under-insured. Because full Medicaid coverage is available to SSI recipients, a benefit usually provided to those with no work history, adults with work history who receive Social Security benefits are far more likely to have a spend down.

At current levels, the protected income level does not provide sufficient funds for many individuals and couples to afford to pay for their non-medical needs. When medical needs arise, the individual/couple may not have the means to pay these expenses. If the choice is made to forgo treatment, greater medical expenses in the future are a significant concern. If treatment is provided and the individual cannot pay, the provider may have to absorb the costs. Increasing the protected income limit would provide resources and a stable source of health care for needy, disabled and elderly individuals, and would offset uncompensated care for providers, both accomplished using a match of federal dollars.

Options to Fill Policy Gaps

- **Increase the Protected Income Level to Social Security Income (SSI) Limits.** The current protected income level for a couple was last increased almost 15 years ago in 1994 and for a single person in 1997. Previously, annual increases kept pace with the SSI monthly benefit rate. Returning to this standard is a natural transition because of the close association Medicaid has with the SSI program. Using the SSI benefit rate also provides a level playing field for persons with work history, as they are at a great disadvantage under the current structure. Also, by linking the income limit to an existing program with annual adjustments built in, such as SSI, protection against inflation is also provided. Annual cost of living adjustments are also needed in order to keep the protected income level at levels equal to those of the SSI program.

  - The current protected income limit is a little more than half of the poverty level, or about 55% of the Federal Poverty Level (FPL) for an individual and 41% for a couple. In contrast, the cost of living has increased approximately 31.8% since 1997 while the protected income level has remained fixed. The SSI limits are currently $637 for a single and $956 for a couple (about 74% of the FPL for a single and 82% for a couple).

  - Persons in these income ranges may go without health care coverage, or other basic needs, because they cannot afford them. Neglecting health care needs can have severe consequences, which may ultimately cost more than providing for primary preventive health care needs up front. Federal funding is available to help with some of these costs but is not currently being leveraged.

- **Provide Medically Needy Coverage to Caretakers.** The current medically needy program falls short of covering caretaker adults. There is no assistance for able-bodied adults in medical need under this program. Expanding coverage to caretakers will provide catastrophic protection to parents with higher incomes who may not be able to afford health insurance, including
people who have transitioned off of Medicaid. Kansas previously covered this group prior to 1992, when it was eliminated due to budget issues. Reinstating this coverage now would provide a substantially lower, but valuable level of protection for parents given the large effective drop in the caretaker income levels due to 15 years of inflation.

Long-Term Care Groups

The long-term care eligibility groups serve children and adults who are receiving institutional or assistive living services. There are a wide range of both institutional and community-based options, including coverage for nursing home residents, in-home medical assistance under Home and Community Based Services (HCBS) and Work Opportunities Reward Kansans (WORK), as well as managed care in the Program for All-Inclusive Care for the Elderly (PACE). Each qualifying individual must pass a clinical screening to justify a medical need for institutional placement or community services.

Offering a variety of care options, especially community based alternatives, is a high priority of all state agencies responsible for administering long-term care. Continued movement toward home and community based services is absolutely critical for both social and budgetary resources. But, these expansions do not come without complications as each of these groups uses unique eligibility rules. This information needs to be made easily available and accessible to eligible families. For example, family groups that would normally be budgeted together due to their legal responsibilities are budgeted separately for purposes of eligibility for long-term care services - an adult applicant/recipient is budgeted separately from his spouse and a child applicant/recipient is budgeted separately from his or her parent(s).

Cost-sharing. Each qualifying individual must meet all financial eligibility criteria, including specific income and resource limits. Once qualified for coverage, and for those (the vast majority) who are able to pay, there is also a cost-sharing component for the recipient in all of the long-term care groups in the form of a monthly obligation or premium. Those in a nursing home or receiving coverage under the HCBS or PACE groups may pay an obligation to the provider. WORK program recipients may be obligated to pay a premium to participate in the Working Healthy program upon which the WORK program is based.

Protected income level. The amount of the monthly obligation is determined by the individual’s own income. A certain amount of income to meet non-medical needs is protected in this determination. That amount is known as the protected income level (PIL). The amount of income in excess of the PIL is the monthly obligation. The current nursing home PIL is $60/month. This is the amount sheltered for personal needs (all other needs are being provided by the facility). This will increase to $62 effective January 1, 2009. The HCBS PIL is $727/month - this protects a higher amount of income since the individual remains responsible for regular non-medical household expenses like rent, utilities and food. The PACE program uses either the nursing home or HCBS PIL depending on the individual’s particular living situation. The Working Healthy program premium amount for an individual ranges from $0 to $152 indexed to monthly income of $0 to $2,600.

Asset limits. Medicaid coverage for recipients of long-term care is designed to serve as a safety net for those individuals who cannot afford needed health care, which can cost tens of thousands of dollars per year and hundreds of thousands of dollars over a lifetime. In keeping with the principle that Medicaid is the payer of last resort, and that families should meet their own needs to the extent possible, there is an asset limit for each of the long-term care groups. As a result,
there is an asset limit for all of the long-term care groups. The resource limit for the nursing home, HCBS and PACE groups is $2,000. The resource limit for the WORK program which encourages and supports the individual’s employment towards self-sufficiency is $15,000.

Types of assets. Application of the resource limit in the Medicaid eligibility determination can, in many instances, be complicated and involved. Assets such as life insurance policies, funeral plans, stocks, bonds, contracts, business partnerships, real estate, life estates, trusts and annuities all require thorough analysis to determine the availability and value to the individual. Other complicating variables such as multiple owners, encumbrances on the property and issues of inheritance must also be considered. Eligibility staff frequently must explain these subtle nuances to lawyers, bankers, financial planners, realtors, insurance agents and other professionals. All gifts, sales, purchases and other transactions involving an applicant’s financial assets occurring within 60 months of application for assistance must be formally disclosed as part of the application process for the long-term care groups. Further complications arise when individuals or their family choose to be less than forthcoming in reporting and/or fully cooperating in documenting this resource information. Relevant information may at times be intentionally or inadvertently omitted. This could include the failure to report the actual existence or transfer of resources. Eligibility staff rely heavily on the prudent person concept which requires investigation and reconciliation information that a prudent person would consider incomplete, unclear or contradictory information.

Spouse protections. Special rules for married individuals add an additional layer of complexity. These special rules, known as Spousal Impoverishment or Division of Assets, allow additional resources to be protected for the non-long-term care spouse. This resource evaluation process involves an additional thorough, detailed analysis of the couple’s resources at two specific points in time - at the time the long-term care arrangement began and at the time of application for assistance. The first point in time will determine the amount of resources the non-long-term care spouse can shelter for him or herself. The second point in time determines whether the long-term care spouse is resource eligible for assistance. Since this is such a complex process, eligibility staff frequently invest a significant amount of time explaining these rules and the consequences to the long-term care individual’s spouse and family.

Integrity of Medicaid programs. While the long-term care groups provide a very important benefit to those individuals who are most in need, efforts to exploit these benefits through Medicaid estate planning activities - also known as planned poverty or artificial impoverishment - have caused Medicaid groups in every state to redirect a remarkable amount of resources and energies towards protecting the integrity of the Medicaid program from these abuses. The intent of Medicaid estate planning is to create a process where an individual presents the legal appearance of being impoverished within the existing resource limits with the express purpose of achieving Medicaid eligibility, even though he could have paid for some or all needed care. Various techniques have been employed over the years to help consumers qualify for Medicaid - Medicaid qualifying trusts, transfer/gifting of assets, “loans” to family members, contracts for care, and most recently, the purchase of annuities. A more or less continuous stream of state and federal laws has been enacted over the years to thwart these practices. The most recent and wide sweeping was the federal Deficit Reduction Act of 2005.

Penalty Periods. One such policy to curtail these abuses involves the application of penalty periods - a delay in Medicaid eligibility, for individuals who transfer property without receiving a fair value in return. Penalty periods may be applied when an individual gifts money or property, sells property for less than fair market value, or refuse an inheritance or other property he is legally
entitled to receive.

**Estate Recovery.** A second key policy initiative was the creation of the Estate Recovery program. Upon the death of a long-term care recipient or the recipient’s spouse, the state is allowed to recover any remaining assets in the individual’s estate up to the amount in Medicaid claims paid for the individual. Assets may range from small bank accounts to houses to businesses. KHPA’s estate recovery efforts recovered over $7 million in FY 2008.

### Options to Fill Policy Gaps

- **Increase the HCBS protected income level to a specific percent of poverty.** The current HCBS protected income level is $727, or about 84% of poverty ($867). Increasing the protected income level will meet a legitimate need, but should be considered together with options for improving coverage of other long-term care groups so as not to create or make worse, some inappropriate incentives for applicants.

  Because the HCBS PIL ($727) is much higher than the Medically Needy PIL ($475 for a single or couple), individuals are drawn to the HCBS waiver in order to eliminate a cost sharing spend-down. This inherent discrepancy in the PIL’s between the groups creates the potential for abuse in qualifying individuals for the HCBS program. Although all recipients for HCBS have been screened eligible for services under the program, those services may not be their primary need.

### Medicare Savings Plans Group

The Medicare savings plans are designed to help low-income Medicare recipients with out-of-pocket Medicare expenses through the Medicaid program. Three separate groups are actually included as Medicare Savings Plans: The Qualified Medicare Beneficiary (QMB) program, which is much like a Medicare supplement program in that Medicaid pays for the Medicare premium and any co-pays and deductibles; the Low Income Medicare Beneficiary (Regular LMB), in which Medicaid pays only the Medicare Part B premium; and the Expanded LMB program, in which Medicaid pays only the Medicare Part B premium, but is 100% federally funded.

These Medicaid eligibility groups all have resource and income limits. The resource limit is $4,000 for an individual and $6,000 for a couple. The QMB income limit is 100% of the FPL ($867/month for an individual, $1,167/month for a couple). The Regular LMB limit is 120% of the FPL ($1,040/month for an individual, $1,400/month for a couple). The Expanded LMB income limit is 135% of the FPL ($1,170/month for an individual, $1,575/month for a couple).

All individuals who receive coverage under a Medicare savings plan also receive a Medicare Part D subsidy. Medicare Part D subsidy pays the prescription drug premium, provides reduced co-payments and eliminates the gap in coverage.

Together with low-income subsidies for Part D, the Medicare savings plans help low-income seniors and persons with disabilities to access comprehensive health coverage medical care. Offering assistance with Medicare related expenses ensures access to affordable health care through established networks. Beneficiaries can also benefit by using the funds available through premium relief to help with nutrition and housing expenses.
Estate recovery is not applicable to the Medicare Savings Plans and a simplified application and brochure are available.

**Options to Fill Policy Gaps**

- *Expand coverage of the Medicare Savings Plans by raising the income limits to 150% for QMB, 170% for Regular LMB and 185% for Expanded LMB and by eliminating the resource test for these groups.* The Medicare Savings Programs allow individuals to receive significant benefits for a relatively small amount of state funds. For a small investment (about 40% of the cost of the Medicare Part B premium, currently $96.40/month) an individual can also obtain subsidized drug coverage and, with QMB, the equivalent of a Medicare supplement insurance plan. Table 2 illustrates what this expansion would cost per person in State General funds (SGF).

<table>
<thead>
<tr>
<th>Medicare Savings Plan</th>
<th>Cost Per Beneficiary Per Month</th>
<th>Approximate Benefit</th>
<th>Income Limit Increase</th>
<th>State General Fund/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB</td>
<td>$117</td>
<td>$5250</td>
<td>100% → 150%</td>
<td>$47</td>
</tr>
<tr>
<td>LMB</td>
<td>$96</td>
<td>$4750</td>
<td>120% → 170%</td>
<td>$38</td>
</tr>
<tr>
<td>ELMB</td>
<td>$96</td>
<td>$4750</td>
<td>135% → 185%</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Table 2:**

*Estimated Benefit Value For Medicare Savings Plans*

**Eligibility Operations**

Before medical benefits and services can be delivered to a medical beneficiary, his or her eligibility must be established. However, establishing eligibility isn’t enough. Determinations must also be made regarding the type of coverage for which the individual is eligible, premium amount, cost sharing, and a myriad of other variables. Staff in eligibility operations use program rules and policies to make individual eligibility determinations.

**Initial Eligibility**
**Multiple program applications.** Eligibility for medical assistance begins with an application for coverage. Kansas Medicaid uses a variety of applications in order to offer several methods to access program benefits. Two multiple-program applications are offered for people applying for medical assistance and other benefits (such as food stamps or child care). These applications are generally lengthy, but may be more efficient for an applicant who desires multiple services. These applications are also suitable for individuals who potentially qualify under several categories.

**Targeted applications.** KHPA has also developed a variety of targeted applications for persons who only want medical coverage, or only want a specific type of medical coverage. These applications are much shorter and more convenient, as the questions on the application are limited in order to gather only the information pertinent to the particular program. The most popular targeted application is the HealthWave application. This application allows a family who only wants medical coverage to avoid questions about assets or shelter expenses, as they aren’t eligibility factors for the HealthWave program. Other targeted applications allow eligibility only for a special category of coverage. For example, a special application for women seeking coverage under the Breast and Cervical Cancer program asks limited questions, but can only be used to establish Medicaid under that program. Other targeted applications include those for the Medicare Savings Plans and Tuberculosis coverage.

**Time limits.** Regardless of the application form used, an eligibility determination must be completed on an application within 45 days of the day it is received by the agency. This time limit increases to 90 days when a disability determination must be completed in order to make a decision. The date which medical assistance coverage is made effective is the first day of the month the individual is eligible. In other words, if an individual is eligible for one day of the month, that individual is eligible for the full month. Medicaid also provides up to three months of prior medical coverage. Thus, an individual who makes application in July may be eligible as far back as April 1.

**Ongoing Eligibility**

Once eligibility is established, members are required to report changes that impact their eligibility. These reporting requirements differ by eligibility group, as a change may or may not impact the individual’s eligibility. A complete redetermination of eligibility occurs annually. These redeterminations, or reviews, require an individual to complete an application and provide current verification of certain eligibility requirements.

Persons who comply with these reporting requirements and continue to meet the specific requirements of the Medicaid eligibility group may receive coverage indefinitely, although turnover is frequent for many eligibility groups. Coverage may end for the following reasons:

- The individual hasn’t complied with a program requirement, such as failure to return a review or provide additional information.

- Financial criteria are no longer met for example, income exceeds the limit or they own excess resources.

- Non-financial criteria are no longer met, such as when an individual moves out of state.
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- Categorical or basic group requirements are no longer met, such as when children reach the age of 19.

When coverage terminates due to the death of a member, the estate recovery process begins for persons who were over age 54 or received coverage in a medical institution, such as a nursing home. With estate recovery, the assets owned by the individual at the time of death are subject to recovery by the state as a way to reimburse taxpayers for medical costs that were paid by Medicaid. Most of these requirements are federally-mandated, and reflect Medicaid’s status as payer of last resort. KHPA currently contracts with Health Management Systems (HMS) to provide most estate recovery services.

Eligibility Business Model

In an effort to accommodate a variety of individual needs, persons are offered various avenues for accessing medical assistance. Applications are accepted by mail, fax, electronically with a manual signature, or in-person delivery. Face-to-face interviews are not required, but may be completed at the individual’s choice. Various application forms are also used to allow the person to apply for multiple groups or special groups. For all applicants, any additional information needed to process is requested in writing. The customer is given 10 days to provide the additional information. A letter is sent to all applicants explaining the outcome of the eligibility determination regardless of the program or the location of the request.

KHPA relies on internal staff, as well as SRS and contract staff to make eligibility determinations. The following describes the medical assistance service delivery model:

HealthWave Clearinghouse. The Clearinghouse is a centralized processing center designed to handle the majority of Family Medical eligibility determinations. Families may apply for assistance at the Clearinghouse or at an SRS office, but all ongoing family medical cases are managed by the Clearinghouse. The Clearinghouse is operated by a contractor, currently Maximus, with KHPA staff also stationed at the Clearinghouse to provide oversight and make final Medicaid determinations, as required by CMS. The HealthWave Clearinghouse processes applications through a mail-in process; face-to-face contact with an eligibility counselor at the Clearinghouse is rare.

When an application is submitted, it is registered and then forwarded to an eligibility counselor (EC) for screening. Screening is the process by which the EC reviews the application and any supporting documentation to determine if additional information is needed. If additional information is needed, the EC can attempt to contact the consumer by phone but must also send a letter requesting the information. The goal at the Clearinghouse is to process the applications quickly and accurately.

Department of Social and Rehabilitation Services (SRS). SRS is responsible for processing and maintaining all elderly and disabled medical assistance applicants and recipients. SRS staff also process some initial family medical determinations, but send the cases to the Clearinghouse for ongoing maintenance.

SRS uses a caseworker model for nearly all cases. This means a single caseworker is responsible for ensuring eligibility actions are completed for the case. Persons can apply for medical assistance at any of the SRS offices throughout the state. Applicants may want other benefits in addition to medical, such as food stamps or cash assistance. The SRS model is set up to streamline these processes and consolidate requests and communication with the applicant. Persons may
also limit their requests to just medical assistance. Although interviews are not required for medical assistance, one is often conducted because the individual is applying for other benefits or if the individual makes a specific request for an interview. This is especially true with persons applying for the elderly and disabled groups, where face-to-face contact may be beneficial when explaining complex program rules and steps.

Eligibility Staff Training

Trained eligibility staff are essential to a successful eligibility operation. KHPA is responsible for developing and overseeing the training groups for KHPA and SRS medical eligibility staff. Providing staff with the knowledge, tools and confidence needed to make complicated eligibility decisions is best achieved through a strong training program.

The training program is developed to address three major competencies:

- **Social skills.** Eligibility staff must have the ability to work with a wide variety of people. Examples include attorneys, financial planners or life insurance agents asking about long-term care eligibility; families and individuals in crisis desperately trying to take care of their loved ones; medical providers uncertain if coverage levels warrant providing a specific medical procedure; or social workers trying to plan the reintegration of a child back into a home from which he or she was removed. Eligibility workers need unique people skills that allow all people seeking help to feel comfortable.

- **Technical skills.** Eligibility staff are responsible for making determinations for more than 35 different sets of eligibility requirements. Staff must know the eligibility rules for each eligibility group, and be able to successfully navigate the system’s multiple tools in order to record the results of eligibility decisions. In addition, many workers must also process other benefit groups too, such as food stamps, cash assistance and child care. Accordingly, eligibility workers must demonstrate both efficiency and good organizational skills.

- **Flexibility.** Eligibility staff must be able to adapt fluctuations in workload and changing rules. Because Medicaid is an entitlement program, the size of the caseload and the volume of work is difficult to predict, a factor that is important when managing a caseload and day-to-day work. Additionally, medical assistance policies are continuously being updated and changes in eligibility policies are common. These changes often require the eligibility worker to re-learn both the policy and the processes related to the change. Eligibility workers must be very flexible and able to retain and process frequent changes.

KHPA has developed two separate training path groups: one for Family Medical and one for Elderly and Disabled Medical. Both training path groups consist of detailed eligibility rules and processes, information on benefits, service delivery models and payment methods of various eligibility groups. Internal staff at both the SRS offices and the Clearinghouse are responsible for delivery of most training modules. KHPA has recently updated trainings with software to aid with online course development. KHPA partners with SRS to document training in a common learning management system. KHPA training staff determine training priorities in collaboration with training staff at the Clearinghouse and SRS.

Basic Training courses

- **Basic Eligibility Training.** The Personal Trainer is a web-based training course (anywhere, any-
time instruction delivered over a secure web site) that is used to present the basics of the Medical eligibility groups and policy. The course introduces new eligibility staff to basic principles and concepts used in the eligibility process. This course usually takes three to six months to complete. At the same time, the worker may be shadowing other workers, observing others in consumer interviews, spending time with a trainer or supervisor talking about policy or procedures, and generally getting acquainted with the agency and the duties of their job. Many are also processing a small caseload or doing basic work on their own.

- **Training Academy** - Classroom style training is available for staff that have completed Basic Training. These courses are designed to provide detailed level instruction and to secure concepts. Although the Elderly and Disabled modules are currently operational, Family Medical Training Academy courses are currently under development.

- **New Policy Training** - KHPA provides face-to-face training on major policy changes when necessary. However, most new policy training is delivered by the program manager via teleconference. Fact sheets and desk aids are frequently used to supplement these sessions.

- **Refresher Training** - KHPA plans to develop a series of refresher courses for experienced eligibility staff in the next two years. These courses will not only ensure long-term staff have kept up with policy changes, but will also allow eligibility staff an opportunity to share information with their peers.

### Eligibility Outreach

The ultimate goal of the eligibility outreach program is to increase enrollment and retention of eligible beneficiaries. Increasing overall access to care reduces the number of uninsured. Partnerships with community organizations and advocacy groups are critical to achieving this goal.

The following principles guide KHPA’s outreach efforts:

- A fully-staffed, well-trained eligibility staff is essential to successful outreach.

- Simplified eligibility policy and processes are used to the extent possible given fiscal and program limitations.

- Multifaceted campaigns which include both mass marketing and direct marketing approaches are preferred.

- Strategies are consumer-driven.

- Maximize the use of technology in outreach efforts, such as community-based enrollment options and the development of the online application.

KHPA hopes to further develop outreach strategies with the formation of the statewide Outreach Advisory Council, which began meeting in August 2008. The council consists of representatives from state agencies, community and advocacy organizations and medical foundations. The council will advise KHPA regarding the best approaches to take when attempting to reach potentially eligible uninsured, and underinsured, Kansans. KHPA is especially interested in strategies that can help hard-to-reach populations such as Native Americans. KHPA is also actively engaging in con-
sumer education for Medicaid eligibility through staffing exhibits and providing presentations at various statewide events.

The goal of outreach is to increase enrollment in and retention of eligibility beneficiaries in public insurance programs. This both improves access to health care and reduces the number of uninsured. Providing direct information and support to the uninsured by partnering with established, trusted health care providers such as safety net clinics has proven successful. The 2008 Kansas Legislature showed tangible support for these outreach initiatives by including a line item specifically calling for outreach and enrollment services in the health reform legislation, Senate Bill 81. However, the program failed to receive necessary funding.

Four specific initiatives for increased outreach were included as part of health reform in SB 81:

- Place an out-stationed eligibility worker at 10 health clinics throughout the state.

- Provide administrative funding necessary to support the Presumptive Eligibility program, which allows select medical providers to make a basic, temporary eligibility determination at the time of service. The Presumptive Eligibility Option will be expanded to five additional health clinics over the next year.

- Provide funding for direct marketing of KHPA’s public health insurance programs, primarily HealthWave.

- Support additional administrative costs of the online application KHPA currently in the procurement process.

Automated Systems

Prior to 1988, eligibility determinations for all public assistance groups, including medical assistance, were recorded on paper. Forms were developed, appropriate data and figures were entered on the forms, and calculators were used to make final eligibility determinations. Once the determinations were made by eligibility staff, the forms were sent to a central data processing center that would issue the benefits that were approved. One problem with this manual process was that it relied entirely on each caseworker’s knowledge and ability to apply policy correctly and consistently, even as the Medicaid program became increasingly more complex.

The Kansas Automated Eligibility and Child Support Enforcement System (KAECSES) was developed and implemented in 1988 in order to streamline eligibility determinations. Caseworkers were still required to know which eligibility groups an applicant might be eligible for, which questions to ask in an interview, and all of the policy that drove a determination of eligibility, but the system did most of the computing. To the extent that workers could collect and enter the appropriate data, the system could consistently apply calculations and policy to arrive at reasonably consistent results. Eligibility workers, however, still required substantial knowledge of eligibility policy to obtain appropriate information and communicate properly with consumers.

With passage of “welfare reform” in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), and the Balanced Budget Act of 1997 (BBA), the complexity of the eligibility process significantly increased. PRWORA required de-linking of medical assistance (Medicaid) from cash assistance (welfare) and allowed states to develop unique cash assistance groups. In Kansas, some new welfare reform options available to states were implemented.
example, the resource test for family medical groups was eliminated and penalties related to
work program participation were no longer applicable to Medicaid. The BBA established the State
Children’s Health Insurance Program (SCHIP). Implementation of the Kansas SCHIP program
(HealthWave) further distanced medical assistance from cash by establishing continuous eligible
for children. In addition, numerous other programs added complexity to Medicaid, such as the
growth of Home and Community Based Services (HCBS) waivers for the elderly and disabled. Addi-
tional provisions passed as part of the Deficit Reduction Act of 2005 added yet more complexity
with new rules for resource divestiture and estate planning, as well as the creation of the Medi-
care Part D pharmaceutical benefit.

Because of these additional requirements, the KAECSES system struggled to support public assis-
tance eligibility determination, especially for medical groups. Although changes to eligibility pol-
icy were implemented by eligibility staff, re-programming KAECSES to fully reflect changes in eli-
gibility policy nearly always pointed to a two to three year effort. Consequently, the modification
requests for KAECSES were limited to elementary requests only, or just the minimum necessary to
get the eligibility data to the appropriate other systems. In time, even the minimal eligibility
change requests were too much. Instead, workers had to revert to making paper determinations,
much as the workers did prior to 1988.

For over 10 years, eligibility staff have used a system that does not fully support their work. The
problems that KAECSES initially alleviated, such as inconsistently applied policy, computation er-
rors, and excessive human intervention, have resurfaced. KAECSES is the starting point for all
data and eligibility information that feeds into other systems (see Figure 3). Yet KAECSES does
not and cannot collect all of the data and provide sufficient decision support necessary to effi-
ciently administer eligibility for the medical assistance groups.

KHPA continues to seek ways to compensate for KAECSES. For example, the Maxe\textsuperscript{2} system, a pro-
prietary system owned by KHPA’s enrollment subcontractor, MAXIMUS, is used to provide manage-
ment reports and other administrative staff tools for the HealthWave Clearinghouse operation.
Electronic worksheets have been developed to compute countable income, penalty periods and
other eligibility factors which aren’t fully supported by KAECSES. Appendix B provides a more de-
tailed description of some of the information systems upon which eligibility staff rely.

**Future Systems**

**Modern Automated Eligibility System**

KHPA, along with Social and Rehabilitation Services (SRS), has worked for the past year on the de-
sign of a web-based eligibility determination system. KAECSES has reached its maximum capabili-
ties and is unable to effectively implement new groups. The system requires staff to conduct off-
system, paper-based determinations and manual work-arounds, which are cumbersome and error-
prone. Because both KHPA and SRS routinely add new groups and change existing groups, a mod-
ern, flexible integrated system that is easily modified is essential in order to keep pace with these
changing groups. New systems also offer expanded opportunities to standardize procedures and
improve accuracy. A new integrated system will allow multiple ways for customers to utilize and
receive benefits, including e-mail notices and a portal to report all changes online. An efficient,
reliable new system will also allow staff to focus more on prevention and customer/case manage-
ment.
An automated eligibility system which is more flexible and requires less technical expertise to implement a greater variety of changes is necessary. A system built on the concept of a rules-drive decision tree would improve flexibility to implement new groups and allow current program determinations to be made by the system. Having this type of system will decrease the number of manual work-arounds, and ultimately decrease human errors made in eligibility work.

Currently, several types of eligibility are determined from the system, and the current system was not built with current data needs in mind, so data needs are not always met. All program eligibility determination needs to be done in the system and a robust, flexible and user friendly reporting system is needed.

Because eligibility determinations continue to become more technically complex, a new system is needed to incorporate more of the eligibility determination based on the rules maintained within the system. This will improve accuracy. Improved accuracy could prevent overpayments and potentially be a cost savings.

KHPA and SRS continue to work together to determine the best strategy for addressing this core business need.

Online Application

KHPA is in the process of acquiring and implementing an innovative online application system to apply for public insurance as well as a tool for designated entities to utilize for the presumptive medical eligibility process. This will be a web-based application that offers customizable features for varying types of users. It will feature an electronic signature making it possible for persons to apply anywhere, anytime. KHPA views this application as a critical building block for development of the outreach plan. It is a tool community partners can utilize to save time and money as well as facilitate ease of customer use. It is important to note that although an online application is available through SRS, it is not program specific and does not include an electronic signature. Implementation of the KHPA online application is planned in 2009.

Beneficiary Self Service Options

KHPA has recently implemented a multi-functioning web-based tool for members to obtain information about their benefits and to perform functions related to maintenance of their medical assistance. This tool, commonly referred to as the beneficiary web portal, also serves as an information center by providing tips on health care management, general and specific information regarding medical assistance benefits and links to related websites. In addition to web-based services, a Beneficiary Automated Voice Response System (AVRS) is available. ROSIE, as the AVRS is called, allows a check of eligibility through a simple phone call. Both systems were implemented on November 3, 2008.

Imaging

KHPA is initiating a centralized uniform document management and imaging system. Currently, fragmented imaging services exist at KHPA. Departments essentially function as individual entities utilizing individual contracts and vendors. Upon the completion of this project the Clearinghouse, workers compensation, presumptive disability, the finance and operations department, and the state employee health plan will all utilize imaging services from a single vendor.
Program Review of Eligibility Policy and Operations of Public Insurance Programs—January 2009

Premium Billing

KHPA is also in the process of procuring services that will centralize premium billing and collection services and related customer service across multiple departments. The goal is to utilize a single vendor for the entire agency. Implementation will occur in phases based on need and as departmental contracts with current vendors expire. Two medical assistance groups currently include a premium requirement, Working Healthy and SCHIP. Providing an automated and modern premium billing approach will allow eligibility staff to update premium obligations much easier and will also enable them to receive up-to-the-minute information without making phone calls or monitoring reports.

Program Integrity

As the single state agency ultimately responsible for medical assistance administration in the state, KHPA has an obligation to monitor the quality and accuracy of eligibility determination. The purpose is two-fold. First and foremost, it is critical that fair and accurate determinations are made for every applicant and recipient. We must ensure that customers receive correct benefits. The second reason is fiscal - to ensure that monies are expended appropriately. This involves avoiding incorrect payments and federal sanctions that may result from poor quality determinations.

Performance Measurement and Outcomes

As required by federal rules, KHPA formed a Medicaid Eligibility - Quality Control (ME QC) section with responsibility for both the ME QC function and the eligibility portion of the upcoming Performance Error Rate Measurement (PERM) project. The Centers for Medicare & Medicaid Services (CMS) implemented the PERM program to measure improper payments in both Medicaid and SCHIP. PERM is designed to comply with the Improper Payments Information Act of 2002. For PERM, CMS is using a national strategy to measure payment accuracy. Eligibility is one component in the process. States are involved in the PERM review once every three years. Although Kansas participated in a PERM pilot project a few years ago and was a first-round PERM state in October 2006, this is the first year a PERM eligibility review will be conducted in Kansas. Kansas operates exploratory pilot projects in the ME QC program - an option given to the state several years ago because of a history of low error rates - PERM will require a review of the quality and accuracy of eligibility decisions.

Given this heightened attention by the federal government regarding program error rates, Medicaid and SCHIP are coming under increased scrutiny. Separate from these federal efforts, KHPA is committed to maintaining the integrity of these groups and to establishing standards for key eligibility functions, including timeliness of application processing, accuracy of determinations, and customer experience. KHPA is in the process of developing program measures that will accurately reflect the condition of the program across a number of metrics. Measurements are needed across all aspects of eligibility-related work, including determinations made at the Clearinghouse and SRS and program support work provided by the MMIS contractor and any new contractors that will join in serving the Medicaid program under the new contracts.
Incorrect Payments

Medicaid beneficiary overpayments occur when eligibility is incorrectly determined and claims are paid in error. Claims may be traditional fee-for-service expenses, managed care capitation payments or service payments - such as HIPPS or Medicare buy-in. In theory, the eligibility worker will establish the Medicaid overpayment and initiate recovery. However, difficulty with the entire process, from establishing the actual overpayment amount to collecting the funds has resulted in low recoveries.

To complicate matters, when willful client error or beneficiary fraud is suspected, KHPA does not have access to investigators to look into the circumstances and gather evidence to support the case. These investigations could involve researching deeds, gathering bank records, and contacting collateral entities such as landlords, employers, brokerage houses and attorneys.

Long-term care cases present unique challenges for the program integrity project. Because long-term care is so expensive, beneficiaries often employ professional estate planners or estate planning techniques to qualify for Medicaid benefits. Efforts to curtail these activities are time-consuming and require a substantial amount of human resources.

If it is later discovered that benefits were not properly provided, an overpayment can be established. Efforts must then be made to recover the overpayment. The applicant may not be banned from assistance unless there is a federal conviction on a fraud charge, something that hasn’t occurred in Kansas in recent history. By contrast, the Medicaid provider process has an extensive and substantial process for dealing with overpayments and fraud, including banning providers.

Summary

This program review has described Medicaid eligibility policy and operations in detail, identifying areas of potential areas of investment that would both improve Medicaid coverage and better facilitate access to existing coverage. The report identifies a number of populations with significant health needs, or who cannot afford care, who would benefit from expansions in Medicaid coverage. In particular, we note that the KHPA Board has endorsed in its broad health reform agenda the expansion of Medicaid to parents living in poverty. This recommendation is listed below, along with several other options identified by KHPA staff as representing the areas of greatest need that could be addressed through the Medicaid program.

This review has also identified improvements in Medicaid operations and outreach that would help eligible Kansans take advantage of the existing program to gain access to needed services and coverage. These improvements are outlined in the recommendations and options listed below. Future program reviews will closely review the dynamics of Medicaid enrollment in recent years, and will focus to a greater extent on the performance of the state eligibility and enrollment system.

KHPA Staff Recommendations

- Promote community-based outreach by placing state eligibility workers on-site at high-volume community health clinics. Eligibility workers out-stationed at these clinics will be able to make full determinations at sites serving populations most likely to be eligible for public health insurance.
Chapter 15 — Eligibility Policy and Operations of Public Insurance Programs

Cost to provide out-stationed eligibility workers

<table>
<thead>
<tr>
<th>State General Fund (SGF)</th>
<th>FY 09</th>
<th>FY 10</th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>5 Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SGF</td>
<td>$0</td>
<td>$560,000</td>
<td>$565,000</td>
<td>$580,000</td>
<td>$595,000</td>
<td>$2,300,000</td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$1,102,000</td>
<td>$1,130,000</td>
<td>$1,160,000</td>
<td>$1,190,000</td>
<td>$4,582,000</td>
</tr>
</tbody>
</table>

- Expand access to care for needy parents by increasing the eligibility income limit to 100% Federal Poverty Level (FPL), ($1,467 per month for a family of three). Current coverage levels are no greater than 30% FPL ($440 per month for a family of three), and fall each year as inflation eats away at the fixed dollar threshold for eligibility.

Cost to expand Medicaid for parents (caretakers) up to the federal poverty level

<table>
<thead>
<tr>
<th>100% FPL</th>
<th>FY 09</th>
<th>FY 10</th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>5 Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SGF</td>
<td>$0</td>
<td>$10,500,000</td>
<td>$41,000,000</td>
<td>$65,350,000</td>
<td>$73,500,000</td>
<td>$190,350,000</td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$31,000,000</td>
<td>$102,000,000</td>
<td>$162,700,000</td>
<td>$183,000,000</td>
<td>$478,700,000</td>
</tr>
</tbody>
</table>

Additional Options Identified by KHPA Staff

- Increase the number of people on Medicare who have access to full prescription drug coverage and who do not have to pay the Part B premium by eliminating asset tests and increasing the income limit for Medicare Savings Programs (MSPs) up to 185% Federal Poverty Level (FPL).

- 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. The last increase for this program was in 1994 and it is currently at $475 per month for both single people and couples (55% and 41% FPL respectively).

- Change household composition rules for pregnant women so that they are consistent with other populations and reflect equitable standards.

- Expand coverage to childless adults under the age of 21.

- Expand Medically Needy coverage to parents and other caretakers of children to provide catastrophic coverage.

- Develop a Medicaid Eligibility Program Integrity Project. This option is to review the state’s process for determining and addressing beneficiary fraud in the medical assistance programs as a whole. The initial focus would be to identify and investigate positive eligibility decisions that were based on potentially incorrect information provided by the member; investigation could determine intent. The program would also need to focus on ways to detect and investigate possible fraud. It would also pursue prosecution and recover inappropriate expenditures where appropriate. Special focus will also need to be given to long-term care cases, where specialized staff would analyze the techniques employed and examine the current eligibility policies to determine how those policies might be adjusted in the future to combat estate planning techniques.

- Utilize claims information to identify women who are no longer pregnant. Medical coverage is not available to women in the third month following pregnancy termination. Women who mis-
carry are often not identified until the due date has passed, resulting in incorrect Medicaid payments. By establishing agreements with the Medicaid MCO’s to report women appear to no longer be pregnant, coverage could be terminated timely and result in savings to the Medicaid program.
Attachment A

Kansas Case Studies
These case examples illustrate the current eligibility thresholds of each program. For most groups featured in this section, the income eligibility limits are at or below the federal poverty level (FPL). Many policymakers assume that publicly funded, basic health care coverage is available for all persons at or below the poverty level, yet in Kansas the eligibility threshold for most low-income parents is below 30% of the poverty level and Kansas Medicaid does not cover working age childless adults at any income unless they are disabled or pregnant. For people with disabilities, the level of coverage in the MediKan program is about 20% FPL. Nationally, over 13.9 million parents and childless adults with incomes less than 200% of the FPL are not eligible for Medicaid and are uninsured. A recent Kansas Health Institute study indicates about 340,000 Kansans are uninsured.

**TAF-related Medical Group**

**Case Study: Joe**

Joe is a divorced father of three. Joe injured his back a few years ago and was unable to work. He was not eligible for workers compensation or unemployment benefits at the time, so Joe applied for cash benefits through his local SRS office. He and his children were also approved for MACM coverage at the same time, which allowed Joe to get treatment for his injury.

Joe returned to work, part-time at first to ensure that a re-injury didn’t occur. Soon after his return to work, Joe’s cash case closed as he was over the income guidelines for TAF benefits. He was also over the income guidelines for MACM, but instead of ending his benefits, Joe and his children were approved for the Transitional Medical or TransMed program. This gave Joe an additional six months of medical coverage, with a potential to increase this to a full year of coverage. Since Joe followed the requirements of the TransMed program, he was able to receive the full year of benefits. At the time his coverage ended, Joe had signed up for his company’s health insurance. His children transitioned to the SCHIP program at review.

**Case Study: Josie**

Josie is a single mother of two children. Josie works full-time as a cook at a local café where she makes minimum wage ($6.55/hour, see Appendix D for more information regarding the minimum wage) and has a second part-time job cleaning office buildings every other weekend, where she earns $10/hour. Josie’s children, ages 8 and 4, also receive a small amount of child support from her ex-husband. She is grateful to her mother who cares for her children when she is at work at a very low cost. Josie would like to buy a home, but can’t save enough for the down payment. Josie’s budget is very tight:
Josie’s health is fairly good, though she does have severe migraine attacks which require her to miss work at times. Her children are fairly healthy too, though they don’t seek medical care very often as no one in the household has health insurance. The family lives at least 30 miles from the nearest free health clinic.

Lately, Josie’s migraines have been more frequent, putting her employment at risk. Josie applies for the MACM program, but was denied because her monthly income, $1500, exceeds the guideline of $403 that applies to her household size, living arrangement and county of residence. However, both of Josie’s children are approved for Medicaid (HealthWave 19) coverage, but that doesn’t solve her own health problems.

Because of her ongoing problems with migraines, Josie must give up her cleaning job and her hours are cut at the café to about 22 per week. Her monthly income is reduced:

<table>
<thead>
<tr>
<th>Income:</th>
<th>Café</th>
<th>$620</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cleaning</td>
<td>$000</td>
</tr>
<tr>
<td></td>
<td>Child Support</td>
<td>$100</td>
</tr>
<tr>
<td>Total Income:</td>
<td>$720</td>
<td>Note: This amount is about 49% of poverty.</td>
</tr>
<tr>
<td>Take Home Pay:</td>
<td>$680</td>
<td></td>
</tr>
</tbody>
</table>

Because of the income change, Josie applies for, and receives, food stamps and child care assistance. She applies for MACM again, but is denied because her income continues to exceed the guidelines. She continues to work, pay her bills, and parent her children, in between her migraine attacks.
Pregnant Women Group

Case Study: Carrie

Carrie is a married mother of one child, and is also 7 months pregnant. Until recently, Carrie and her family had been living in Utah, where she was receiving medical coverage. Carrie’s husband, a recent college graduate, obtained employment in Kansas, necessitating the family’s move. When the family relocated, Carrie’s medical coverage through her previous state of residence ended. Carrie now lived in a new and unfamiliar place, had no income (for the past two months), and had no medical coverage during the final stages of her pregnancy.

Prior to her move, Carrie had contacted KHPA to inquire about the application process. She was given information on the application process for pregnant women, how to fill out the application, and what to submit with it. She followed all of the suggestions and was approved for ongoing pregnant woman coverage within 7 days of the receipt of her application. Carrie was able to receive adequate, timely pre-natal care in her new state of residence.

Case Study: Mary and Richard

Mary and Richard are the proud parents of two children, ages 8 and 6. Richard is employed full-time at Wal-Mart while Mary is employed as a paraprofessional through the school district. They have just enough money to meet expenses each month.

Because of their tight budget, Richard and Mary are unable to afford health insurance for themselves or their family. Both of their children have health coverage through the HealthWave medical groups. Richard and Mary are in fairly good health and appear to be making it without health insurance.

Mary finds out she is pregnant. Mary immediately applies for Pregnant Woman coverage through HealthWave as this program provided access to health care during her previous pregnancies. Mary is sure she’ll be covered since her children receive coverage and the household’s income is modest.

Mary, however, receives a denial notice in the mail telling her that she’s over income for the Pregnant Women (PW) program. When she calls for clarification, she is told that her other children are not considered part of the household for pregnant woman coverage - only she, her husband and her unborn child are considered. Since all of the family’s income counts, the family is less likely to fall under the poverty-based eligibility threshold, since poverty thresholds are lower for smaller families. She and Richard are left to consider how, or if, they will pay for her pre-natal care.

Children’s Medical Group

Case Study: Oscar and Tina

Oscar and Tina are married with two children. Both Oscar and Tina have lived and worked in the United States for a number of years and recently learned they were both approved for Lawful Per-
permanent Residence status. They plan to become United States citizens as soon as possible. This is important to them as their children were born here and are already citizens.

Oscar works a well-paying job as a contractor for a construction company. He has no insurance as he can’t afford to pay the premiums. Tina stays at home to provide care for their children, but earns some money teaching piano to a few young children.

Tina begins to worry about the health of her youngest child, who appears increasingly lethargic and pale. She takes both children to a clinic offering Presumptive Eligibility. The staff at the clinic determine that the child is anemic and prescribe the necessary medications to treat the condition.

Tina is referred to an office worker at the clinic who explains the Presumptive Eligibility and HealthWave groups; this worker then proceeds to help Tina complete the applications for both groups. Based on the applications, the children are presumptively approved for SCHIP coverage. Because Tina now has coverage, she goes to the pharmacy to pick up the prescription for the children. Staff at the clinic also helped Tina complete the full HealthWave application, which they submit.

**Case Study: Brandon**

Brandon recently graduated from high school and plans to enter college in the fall. When he was 6, Brandon was diagnosed with juvenile diabetes. Although it’s under control, he has to carefully watch his diet and monitor his blood sugar levels. Brandon has been covered under HealthWave since the program began in 1999. It’s the only health insurance coverage he has ever had. This month, Brandon turns 19 and he received a notice that his HealthWave coverage is ending. Both he and his mother are worried how he can manage his condition while at college without comprehensive health insurance coverage.

**Medically Needy Group**

**Case Study: Harold and Maude**

Harold is 71 years old and his wife Maude is 63. He worked up until last year when he had a stroke. He was in the hospital for months which took all of their savings. He is scheduled to go back in the hospital for more surgery in the fall.

Harold worked all his life selling insurance and Maude worked some of the time after the kids went to school, and until Harold’s stroke, when she quit to take care of him. Both get Social Security and have Medicare. They didn’t think they could afford Medicare Part D, so they do not have prescription drug coverage. They could use it now, but it’s not open enrollment.

Harold’s sister-in-law went to the senior center for lunch one day and brought him a flier telling about a program from the government. It will pay premiums, the co-pays and can even get him enrolled in a prescription drug plan. They filled out the form and received word they were approved for coverage. Soon, their Social Security checks went up almost $100 each because the Medicare premium wasn’t being taken out. They were also enrolled in a prescription drug plan with no premiums and only small co-payments - never more than $7 for a prescription. With the
extra money in their pocket, Maude could afford to buy fresh vegetables at the grocery store. Harold and Maude were also able to go play Bingo for the first time since the stroke.

Case Study: June

June was born in 1922 and just celebrated her 86th birthday. When June was a young adult she worked as a secretary for a coal mine. When WWII began she worked in the local ammunition plant. She met Kenneth and they were married in 1946. During WWII, Kenneth enlisted in the Navy and flew blimps with the Wing 3 Squadron ZP-33. During their first years of marriage, Kenneth worked for a wholesale grocery distributor until they built and began operating their own grocery store in 1949. Kenneth and June lived above the store with their two children. In 1971, Kenneth and June sold the store due to competition from bigger chain stores. He made the most money ever that year: $12,000 and worked from 4:30 a.m. to 10 p.m. every day. After selling the store, Kenneth worked various jobs and June worked as a part-time secretary for the ambulance services. Once they became eligible for Social Security retirement benefits, Kenneth received $760 and June received $655.

Kenneth and June worked hard, drove used cars, canned food for the winter and saved money in a savings account where it was protected by FDIC. Everything was reused, including plastic sandwich bags. Kenneth would clean them out and dry them by the sink.

June and Kenneth could have used helped with their Medicare premiums, co-pays and deductibles but they would not have asked. That was not their way.

In 2006, Kenneth died and June, who has macular degeneration and is legally blind, was left alone. Although her income of $760/month fell below the limit for Medicare Savings Plan, the cash value of the life insurance policy that Kenneth purchased for her kept her from qualifying by placing her resources over the limit. She continues to pay her Medicare Part B premium of $96.40, along with a $300 per month Medicare supplement to help with co-pays and her Medicare deductible. This is to cover her in case of a catastrophic event, such as a hospitalization or surgery. She can live within her means most of the time. There are months when she has medical bills or extra expenses and she has to access her savings account.

Case Study: Harriet

Harriet is 58 years old and stopped working just seven months ago after 22 years as a printing press operator at the local newspaper. Harriet was forced to stop working due to the progression of her Multiple Sclerosis, which aggravated the asthma attacks she has had since she was a child. Harriet now receives Social Security Disability of $894 a month as her only income. Harriet does not have any health insurance and is still waiting to reach the age of eligibility for Medicare.

Harriet has an apartment in the city’s subsidized housing complex so her lodging expenses are monthly rent of $250 and monthly fixed electric bill of $75. Harriet still has the one new car she bought in her life - her 1989 Chevrolet Impala. Harriet drives approximately 30 miles each week which includes a 24 mile round trip to visit her mother at a nursing home in a neighboring town. Because her condition is becoming so debilitating, Harriet is afraid to drive much.

Harriet is supposed to be on a strict diet for her condition. The only time Harriet eats out is one breakfast a week with her bridge friends at the City Square Café and she always has the $3 special. Even though Harriet shops frugally she still estimates that she needs to spend approximately
$55 a week for groceries, household supplies and her breakfast special.

Harriet’s biggest expenses are for medical care. Harriet is supposed to have a standing appointment with the doctor each month, takes five medications, and her doctor wants her to take vitamins and to drink nutrition drinks (like Ensure). When Harriet’s doctor prescribes another medication, she knows that she is in trouble. Harriet’s medical expenses should be about $600 per month, but she can’t always afford to buy her medications. Sometimes she cuts them in half. With the new prescription, her medical expenses will be close to $800/month.

<table>
<thead>
<tr>
<th>Harriet’s monthly budget looks like this:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td>Social Security Disability</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
</tr>
<tr>
<td>Rent:</td>
</tr>
<tr>
<td>Utilities (electric):</td>
</tr>
<tr>
<td>Vehicle insurance &amp; taxes:</td>
</tr>
<tr>
<td>Vehicle gasoline:</td>
</tr>
<tr>
<td>Food &amp; household supplies:</td>
</tr>
<tr>
<td>Medical expenses:</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
</tr>
</tbody>
</table>

Harriet has found that she cannot meet her expenses on her income so she is not appropriately following her medical regimen. Harriet applied for Medicaid assistance. She was told she has a spenddown of $2,394 and that she would have to spend that amount on medical expenses before Medicaid would help with her bills. The eligibility worker explained to Harriet that this amount was reached by the following calculation:

| Harriet’s monthly income of:              | $894 |
| Minus the protected income level of:      | $495 |
| Available Income for Medical              | $ 399 |
| Multiplied by 6 Months                    | X  6 |
| **Total Spenddown**                      | $2,394 |

Harriet eventually meets her spenddown when she has her prescriptions filled. But, she is now behind on her rent by two months. Even though Harriet is proud that she was able to work all her life, despite having two severe medical conditions, she is discouraged by the fact that others who haven’t worked may be better off. Even living frugally, her non-medical expenses exceed the monthly income limit.

**Long Term Care Groups**

**Case Study: Rick**

Rick is a 45-year-old who has been determined disabled by Social Security. Rick worked as a construction worker but his job did not offer health insurance coverage. For the last couple of years, Rick has felt tired, lost weight, and his vision is not what it used to be. Rick figured he was get-
ting older and keeping up with the physical demands of the job could explain his symptoms. It wasn’t until he ended up in the hospital and had his leg amputated that he became diagnosed with Type 2 Diabetes.

Since Rick worked and paid into Social Security, he had to wait five months to receive his Social Security Disability income of $900 and will not have Medicare coverage until he has been disabled for 24 months. If Rick had not worked and contributed to the Social Security system, he could have potentially been eligible for SSI and received automatic Medicaid coverage.

Rick applies with the local SRS office and is found eligible for the Medically Needy (spend-down) program. His spenddown or deductible will be $2,430. This will be the amount he has to pay out-of-pocket for medical expenses before Medicaid coverage will begin.

Rick doesn’t feel he can spend almost half of his income on medical expenses. The worker refers him to the local clinic that helps those without medical coverage. The local clinic informs Rick that he has to receive a denial from SRS in order for the clinic to help. However, Rick’s case cannot be denied as he is eligible for a spenddown. Rick asks if he can withdraw his application. The clinic states that he has to be denied for assistance and a voluntary withdrawal will not be considered. Rick asks his doctor for samples but they cannot give out samples of insulin. Rick contacts the pharmaceutical companies for help but has been denied as his income is too high.

Rick doesn’t know what to do. He ends up going without his medication. Rick’s blood sugar levels skyrocket. He is found unconscious in his apartment and rushed to the hospital. Doctors are able to stabilize him, but there may be irreversible damage to his kidney and brain functions. Due to the high cost of hospitalization, Rick meets his spenddown and receives Medicaid coverage.

Three months later, Rick resides in a nursing home. He is doing speech and physical therapy to try and regain some of his abilities. His condition is such that he will have to remain in a long-term care facility such as a nursing home or assisted living center.

**Case Study: Doris**

Doris is 89 years old and was active in her church, the Junior League and volunteering with the American Cancer Society until she suffered a stroke at age 83. She has been living in a nursing home since the stroke. Doris had substantial assets and was able to pay for her own care for many years. Her son, an attorney, takes care of her affairs. He read about a Medicaid planning seminar in the local paper and heard about a technique called the “half-a-loaf,” where people transfer half of their remaining assets to a family member and use the remaining assets to pay for their care. The presenter at the seminar told him that even though Medicaid will determine a penalty, the penalty period will expire before her remaining assets are spent. It seemed like the perfect plan to preserve some of mother’s resources and he immediately transferred $50,000 to himself.

Nine months later he applied for Medicaid and found out that the rules had changed - the eligibility worker told him he would have to wait 12 months before Doris would be eligible. He panicked since she was out of money. However, after checking with three lawyers and going through a formal appeal process he felt he had no other recourse. He took out a loan to pay Doris’ nursing home bill for the rest of the year.
Attachment B

KAECSES and Other Systems Used By Eligibility Staff
Current Systems

The three primary computer systems that are used in the eligibility process are KAECSES (Kansas Automated Eligibility and Child Support Enforcement System), Maxe² (MAXIMUS Eligibility and Enrollment) and the MMIS (Medicaid Management Information System).

KAECSES

The KAECSES system is used to determine eligibility for all Medical groups. It is managed by SRS and used by staff in SRS, KHPA and KDHE. This system became operational in 1988. It has had numerous modifications made to it during the last 20 years to accommodate changes to the various groups it supports. Medical eligibility information is sent from KAECSES to the MMIS every night in order to provide beneficiary records to the claims payment system.

There are numerous interfaces and auxiliary systems that work with KAECSES to help eligibility workers. Staff have access to information from other agencies or groups through these systems. Formal interfaces have been established with some entities, such as Social Security and Child Support, to electronically exchange information. Access to information is obtained from many other systems that allow staff to obtain information about an individual’s involvement with the other program or agency, such as driver’s license records with the Department of Revenue. Automated access to auxiliary systems improve efficiencies and can reduce the workload of staff.
This system is owned and operated by Maximus, the contractor that operates the HealthWave Clearinghouse, and is used by the Clearinghouse staff to track and monitor the applications that are received and processed. This system helps the Clearinghouse staff organize their work and produces key management reports to KHPA that are not available through KAECSES. KAECSES sends a nightly file to the Maxe² system to support eligibility operations in the Clearinghouse. The Clearinghouse contract is being re-bid in FY 2009.

**MMIS**

The MMIS is used to pay the claims for the beneficiaries who are found to be eligible for medical coverage. The current fiscal agent operating the MMIS is Electronic Data Systems (EDS). The MMIS maintains nearly all of the information necessary to manage the medical assistance groups. Information on beneficiary eligibility, medical providers, managed care enrollment and claims payments is maintained and housed in the MMIS. The MMIS sends numerous electronic files to subcontractors, federal agencies and others as necessary in order to manage the program operation. The MMIS is the primary source of information on both medical service expenditures and health care experiences as well as enrollment and eligibility. Performance, management and analytic reports are generally unavailable from KAECSES.
Attachment C

Poverty in Kansas
Poverty in Kansas

Introduction

Health insurance for those in poverty is often at the core of discussions about health care reform at both the national and state levels. The Centers for Disease Control reports that people with lower incomes experience more disease, have more chronic illnesses and live shorter lives (National Health Center for Health Statistics, 2007). A study prepared for the Task Force on Poverty at the Center for American Progress estimated that childhood poverty raises U.S. health care expenditures by almost $22 billion per year (Holzer, Schanzenbach, Duncan and Ludwig, 2007). Other researchers have also pointed out the strong correlation between poverty and poor health (Feinstein, 1993), (Kawachi, Kennedy, Lochner and Prothrow-Stith, 1997), (Mackenbach, et al., 2008).

While Medicaid covers most children and pregnant women in poverty, many states - including Kansas - cover very few non-elderly and non-disabled adults and often cover the aged and disabled at less than the poverty level. The national median eligibility threshold for working parents is 63% of the federal poverty level (FPL) and 41% for non-working parents (The Kaiser Commission on Medicaid and the Uninsured, 2008). In Kansas, these thresholds are about 33% and 27%, respectively.

It is estimated that 13.9 million parents and childless adults with incomes less than 200% of FPL, and who are not eligible for Medicaid, are uninsured (NIHCM Foundation, 2008). The Kaiser Commission on Medicaid and the Uninsured reports that 37% of the uninsured in Kansas have family incomes below the FPL, while 30% have incomes from 100%-199% of the FPL (The Kaiser Commission on Medicaid and the Uninsured, 2008).

Discussions about the poor, the FPL and health insurance raise the fundamental question of what is meant by the term poverty, and who is living in poverty.

What is Poverty?

The U.S. Bureau of the Census uses poverty thresholds to determine who is in poverty. These thresholds, originally developed in the 1960’s, are updated annually and are used primarily for statistical estimates of the extent of poverty in the U.S. These thresholds do not vary geographically and are roughly based on what a family of three would need to spend to buy groceries for what the Department of Agriculture terms the economy food plan (developed for temporary or emergency use) (Fisher, 1997). The definition of poverty used to develop these thresholds uses gross income, but does not include noncash benefits (e.g. food stamps) or capital gains. The Bureau of the Census states that the thresholds are not a “complete description of what people and families need to live (DeNavas-Walt, Proctor and Smith, 2007).”

Attempts have been, and still are, being made to develop a clearer way of measuring poverty. Most recently, researchers at the Center for the Study of Poverty and Inequality at Stanford University have proposed a measure that would include government benefits (Frier, 2008). The National Research Council has also sponsored research into different ways to measure poverty (U.S. Department of Health and Human Services, 2007).
The current poverty thresholds are listed in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Size of family unit</th>
<th>Related children under 18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>One person (unrelated individual)</td>
<td></td>
</tr>
<tr>
<td>Under 65 years</td>
<td></td>
</tr>
<tr>
<td>65 years and older</td>
<td></td>
</tr>
<tr>
<td>Two people</td>
<td></td>
</tr>
<tr>
<td>Householder under 65 years</td>
<td></td>
</tr>
<tr>
<td>Householder 65 years and older</td>
<td>12,166</td>
</tr>
<tr>
<td>Three people</td>
<td></td>
</tr>
<tr>
<td>Four people</td>
<td></td>
</tr>
<tr>
<td>Five people</td>
<td></td>
</tr>
<tr>
<td>Seven people</td>
<td></td>
</tr>
<tr>
<td>Eight people</td>
<td></td>
</tr>
<tr>
<td>Nine people or more</td>
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</table>

<table>
<thead>
<tr>
<th>Size of family unit</th>
<th>Related children under 18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eight or more</td>
</tr>
</tbody>
</table>

Based on the Bureau of Labor Statistics Consumer Expenditures report for 2005 (U.S. Bureau of Labor Statistics, 2007), the average percent of income spent on various necessities is as follows:

- Housing 32.7%
- Food 12.8%
- Transportation 18.0%
- Clothing 4.1%

For a hypothetical family of four which has less than $20,444 as their income, 33.6% of their income ($6,787) would be available for child care, health care, insurance, and other expenses. The average annual child care cost for a 4-year old in full-time daycare (in a family home – less expensive than a center) in Kansas is $4,940, leaving very little for other expenses and far less than would be required to purchase health insurance on their own.

The Census Bureau reports that the total poverty rate in the U.S. for 2006 is 12.3%, down from 12.6% in 2005 (U.S. Department of Health and Human Services, 2007). In Kansas, the total poverty rate for 2005 - the most current year of estimation - is 11.7% (U.S. Bureau of Census, 2008). When the number of people in poverty is broken down by other factors, such as race or gender, the rate of poverty can be higher or lower than the overall rate.

Poverty guidelines are issued annually by the U.S. Department of Health and Human Services (HHS). They are a simplified version of the poverty thresholds and are used to determine eligibility for various federally funded programs. Table 2 shows the current poverty guidelines.
Table 2
2007 HHS Poverty Guidelines

<table>
<thead>
<tr>
<th>Persons in Family or Household</th>
<th>48 Contiguous States and D.C.</th>
<th>Alaska</th>
<th>Hawaii</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,210</td>
<td>$12,770</td>
<td>$11,750</td>
</tr>
<tr>
<td>2</td>
<td>13,690</td>
<td>17,120</td>
<td>15,750</td>
</tr>
<tr>
<td>3</td>
<td>17,170</td>
<td>21,470</td>
<td>19,750</td>
</tr>
<tr>
<td>4</td>
<td>20,650</td>
<td>25,820</td>
<td>23,750</td>
</tr>
<tr>
<td>5</td>
<td>24,130</td>
<td>30,170</td>
<td>27,750</td>
</tr>
<tr>
<td>6</td>
<td>27,610</td>
<td>34,520</td>
<td>31,750</td>
</tr>
<tr>
<td>7</td>
<td>31,090</td>
<td>38,870</td>
<td>35,750</td>
</tr>
<tr>
<td>8</td>
<td>34,570</td>
<td>43,220</td>
<td>39,750</td>
</tr>
<tr>
<td>For each additional person, add</td>
<td>3,480</td>
<td>4,350</td>
<td>4,000</td>
</tr>
</tbody>
</table>

SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

Although HHS cautions against using the term “Federal Poverty Level” to refer to poverty guidelines, it is widely used in just that way. The overall percentage of Kansans who are poor or near-poor - using the HHS poverty guidelines (rather than the Census Bureau poverty thresholds) as a measure - is similar to that of the U.S., as Table 3 illustrates.

Table 3
Population by Federal Poverty Level

<table>
<thead>
<tr>
<th>INCOME</th>
<th>KS</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100% FPL</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>100-199% FPL</td>
<td>18%</td>
<td>19%</td>
</tr>
</tbody>
</table>


Who is in Poverty?

Any number of factors correlate with the presence of poverty, many of which occur disproportionately in women, children and minorities, including:

- Job loss
- Bankruptcy
- Divorce
- Lack of education or job skills
- Disability or chronic ill health
- Poor English skills

Being born and raised into poverty can also result in people remaining in poverty, if circumstances combine to help keep them there. There are no clear reasons why a person falls into, or remains, in poverty.
U.S. Census Bureau Small Area Income and Poverty Estimates (SAIPE) for 2005 - the most recent estimates available - report the overall poverty rate in Kansas as 11.7%, compared to 13.3% for the U.S. Both nationally and in Kansas, among adults in poverty, more are female than male and more have children than are childless. A greater percentage of blacks, Hispanics and other minorities are in poverty than whites, although the poverty rate decreased nationally for Hispanics in 2006 (DeNavas-Walt, Proctor and Smith, 2007). More children are in poverty than adults - a reflection of the number of single parent households with more than one child (DeNavas-Walt, Proctor and Smith, 2007). For example, the poverty rate for female heads of households, with no husband present, in 2006 was 30.5%, compared to 4.9% for married-couple families (DeNavas-Walt, Proctor and Smith, 2007).

In addition to the overall poverty rate, on other demographics related to poverty, Kansas also mirrors national rates, with the exception of race. Table 4 shows these comparisons.

<table>
<thead>
<tr>
<th>DEMOGRAPHIC</th>
<th>KS</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Male</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Black</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 and under</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>19-64</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>65+</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Family Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with children</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>Adults without children</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>


With the exception of the poverty rate for blacks, Kansas poverty rates are consistently close to the national rates, although the State has slightly fewer elders in poverty. The geographic distribution of poverty across Kansas is uneven, however, ranging from 5.2 in Johnson County to 20.2 in Riley County. Figure 1 shows the distribution of poverty rates across the State. Table 5 lists the top and bottom five counties in terms of percent living in poverty.
Figure 1
County-Level Poverty Rates for Kansas
Percent of total population in poverty, 2005

Table 5
Kansas Counties with the Lowest and Highest Poverty Rates

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>PERCENT IN POVERTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td></td>
</tr>
<tr>
<td>Johnson</td>
<td>5.2</td>
</tr>
<tr>
<td>Miami</td>
<td>7.1</td>
</tr>
<tr>
<td>Scott</td>
<td>7.3</td>
</tr>
<tr>
<td>Leavenworth</td>
<td>7.9</td>
</tr>
<tr>
<td>Jefferson</td>
<td>8.0</td>
</tr>
<tr>
<td>Highest</td>
<td></td>
</tr>
<tr>
<td>Riley</td>
<td>20.2</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>19.5</td>
</tr>
<tr>
<td>Crawford</td>
<td>19.4</td>
</tr>
<tr>
<td>Elk</td>
<td>17.2</td>
</tr>
<tr>
<td>Cherokee</td>
<td>17.1</td>
</tr>
</tbody>
</table>


The low rates in Johnson, Miami and Leavenworth counties reflect the prosperity that Johnson County has always experienced and that is now spreading to the other two counties as the Kansas suburbs of the Kansas City metropolitan area sprawl north and south. Scott County’s low poverty rate is likely due to large corporate hog farming operations. The reason for Jefferson County’s relatively low poverty rate is unclear.

On the other end of the spectrum, Riley County is home to many military families and college students, while Wyandotte County is home to a high concentration of both blacks and Hispanics - both groups that are more likely to be poor than whites. The remaining three counties are in southeast Kansas, an area of the state that has never recovered from the end of the strip mining and railroad eras.
How Does Kansas Compare?

Based on 2005 (SAIPE) estimates, Kansas ranks 20\textsuperscript{th} nationally in lowest poverty rate (the same ranking it had in 2004) in the percent of all ages living in poverty. Since 2003, Kansas has dropped from a 17\textsuperscript{th} ranking and had an overall poverty rate increase of 1.3%.

New Hampshire has the lowest poverty rate, while Mississippi has the highest (U.S. Bureau of Census, 2008). Table 6 lists the highest and lowest poverty rates among all states and the District of Columbia.

### Table 6

<table>
<thead>
<tr>
<th>States with the Lowest and Highest Poverty Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Lowest</strong></td>
</tr>
<tr>
<td>New Hampshire</td>
</tr>
<tr>
<td>Connecticut</td>
</tr>
<tr>
<td>Maryland</td>
</tr>
<tr>
<td>New Jersey</td>
</tr>
<tr>
<td>Minnesota</td>
</tr>
<tr>
<td><strong>Highest</strong></td>
</tr>
<tr>
<td>Mississippi</td>
</tr>
<tr>
<td>Louisiana</td>
</tr>
<tr>
<td>New Mexico</td>
</tr>
<tr>
<td>District of Columbia</td>
</tr>
<tr>
<td>West Virginia</td>
</tr>
</tbody>
</table>


Fewer Kansans are likely to experience poverty than citizens of most southern states, Arizona, California, New York, and some northwestern states, as illustrated by Figure 2.

**Figure 2**

Percent of Total Population in Poverty : 2005

**SOURCE:** U.S. Census Bureau, Small Area Income and Poverty Estimates Program, January 2008
Kansas has a similar rate of poverty when compared to the states immediately surrounding it, and to Iowa, with the exceptions of Missouri and Oklahoma - both of which have significantly higher rates (U.S. Bureau of Census, 2008). Table 7 shows this comparison.

### Table 7

**Kansas and Region Poverty Rates**

<table>
<thead>
<tr>
<th>State</th>
<th>Percent in Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>10.8</td>
</tr>
<tr>
<td>Colorado</td>
<td>10.9</td>
</tr>
<tr>
<td>Nebraska</td>
<td>11</td>
</tr>
<tr>
<td>Kansas</td>
<td>11.7</td>
</tr>
<tr>
<td>Missouri</td>
<td>13.6</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>16.4</td>
</tr>
</tbody>
</table>


### Conclusion

Kansas fares better than many states in terms of its overall poverty rate, but has areas within the State with higher than average rates. This paper did not attempt to examine rates beyond the county level, but it is expected that there are regions in the state with both higher and lower than average poverty rates.

Whatever the poverty rate, ample evidence exists that poverty contributes to poor health in both direct and indirect ways (Feinstein, 1993), (Mackenbach, et al., 2008). Poverty can lead to:

- Lack of access to health care - both through no insurance and the lack of available health care providers in or near poor neighborhoods
- Racial and ethnic disparities, since many minority groups are disproportionately poor
- Lower life expectancies, through greater infant mortality and death from chronic, treatable diseases
- Poor nutrition and substandard housing, both of which contribute to poor health (National Center for Health Statistics, 2007)

Poverty is a multidimensional problem, but it has clear effects on health. Providing health care coverage to the poor does not address all the health issues that are connected to poverty, nor health, but could ameliorate access issues and reduce disparities. Additionally, providing such coverage would allow the poor to have more income for other necessities by reducing personal spending on health care.
References


Attachment D

The Minimum Wage in Kansas
The Minimum Wage in Kansas

Background

The Kansas minimum wage is the lowest state minimum wage in the nation at $2.65/hour. Although this wage has no effect on workers covered by the federal minimum wage, a number of Kansas workers may be only covered by the Kansas minimum or exempted from all minimum wage requirements.

Kansas Minimum Wage

A total of 20,000 Kansas workers received less than the federal minimum wage in 2006 (United States Bureau of Labor Statistics, 2008). However, this does not necessarily indicate that they were all paid the Kansas minimum wage since there is no data on the number of workers receiving the Kansas minimum. The 20,000 could include self-employed workers and those not covered by either Kansas or the federal law.

Employees covered by the Kansas minimum wage but not the federal standard include:

- Employees of private firms grossing less than $500,000 per year and not engaged in or producing for interstate commerce, education, residential care or running a hospital
- Employees of certain seasonal amusement or recreational establishments
- Employees of certain small newspapers and switchboard operators of small telephone companies
- Childcare workers
- Companions to the elderly or infirm

An unknown number of workers who are not classified as employees or who are members of what a report by the Ad Astra Institute refers to as the “underground economy” received less than the Kansas minimum wage. This group includes workers who are not reported as employees by their employer for reasons such as undocumented immigration, a desire to avoid paying taxes or child support, a desire to keep their name or location unknown, performance of illegal child labor, or work in support of an illegal enterprise. This report estimates that 2.2 percent of Kansas workers paid by the hour received less than the federal minimum wage in 2006 (Burress, 2007).

Federal Minimum Wage

Two-thirds of working-age poor in Kansas work at least part of the time. Of the 300,000 people living in poverty in Kansas in 2004, 170,000 were of working age and 110,000 worked full or part time. Many of these individuals earned minimum wage.

Twenty-six percent of federal minimum wage earners in Kansas are parents who would benefit from the scheduled increases. It is important to note, however, that these increases will probably not be enough to lift their families out of poverty. For example, the poverty level for a family of three in 2007 was $17,170. An individual working 40 hours 52 weeks out of the year for $7.25/hour would only earn slightly over $15,000. It would take a larger increase to lift this family out of poverty (Burress, 2007).
It is also important to note how the real value of the federal minimum wage has decreased. Since its inception in 1947, the real value of minimum wage peaked in 1969, but has decreased significantly since that time. A chart produced by the Economic Policy Institute shows the value of minimum wage in 2006 dollars from 1947 to 2006 (Economic Policy Institute, 2007).

![Figure 1: Real value of the minimum wage, 1950-2006*](image)

*through May 2006

Low-paying Jobs in Kansas

The Kansas Department of Labor released the 2007 Kansas Wage Survey in September of 2007. Below is a chart from the survey showing the ten lowest-paying jobs in Kansas for 2007 compared to the national average pay rate for the same occupation. None of the ten lowest-paying occupations in Kansas paid more than the national average (Kansas Department of Labor, 2008).
Inequality of Income in Kansas

According to a report by the Center on Budget and Policy Priorities and the Economic Policy Institute, the gap between the richest and poorest Kansas families is the 28th largest in the nation. The average incomes of the richest 20 percent of families are 6.8 times as large the poorest 20 percent. This ratio has grown over the past two decades, as the ratio was only 5.0 in the late 1980s. This growth in inequality is the eighth largest in the nation (Center on Budget Priorities and Economic Policy Institute, 2008).

When comparing the richest 20 percent of families with the middle 20 percent, the average incomes are 2.5 times as large. This has grown from 2.0 times in the late 1980s and is the 12th largest growth inequality for these groups in the nation (Center on Budget Priorities and Economic Policy Institute, 2008).

Historical Poverty Rates

Over the past two decades, the poverty rate in Kansas has remained relatively steady, hovering at around 11 percent most years. The chart below is compiled from information from the U.S. Census Bureau (http://www.census.gov/hhes/www/saipe/county.html), and shows the poverty rate in Kansas for all years that data is available since 1989.
The chart also shows where Kansas ranked nationally compared to other states. As shown, Kansas ranked between 15 and 21 on a national scale, but normally fluctuated around the 19-20th place.

### Conclusion

Even with the federal step increases in minimum wage that were enacted in 2007, many Kansas workers will earn less than workers in other states for the same occupation. For some, the increase in the federal minimum wage will not be enough to lift them out of poverty. Those workers earning the Kansas minimum wage or less than the federal minimum wage are among the lowest-paid workers in the nation.
References


Chapter 16: Quality Improvement in KHPA’s Health Care Programs

Executive Summary

Description

The primary goal of quality improvement at KHPA is to use the resources the agency manages to purchase and promote high quality health care for the populations we serve. In operational terms, quality health care can be described as successfully obtaining the health care services needed, at the time they are needed, to achieve the best possible results. Quality health care may also be defined as appropriate utilization of health care services by avoiding underuse, over-use, and eliminating misuse. KHPA quality improvement efforts are intended to systematically and deliberately assess, measure and analyze quality within and across its programs. Quality monitoring is a process of ongoing regular collection and analysis of a core set of health indicators. For KHPA programs, these indicators are focused on optimal health outcomes and efficiencies.

KHPA will use the following strategies to identify and address opportunities for improving the quality of care provided in our health care programs:

1. Regular and systematic assessment and monitoring of available quality data in the form of:
   a. Routinely collected and standardized data drawn from surveys and administrative health data.
   b. Targeted analyses and special data collections.
2. Identifying measures across KHPA programs to compare quality and enhance coordination of health care purchasing.
3. Working with program managers and agency leadership to review program quality data and make that data available to the public.
4. Recommending quality-enhancing policies to program managers and agency leadership.

Key Points

- Limited Quality Evaluation Within Programs
  Health care quality evaluation for KHPA’s programs has historically focused on HealthWave, the Medicaid managed care program that provides health care services to low income Kansas children and pregnant women. The quality improvement activities in HealthWave have consisted primarily of those required by the Center for Medicare and Medicaid Services (CMS). However, neither the quality of services provided under the traditional FFS Medicaid program, HealthConnect, or the State Employee Health Benefits Plan (SEHBP) have been systematically evaluated.

- Limited Comparability of Quality Improvement Across Programs
KHPA has engaged in a number of quality improvement efforts in HealthConnect, Medicaid FFS, SEHP, and the state worker’s compensation plan. However, different measures have been used to assess each of the KHPA programs and therefore results are not comparable across programs.

Kansas Health Policy Authority (KHPA) Staff Recommendation

- Share baseline quality health care data publicly. The first step in a quality improvement process is to establish baseline levels of program performance, and to share these results widely. Sharing quality data facilitates understanding, motivates change and informs consumers. This review of the quality program will serve as a baseline for continuous improvement, outline the quality activities currently underway across KHPA programs and highlight gaps and opportunities for improvement. The Kansas Health Policy Authority will publish quality and outcomes data that are currently collected for the HealthWave and HealthConnect programs. This complements the work of the KHPA Data Consortium, an advisory group to the KHPA Board, which is tasked with developing recommended quality indicators and health measures for the state as a whole.

- Obtain funding for new data collection. Data will be collected from beneficiaries and providers participating in our fee-for-service programs in order to evaluate performance, identify opportunities for improvement and facilitate comparability across programs. The data will be analyzed by KHPA’s external quality review organization (EQRO). KHPA is currently re-bidding its EQRO contract for Medicaid and HealthWave. Although additional data from beneficiaries and providers is needed, our goal is to minimize any administrative burden for those who participate in Kansas Medicaid.

- Promote the use of health information technology in the Kansas Medicaid and State Employee Health Plan programs by implementing a Community Health Record for all program participants statewide. Two health information technology pilots are currently being tested and preliminary reviews suggest promising results. KHPA promotes the use of health information technology to better coordinate care, especially in the context of a medical home, improve health outcomes and ultimately help to reduce health care costs.

Program Overview

In 2006 the Kansas Health Policy Authority (KHPA) was established with the duty to “develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care ... to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs (K.S.A. 75-7401 et seq.).” Under this authority, KHPA is responsible for all of the state’s publicly funded health insurance programs, including Medicaid, State Children’s Health Insurance Program (SCHIP) and MediKan (Table A). The state is also responsible for health care coverage for state employees through the State Employee Health Benefits Plan (SEHBP) which has two components. One component is health care coverage for state employees, eligible retirees and non-state groups – the State Employee Health Plan (SEHP). The second component manages the State Self-Insurance Fund (SSIF) that administers worker’s compensation benefits for state employees. Table A displays the specific programs for which KHPA has purchasing and payment responsibilities. Oversight of the agency lies with an independent board of health care experts, practitioners and cabinet officers.
Chapter 16—Quality Improvement in KHPA’s Health Care Programs

Program Review of Quality Improvement in KHPA’s Health Care Programs — January 2009

Table A
Public Insurance Programs and Populations Served

<table>
<thead>
<tr>
<th>TitleXXI</th>
<th>TitleXIX Pregnant Women, Children* and Adult Caretaker Medical</th>
<th>Title XIX SSI, MediKan3 Disabled</th>
<th>Title XIX Elderly and Other*</th>
<th>Responsible State Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Programs</td>
<td>HealthWave</td>
<td>HealthWave</td>
<td>HealthConnect PCCM</td>
<td>FFS</td>
</tr>
<tr>
<td>Behavioral Health Programs</td>
<td>HealthWave</td>
<td>PAHP5</td>
<td>PAHP</td>
<td>PAHP</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>HealthWave</td>
<td>PIHP7</td>
<td>PIHP – Disabled only</td>
<td>PIHP</td>
</tr>
</tbody>
</table>

1Children: Persons from birth up to 19 years of age.
3MediKan: Physical health program through state funds only.
4KHPA: Kansas Health Policy Authority.
5PAHP: Prepaid Ambulatory Health Plan for mental health benefits.
6SRS: Social Rehabilitation Services.
7PIHP: Prepaid Inpatient Health Plan for mental health benefits.

*Managed care opt-out populations are identified in 42 CFR 438 as SSI Children under 21 years of age, Children with Special Health Care Needs and/or Native Americans.

KHPA purchases health care for nearly half-million Kansans each year, with total expenditures of nearing $2 billion annually. To provide direction in policy making and program administration the Board established vision principles (Appendix A). These six principles include three that are focused on quality in health care:

- **Access to Care.** Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.

- **Quality and Efficiency in Health Care.** The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.

- **Stewardship.** The Kansas Health Policy will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility and transparency.

**Quality Improvement Program**

The quality improvement program provides KHPA, our partners, policymakers and stakeholders with information about health outcomes, resource use and program effectiveness. The rationale for sharing quality data is to better inform decision making by beneficiaries, program staff, KHPA and other policymakers.
A number of quality improvement initiatives are currently conducted by KHPA, building on the work of several long-standing advisory groups and committees that have historically served Kansas Medicaid. In 2008, an internal quality workgroup was created with representation from all of KHPA’s programs. The prime functions of the working group are to provide coordination of quality planning and initiatives and to identify and develop quality activities within programs and across the agency. This group meets on a regular basis every other month subject to need. A description of the Medicaid advisory groups that support KHPA’s quality improvement activities is presented below.

### What are the long-standing advisory groups and committees for Kansas Medicaid?

- **The Peer Education and Resource Council (PERC)** is an advisory board that assists KHPA with clinical and quality of care issues affecting HealthConnect (HCK) and Fee-For-Service (FFS) beneficiaries. The membership includes physicians, an Advanced Registered Nurse Practitioner (ARNP), and a pharmacist. Issues are addressed through peer-to-peer interaction and education with the objectives of performance improvement and greater quality of care.

- **The Medical Care Advisory Committee (MCAC)** is to provide advice to the Medicaid agency about health and medical care services. The committee membership includes representatives of the health care professions including physicians and others, members of consumer groups including Medicaid recipients and the director of the public health department. The committee will also participate in policy development and program administration. ([http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr431.12.pdf](http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr431.12.pdf)). The MCAC is expected to advise the agency on quality issues that may include quality reporting and policy by providing the perspective of the partners and stakeholders represented by the membership.

- **The Quality Assurance Team (QAT)** assists KHPA in meeting the goals of improved quality care, access, education, correct billing and cost containment. This is accomplished by monitoring of issues brought by HealthConnect (HCK) and Fee-For-Service (FFS) beneficiaries and providers. This team is a partnership between the Quality Assurance and Grievance Team of the Quality section of Electronic Data Systems (EDS) and KHPA staff. The QAT strategy for providing information to meet the stated goals include gathering data by conducting utilization reviews for established patterns, instituting corrective action plans (CAPs), participating in special studies and interacting with the PERC.

- **The Data Consortium** (see Current Initiatives below) advises KHPA in the development of health data policies for the state. It is also charged with the development of indicators that support an annual assessment of health in the state. The indicators address four of KHPA’s vision principles including quality and efficiency. This statewide effort will help guide KHPA in the selection of quality indicators for its specific programs, where possible, to either be consistent with statewide measures or to compliment them with program specific data.

- **The Medical Workgroup** conducts weekly meetings to address issues brought by program managers for Medicaid and HealthConnect. This group is comprised of the Medicaid FFS team, the HCK program manager, the pharmacy program manager, the Medicaid Medical Director, a consultant physician and the quality coordinator. Issues regarding policy, criteria, coverage, prior authorization and other program-related medical issues are the focus of this committee.
Defining Quality

The primary goal of quality improvement at KHPA is to use the resources the agency manages to purchase high quality health care for the populations it serves. In its seminal review of patient safety across the country, To Err is Human, the Institute of Medicine adopted Harold Van Cott’s definition of quality of care, which is the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The Institute of Medicine’s follow-up publication, Crossing the Quality Chasm: a New Health System for the 21st Century, included a set of six proposed aims for improving quality in health care; that it be safe, effective, patient-centered, timely, efficient, and equitable.

In more operational terms, quality health care has been described as successfully obtaining the health care services needed, at the time they are needed, to achieve the best possible results. This definition of quality health care assumes appropriate utilization of services by avoiding underuse, overuse and eliminating misuse.

Defining and assessing quality of care is an ongoing process and may result in different quality measures across programs. However, KHPA is committed to coordinating quality measurement and health care purchasing whenever possible by seeking commonality and comparability. The following are examples of measures that could serve as indicators for each of the characteristics noted in the previous description of quality health care:

- Getting the right health care - delivery of preventive and maintenance care based on practice standards for persons diagnosed with diabetes as assessed by Healthcare Effectiveness Data and Information Set (HEDIS) measurement.
- At the right time: Children are fully immunized by the age of two years.
- Using the right services: Walk-in urgent care, clinics, or physician offices are used for the assessment of earaches.
- Avoiding underuse: Increased rate of age-appropriate screening testing for colorectal cancer.
- Avoiding overuse: Reduced rate of Emergency Room visits for non-emergent health concerns.
- Eliminating misuse: Reduced use of antibiotics for upper respiratory viral infections.

Improving Quality

KHPA quality improvement efforts are intended to systematically and deliberately assess, measure and analyze quality within and across its programs. Quality monitoring is a process of periodic collection and analysis of a core set of health indicators. For KHPA programs these indicators are focused on optimal health outcomes and efficiencies. Continuous monitoring of selected indicators enables assessment of health facilities’ or programs’ overall functioning to ensure that desired outcomes are achieved (http://www.qaproject.org/methods/resqa.html August 28, 2008).

As mentioned earlier, KHPA will use the following strategies to identify and address opportunities for improving the quality of care provided in its health care programs:

- Regular and systematic assessment and monitoring of available quality data in the form of
Chapter 16—Quality Improvement in KHPA’s Health Care Programs

Program Review of Quality Improvement in KHPA’s Health Care Programs — January 2009

- a. Standardized data drawn from surveys and administrative health data.
- b. Targeted analyses and special data collections.

- Identifying measures across KHPA programs to provide opportunities for consistency that will facilitate comparisons and enhance coordination of health care purchasing.
- Working with program managers and agency leadership to assess programmatic quality data that is to be made publicly available.
- Recommending quality-enhancing policies to program managers and agency leadership.

Transparency - providing detailed information about KHPA programs - is critical to effective quality improvement. Our programs provide coverage to nearly a half-million Kansans each year and disburse nearly $2 billion in health care payments to thousands of providers. Stewardship over such a large portion of the state’s resources requires public oversight, trust and involvement. Transparency is an integral component of KHPA’s vision principles and the agency is engaged in a broad range of activities to make program and other health information more widely available to stakeholders and the general public. KHPA values public reporting for what it serves to contribute by:

- Exhibiting accuracy and accountability in KHPA programs and MCOs
- Supporting beneficiary choice of plans and programs
- Informing stakeholders and policymakers about program strengths and needs
- Supporting better policy making
- Encouraging continuous quality improvement

The commitment to make quality information public puts Kansas in the forefront of public reporting. A 2007 study found, “Most of the states with large full-risk MMC (Medicaid Managed Care) programs are now publicly reporting some quality data by plan (17 of the 20 states with at least 200,000 enrollees). Conversely, states with smaller programs tended not to report (11 of 15 states).” (Felt-Lisk, Barrett, and Nyman, 2007) It is the commitment of KHPA to develop a quality approach in Kansas that will stand out among both large and small states. This approach includes publishing the managed care plan data as well as quality data from other Medicaid programs and the state employee-related programs.

Review of KHPA Quality Activities

This review describes the gaps in quality measurement and the formulation of recommendations for quality improvement initiatives in the upcoming year. Assessment of quality data includes identifying existing quality-related reports, activities and initiatives:

Current Quality-Related Initiatives

In addition to specific programmatic quality reports and data, KHPA has implemented initiatives that support and enhance the quality improvement process. These initiatives are statewide efforts and include specific measures designed to improve the delivery and quality of health care.

1. Data Consortium: this advisory group of community experts and stakeholders began meeting in December 2007. As its first major task, KHPA asked the Consortium to develop a set of measures for health indicators related to four of the six Vision Principles listed previously: (1) Access to Care; (2) Affordable, Sustainable Health Care; (3) Quality and Efficiency; and (4) Health and Wellness. Four working groups were created to complete this objective and make recommendations to the KHPA Board in calendar year 2008. Additionally a report will

2. State Quality Institute: In 2008 Kansas was selected as one of eight states to participate in the State Quality Improvement Institute (SQI) organized and funded by the Commonwealth Fund and Academy Health. States that are ready or have already made a commitment to health care quality improvement were chosen following an intensive, competitive-selection effort. Kansas’ quality improvement project topics are the development of medical homes for children and preventing hospitalization for asthma.

3. Medicaid Transformation Grant: Passed by Congress in 2006, the Deficit Reduction Act (DRA) authorized new grant funds to states for the adoption of innovative methods of improving effectiveness and efficiency in Medicaid. Kansas was awarded a grant within the category of Quality and Health Outcomes. The objectives of this grant address technology improvements in preventive care for disabled Medicaid beneficiaries.

4. Health Information Technology: There are two active initiatives related to promoting health information technology and exchange at the KHPA.

   a. A Medicaid Community Health Record Pilot used by providers treating beneficiaries in Sedgwick County, with a total of 40 provider sites. Providers are given secure internet access to beneficiary health records populated by claims information. Providers can access the patient record to review information such as past hospitalization, physician visits, allergies, immunizations and EPSDT forms completion, and can add to the patient record. Use of information technology in health care can lead to better coordinated care, improved health outcomes and potentially reduced health care costs.

   b. An Employer Based Community Health Record Pilot program in the Kansas City area for a sample of State Employee Health Plan members. This project utilizes the same health information technology platform as the Medicaid pilot to provide secure internet access to consumer’s personal health record which is shared with providers based on consumer preferences.

5. Data Analytical Interface (DAI): The DAI is a tool that will provide desktop access for KHPA staff to health care program data from multiple sources. The DAI will significantly increase access to detailed program data at all levels of program management. Enhanced access to data is expected to enhance programmatic learning within the organization, provide more comprehensive surveillance of medical trends and outcomes and assist in the development of health policy. Use of the DAI will improve program enhancing, closer monitoring and assessment of policy impacts.

6. Medicaid Transformation: The KHPA board convened a subcommittee to oversee Medicaid transformation in June 2008 and report recommendations to the full board. The purpose of the transformation process is to assess major program and services areas with the objective of improving efficiency and quality and to identify trends in expenditures. As part of the transformation process program managers reviewed 14 programs and service areas generating written reports with recommendations for changes for the upcoming year. The program reviews will be published in the January 2009.
Although included in the Medicaid transformation process, this program review is intended to evaluate quality improvement efforts across all of the agencies’ health care programs.

Quality-Related Activities In KHPA’s Health Care Programs

Medicaid and HealthWave

**HealthWave - Capitated Managed Care Organization System:** The Medicaid Managed Care (MMC) program and the State Children’s Health Insurance Program (SCHIP) were merged in 2001 into the HealthWave program, creating a seamless product which allows families receiving services through more than one program to have the same health plan and/or provider. The HealthWave program also serves parents and children who are eligible under Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs.

HealthWave is administered as a capitated Managed Care Organization (MCO) program in three “regions” across the state. Regions 1 and 2 cover the eastern two-thirds of the state and region 3 covers the western one-third (Figure 1). In regions 1 and 2, HealthWave eligible members may choose between two MCO plans. In region 3 there is a single MCO plan and a Primary Care Case Management (PCCM) plan called HealthConnect Kansas (HCK), described below. Since January 2007, KHPA has contracted with two MCOs to provide coverage for HealthWave beneficiaries. UniCare Health Plan of Kansas serves all three regions statewide, while Children’s Mercy Family Health Partners serves Regions 1 and 2.

**Figure 1**

**HealthWave Regions**

Federal oversight requirements for MCOs are summarized in the Code of Federal Regulations (CFR): Title 42 § 438.352. Based on these requirements, the state monitors and performs oversight for quality data on a regular and systematic basis and conducts annual reviews of the MCO plans. The CFR requires validation of specific aspects of our programs by an External Quality Review Organization (EQRO) to ensure quality and regulatory compliance. The EQRO validates a sample of measures from Healthcare Effectiveness Data and Information Set (HEDIS), and also validates the study design and sample selection for the Performance Improvement Projects.
The state and the EQRO perform programmatic monitoring, audits; and data validation to identify trends and concerns and to highlight successes in the managed care programs. The external quality review analyzes and evaluates data to provide information about access, timeliness and quality of care that an MCO or Prepaid Inpatient Health Plan (PIHP) or their contractors provide to Medicaid recipients. The following reports, surveys, and data are used by KHPA to assess the performance of our two MCOs serving the HealthWave population.

Quality aspects that are monitored in the MCO plans include:

- **Customer Service/Satisfaction:**
  - Call center statistics reports
  - Grievance and appeals reports
  - Performance improvement projects (PIP)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey (Appendix B)
  - Provider Satisfaction Survey
  - Comparison Report: The EQRO produces a report of the (CAHPS®) results comparing the HealthConnect Kansas (HCK) product and the MCO plans.

- **Providing Quality Care:**
  - Reporting of CMS required Health Employer Data Information Set (HEDIS®) Measures (See Table B),
  - Child Immunization Rate Study - The Immunization Rate Study utilizes a combination of Medicaid and SCHIP fee-for-service claims, MCO encounters, and Kansas Immunization Registry data to develop a HEDIS-like Immunization Rate
  - Kan Be Healthy (KBH) screening monitoring

- **Getting Care/Access:**
  - Provider network reports
  - Access monitoring
  - CAHPS®
Table B

<table>
<thead>
<tr>
<th>CMS-Required HEDIS Measure Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult access to preventive/ambulatory health services</strong></td>
</tr>
<tr>
<td>20-44</td>
</tr>
<tr>
<td>45-64</td>
</tr>
<tr>
<td>65+</td>
</tr>
<tr>
<td><strong>Comprehensive diabetes care</strong></td>
</tr>
<tr>
<td>HbA1c testing</td>
</tr>
<tr>
<td>Poor control HbA1c</td>
</tr>
<tr>
<td>Good HbA1c</td>
</tr>
<tr>
<td>Eye Exam</td>
</tr>
<tr>
<td>LDL-C Screening</td>
</tr>
<tr>
<td>LDL-C &lt;130</td>
</tr>
<tr>
<td>LDL-C &lt;100</td>
</tr>
<tr>
<td>Diabetic nephropathy</td>
</tr>
<tr>
<td>B/P monitor</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
</tr>
<tr>
<td>✓</td>
</tr>
<tr>
<td><strong>Postpartum care</strong></td>
</tr>
<tr>
<td>✓</td>
</tr>
<tr>
<td><strong>Children’s access to primary care practitioners</strong></td>
</tr>
<tr>
<td>12-24 months</td>
</tr>
<tr>
<td>25 mos-6 years</td>
</tr>
<tr>
<td>7-11 years</td>
</tr>
<tr>
<td>12-19 years</td>
</tr>
<tr>
<td><strong>Use of appropriate medications for asthma</strong></td>
</tr>
<tr>
<td>✓</td>
</tr>
<tr>
<td><strong>WCV in first 15 months</strong></td>
</tr>
<tr>
<td>&gt;6 visits</td>
</tr>
<tr>
<td><strong>WCV in the 3-6 year of life</strong></td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

Existing reports will be included in KHPA’s initial public quality reports. This first reporting of managed care plan data will begin with the CAHPS® surveys and other required MCO reporting as indicated in Appendix B.

**HealthConnect Kansas (HCK - Primary Care Case Management (PCCM) plan**: Some beneficiaries receive health care benefits through HealthConnect Kansas (HCK), our primary care case management model of care. To be eligible, beneficiaries must qualify for Title XIX (S-CHIP) or for one or more of the following programs: Temporary Assistance to Family (TAF), Poverty Level Eligible (PLE) Pregnant Women and Children, Supplemental Security Income (SSI), General Assistance (GA), or the Caretaker Medical Assistance (MACM). A list of the primary-care-providers (PCP) who contract to be primary care case managers (PCCM) is available to beneficiaries. The beneficiary selects a PCCM as his/her provider. If a beneficiary does not select a provider, a provider is selected for him or her. Beneficiaries are required to receive services from their PCCM or obtain a referral from the PCCM to another provider. Services excluded from this requirement are emergency services provided in the emergency room and those services exempt from case management referral (such as obstetrical care or family planning). An HCK PCCM agrees to provide medical care to a select group of Title XIX members and is paid a monthly fee for each beneficiary assigned to him/her plus the established fee-for-service payment for allowed medical services.
Effective January 1, 2007, KHPA implemented policy changes that resulted in approximately 50,000 Medicaid beneficiaries moving from the HCK program into MCO coverage. This change decreased the HCK population by approximately 66%. Figure 2 illustrates the shift in the managed care population. Because those beneficiaries moved into MCO coverage were the youngest and generally the healthiest Medicaid beneficiaries (PLE children and pregnant women, TAF parents and children, and Caretaker medical eligible beneficiaries), beneficiaries remaining in HCK include many individuals with multiple co-morbidities including chronic diseases, disabilities and mental health conditions.

**Figure 2**

<table>
<thead>
<tr>
<th>COMPARISON OF HEALTHCONNECT (HCK) AND HEALTHWAVE XIX ENROLLMENT</th>
<th>May 2006 - April 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Eligible</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>20,000</td>
<td></td>
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<tr>
<td>40,000</td>
<td></td>
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<tr>
<td>60,000</td>
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<td>80,000</td>
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<td>100,000</td>
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</tr>
<tr>
<td>120,000</td>
<td></td>
</tr>
<tr>
<td>140,000</td>
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</tr>
</tbody>
</table>

The quality elements that are currently monitored in HCK include:

- **Customer Service/Satisfaction - Patient-centered care:**
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey: This survey is administered to beneficiaries and measures access, quality of service and quality of care.
  - Provider Satisfaction Survey: This survey is administered by the EQRO to providers serving HCK members. In 2009, the EQRO will develop and administer a single survey to primary care providers for both MCOs and HCK.
  - Grievances and appeals: Customer service call centers collect information and refer members and providers to the Quality Assurance Team (QAT). The QAT investigates grievances and reports data from this process to KHPA monthly.
  - EDS Call center statistics.
  - Comparison Report: The EQRO produces a report of the CAHPS® results comparing the HCK product and the MCO plans.

- **Providing Quality Care:**
  - Focus studies: Ongoing calculation of the HEDIS® child immunization measure.
  - Kan Be Healthy (KBH) reports: Screening monitoring and regular well child health checks
  - CAHPS® survey selected questions
• Getting Care/Access:
  ◦ CAHPS®
  ◦ Access to providers survey
  ◦ Comparison Report: The EQRO produces a report of the CAHPS® results comparing the HCK product and the MCO plans.

Some measures of HealthConnect Kansas are already evaluated by our EQRO contractor because the program is an alternative to care provided through an MCO. However, because HCK is also reimbursed through fee-for-service, there are quality measures that are currently not assessed such as HEDIS® measures, separate studies on resource utilization or record reviews for clinical quality. KHPA will be evaluating these quality measures in the future.

Medicaid Fee-For-Service - FFS: Traditional Medicaid fee-for-service (FFS) is a system of direct payments to providers for individually-billed services. The FFS system pays providers for covered services under clearly established payment criteria and includes safeguards to help prevent fraud and misuse of Medicaid services. The Kansas FFS Medicaid program is designed to maintain appropriate, effective and up-to-date coverage as well as accurate and timely payment to providers. Oversight and monitoring for service areas are performed by program managers who review data related to their programs on an ongoing basis. These quality reviews include information from formal, longstanding management and advisory groups, direct input from providers and customers, and program manager experience in directly managing services.

Current initiatives or advisory groups in FFS that promote quality include:

• Customer Service/Satisfaction:
  • Grievances and appeals: Customer service call centers collect information and refer members and providers to the Quality Assurance Team (QAT). The QAT investigates grievances and reports data from this process to KHPA monthly.
  • Call center statistics summarizing the volume and nature of contacts by customers.

• Providing Quality Care:
  • Peer Education and Resource Council (PERC) assists with clinical and quality of care issues affecting the HCK and FFS beneficiaries
  • Pharmacy management
    ◦ the Medicaid Drug Utilization Review (DUR) program
    ◦ the Behavioral Pharmacy Management Program
  • Surveillance and Utilization Review System (SURS) unit that audits and reviews provider claims to ensure compliance with Medicaid rules and provides utilization review for additional program needs
  • Hospital utilization review
  • Targeted program interventions and special projects undertaken by staff in conjunction with subcontractors, such as a recent effort to educate and support home health agencies to improve their processes, increase system efficiency and develop an organizational culture of quality.

KHPA modifies policy in response to feedback from one or more of these initiatives or advisory groups. Policies consist of hard-coded rules such as covered medical services, coverage criteria, eligibility criteria for specific services and payment rates. When an issue with a policy is identified, it is researched and is addressed by the program manager with potential input from other staff, subcontractors, providers, etc. The Medical Workgroup provides a forum to present policy,
coverage criteria, practice standards and quality issues. This committee also reviews activities from the Medicaid Evidence-based Decisions (MED) Project. Kansas is one of 11 states participating in governance and topic selection for the MED Project on a subscription basis. The MED Project makes high quality evidence available to the member programs by providing rigorous, evidence-based research to decision makers on clinical effectiveness and the broader impact of health technologies and clinical coverage decisions among collaborating state Medicaid programs.

Utilization of these advisory groups and initiatives is designed to ensure careful and responsive management of health care coverage in the FFS program, and it often results in program improvements. Recent examples include the use of prior authorization to insure the medical necessity of services requested in the Home Health (HH) and Non-Emergency Medical Transportation (NEMT) programs. This has resulted in improved program compliance and a reduction of Medicaid expenditures. In addition, this process has resulted in changes in the Medicaid provider manual.

Although there is a wide range of medical services managed through FFS by different KHPA programs (such as pharmacy, outpatient services, and home health) the team approach described above provides the basis for a consistent quality improvement process across programs. A systematic approach to quality improvement can further improve these processes.

The first step in developing a systematic and thorough approach to quality improvement is regular data-driven evaluation of each major fee-for-service program area. KHPA began the Medicaid Transformation process in 2008 in order to evaluate our programs and services and present the results publicly. Ten out of 14 program reviews are focused on FFS programs. Surveys, such as the CAHPS product administered to KHPA’s HealthWave beneficiaries, collect information on key outcomes such as satisfaction, self-reported levels of access, customer service and timeliness as well as standardized and direct measures of quality in health care (See Appendix B for a complete list). This type of data is currently missing in Kansas’ Medicaid’s fee-for-service program, leaving a potential gap in knowledge about program outcomes, and preventing comprehensive comparisons across the HealthWave and HealthConnect programs. These gaps are the initial focus for enhancements in quality improvement activity and data collection recommended for FY 2010.

**MediKan**

MediKan is a health care program for low income adults applying for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) - both federal disability programs. The program is available to those who do not qualify for Medicaid. Eligibility is limited to 24 months, historically, which is the expected length of time for the average person to be evaluated by the Social Security Administration for disability programs, although concerns have been raised recently about delays in these evaluations in Kansas. MediKan has a reduced set of benefits (as compared to the Medicaid program) and is financed solely using state funds with no federal matching dollars. Individuals in MediKan are assigned to a primary care case manager within the HealthConnect Kansas program to manage their physical health care needs. Health care services are reimbursed on a fee-for-service basis. Mental health services are provided by the Pre-paid Ambulatory Health Plan (PAHP). Quality improvement activities for mental health services are conducted by Kansas Social and Rehabilitative Services (SRS). KHPA proposes additional data collection and quality of care evaluation for MediKan similar to that described above for as a component of the Medicaid FFS program.

**State Employee Health Benefits Plan (SEHBP)**
KHPA manages the State Employee Health Benefits Plan. It is composed of the State Employee Health Plan (SEHP), which administers health insurance plan for state employees and their dependents, and the State Self-Insurance Fund (SSIF), which assesses and investigates worker’s compensation claims for state employees. SEHP is organized into four work groups: Health Plan Operations, Health Plan Design and Fiscal Management, Membership Services, and Wellness. KHPA, in conjunction with the Health Care Commission, contracts with insurance carriers to provide access to medical coverage, dental coverage, vision coverage and pharmacy benefits plan for qualified members. The Kansas State Health Care Commission was created by the 1984 Legislature through the enactment of K.S.A. 75-6501 et. seq. to develop and provide for the implementation and administration of a state health care benefits program. Because our SEHP is self-funded, the insurance carriers serve as administrative service organizations (ASOs). For the 2008 benefit year, the SEHP Operations provided coverage for over 90,000 lives.

Several quality improvement activities are currently underway and vary by carrier and/or program. Each insurance carrier offers disease management or case management services. Member participation in these options is voluntary and perceptions regarding impact or benefit from participation is unclear. The carriers are managed through contract specific deliverables. KHPA staff analyze eligibility and claims data reported by the SEHP vendors. Understanding current activities related to health care quality measurements is dependent on the validation of current data, which is to be completed by the beginning of FY 2009. The goal is to balance quality care for plan members with fiduciary responsibility. The current focus is on comparing SEHP measures to a set of national benchmarks provided by a vendor, including medication adherence ratios, medication use rates and costs per-person. These measures can be evaluated for comparisons to “other external benchmarks.” Data and information from the plan databank are being used in the “development plan design” and are being applied to inform medical care issues. For example, plan data is being used to develop targeted letters concerning medication compliance and in the wellness program to aid in providing the right level of Health Care Coaching and interaction with members.

The Pharmacy Benefit Manager (PBM) under contract with the SEHP to provide prescription drug coverage (currently CareMark) provides two retrospective benefit reviews focusing on controlled substance usage and analysis of patterns in prescribing and utilization. Patterns such as polypharmacy, use of multiple prescribers and risk for adverse drug interactions are the focus. Reporting is targeted toward informing providers about patterns of prescribing that have been identified through the program.

The SEHP is a participant in an employer-based health information technology pilot of the Community Health Record. A subset of State Employee Health Plan members living in the Kansas City area
are a part of this pilot. CareEntrust Health Information Exchange (HIE) is the health record system being used. A CareEntrust Health Record collects and organizes health care visit information including medication and lab data to create a secure repository for much of what a health care provider needs to know in order to effectively treat his or her patients. Participation in this project will help to assess whether this type of information system will assist KPHA to leverage purchasing power to enhance quality, lower costs and improve efficiency. Increasing provider and member access to existing health information such as detailed records of each health claim, is expected to improve patient awareness, lower costs and significantly increase the effectiveness and timeliness of patient care. This program began April 1, 2008.

HealthQuest is the wellness program for state employees and their families, Direct Bill members, and persons qualified within non-state groups. The mission is to partner with employees to improve their health and well-being and to better manage health care costs. Incentives to encourage positive health behaviors have been implemented in 2008 and additional incentives will be implemented in the 2009 plan year. Data for this program are collected and reported by the contracted vendor. The vendor reports the following evaluation metrics to KHPA: Clinical Outcomes, Activity Based Measures, Member/Provider Satisfaction; and Financial Outcomes. Health and wellness services available in the 2008 plan year are health coaching, health screening, personal health assessments, online resources and tobacco control, weight management and stress management programs. Participation in the health screenings occurred early in the calendar year 2008 and resulted in participation of 7,956 members. As of June 22: 12,677 plan members completed the personal health assessment. The goal for participation in the 2009 plan year is to increase participation in the wellness program to 24,000 members. A second initiative is to improve linkage between screening and assessment. Premium incentives to reinforce healthy life choices - such as not smoking or quitting smoking - are being developed around use of medical benefits consistent with Value Based Benefit Design. Dental plan incentives are in progress for 2010 implementation. These are designed to link preventive service utilization to increase the percentage pay rate for reconstructive repairs.

Staff also provide customer service to state and non-state entities. Opportunities for program improvement include updating the information manuals distributed to each state agency’s human resource managers, cross-training of KHPA’s Membership Services staff, updating membership service staff procedural manuals, and improving collaboration between the service areas within the SEHP. Customer surveys are in the process of being administered to state, non-state members and insurance carriers to measure our member services, policies, procedures and tools. The SEHP is currently participating in a Dependent Eligibility process review to ensure only qualified dependents are covered within families. Customer service calls for Direct Bill members, all communication forms and exception requests are being routed through a single line or central location to ensure full collection of data. A system for logging the information will facilitate the analysis of aggregated data.

The State Employee Health Plan has taken many steps to improve the overall quality of its programs, but there remain opportunities for improvement. The collection of comparable data across programs is the first step to improving quality in SEHBP programs. Fusing data from worker’s compensation, the health plan, and the wellness initiative would be an informative first step. Comparison with other KHPA insurance programs such as Medicaid is a key step towards the agency’s statutory mission to coordinate health care purchasing and leverage improvements in the marketplace. Perhaps the most important keys in managing employee benefits are systematic collection of consumer input related to the relative ease of using SEHBP services; responsiveness of the SEHBP staff; responsiveness of contracted health care providers; and the overall perception of
value in terms of the State Employee Health Plan offering.

**State Self-Insurance Fund (SSIF)**

The SSIF was established by the Kansas legislature to administer claims on behalf of State of Kansas employees who report personal injury arising out of and in the course of employment (worker’s compensation). Non-state groups are not covered by this fund. Employees who sustain compensable injuries from an occupational accident or disease may be entitled to the following:

- Reasonable and necessary medical treatment expenses for the related injury or illness
- Disability compensation to replace part of the wages lost due to a disability
- Survivor benefits if death results

Providing high quality medical care, prompt disability and death benefits, return to work options, and customer service to state employees covered under the Kansas Worker’s Compensation Act is the mission of the SSIF. The program philosophy is to provide worker’s compensation services that meet the expectations of customers, professional competency, responsiveness, fairness, cost-effectiveness, consistency, accuracy and the highest ethical standards of conduct in all its operations. To improve customer service and staff efficiencies, the SSIF has engaged a preferred vendor to provide document scanning, issue claims payments and additional expertise in the management of highly complex cases. These changes have allowed SSIF staff more opportunity to focus on managing caseload and actively engage with the claimant. Other goals for the program are to provide data about risk factors, preventive actions, training and the dissimulation of data tracking the incidence of employment related injury and illness. A number of changes in the overall management of the SSIF have been implemented, and will be evaluated in 2009 to determine whether additional improvements in the program are needed.

**Conclusions**

This review has highlighted a number of ongoing quality improvement activities and management efforts in KHPA’s health care programs. Efforts to analyze and understand each program’s impact on health and wellbeing of the populations served have not been coordinated across programs. Quality-related data has been assessed in isolation and has not been shared publicly. Publicly sharing quality related data has been identified as an opportunity in directing program improvement and supporting coordinated health care purchasing.

In addition, gaps have been highlighted in available data on the quality of the care reimbursed through state funded health care programs. A continuous quality improvement approach would address these gaps by collecting and aggregating data consistently across populations and programs and by regularly analyzing trends, utilization and health outcomes. KHPA supports a structured approach to quality improvement. The quality workgroup will serve as the mechanism to direct change and implement recommendations developed as a result of this review.

**Recommendations**

KHPA is committed to making quality information and data available to the public and establishing a structure for continuing quality improvement.
1. Publish accurate information and program data for the public, partners and stakeholders.
   a. Publicly post information developed from the 2008 annual program reviews.
   b. Establish a phased approach for posting existing quality data.
   c. See Table C for a recommended schedule of publication.

2. Develop quality and measurements across programs, with an initial focus on gaps identified in KHPA’s FFS Medicaid program and the SEHP.
   a. Conduct CAHPS® Consumer Survey (see Appendix B) in Medicaid FFS and the SEHP.
   b. Conduct a provider satisfaction survey within the FFS providers.

3. Promote the use of health information technology in the Kansas Medicaid and SEHP programs by implementing a Community Health Record for all program participants statewide.
Attachment A

Kansas Health Policy Authority
Vision Principles
Created to help the KHPA to define its direction for policies and programs, and to help make decisions on allocation of resources, including both capital and people.

**Access to Care** - Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price. Health promotion and disease prevention should be integrated directly into these services.

**Quality and Efficiency in Health Care** - the delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.

**Affordable and Sustainable Health Care** - the financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers and government.

**Promoting Health and Wellness** - Kansans should pursue healthy lifestyles with a focus on wellness—to include physical activity, proper nutrition, and refraining from tobacco use—as well as a focus on the informed use of health services over their life course.

**Stewardship** - The Kansas Health Policy Authority will administer the resources entrusted to us by the citizens and the State of Kansas with the highest level of integrity, responsibility and transparency.

**Education and Engagement of the Public** - Kansans should be educated about health and health care delivery to encourage public engagement in developing an improved health system for all.
Attachment B

CAHPS® Survey Scores and Ratings
CAHPS® survey themes of composites, scores, and ratings of the experiences and level of satisfaction consumers encountered with their medical care and health plan are as follows:

**Composites**
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making (Adult Only)
- Courteous and Helpful Office Staff (Child Only)

**Additional CCC Composites**
- Access to Prescription Medicines
- Access to Specialized Services
- Family Centered Care: Personal Doctor or Nurse Who Knows Child
- Family Centered Care: Shared Decision Making
- Family Centered Care: Getting Needed Information
- Coordination of Care

**Ratings**
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

**Question Summary Rates**
- Health Promotion and Education
- Coordination of Care

**Questions Involving Access, Quality, and Timeliness**

**Access**
- Getting appointments with specialists
- Getting care, tests, or treatment you thought you needed through your health plan
- Getting a personal doctor or nurse you are happy with
- Getting a referral to a specialist you needed to see
- Getting the care, tests, or treatment you or your doctor believed necessary
- Delays in health care while awaiting approval from health plan
- Doctor’s office staff being as helpful as you thought they should be
- Getting the help needed when calling the health plan’s customer service
- Getting your child’s prescription medicine (CCC only)
- Getting special medical equipment for your child (CCC only)
- Getting special therapy for your child (CCC only)
- Getting treatment or counseling for your child (CCC only)

**Quality**
- Doctors listening carefully to you
• Doctors showing respect for what you had to say
• Doctors spending enough time with you or your child
• Customer service staff treating you with courtesy and respect
• Rating of health care
• Rating of specialist
• Rating of personal doctor
• Doctors explaining things in a way you or your child could understand
• Understanding information in the written materials or on the Internet
• Doctors talking to you about the pros and cons of health care treatment choices
• Finding and understanding information
• Understanding health plan paperwork
• Doctor or nurse talking with you about your child is feeling, growing and behaving (CCC only)
• Doctor or nurse understanding how health conditions affect your child’s daily life (CCC only)
• Doctor or nurse understanding how health conditions affect your family’s daily life (CCC only)

**Timeliness**
• Getting an appointment as soon as you wanted, when care was not needed right away
• Getting care as soon as you thought you needed, when care was needed right away
• Taken to exam room within 15 minutes of appointment time
• Getting the help or advice needed when calling during regular office hours
• Getting specific information you needed from child’s doctor or other health providers (CCC only)
Attachment C

Current 2007–08 Reportable Quality Data
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</table>
References

Appendix A

Oral Health Plan
Dear fellow Kansans,

I am pleased to present to you the Kansas Oral Health Plan, the first statewide, collaborative and comprehensive action plan targeting oral health in Kansas. The Kansas Department of Health and Environment (KDHE) is committed to working closely with our partners around the state to advance oral health issues through education, surveillance and policy development. This living document will coordinate oral health efforts statewide to protect the health and quality of life for all Kansans.

Optimal oral health remains a challenge for many Kansans. Limited financial resources, lack of access to dental providers and lack of water fluoridation in all communities are just some of the barriers to oral health improvement. Fifty-five (55) percent of Kansas children have experienced dental decay by the time they reach third grade. Even though dental decay is preventable and treatable, many do not receive routine care. Untreated dental decay can lead to pain, tooth loss, and serious, sometimes deadly infections. Dental disease is a major cause of missed school and workdays.

It is time that we recognize that good oral health is essential to protect overall good health. Oral disease can contribute to systemic diseases such as diabetes and cardiovascular disease and has been associated with less than optimal birth outcomes in pregnant women. As is true with many serious health problems, poor oral health is most common in our most vulnerable citizens, including very young children, those living in poverty, the elderly and racial and ethnic minority groups.

KDHE recognizes that this plan would not be possible without the active participation of many partners, including the state oral health coalition, Oral Health Kansas, the Kansas Dental Association and the Kansas Dental Hygiene Association. We also recognize Kim Moore and the United Methodist Health Ministries Fund’s long-standing support of oral health in Kansas and specifically their support of the Office of Oral Health at KDHE.

This statewide plan is a big step for the oral health community. Working together, we can ensure better oral health for all of us who live and work in Kansas.

Be well,

Roderick L. Bremby
Secretary, Kansas Department of Health and Environment

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1368
Voice 785-296-0461   Fax 785-368-6368
November 2007

Dear Stakeholders:

Oral Health Kansas, the statewide oral health coalition, is a membership organization with over 160 multidisciplinary members, including both individuals and organizations that are passionate about increasing the oral health status of Kansans. Our mission is to improve oral health in Kansas through advocacy, public awareness and education.

The coalition is thrilled to be working closely with the Kansas State Office of Oral Health and has long visioned having a state oral health plan. The plan that follows was collaboratively written with stakeholders from across the state, ensuring that all voices and concerns were considered and included. Both Oral Health Kansas and the State Office of Oral Health look forward to working with our partners to ensure the plan's viability and impact over the next several years.

No matter where I go, Kansas leaders almost always express concern for the lack of access to dental care for their constituents. This is universally true for children, the elderly, individuals with disabilities and other special health care concerns, those living in poverty and especially for those living in rural areas of this state. Much of the passion of our members is driven by these continuing concerns, especially when it is so clear that oral health affects general health and well-being. Good oral health is not just about having a pretty smile, but also about being healthy. Mounting evidence demonstrates a clear connection between oral health and overall health, including conditions like heart disease, stroke, diabetes and pre-term, low birthweight babies. Our responsibility is to continue to take this message to state and federal policy makers and leaders to ensure that the importance of good oral health is not ignored or forgotten.

The good news for all of us is that oral disease is one that is almost completely preventable, which gives us much hope for the future. Following the road map provided by the state oral health plan will continue to lead all Kansans down the path to better oral health.

We look forward to working with you to meet the objectives of the plan.

Sincerely,

Teresa R. Schwab, LMSW
Executive Director
November 1, 2007

Dear Fellow Kansans:

The Office of Oral Health at the Kansas Department of Health and Environment is pleased to present Kansas’ first state wide collaborative Oral Health Plan. The Office of Oral Health seeks to improve the Oral Health of all Kansans by increasing awareness about the importance of oral health. We provide education, consultation and training that focuses on health promotion and disease prevention. This Kansas Oral Health Plan will build on our mission by providing oral health professionals and advocates with guideposts on how we can work together to improve and enhance the oral health of all of Kansas citizens.

The drafting of this plan was an intensive year long project. Kansas is blessed to have many dedicated and knowledgeable oral health advocates that were willing to devote time and expertise to the plan’s development. Community partners that worked on this plan included members of the dental and medical professions, health care administrators, health advocacy groups, and interested citizens. The diverse backgrounds of all of these people allowed the plan to be a reflection of wants and needs of real Kansans. The Office of Oral Health is grateful to everyone who participated in this process.

Lastly, the Office of Oral Health wants to thank our state oral health coalition, Oral Health Kansas, for their support, advocacy and assistance in the development of this plan. Without their tireless work, this process would have been impossible.

The Kansas Oral Health plan is meant to be a living document, and we welcome comments and revisions. Feel free to contact the Office of Oral Health at 785-296-5116 or kweno@kdhe.state.ks.us. I hope this plan will be used to make a positive change in the oral health of Kansans!

Sincerely,

[Signature]

Katherine Weno
Director, Office of Oral Health

OFFICE OF ORAL HEALTH
1000 SW Jackson, Suite 300 Topeka, Kansas 66612-1365
ACKNOWLEDGMENTS

This plan represents the work of many diverse stakeholders throughout the state of Kansas. Many thanks are due to all partners who spent their time and talents on the development of this document. Key participants in the drafting of the plan include the following individuals and organizations:

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Caron Shipley, RDH, BSDH, School Oral Health Coordinator
Maggie Smet, RDH, Professional Outreach Coordinator
Ashley McMahan, Administrative Assistant

Oral Health Kansas:

Teresa Schwab, LMSW, Executive Director
Marcia Manter, MA, Community Development Specialist
Jessica Barr, Office Manager

Mary Baskett, M.P.A., Kansas Head Start Association
Dr. William Donigan, DDS, MPH
Jane Faubion, Kansas Association for the Medically Underserved
Janelle Garrison, RN, BSN, Kansas Public Health Authority
Barbara Gibson, MS, Office of Local and Rural Health, Primary Care Section, KDHE
Becky Tuttle, MA, BS, Tobacco Use Prevention Program, KDHE

Kansas Dental Association
Kansas Dental Hygienists’ Association

United Methodist Health Ministry Fund
REACH Healthcare Foundation
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KANSAS ORAL HEALTH PLAN
EXECUTIVE SUMMARY

The Kansas State Oral Health Plan is a framework for oral health programming intended to create a unified vision for improved oral health outcomes across the state. Developed in collaboration with community and state partners, this document reflects the priorities and ideas of many oral health advocates. The plan has been divided into four sections: Dental Workforce, Financing, Community and Public Health, and Children’s Oral Health. Under each section, objectives and creative strategies were developed. The entire state plan details the objectives with strategies, action steps and timelines that will be implemented by responsible parties. The state plan is a template for action for all of us that work on improving the oral health of Kansans.

I. Oral Health Workforce Objectives:

- Encourage Oral Health Professionals to Work in Dentally Underserved Areas
- Increase Access to Dental Services by Using Non-Traditional Delivery Models
- Improve Options for Kansas Based Dental Education

II. Financing Oral Health for Underserved Populations Objectives:

- Create and Sustain Dental Hubs
- Improve the Kansas Medicaid Dental Program
- Support Charitable Dental Care

III. Community and Public Oral Health Objectives:

- Increase Awareness about the Importance of Oral Health
- Create a Centralized Kansas Oral Health Information System
- Include Oral Health in Statewide Tobacco Initiatives
- Create Oral Health Activities for Specific Populations
- Support Community Based Oral Health Programming

IV. Children’s Oral Health Objectives:

- Develop an Oral Health Screening Program For Children in Kansas Schools
- Improve the Oral Health of Pre-School Children (Age 0-5)
- Integrate Oral Health into Kansas’ Coordinated School Health Policy Guidelines
INTRODUCTION

– THE DEVELOPMENT OF THE KANSAS ORAL HEALTH PLAN –

The development of a statewide collaborative Kansas Oral Health Plan was a joint project between the Kansas Department of Health and Environment’s Office of Oral Health and the state oral health coalition, Oral Health Kansas. Kansas had previously completed targeted oral health plans for specific populations such as Head Start and Children with Special Health Care Needs, but a statewide, all inclusive plan had never been developed. Oral health stakeholders desired a comprehensive oral health tool that could be used as a road map to address state and local oral health needs in a way that efficiently used financial and political resources. With the hiring of a Dental Director at the Office of Oral Health in Spring of 2006, the stage was set for the creation of a Kansas Oral Health Plan.

Initial work on the plan began in the Fall of 2006 with the Office of Oral Health consulting with the Association of State and Territorial Dental Directors (ASTDD). ASTDD and the Centers for Disease Control created a template for Oral Health Plan development, as well as developed best practices for the creation of a state oral health agency with sustainable infrastructure. In September of 2006 a team of state dental directors and national oral health experts visited the Office of Oral Health in Topeka, meeting with Kansas oral health advocates and state and community organizations. They completed a State Oral Health Program Review to assist Kansas in building state oral health infrastructure. This visit also started the stakeholder discussions about what a Kansas Oral Health Plan should contain and how the plan would be developed.

To engage all oral health stakeholders, Oral Health Kansas and the Office of Oral Health sponsored a State Oral Health Summit on February 23, 2007 in Topeka. The Summit was coordinated with Oral Health Kansas’ Advocacy Day events at the capitol. Almost one hundred people attended this meeting, including dentists, dental hygienists, community health center staff, state and local health department representatives,
and educators from area dental educational programs. A list of summit attendees is included in Appendix A. The summit featured a facilitated discussion around four different oral health areas: Workforce, Financing, Public Health and Education. The four workgroups brainstormed about possible goals and strategies. The ideas shared that day became the framework for this document.

Since February additional meetings were held on specific topics that merited more discussion prior to their inclusion in the State Plan. Kansas is a state with an aging dental workforce and no dental school, so many advocates and legislators felt that a Kansas dental school is an option that needed to be explored. To discuss this further, Oral Health Kansas and the Office of Oral Health invited Dr. Jack Dillenberg to share his experiences in opening the Arizona School of Dentistry and Oral Health. Other topics were handled by oral health partners. The Kansas Dental Association sponsored a meeting about oral health care for elders. Kansas Head Start met with their staff and safety net clinics about children’s oral health care. The Kansas Association for the Medically Underserved facilitated the development of a new dental access concept entitled Dental Hubs. All of these individual initiatives were considered when the plan was drafted in the Summer and Fall of 2007.

As pieces of the plan were developed, they were shared with attendees of the original Oral Health Summit and key partners such as the Dental and Dental Hygiene Associations, Community Dental Clinics, and area Dental Educational programs. Based on comments made, the plan was updated and re-circulated, creating the final document seen here. Although the plan has been released, it is by no means finished. The Kansas Oral Health Plan is intended to be a living document, and will be adapted, changed and updated to meet the needs of future Kansans. Comments on the Plan are always welcome, and will be included in future updates.
Chapter 3—Dental Services—Appendix A: Oral Health Plan

ORAL HEALTH WORKFORCE

A. KANSAS DENTAL WORKFORCE

To ensure oral health access for all Kansans, the state must have an adequate supply of oral health professionals. As of June 2007, 1,367 dentists and 1,473 registered dental hygienists had active Kansas licenses and a practice address within the state. Kansas is thirty-third in the nation in the number of dentists per capita, with a statewide Kansas dentist to population ratio of one to 2,557. This is under the national average of one U.S. Dentist per 1,650 residents.

In 2007 the Office of Oral Health surveyed Kansas dentists about their practice patterns. Our average respondent was a white, non-Hispanic, fifty year old male working as a general dentist in a private practice in or near a metro area. Most of them were Kansas natives, and almost 46% returned home to practice dentistry in the same county where they graduated from high school. Although a large majority of Kansas dentists are male, the younger respondents that joined the profession after 1995 were 42% female. Workforce information from the American Dental Association indicated that female dentists are more likely to work part time, but this was not reflected in our survey. Both female and male respondents worked an average of 32 hours a week in direct patient care. Geographically dental practices are clustered in and around population centers. Almost 74% of our survey respondents reported practicing in one of five metro (Johnson, Wyandotte, Shawnee, Sedgwick and Douglas) counties. The survey also reported dental practices for sale and jobs for associates available across the state. More than half of prospective employers who were looking to hire a dentist had been looking for over a year. When asked about their retirement plans, 14% of respondents said they were planning to retire within the next five years. Over 30% said they expected to retire within the next ten years.
B. Kansas Dental Health Professional Shortage Areas

The Kansas Department of Local and Rural Health designates Kansas counties as dental and medical Health Professional Shortage Areas (HPSAs). The HPSA criteria requires three basic determinations for a geographic area request: (1) the area involved must be rational for the delivery of health services, (2) a specified population-to-practitioner ratio representing shortage must be exceeded within the area, and (3) resources in contiguous areas must be shown to be over-utilized, excessively distant, or otherwise inaccessible. As of May, 2007 twenty seven Kansas counties were designated whole county Dental Health Professional Shortage Areas (HPSA). Another sixty three counties were designated low-income or Medicaid provider Dental Health Professional Shortage Areas (HPSA). Eleven Kansas counties reported having no dentist at all.
C. PROFESSIONAL DENTAL EDUCATION IN KANSAS

Recruiting dental professionals to Kansas is a challenge. Kansas does not have a dental school, but has an agreement with the University of Missouri- Kansas City (UMKC) School of Dentistry7 to reserve slots for Kansans, and provide them with in-state tuition. Kansas students receiving this benefit have no obligation to return to Kansas to practice. Currently there are four Dental Hygiene Schools in the state; Johnson County Community College, Fort Scott Community College at Pittsburg, Wichita State University, and Colby Community College.

In 2006 the Kansas legislature appropriated three years of start up funding for an Advanced Education in General Dentistry (AEGD) Program to be located in Wichita, Kansas. An AEGD is a post graduate dental residency that gives new dentists another year of advanced training under the supervision of experienced dental faculty. The Kansas AEGD will be associated with Grace Med Clinic, a community health clinic that serves Medicaid and underserved populations. Dental residents at Grace Med will be used to increase the numbers of dental services provided at Grace Med. The program is targeted to begin in fall of 2009.

For new graduates with student loan obligations, the Office of Local and Rural Health works with two loan re-payment programs that can be utilized by dentists and dental hygienists, the National Health Service Corps (NHSC) and the State Loan Repayment Program (SLRP). Both programs offer repayment assistance of qualified educational loans in return for a minimum 2-year commitment to serve full time at an approved site in a designated dental Health Professional Shortage Area (HPSA).

D. THE REGULATION OF DENTAL PRACTICE IN KANSAS

The Kansas Dental Practice Act (K.S.A. Chapter 65 Article 14)11 regulates all licensed dental professionals. The Practice Act defines the scope of work for dental professionals and regulates how dental practices can be owned and operated within the state. The Kansas Dental Board enforces the Practice Act, monitoring dental professional compliance and issuing dental licenses and permits.

To improve access to preventive oral health services to underserved populations, a coalition of oral health advocates developed the Kansas Extended Care Permit for Registered Dental Hygienists. Hygienists that
hold an extended care permit (ECP) can provide Hygiene services without direct supervision by a dentist in certain types of community settings. ECP hygienists must meet minimum practice hour requirements and have a Kansas licensed sponsoring dentist who reviews their treatment records and findings. As of April 2007 fifty Kansas dental hygienists held an extended care permit.

The Kansas Dental Practice Act also allows for “scaling assistants”, non-licensed personnel that do coronal scaling under direct supervision of a dentist. Scaling assistants must complete a training course, and report this to the Kansas Dental Board. As of April 2007, 400 assistants had submitted certificates of course completion to the Dental Board. There is no statutory requirement for the Board to continue to monitor these assistants so there is no data on how many of these 400 continue to scale teeth or where they are currently working.

Kansas has also attempted to extend oral health services to underserved populations by utilizing other health care personnel to do oral health education and preventive services. The Kansas Medicaid program will reimburse medical providers for fluoride varnish done in their offices up to three times a year. The Office of Oral Health has a project to educate medical providers about fluoride varnish as well as how to do an oral health screening. Other projects to promote fluoride varnish are underway across the state. Additionally plans are underway to integrate oral health into primary care by doing caries risk assessment and parental education to young children during their well baby checks. This “Oral Health Collaborative” will be piloted in selected safety net clinics in the near future.
## Oral Health Workforce

### Objective 1 - Encourage Oral Health Professionals to Work in Dentally Underserved Areas

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Parties</th>
<th>Target Date</th>
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</thead>
</table>
| 1. Develop a Statewide Recruitment System for Dentists and Dental Hygienists | Office of Oral Health  
Office of Local and Rural Health  
Kansas Dental Association  
Kansas Dental Hygienists’ Association  
Kansas Association for the Medically Underserved  
KU Medical Center - Wichita | Early 2009 |
| Activities:  
- Investigate a collaboration with the KU Medical Center to develop a Dental Professional Recruitment Program.  
- Integrate recruitment resources like the National Health Service Corp website, 3 R Net, the Kansas Dental Association and KAMU to develop a Kansas specific web site about dental professional job openings.  
- Explore ways to inform new Kansas licensees about job openings in Kansas.  
- Work with area dental schools and dental hygiene programs to provide accurate information to students with practice opportunities in Kansas. | |
| 2. Improve Kansas Loan Re-Payment Programs | Office of Local and Rural Health  
– Primary Care Section  
Office of Oral Health | Early 2008  
On-going |
| Activities:  
- Reduce community barriers by providing financial match assistance for communities trying to recruit dental professionals.  
- Increase awareness of Kansas Loan programs by providing information and doing outreach at dental and dental hygiene programs. | |
<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>RESPONSIBLE PARTIES</th>
<th>TARGET DATE</th>
</tr>
</thead>
</table>
| 3. Reduce Barriers to Rural Practice in the Kansas Dental Practice Act    | Oral Health Kansas  
Kansas Dental Association  
Kansas Dental Hygienists’ Association  
Kansas Association for the Medically Underserved | 2008 Legislative Session                                                     |
| Activities:                                                               |                                                                                     |                           |
| • Collaborate to develop legislative changes to exempt underserved areas from portions of the Kansas Dental Practice Act. |                                                                                     |                           |
| • Advocate for these changes in the state legislature.                    |                                                                                     |                           |
| 4. Explore Options to Assist Students Interested in Kansas Public Health Dentistry to Enter Dental School and Finance their Dental Education | Office of Oral Health  
Oral Health Kansas  
UMKC – School of Dentistry | Early 2008  
Late 2010                                                   |
| Activities:                                                               |                                                                                     |                           |
| • Form a task force that includes oral health advocates, area dental schools and interested funders to develop a Kansas specific program. |                                                                                     |                           |
| • Collaborate with public and private funding sources to finance the program. |                                                                                     |                           |
| • Implement program.                                                      |                                                                                     |                           |
### Objective 2 - Increase Access to Dental Services by Using Non-Traditional Delivery Models

<table>
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<tr>
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<td>1. Support and Encourage Community Based Extended Care Permit Hygienists</td>
<td>Oral Health Kansas Kansas Dental Hygienists’ Association</td>
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<tr>
<td>Activities:</td>
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<tr>
<td>• Provide educational opportunities to increase knowledge among dentists and hygienists about ECP practice.</td>
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<tr>
<td>• Encourage more hygienists to get their ECP.</td>
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<tr>
<td>• Monitor ECP statute and practice experiences to evaluate the ECP program.</td>
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<td></td>
</tr>
<tr>
<td>Activities:</td>
<td></td>
<td></td>
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<tr>
<td>• Educate medical providers about oral health and preventive procedures.</td>
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<tr>
<td>• Monitor Medicaid reimbursement of fluoride varnish by primary care physicians.</td>
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<tr>
<td>• Encourage integration of medical and dental clinics at community health clinics by implementing an Oral Health Collaborative model at pilot sites.</td>
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### OBJECTIVES 3 - IMPROVE OPTIONS FOR KANSAS BASED DENTAL EDUCATION

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<td>1. Evaluate the costs and benefits of a Kansas Dental School and/or more Dental Residency Programs Activity:</td>
<td>Office of Oral Health Oral Health Kansas</td>
<td>Fall 2009</td>
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<tr>
<td>• Convene an ongoing work group on Kansas dental education to monitor current educational programs and reciprocity agreements with area dental schools.</td>
<td></td>
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<tr>
<td>2. Support and Monitor the Wichita AEGD program Activities:</td>
<td>Office of Oral Health Oral Health Kansas Wichita State University</td>
<td>Yearly On-Going</td>
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<tr>
<td>• Update the Legislature about the Progress of the Program’s Development.</td>
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<tr>
<td>• Work with Program Director to develop curriculum and utilize residents to improve oral health access.</td>
<td></td>
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</tr>
<tr>
<td>• Track AEGD residents practice patterns post residency.</td>
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</tr>
<tr>
<td>3. Provide Educational Opportunities (externships) for Dental and Dental Hygiene Students in Underserved areas in Kansas Activities:</td>
<td>Kansas Dental Board Kansas Association for the Medically Underserved UMKC School of Dentistry Kansas Dental Hygienists' Programs Dental Education Work Group</td>
<td>Fall 2008 On-Going</td>
</tr>
<tr>
<td>• Monitor dental board regulations to allow interested dental students to return to Kansas for externships at Community Health Clinics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Work with UMKC and area dental Hygiene programs to encourage students to do externships in underserved areas in Kansas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor the number of students doing externships in Kansas, and their post-graduation plans.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FINANCING INTRODUCTION

A. HOW ARE DENTAL SERVICES PAID FOR IN KANSAS?

Oral health services in Kansas are paid from several sources including commercial dental insurance, publicly funded programs like Medicaid and the State Children’s Health Insurance Program (SCHIP), and individual out of pocket expenditures. Approximately 65.5% of Kansans reported having some sort of dental insurance coverage, including commercial insurance, public programs, and Medicaid. Those without dental coverage tended to be older, less educated and have a lower income. Of those surveyed, 12.5% said they had needed dental care in the twelve months but did not get it. The overwhelming reason for not accessing care was because they couldn’t afford the costs (78%).

**Do you have any kind of insurance coverage that pays for some or all of your routine dental cares, including dental insurance, prepaid plans such as HMO’s or government plans such as Medicaid?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>65.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>38.3</td>
</tr>
</tbody>
</table>

Among all respondents, excluding unknowns and refusals.

**During the past 12 months was there any time when you needed dental care but did not get it?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>12.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>89.9</td>
</tr>
</tbody>
</table>

Among all respondents, excluding unknowns and refusals.

**What was the main reason you did not receive the dental care you needed?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear, apprehension, nervousness, pain, dislike going</td>
<td>11.6</td>
</tr>
<tr>
<td>Could not afford/cost/too expensive</td>
<td>78.0</td>
</tr>
<tr>
<td>Dentist would not accept my insurance, including Medicaid</td>
<td>5.7</td>
</tr>
<tr>
<td>Do not have/ know a dentist</td>
<td>2.3</td>
</tr>
<tr>
<td>Lack transportation/too far away</td>
<td>1.2</td>
</tr>
<tr>
<td>Hours aren’t convenient</td>
<td>5.4</td>
</tr>
<tr>
<td>Other</td>
<td>12.9</td>
</tr>
</tbody>
</table>

Among all respondents who reported not getting needed dental care in past 12 months, excluding unknowns and refusals.
B. Kansas Medicaid

Medicaid is a primary source of health and dental coverage for eligible Kansans with limited resources. Medicaid is a public health care program, jointly funded by state and the federal government. Each state has its own Medicaid program and in Kansas, Medicaid is administered by the Kansas Health Policy Authority. To enroll in Kansas Medicaid you must meet income requirements, be a qualified Kansan resident, and be included in one of these categories: children, pregnant women, families with minor children, persons with disabilities and the elderly. Children in families with slightly higher incomes may be eligible for HealthWave, Kansas’ State Children’s Health Insurance Program (SCHIP). In April, 2007 85,386 children were enrolled in Kansas Medicaid and over 34,209 were enrolled in the HealthWave program. Kansas Medicaid also provided health coverage for at least 6,668 pregnant women, 21,625 aged and 44,334 disabled individuals.

Kansas provides dental benefits for all children in the Medicaid and HealthWave programs. Children’s benefits include most preventive and restorative procedures. Dental benefits for most adults on Medicaid are limited to emergency services. The 2006 and 2007 Kansas legislature provided funding for dental services to certain adult populations covered by Medicaid waiver programs. As of April 1, 2007 persons enrolled in the Developmental Disabilities waiver (6869 persons), the Physical Disabilities waiver (6005 persons) and the Traumatic Brain Injury waiver (238 persons) were given a dental benefit that includes preventive and restorative services. The 2007 legislature approved the same benefits and an additional denture coverage benefit for seniors covered by the Frail Elderly waiver (7807 persons in year 2007).

In order for a Medicaid recipient to receive dental services, they must go to a Medicaid enrolled dental provider. As of April 2007, 608 dentists were enrolled with Kansas Medicaid. Although they may have enrolled, not all dentists with a Medicaid number routinely see Medicaid patients in their offices. Of the 608 dentists with a Medicaid provider number, only 370 have submitted a claim in 2007. As of July 1, 2006 Kansas Medicaid contracted out the dental program to a dental program administrator, EDS. EDS has been doing aggressive dental provider recruitment. Since EDS took over the program, 36 new Medicaid providers and 38 new HealthWave providers have been added. Medicaid reimbursement rates remain low when compared to commercial dental insurance. On average, Kansas Medicaid fees are 48% of usual and customary rates (UCR). The last time Medicaid reimbursement rates were evaluated in Kansas was 2001 and 2002, which resulted in increasing the rates for targeted preventive codes.
C. THE KANSAS DENTAL SAFETY NET

For Kansans without insurance and financial resources, accessing health care services is extremely challenging. Medicaid, uninsured and underinsured patients in Kansas often obtain health care through a network of primary care safety net clinics that provide care to underserved populations regardless of their ability to pay. Some of these clinics provide dental services. The safety net clinics are funded by the state and federal government, as well as faith based and private foundation grants. Most of the dental clinics are Medicaid providers, but also do a large amount of uninsured and uncompensated care. In 2006, there were 24,969 unduplicated dental service users in 15 safety net clinics and one voucher program.9

Kansas’ State Primary Care Association, the Kansas Association for the Medically Underserved (KAMU) created the “Dental Hub” concept for expanding oral health access for the underserved in Kansas. The concept will create a series of regional dental hubs operated by safety-net clinics. A dental hub is in a central underserved location, with spokes of care radiating out to satellite sites. The hubs would focus solely on providing preventive, emergency and restorative dental services to the underserved. The spokes of the hub would provide services in other areas of the region, for instance, a dental hygienist and portable chair traveling to a neighboring community, nursing home or school. In 2007 the Kansas Legislature allocated funds to start implementation of the dental hub concept. Private foundations are working with the state to coordinate funding to safety net clinics that are interested in becoming dental hubs.
D. CHARITABLE CARE

Dental professionals in Kansas have a proven commitment to providing charitable care to underserved populations. In the 2007 survey of Kansas dentists done by the Office of Oral Health, 75% of the respondents reported participating in some type of volunteer oral health activity. The Kansas Mission of Mercy (KMOM) has provided free dental care with volunteer dentists in events in Topeka, Garden City, Salina, Pittsburg and Kansas City, Kansas. The 2007 Mission of Mercy event was held at the Topeka Expo Center on February 2nd and 3rd. The event provided treatment to 1,441 patients. The majority of the patients seen at KMOM had not seen a dentist for two years or more before the event, and 87.9% said the reason for this was that they did not have insurance and/or could not afford to pay for treatment. Kansas Mission of Mercy is organized by the Kansas Dental Charitable Foundation.

The Kansas Foundation of Dentistry for the Handicapped and the Kansas Dental Association founded the Kansas Donated Dental Services project in 1996 to help disabled adults and elderly who have no comprehensive dental insurance coverage. Volunteer dentists and laboratories provide comprehensive care to one or two patients a year. In the 2006-2007 fiscal year 247 patients were treated, and 303 volunteer dentists and 80 dental laboratories participated in the program. The Kansas program is overwhelmed with requests for care, and at the end of FY 2007 there were still 467 applications waiting to be referred to a volunteer dentist.
# FINANCING ORAL HEALTH FOR UNDERSERVED POPULATIONS

## OBJECTIVE #1 CREATE AND SUSTAIN DENTAL HUBS

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Parties</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Secure Funding for a Second Round of Dental Hub Grants, to Procure New Funding for Not Less than four Previously-Unfunded Dental Clinics</td>
<td>Kansas Association for the Medically Underserved</td>
<td>Late 2007</td>
</tr>
<tr>
<td>Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Work with private foundations to commit funding and develop next request for proposal.</td>
<td></td>
<td>Spring 2008</td>
</tr>
<tr>
<td>• Work with State partners (KDHE, OHK, Office of Oral Health, etc.) to secure legislative funding.</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>• Advocate for funding at the Legislature.</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>2. Secure Increase in State Funding for Primary Care Clinics to Support Growing Hubs</td>
<td>Kansas Association for the Medically Underserved</td>
<td>On-going</td>
</tr>
<tr>
<td>Activities:</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>• Collect hub data, measure hub performance, produce reports.</td>
<td>Office of Oral Health</td>
<td></td>
</tr>
<tr>
<td>• Actively engage in a Legislative Advocacy Campaign to fully fund hub clinical professionals.</td>
<td>Kansas Dental Hygienists’ Association</td>
<td></td>
</tr>
<tr>
<td>• Engage media in dental hub story.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Provide Training and Technical Assistance to Hub Clinics to Support Efficient Expansion and Provision of Oral Health Services</td>
<td>Kansas Association for the Medically Underserved</td>
<td>On-going</td>
</tr>
<tr>
<td>Activities:</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>• Participate in dental work force development activities</td>
<td>Office of Oral Health</td>
<td></td>
</tr>
<tr>
<td>• Add dental providers to Kansas Rural Recruitment Center’s services.</td>
<td>Kansas Dental Hygienists’ Association</td>
<td></td>
</tr>
<tr>
<td>• Promote and recruit at schools of dentistry nationwide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop state scholarships and loan repayment programs for DDS and ECP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop additional Kansas AEGD sites.</td>
<td>Kansas Association for the Medically Underserved</td>
<td>2007-2010</td>
</tr>
<tr>
<td>4. Work to Assure that 12 Hubs Have At Least 2 FTE dentists and One FTE ECP Hygienist by 2011</td>
<td>Kansas Association for the Medically Underserved</td>
<td>2007-2010</td>
</tr>
<tr>
<td>Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Participate in dental work force development activities</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>• Add dental providers to Kansas Rural Recruitment Center’s services.</td>
<td>Office of Oral Health</td>
<td></td>
</tr>
<tr>
<td>• Promote and recruit at schools of dentistry nationwide.</td>
<td>Kansas Dental Hygienists’ Association</td>
<td></td>
</tr>
<tr>
<td>• Develop state scholarships and loan repayment programs for DDS and ECP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop additional Kansas AEGD sites.</td>
<td>Kansas Association for the Medically Underserved</td>
<td></td>
</tr>
<tr>
<td>STRATEGIES</td>
<td>RESPONSIBLE PARTIES</td>
<td>TARGET DATE</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 1. Obtain a Full Dental Benefit for all Adults on Medicaid Activities:  
  • Estimate numbers of adults on Medicaid without dental coverage and estimate cost to include them with a dental benefit, including dentures.  
  • Develop educational materials for legislators about a Medicaid dental benefit for adults.  
  • Legislative Advocacy on Adult Medicaid Benefit. | Kansas Health Policy Authority  
Oral Health Kansas | Fall 2008  
2008-2009  
2008-2009 |
| 2. Increase Medicaid Dental Provider Reimbursement Rates Activities:  
  • Provide current Medicaid reimbursement information, with % of UCRs for covered procedures.  
  • Collaborate on a plan to increase dental reimbursement for Kansas Medicaid providers.  
  • Provide Legislators with information on Medicaid costs and reimbursement rates.  
  • Legislative advocacy on increased reimbursement rates. | Kansas Health Policy Authority  
Kansas Dental Association  
Oral Health Kansas  
Oral Health Kansas  
Kansas Dental Hygienists’ Association  
Oral Health Kansas | Fall 2008  
2008-2009  
2008-2009  
2008-2009  
2008-2009 |
<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>RESPONSIBLE PARTIES</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Increase Dental Providers who Treat Medicaid Patients, including the Elderly and Special Needs Patients</td>
<td>EDS&lt;br&gt;Kansas Dental Association&lt;br&gt;Oral Health Kansas</td>
<td>On-Going</td>
</tr>
<tr>
<td>Activities:</td>
<td>EDS&lt;br&gt;Kansas Dental Association&lt;br&gt;Oral Health Kansas&lt;br&gt;SRS&lt;br&gt;Dept of Aging&lt;br&gt;Kansas Dental Hygienists’ Association</td>
<td></td>
</tr>
<tr>
<td>• Recruitment program to encourage dentists to enroll in Medicaid program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Educate dentists about waiver populations and new dental benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop a specific recruitment program for dental providers of elderly and special health care needs patients.</td>
<td>Oral Health Kansas</td>
<td>2008-2009</td>
</tr>
<tr>
<td>Activities:</td>
<td>Office of Oral Health&lt;br&gt;Oral Health Kansas&lt;br&gt;Kansas Dental Association</td>
<td>Early 2009</td>
</tr>
<tr>
<td>• Explore all options for Medicaid reimbursement for preventive procedures performed by ECP hygienists in underserved areas such as Head Start.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Research possible incentives for dentists that are Medicaid providers or implementation in Kansas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Promote oral health in policy discussions at the Kansas Health Policy Authority.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Objective #3 - Support Charitable Dental Care

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Parties</th>
<th>Target Date</th>
</tr>
</thead>
</table>
| 1. Support the Kansas Mission of Mercy Project  
Activities:  
- Organize yearly event where volunteer dental professionals provide free care to individuals in need.  
- Collect data on numbers of KMOM patients, and types of care provided. | Kansas Dental Charitable Foundation  
Kansas Dental Association  
Kansas Dental Hygienists’ Association | Yearly |
| 2. Encourage Dentists to participate in the Donated Dental Services (DDS) and “Give Kids a Smile” programs  
Activities:  
- Educate dentists on the programs and promote participation.  
- Collect data on the patients served and types of care provided. | Kansas Dental Charitable Foundation  
Kansas Dental Association  
Kansas Dental Hygienists’ Association | On-Going |
| 3. Support Community Level Programs that Increase Dental Access by using Dental Professional Volunteers  
Activities:  
- Provide technical assistance and recruitment support to community dental programs.  
- Assist programs in engaging the media to attract more support to their programs. | Oral Health Kansas Office of Oral Health | On-Going |
COMMUNITY AND PUBLIC HEALTH INTRODUCTION

Dental public health is a form of dental practice that serves the community as a whole. Public health dental professionals promote oral health by assessing the oral health needs of the community, designing and implementing oral health policy and developing community programming to address oral health issues. Kansas had some of the earliest public health programs and continues to have a strong public health tradition. Kansas is building on this foundation with an active public oral health community that is creating innovative and effective oral health policy and programming.

The Kansas oral health coalition, Oral Health Kansas, Inc. was formed in 2003 to create a more coordinated effort to improve the oral health status of Kansans. The organization has developed into a significant coalition of individuals and organizations representing diverse backgrounds. Oral Health Kansas has had great successes in its short history. Specifically, OHK has been instrumental in the creation and promotion of the Kansas Extended Care Permit for Dental Hygienists program, formed a statewide leadership program entitled “Dental Champions”, and done effective legislative advocacy that secured funding for an Office of Oral Health at the Kansas Department of Health and Environment.
The state oral health agency, the Office of Oral Health, is housed in the Division of Health at the Kansas Department of Health and Environment. Their mission is to collaborate with and provide technical assistance to communities, schools, health professionals, local health departments, and others to increase awareness of the importance of oral health and improve the oral health status of Kansas. Specific projects include data collection on the oral health of Kansans, and targeted oral health programming such as school sealant programs and fluoride varnish promotion to medical providers.

A. ORAL HEALTH PROGRAMMING

Kansas has many dedicated professionals working on improving the oral health of its citizens. Most of these programs were instigated locally by individuals that saw a need in their community. Efforts mentioned here are not the only strategies that are working in Kansas, but are examples of the types of programs that have been done and may be replicated in the future.

Educating the public about the importance of oral health is a challenge. Recent evidence has shown strong connections between oral health and diabetes, healthy pregnancy, and cardiovascular disease. Disseminating oral health information to targeted populations is one strategy to improve oral health to large population groups. Kansas has done some oral health marketing in the past. “Your Mouth Matters” was a statewide oral health educational campaign done by Kansas Action for Children and Oral Health Kansas. The campaign included printed materials, as well as TV and radio spots. Local educational efforts include the Kansas Head Start’s Teeth for Two for pregnant women, Cowley County’s Tiny Teeth for pre-K kids, and United Methodist Mexican-American Ministries in Garden City’s Lifetime Smiles project.
Most childhood decay begins in the deep grooves and pits on the chewing surfaces of the posterior teeth. Dental sealants are a plastic material that can be bonded in these grooves. The application of dental sealants is painless and cost effective. Kansas dental hygienists can apply dental sealants, and with the Extended Care Permit, hygienists can apply sealants to underserved children in school and community settings. Safety net clinics, local school districts and dental professionals are working together to develop school based sealant programs across the state.

Fluoride varnish is a topical preventive treatment for populations at risk for dental decay. The varnish is a strong resin that is painted on the teeth and is able to hold fluoride in close contact with the tooth surface for a period of two to four hours. It is easy to apply, quick and safe. In Kansas, Medicaid will reimburse both dentists and physicians for fluoride varnish applications. The Office of Oral Health promotes the use of fluoride varnish in medical offices by provided training for primary care providers in their offices. State dental hygienists provide physicians and their staff with oral health education and demonstrate the use of fluoride varnish.

B. ORAL HEALTH ASSESSMENT

A cornerstone of public health is assessment. Regular oral health surveillance is necessary to measure the magnitude of the oral health need, develop oral health policy, and monitor the progress of oral health programming. Kansas state specific oral health data is sparse. In 2004 the first statewide survey on the oral health of Kansas third graders was completed by the Kansas Office of Oral Health. The survey was done in accordance with the Association of State and Territorial Dental Director’s Basic Screening Survey protocols. The survey was repeated in the spring of 2007.
The Behavioral Risk Factor Surveillance System (BRFSS), which is coordinated and partially funded by the Centers for Disease Control and Prevention, is the largest continuously conducted telephone survey in the world. It is conducted in every state, the District of Columbia, and several United States territories. Kansas collects oral health information through the BRFSS questionnaire. Kansas specific oral health data is also obtained from other sources, including Medicaid claims data, local oral health projects, and area educational institutions and as well as state policy research entities like the Kansas Health Institute.

### 2006 BRFSS ORAL HEALTH QUESTION

How long has it been since you had your teeth cleaned by a dentist or dental hygienist?

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the past year (any time less than 12 months ago)</td>
<td>70.1</td>
</tr>
<tr>
<td>Within the past 2 years (1 year but less than 2 years ago)</td>
<td>12.2</td>
</tr>
<tr>
<td>Within the past 5 years (2 years but less than 5 years ago)</td>
<td>8.1</td>
</tr>
<tr>
<td>5 or more years</td>
<td>12.1</td>
</tr>
<tr>
<td>Never</td>
<td>2.1</td>
</tr>
</tbody>
</table>

*Among respondents who have not had all of their teeth removed, or who have ever visited a dentist or dental clinic for any reason excluding unknowns and refusals.*

C. TOBACCO

Tobacco is the number one preventable cause of death in Kansas. More than 3900 Kansans die of cigarette smoking a year, costing Kansas more than $900 million in health care expenditures. The Kansas Department of Health and Environment Tobacco Use Prevention Program (TUPP) works with state and local partners to promote tobacco cessation and prevent the initiation of tobacco use. In 2005, 17.5% of adults in Kansas smoke. Smoking is more prevalent among the young, with 23.1% of adults aged 18-24 reported being smokers. In 2006, 21.1% of Kansas reported using or trying smokeless tobacco products such as snuff.

Kansas TUPP strategies to reduce tobacco use include the Kansas Tobacco Quitline (1-866-KAN-STOP). The Quitline provides screening, counseling, support materials and referral for tobacco cessation assistance based on individual’s readiness to quit. The program provides comprehensive follow-up counseling for Kansas citizens who are ready to quit or are contemplating a cessation attempt. Kansas TUPP has been educating medical professionals about the Quitline and facilitating referrals. Recent efforts include the “Smokeless Doesn’t Mean Harmless” Spit Tobacco Summit in Hutchinson in August of 2007.
D. Oral Health for Targeted Populations

Kansas oral health leaders have given much attention to the lack of oral health care access for populations with special health care needs. In 2005, the Kansas Head Start Association implemented a planning grant from American Academy of Pediatrics to explore the challenges, needs, and opportunities regarding optimum oral health for children with special health care needs. Fifteen percent of all Kansas children (approximately 101,000) have special health care needs. There are no statistics on the oral health of this population, but our 2004 general survey of third graders, Smiles Across Kansas, reported that one out of every four Kansas children has active, untreated decay. Individuals with special needs face larger barriers to access. A national survey of families with children with special health care needs reported that 78% of their children needed dental care in the last twelve months. These families also reported that dental care is their child’s most prevalent unmet health care need.

Kansas senior populations face their own unique oral health challenges. Seniors are keeping their teeth longer, less than 20% of Kansans over sixty-five have lost all of their teeth. Although they require dental care throughout their lives, Kansans over sixty-five are the age group most likely to lack dental insurance. Medicare and Kansas Medicaid offer few dental benefits for most seniors. Seniors are more susceptible to dry mouth, periodontal disease, decay on the roots of the teeth, and oral cancer. In 2004, there were 287 Kansas cases of cancer of the oral cavity or pharynx and 134 of these were in Kansans over the age of 65.
E. COMMUNITY WATER FLUORIDATION

In 1994 the U.S. Department of Health and Human Services hailed community water fluoridation as one of the top ten public health achievements of the 20th century.10 Fluoridating community water prevents tooth decay in two ways: primarily through direct contact with teeth throughout life, and when consumed by children during the tooth forming years. The annual average cost to fluoridate a large community is approximately fifty cents ($0.50) per person. Assuming a 75 year life span, that is only $37.50 for a lifetime of protection, which is less than the cost of one dental filling/restoration.11 Extensive research conducted over the past 60 years has shown that fluoridation of public water supplies is a safe and effective way to reduce tooth decay for all community residents.12

Approximately 62% of Kansans have fluoridated water through the public water supply system. Kansas has no state mandate to fluoridate the water. Wichita, Hutchinson, Winfield, McPherson, Great Bend, Pratt, Derby, Augusta, Clay Center, Liberal, and many other smaller Kansas communities are still without community water fluoridation.
### Objective #1 - Increase Awareness about the Importance of Oral Health

#### Strategies:

1. Develop a Statewide Social Marketing Campaign Targeted to Vulnerable Populations
   
   **Activities:**
   - Create a task force of stakeholders, including social marketing experts, to explore the possibility of creating a statewide social marketing/educational campaign about the importance of oral health.
   - With the assistance of the task force and the expertise of the Frameworks Institute, determine the intended target audience and determine the overall message of the campaign.
   - With the assistance of the task force, explore potential funding options, including possible partnerships with other states that might be interested in coordinating resources for a social marketing campaign.

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health Kansas</td>
<td>Early 2008</td>
</tr>
<tr>
<td>Oral Health Kansas</td>
<td>Summer 2008</td>
</tr>
<tr>
<td>Oral Health Kansas</td>
<td>Fall 2008</td>
</tr>
<tr>
<td>STRATEGIES:</td>
<td>RESPONSIBLE PARTY</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Activities:</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>• Increase Oral Health Kansas membership to 200 persons.</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>• Identify diverse and sustainable funding sources.</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>• Develop a way to sustain and increase engagement of the Dental Champions Leadership class participants.</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>• Improve the impact of the Oral Health Kansas yearly conference.</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>• Support developing local oral health coalitions in their oral health advocacy efforts.</td>
<td>Office of Oral Health</td>
</tr>
<tr>
<td>• Meet with Kansas Private Foundations to update them on Coalition activities and the progress of the Oral Health Plan.</td>
<td>United Methodist Health Ministry Fund REACH Foundation Sunflower Foundation Delta Dental Foundation Kansas Health Foundation</td>
</tr>
</tbody>
</table>
### Objective #2 - Create a Centralized Kansas Oral Health Information System

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Party</th>
<th>Target Date</th>
</tr>
</thead>
</table>
| 3. Increase Kansas - Specific Oral Health Data that is Accessible to the Public  
   Activities:  
   - Release 2007 Smiles Across Kansas 3rd Grade Basic Screening Survey.  
   - Explore the use of Office of Oral Health’s Website to coordinate oral health school screening data.  
   - Continue oral health questions on BRFSS survey.  
   - Explore options to collect data on adults and special needs populations. | Office of Oral Health  
Office of Oral Health  
Office of Health Promotion  
Office of Oral Health  
Oral Health Kansas | Early 2008  
Early 2009  
Yearly  
Early 2009 |
| 4. Coordinate Oral Health Educational Materials in a Statewide Clearinghouse  
   Activities:  
   - Provide oral health information and speakers to interested parties on request. | Office of Oral Health  
Oral Health Kansas | Early 2010 |
## OBJECTIVE #3 - INCLUDE ORAL HEALTH IN STATEWIDE TOBACCO INITIATIVES

<table>
<thead>
<tr>
<th>STRATEGIES:</th>
<th>RESPONSIBLE PARTY</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incorporate the American Dental Hygienists Association’s “Ask, Advise, Refer” program into Kansas dental office protocol</td>
<td>Kansas Tobacco Use Prevention Program (TUPP) Kansas Dental Hygienists’ Association Kansas Dental Association Office of Oral Health</td>
<td>Summer 2010</td>
</tr>
</tbody>
</table>

Activities:
- Contact information from all oral health professional organizations and provide information regarding regional trainings.
- “Ask, Advise, Refer” trainings will be offered for a targeted one hundred oral health professionals to learn more about the effects of tobacco use and the protocol to assist patients in quitting, including referrals to the Kansas Tobacco Quitline (1.866.KAN.STOP).
- Contact will be continued with oral health professionals via email distribution list.
- Earned media will be developed for placement in oral health professional publications in Kansas.

Kansas Tobacco Quitline (1.866.KAN.STOP) monthly reports will be assessed to determine faxed referrals from oral health providers preceding the trainings.
2. Oral health professionals in Kansas will join efforts of local tobacco control coalitions and the Tobacco Free Kansas Coalition

Activities:
- Contact information from all oral health professional organizations will be accessed by the Tobacco Free Kansas Coalition and the TUPP and will be added to the Tobacco Free Kansas Coalition (TFKC) list-serve.
- Local tobacco control coalitions will be given names and contact information of oral health professionals who may be interested in joining or assisting local grassroots efforts.
- TFKC and the Kansas Tobacco Quitline (1.866. KAN.STOP) will host a display booth at the annual Oral Health Conference.
- Local grassroots tobacco control coalitions will place earned media targeting oral health professionals.
- Kansas Department of Health and Environment, Tobacco Use Prevention Program Community Partner Event Forms will be assessed on a quarterly basis to determine oral health professional involvement.

<table>
<thead>
<tr>
<th>STRATEGIES:</th>
<th>RESPONSIBLE PARTY</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Oral health professionals in Kansas will join efforts of local tobacco</td>
<td>Kansas Tobacco Use Prevention Program (TUPP)</td>
<td>Summer 2010</td>
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<tr>
<td>control coalitions and the Tobacco Free Kansas Coalition</td>
<td>Office of Oral Health</td>
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</tr>
<tr>
<td>Activities:</td>
<td>Oral Health Kansas</td>
<td></td>
</tr>
<tr>
<td>• Contact information from all oral health professional organizations</td>
<td>Kansas Dental Hygienists’ Association</td>
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<tr>
<td>will be accessed by the Tobacco Free Kansas Coalition and the</td>
<td>Kansas Dental Association</td>
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<tr>
<td>TUPP and will be added to the Tobacco Free Kansas Coalition (TFKC)</td>
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<td>list-serve.</td>
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<tr>
<td>• Local tobacco control coalitions will be given names and contact</td>
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<td>information of oral health professionals who may be interested in</td>
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<td>joining or assisting local grassroots efforts.</td>
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<tr>
<td>display booth at the annual Oral Health Conference.</td>
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<tr>
<td>• Local grassroots tobacco control coalitions will place earned media</td>
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<td>targeting oral health professionals.</td>
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<tr>
<td>• Kansas Department of Health and Environment, Tobacco Use Prevention</td>
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<tr>
<td>Program Community Partner Event Forms will be assessed on a quarterly</td>
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<tr>
<td>basis to determine oral health professional involvement.</td>
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<td>STRATEGIES:</td>
<td>RESPONSIBLE PARTY</td>
<td>TARGET DATE</td>
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<tr>
<td>3. Local tobacco control advocates will be trained in academic detailing</td>
<td>Kansas Tobacco Use Prevention Program (TUPP)</td>
<td>Summer 2010</td>
</tr>
<tr>
<td>strategies to educate oral health providers in utilizing the protocol</td>
<td>Office of Oral Health</td>
<td></td>
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<tr>
<td>for assisting patients in quitting tobacco use</td>
<td>Oral Health Kansas</td>
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<tr>
<td>Activities:</td>
<td></td>
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<tr>
<td>• One hundred tobacco control advocates will be trained on the oral</td>
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<tr>
<td>effects of tobacco use and the “Ask, Advise, Refer” model, the Kansas</td>
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<tr>
<td>Tobacco Quitline and engaging oral health professionals</td>
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<tr>
<td>utilizing video conferencing and or “Go To Meeting” to allow for more</td>
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<tr>
<td>participants with geographic restrictions.</td>
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<tr>
<td>• Local grassroots tobacco control coalitions will place earned media</td>
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<tr>
<td>targeting oral health professionals.</td>
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<tr>
<td>• Kansas Tobacco Quitline (1-866-KAN-STOP) monthly reports will be</td>
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<tr>
<td>assessed to determine faxed referrals from oral health providers.</td>
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<tr>
<td>• Kansas Department of Health and Environment, Tobacco Use Prevention</td>
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<tr>
<td>Program Community Partner Event Forms will be assessed on a quarterly</td>
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<tr>
<td>basis to determine oral health professional involvement.</td>
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</table>
### Objective 4: Oral Health Activities for Specific Populations

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Party</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve Oral Health for Children and Adults with Special Health Care Needs</td>
<td>Office of Oral Health</td>
<td>Early 2009</td>
</tr>
<tr>
<td></td>
<td>Oral Health Kansas</td>
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<td></td>
<td>Oral Health Kansas</td>
<td>Fall 2008</td>
</tr>
<tr>
<td></td>
<td>KS Council on Developmental Disabilities</td>
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<tr>
<td></td>
<td>Kansas Dental Hygienists’ Association</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office of Oral Health</td>
<td>Early 2009</td>
</tr>
<tr>
<td></td>
<td>Grace Med Clinic</td>
<td></td>
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<tr>
<td></td>
<td>Grace Med Clinic</td>
<td>Early 2010</td>
</tr>
<tr>
<td></td>
<td>Wichita State University</td>
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<tr>
<td></td>
<td>SRS</td>
<td>Fall 2008</td>
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<tr>
<td></td>
<td>EDS</td>
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<tr>
<td></td>
<td>Oral Health Kansas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KS Council on Developmental Disabilities</td>
<td></td>
</tr>
<tr>
<td>2. Improve Oral Health for Kansas Seniors</td>
<td>Kansas Dental Association</td>
<td>Early 2009</td>
</tr>
<tr>
<td></td>
<td>Kansas Department of Aging</td>
<td>Fall 2008</td>
</tr>
<tr>
<td></td>
<td>EDS</td>
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<td></td>
<td>Kansas Dental Association</td>
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<td></td>
<td>Oral Health Kansas</td>
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<td></td>
<td>Office of Oral Health</td>
<td>On-Going</td>
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<tr>
<td></td>
<td>Kansas Dental Hygienists’ Association</td>
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</tbody>
</table>
## Objective 5 - Support Community Based Oral Health Programming

<table>
<thead>
<tr>
<th>Strategies:</th>
<th>Responsible Party</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support and Promote Community Water Fluoridation Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Convene preliminary community meetings about the need for a statewide education campaign about community water fluoridation.</td>
<td>Office of Oral Health Oral Health Kansas</td>
<td>Spring 2009</td>
</tr>
<tr>
<td>- Investigate funding options for targeted campaigns to encourage community water fluoridation in non-fluoridated Kansas communities.</td>
<td>Office of Oral Health Oral Health Kansas</td>
<td>Fall 2009</td>
</tr>
<tr>
<td>- Work with state agencies to provide more accessible data on water fluoridation in Kansas.</td>
<td>Office of Oral Health KDHE Bureau of Water</td>
<td>Spring 2009</td>
</tr>
<tr>
<td>2. Support and Expand School Based Oral Health Services Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Encourage and support the delivery of preventive services in schools using Extended Care Permit Hygienists.</td>
<td>Oral Health Kansas Office of Oral Health Kansas Dental Hygienists’ Association</td>
<td>On-Going</td>
</tr>
<tr>
<td>- Work with Dental Safety Net Clinics across the state to encourage school based dental programming using clinic staff.</td>
<td>Office of Oral Health</td>
<td>On-Going</td>
</tr>
<tr>
<td>- Encourage data collection on school based services to evaluate the benefits of school based programming.</td>
<td>Office of Oral Health</td>
<td>Fall 2009</td>
</tr>
<tr>
<td>3. Increase the Use of Fluoride Varnish in At Risk Populations Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Provide education to medical offices on the use of fluoride varnish on young children at well baby checks.</td>
<td>Office of Oral Health</td>
<td>On-Going</td>
</tr>
<tr>
<td>- Provide fluoride varnish to children in Head Start and Early Childhood Centers.</td>
<td>Kansas Head Start Association</td>
<td>Fall 2009</td>
</tr>
</tbody>
</table>
CHILDREN’S ORAL HEALTH

Children’s oral health is a significant concern for all Kansans. Dental decay in young children or early childhood caries (ECC) is an infectious disease that can start as soon as an infant’s teeth erupt. ECC can have a detrimental effect throughout a child’s life. Young children with dental pain, infection and tooth loss have difficulty eating nutritious foods, developing positive social and emotional skills, and concentrating on learning new information. To reduce dental disease in young children, communities and government institutions have instituted prevention programs in early childhood settings and schools.

A. EARLY CHILDHOOD ORAL HEALTH

As early as ten months, infants’ teeth can show signs of demineralization. This weakened tooth structure looks like white spots along the gum line. Dental decay is caused by bacteria (Streptococcus Mutans) that are commonly transferred by a mother to her child’s mouth by kissing or sharing eating utensils. These bacteria when combined with poor oral Hygienists’ and inappropriate feeding and nutrition habits cause tooth decay. Americans in most age groups have experienced less dental decay in the last ten years, but tooth decay in primary (baby) teeth of children aged 2 to 5 years increased from 24 percent to 28 percent between 1988-1994 and 1999-2004.1 Repairing the damage of early childhood caries is cost prohibitive for many families. Kansas Head Start estimates that each of its 30 programs will have an average of 5 children per year per program needing this extensive dental care, conservatively amounting to $750,000 per year in just these few sites.2
Kansas has several statewide initiatives to reduce early childhood caries. The Kansas Office of Oral Health (OOH) instituted a statewide outreach program designed to increase the number of physicians’ offices applying fluoride varnish during children’s well-child visits. Partnering with the Kansas Child Care Training Organization (KCCTO), an early childhood teacher oral health training program was developed entitled “Filling the Gap”. KCCTO has included this workshop into its regular course offerings with early childhood providers throughout the state. The Office of Oral Health also trained health department nurses to conduct oral screenings and fluoride varnish applications at WIC and KAN Be Healthy well child visits.

The Kansas Head Start Association is working to build school-ready children and self-sufficient families through professional education, advocacy and special projects. These projects work to build academically, physically, socially and emotionally strong children that are ready for school. The Kansas Head Start Association (KHSA) estimates more than 28% of children enrolling in Head Start programs have diagnosed dental decay, equaling almost 2,000 three and four year olds each year. KHSA established an Early Head Start oral health program to ensure that home visitors were educating parents on their role to keep young children cavity free. Additionally, KHSA implemented Teeth for Two, an oral health educational program targeting pregnant women, and provided oral health tool kits in Head Start classrooms to enhance children’s learning experiences.

Kansas Association of Child Care Resource and Referral Agencies is another partner whose mission is to ensure that high-quality early education is available to all Kansas families. It provides information to families that help them make wise decisions about out-of-home care for their children, as well as education and training for childcare professionals, and research and advocacy with other Kansas early childhood advocates.

Building on this strong foundation of programs designed to keep young children cavity-free, Kansas intends to establish a coordinated system of oral health prevention services through community dentists, safety-net clinics, Extended Care Permit (ECP) hygienists, and early childhood programs. Kansas Head Start Association is taking the lead on this initiative by establishing ten regional areas to serve Head Start programs, community early childhood centers, programs for children with special health care needs, and school district early childhood programs. Guided by an Early Childhood Oral Health Advisory Council, KHSA will link early childhood centers with prevention services and staff/parents.
education offered by safety-net dental clinics and ECP dental hygienists. Participating community dentists and safety-net dentists will provide examinations and follow up restorative dental care. In order to track the growth of this program in keeping young children cavity free, KHSA will commission the design of a web-based data tracking system that dental professionals and early childhood programs can use to report findings and treatment. Success will be based on the increase of children entering kindergarten cavity free.

B. SCHOOL AGE ORAL HEALTH

When children’s oral health suffers, so does their ability to learn. An estimated 51 millions school hours per year are lost because of dental-related illnesses. Students ages 5-17 missed 1,611,000 school days in 1996 due to acute dental disease — an average of 3.1 days per 100 students. Children 2-11, in families with income under $18,000 were nearly twice as likely to experience decay as children in families at the $36,000 income level.

Concerns about the oral health of Kansas school children date back to 1915, when the Kansas legislature passed a statute requiring all Kansas children in school to receive an annual dental inspection. Although Kansas has a statute requiring oral health screenings, it is not uniformly implemented in all Kansas schools. One of the barriers to this screening requirement is that school nurses are the ones who must ensure that the mandate is followed. School nurses are often stretched thin in addressing many other health concerns. Additionally, the legislature does not appropriate funds for oral health screenings, requiring many communities to use volunteers and community health centers to do the screenings. Although the state Office of Oral Health has provided screening cards in the past, there are no current uniform screening forms that are being used statewide. The Office of Oral Health has started a new project that will design and implement a school screening system that all schools can use to screen their students.

In collaboration with the Kansas Department of Health and Environment Bureau of Family Health, efforts were made to develop an oral health screening program with school nurses. The project trained 45 school nurses to use a fluorescent laser dental device to screen for dental decay. This procedure has given school nurses more confidence and information about oral health issues and developed referral networks for the schools to local dental offices. To date, more than 6,000 school children have been screened in this initiative. This project will be folded into the new school screening program that is currently underway at the Office of Oral Health.
Kansas Coordinated School Health (KCSH) is a multi-faceted approach to help youth establish healthful behaviors and attitudes. It begins with a thorough assessment of health influences within a school/community. This assessment directs Coordinated School Health (CSH) leaders toward the greatest areas of student health needs. KCSH asked Oral Health Kansas to design guidelines and information that could be used to integrate oral health into all aspects of school services and classroom activities. The result is Kansas Coordinated School Health Policy Guideline.

Oral Health Kansas developed realistic actions school administrators and staff can take to incorporate oral health services into all aspects of the educational experience. The guideline includes oral health education programming, oral health friendly school environments, physical education, counseling, worksite wellness for staff, family & community involvement, and nutritional services. Oral Health Kansas also produced a set of guidelines for classroom teachers on how to include age-appropriate oral health lessons into traditional subjects such as reading, literature, mathematics, and science, plus other subjects like foreign language and life skills. The set of guidelines include a comprehensive annotated list of oral health curricula to supplement classroom lessons. Oral Health Kansas, in partnership with KCSH, will implement a series of strategies designed to establish oral health as an essential part of school services and curricula for all grades, K-12. This will take a new working relationship with the eleven education services centers (ESC) placed in strategic locations around the state.
# CHILDREN’S ORAL HEALTH PLAN

## OBJECTIVE #1: DEVELOP AN ORAL HEALTH SCREENING PROGRAM FOR CHILDREN IN KANSAS SCHOOLS

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>RESPONSIBLE PARTIES</th>
<th>TARGET DATE</th>
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</thead>
<tbody>
<tr>
<td>• Hire a full-time project coordinator</td>
<td></td>
<td>Winter 2008</td>
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<tr>
<td>• Determine current level of participation in oral health screenings in Kansas school districts.</td>
<td>Office of Oral Health</td>
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<tr>
<td>• Establish an Oral Health Screening Advisory Council.</td>
<td>Oral Health Kansas</td>
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<td></td>
<td>Kansas Dept of Education</td>
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<tr>
<td></td>
<td>KHDE School Nurse Consultants</td>
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<tr>
<td>2. Develop a Reporting System for School Screening Data</td>
<td>Office of Oral Health</td>
<td>Spring 2008</td>
</tr>
<tr>
<td>Activities:</td>
<td>Office of Oral Health Screening Advisory Council</td>
<td></td>
</tr>
<tr>
<td>• Develop a uniform oral health screening form.</td>
<td></td>
<td>Summer 2008</td>
</tr>
<tr>
<td>• Design and implement a web-based data collection system to house school screening data and make it accessible to general public.</td>
<td>Office of Oral Health</td>
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<td></td>
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<tr>
<td>Activities:</td>
<td>Office of Oral Health</td>
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<tr>
<td>• Pilot school screening program in five to seven pilot sites across state.</td>
<td></td>
<td>Spring 2009</td>
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<tr>
<td>• Evaluate Pilot Program and make necessary adjustments.</td>
<td>Office of Oral Health Screening Advisory Council</td>
<td></td>
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<tr>
<td>• Recruit and train regional screeners, and do outreach to expand program statewide.</td>
<td>Office of Oral Health</td>
<td>Fall 2009</td>
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<tr>
<td></td>
<td>Office of Oral Health Screening Advisory Council</td>
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<td></td>
<td>Kansas Dept of Education</td>
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</table>
### Objective #2 – Improve the Oral Health of Pre-School Children (0 to Age 5)

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<thead>
<tr>
<th>Strategies</th>
<th>Responsible Parties</th>
<th>Target Date</th>
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</thead>
<tbody>
<tr>
<td>Activities:</td>
<td>Oral Health Kansas</td>
<td>Winter 2008</td>
</tr>
<tr>
<td>- Establish an Early Childhood Oral Health Advisory Council including members from early childhood and oral health communities.</td>
<td>Kansas Head Start Association, Kansas Association for the Medically Underserved</td>
<td>Spring 2008</td>
</tr>
<tr>
<td>- Target strategic geographic regions for initial implementation and recruit and train oral health professionals in these regions.</td>
<td>Kansas Head Start Association, Oral Health Kansas, Advisory Council</td>
<td></td>
</tr>
<tr>
<td>- Evaluate initial implementation by developing a performance tracking and reporting system for oral health professionals in the program.</td>
<td>Universal Care for Children</td>
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</tbody>
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*Appendix A: Oral Health Plan—January 2009*
### Strategies:

2. Design and Implement an Oral Health Educational Program for Early Childhood Center Staff and Parents of Young Children

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible Party</th>
<th>Target Date</th>
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</thead>
<tbody>
<tr>
<td>Kansas Head Start Association</td>
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<tr>
<td>Recruit ECP hygienists to act as educators to conduct trainings for early childhood staff, pregnant women and young parents.</td>
<td>Kansas Head Start Association</td>
<td>Spring 2008</td>
</tr>
<tr>
<td>Oral Health Kansas</td>
<td></td>
<td></td>
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<tr>
<td>Produce educational materials on oral health for training participants.</td>
<td>Kansas Head Start Association</td>
<td>Spring 2008</td>
</tr>
<tr>
<td>Enlist Head Start programs to schedule and host training sessions in their communities for early childhood teachers and parents.</td>
<td>Kansas Head Start Association</td>
<td>Summer 2008</td>
</tr>
<tr>
<td>Implement oral health education in early childhood centers directed by staff that attended the training sessions.</td>
<td>Kansas Head Start Association</td>
<td>Fall 2009</td>
</tr>
<tr>
<td>Evaluate the impact of the training.</td>
<td>Kansas Advisory Council</td>
<td>Winter 2010</td>
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<tr>
<td>Kansas Head Start Association</td>
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<td></td>
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</table>

3. Collect Data on the Oral Health of Young Children to Monitor Progress and Evaluate Programming

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible Party</th>
<th>Target Date</th>
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</thead>
<tbody>
<tr>
<td>Determine the specific data and outcome indicators to be collected by early childhood programs and hygienists.</td>
<td>Advisory Council</td>
<td>Spring 2008</td>
</tr>
<tr>
<td>Kansas Head Start Association</td>
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<tr>
<td>Office of Oral Health</td>
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</tr>
<tr>
<td>Design and test the software for data collection that will integrate with school screening database.</td>
<td>Kansas Head Start Association</td>
<td>Fall 2008</td>
</tr>
<tr>
<td>Office of Oral Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make aggregate data available to the public.</td>
<td>Kansas Head Start Association</td>
<td>Spring 2009</td>
</tr>
<tr>
<td>Office of Oral Health</td>
<td></td>
<td></td>
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</tbody>
</table>
### Objective #3: Integrate Oral Health into Kansas Coordinated School Health (KCSH) Policy Guidelines

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Responsible Parties</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities:</td>
<td>Oral Health Kansas</td>
<td>Fall 2007</td>
</tr>
<tr>
<td>• Conduct conference workshops for school nurses and coordinated school health staff.</td>
<td>Kansas Coordinated School Health</td>
<td>Fall 2007</td>
</tr>
<tr>
<td>• Post the guidelines on Oral Health Kansas and Kansas Coordinated School Health websites.</td>
<td>KDHE School Nurse Consultants</td>
<td>Winter 2008</td>
</tr>
<tr>
<td>• Publish information in ZIPS (the school nurse web-based newsletter).</td>
<td>Oral Health Kansas</td>
<td>Summer 2008</td>
</tr>
<tr>
<td>• Conduct orientation for school district superintendents at regional educational service centers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities:</td>
<td>Oral Health Kansas</td>
<td>On-Going</td>
</tr>
<tr>
<td>• Collect examples from Schools, KDHE School Nurse Consultants, Kansas Coordinated School Health and Regional Education Service Centers and share best practices.</td>
<td>Oral Health Kansas</td>
<td>Winter 2009</td>
</tr>
<tr>
<td>• Communicate with schools and partners via e-mail and newsletter.</td>
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</tr>
<tr>
<td>• Design and implement a school oral health award program for exceptional school health programs.</td>
<td>Oral Health Kansas</td>
<td></td>
</tr>
<tr>
<td>Activities:</td>
<td>Kansas Coordinated School Health</td>
<td>Summer 2009</td>
</tr>
<tr>
<td>• Determine evaluation criteria.</td>
<td></td>
<td></td>
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<tr>
<td>• Monitor and report on evaluation.</td>
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</tbody>
</table>
In May of 2000 Surgeon General David Satcher released *Oral Health in America*, a report identifying the “silent epidemic” of dental and oral diseases that burdens some population groups. The report called for a national effort to improve oral health among all Americans. The Surgeon General recommended a national course of action that included enhancing the public’s understanding of the meaning of oral health and the relationship of the mouth to the rest of the body. The intent of the report was to increase awareness among policy makers and non-dental health professionals about the role oral health plays in obtaining overall good health. This message was heard at the Kansas oral health planning sessions and is reflected in the Kansas State Plan.

Another set of national oral health benchmarks is Healthy People 2010. Healthy People 2010 is a comprehensive nationwide set of health indicators developed by the Center for Disease Control, the Health Resources and Services Administration, the Indian Health Service and the National Institutes of Health. Healthy People 2010 includes seventeen oral health objectives that are summarized in the table on the next page. Although Kansas does not collect data on all of the objectives, Healthy People 2010 still can be used as a target for many oral health indicators in our state.
# National Oral Health Indicators

### Healthy People 2010 Oral Health Indicators, Target Levels, and Current Status in the United States and Kansas

<table>
<thead>
<tr>
<th>Healthy People 2010 Objective</th>
<th>Target</th>
<th>U.S. Status</th>
<th>Kansas Status</th>
</tr>
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<tbody>
<tr>
<td><strong>21-1: Dental caries experience</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Young children, ages 2-4</td>
<td>11%</td>
<td>18%</td>
<td>DNC&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Children, ages 6-8</td>
<td>42%</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Adolescents, age 15</td>
<td>51%</td>
<td>61%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-2: Untreated caries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young children, ages 2-4</td>
<td>9%</td>
<td>16%</td>
<td>DNC</td>
</tr>
<tr>
<td>Children, ages 6-8</td>
<td>21%</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>Adolescents, age 15</td>
<td>15%</td>
<td>20%</td>
<td>DNC</td>
</tr>
<tr>
<td>Adults, ages 35-44</td>
<td>15%</td>
<td>27%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-3: Adults with no tooth loss, ages 35-44</strong></td>
<td>42%</td>
<td>31%</td>
<td>66%</td>
</tr>
<tr>
<td><strong>21-4: Edentulous (toothless) older adults, ages 65-74</strong></td>
<td>20%</td>
<td>26%</td>
<td>21%</td>
</tr>
<tr>
<td><strong>21-5: Periodontal diseases, adults ages 35-44</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gingivitis</td>
<td>41%</td>
<td>48%</td>
<td>DNC</td>
</tr>
<tr>
<td>Destructive periodontal diseases</td>
<td>14%</td>
<td>22%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>3-6: Oral cancer mortality rates (per 100,000 persons)</strong></td>
<td>2.7</td>
<td>3.0</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>21-6: Oral cancer detected at earliest stage</strong></td>
<td>50%</td>
<td>35%</td>
<td>37.6%&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>21-7: Oral cancer exam in past 12 months, age 40+</strong></td>
<td>20%</td>
<td>13%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-8: Dental sealants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, age 8 (1st molars)</td>
<td>50%</td>
<td>23%</td>
<td>34%</td>
</tr>
<tr>
<td>Adolescents, age 14 (1st &amp; 2nd molars)</td>
<td>50%</td>
<td>15%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-9: Population served by fluoridated water systems</strong></td>
<td>75%</td>
<td>62%</td>
<td>62.5%</td>
</tr>
<tr>
<td><strong>21-10: Dental visit within past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, age 2+</td>
<td>56%</td>
<td>44%</td>
<td>73%</td>
</tr>
<tr>
<td>Adults, ages 18+</td>
<td>56%</td>
<td>44%</td>
<td>70%</td>
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<tr>
<td><strong>21-11: Dental visit in past 12 months, adults in long-term care</strong></td>
<td>25%</td>
<td>19%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-12: Preventive dental care in past 12 months, low-income children and adolescents, age 0-18</strong></td>
<td>57%</td>
<td>20%</td>
<td>34%</td>
</tr>
<tr>
<td><strong>21-31: School-based health centers with oral health components, K-12</strong></td>
<td>NA&lt;sup&gt;3&lt;/sup&gt;</td>
<td>NA</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-14: Community based health centers and local health departments with oral health components</strong></td>
<td>75%</td>
<td>34%</td>
<td>DNC</td>
</tr>
<tr>
<td><strong>21-15: States with system for recording and referring infants with cleft lip and palate</strong></td>
<td>100%</td>
<td>23%</td>
<td>DNC</td>
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<tr>
<td><strong>21-16: States with an oral health surveillance system</strong></td>
<td>100%</td>
<td>NA</td>
<td>100%</td>
</tr>
<tr>
<td><strong>21-17: State and local dental programs with a public health trained director</strong></td>
<td>100%</td>
<td>NA</td>
<td>100%</td>
</tr>
</tbody>
</table>
# Appendix A

**Kansas Oral Health Summit Attendees**

February 23, 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Position</th>
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<tbody>
<tr>
<td>Yvette Alphonse</td>
<td>Sunflower Foundation</td>
</tr>
<tr>
<td>Graham Bailey</td>
<td>Blue Cross Blue Shield of Kansas</td>
</tr>
<tr>
<td>Jessica Barr</td>
<td>Oral Health Kansas</td>
</tr>
<tr>
<td>Mary Baskett</td>
<td>Kansas Head Start Association</td>
</tr>
<tr>
<td>Chris Bergkamp</td>
<td>Kansas Foundation for Medical Care</td>
</tr>
<tr>
<td>Barbara Berry</td>
<td>Junction City-Geary County Health Department</td>
</tr>
<tr>
<td>Diane Brunson</td>
<td>Dental Director, State of Colorado</td>
</tr>
<tr>
<td>DeWayne Bryan</td>
<td>Pratt Health Foundation</td>
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<tr>
<td>Kevin Cassidy</td>
<td>Dentist</td>
</tr>
<tr>
<td>Eldonna Chesnut</td>
<td>Johnson County Health Department</td>
</tr>
<tr>
<td>Barbara Conant</td>
<td>Kansas Department on Aging</td>
</tr>
<tr>
<td>Denise Curtis</td>
<td>Kansas Association for the Medically Underserved</td>
</tr>
<tr>
<td>Janette Delinger</td>
<td>Kansas Dental Hygienists’ Association Legislative Chair</td>
</tr>
<tr>
<td>Debbie Donaldson</td>
<td>Sedgwick County Health Department</td>
</tr>
<tr>
<td>Bill Donigan</td>
<td>Dentist</td>
</tr>
<tr>
<td>Dawn Donnes</td>
<td>REACH Healthcare Foundation</td>
</tr>
<tr>
<td>Wanda Droge</td>
<td>Delta Dental Foundation of Kansas</td>
</tr>
<tr>
<td>Jane Faubion</td>
<td>Kansas Association for the Medically Underserved</td>
</tr>
<tr>
<td>Karla Finnell</td>
<td>Kansas Association for the Medically Underserved</td>
</tr>
<tr>
<td>Karen Finstad</td>
<td>Delta Dental Foundation of Kansas</td>
</tr>
<tr>
<td>Shari Fleshman</td>
<td>Region VII Head Start</td>
</tr>
<tr>
<td>Charles Fox</td>
<td>Wichita State University College of Health Professionals</td>
</tr>
<tr>
<td>Janelle Garrison</td>
<td>Kansas Health Policy Authority</td>
</tr>
<tr>
<td>Farouq Ghouri</td>
<td>Office of Health Promotion, KDHE</td>
</tr>
<tr>
<td>Carla Gibson</td>
<td>REACH Healthcare Foundation</td>
</tr>
<tr>
<td>Barbara Gibson</td>
<td>Kansas Office of Local and Rural Health</td>
</tr>
<tr>
<td>Christina Gore</td>
<td>Dentist</td>
</tr>
<tr>
<td>Annette Graham</td>
<td>Central Plains Agency on Aging</td>
</tr>
<tr>
<td>Chrysanna Grund</td>
<td>Greeley-Wallace County Healthcare Foundation</td>
</tr>
<tr>
<td>Marcia Hawkes</td>
<td>Salina Health Education Foundation</td>
</tr>
<tr>
<td>Glenn Hemberger</td>
<td>President, Kansas Dental Association</td>
</tr>
<tr>
<td>Susan Hemberger</td>
<td>Registered Dental Hygienist</td>
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<tr>
<td>Mark Herzog</td>
<td>Dentist</td>
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<tr>
<td>Greg Hill</td>
<td>Kansas Dental Association</td>
</tr>
<tr>
<td>Liang Hong</td>
<td>University of Missouri – Kansas City College of Dentistry</td>
</tr>
<tr>
<td>Jennifer Hudson</td>
<td>Dentist, Prairie Star Health Clinic</td>
</tr>
<tr>
<td>Kathy Hunt</td>
<td>Extended Care Permit Dental Hygienists, KDHA</td>
</tr>
<tr>
<td>Name</td>
<td>Organization/Role</td>
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</tr>
<tr>
<td>Bonnie James</td>
<td>Junction City-Geary County Health Department</td>
</tr>
<tr>
<td>Catherine Johnson</td>
<td>Disability Rights Center</td>
</tr>
<tr>
<td>Jarrod Jones</td>
<td>Dentist</td>
</tr>
<tr>
<td>Craig Kaberline</td>
<td>Kansas Area Agencies on Aging</td>
</tr>
<tr>
<td>Jamey Kendall</td>
<td>Services for Children with Special Health Care Needs</td>
</tr>
<tr>
<td>Kim Kimminau</td>
<td>University of Kansas School of Medicine</td>
</tr>
<tr>
<td>Susan Krumm</td>
<td>Special Olympics Kansas</td>
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<tr>
<td>Christen Lacey</td>
<td>Registered Dental Hygienist</td>
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<tr>
<td>Sharon Lee</td>
<td>Southwest Blvd Family Services Clinic</td>
</tr>
<tr>
<td>Wayne Logbeck</td>
<td>KS Department of Social and Rehabilitation Services</td>
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<tr>
<td>Patricia Long</td>
<td>Oral Health Kansas</td>
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<tr>
<td>Marcia Manter</td>
<td>Office of Health Promotion, KDHE</td>
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<tr>
<td>Paula Marmet</td>
<td>Flint Hills Community Health Center</td>
</tr>
<tr>
<td>Lougene Marsh</td>
<td>Wichita State University, School of Dental Hygienists'</td>
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<tr>
<td>Denise Maseman</td>
<td>University of Missouri – Kansas City College of Dentistry</td>
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<tr>
<td>Michael McCunniff</td>
<td>Kansas Office of Oral Health</td>
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<tr>
<td>Dawn McGlasson</td>
<td>Bureau of Family Health, KDHE</td>
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<tr>
<td>Ilene Meyer</td>
<td>United Methodist Health Ministries Fund</td>
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<tr>
<td>Kim Moore</td>
<td>Bureau of Family Health, KDHE</td>
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<tr>
<td>Brenda Nickel</td>
<td>Health Ministries Clinic</td>
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<tr>
<td>Tina Payne</td>
<td>Dentist</td>
</tr>
<tr>
<td>Jan Pishny</td>
<td>Dentist, Salina Health Center</td>
</tr>
<tr>
<td>Tim Pivonka</td>
<td>Community Health Center of SE Kansas</td>
</tr>
<tr>
<td>Krista Postai</td>
<td>Kansas Dental Association</td>
</tr>
<tr>
<td>Kevin Robertson</td>
<td>Kansas Department of Health and Environment</td>
</tr>
<tr>
<td>Howard Rodenberg</td>
<td>Extended Care Permit Dental Hygienist</td>
</tr>
<tr>
<td>Susan Rodgers</td>
<td>Oral Health Kansas</td>
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<tr>
<td>Teresa Schwab</td>
<td>Kansas Health Care Association</td>
</tr>
<tr>
<td>Letty Seidl</td>
<td>Kansas Office of Oral Health</td>
</tr>
<tr>
<td>Caron Shipley</td>
<td>Chief Dental Officer, Army Nation Guard</td>
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<tr>
<td>Jason Showman</td>
<td>Kansas Office of Oral Health</td>
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<tr>
<td>Maggie Smet</td>
<td>Smiles Change Lives Foundation</td>
</tr>
<tr>
<td>LeAnn Smith</td>
<td>Community Health Center of SE Kansas</td>
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<tr>
<td>Douglas Stuckey</td>
<td>KU Medical Center - Wichita</td>
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<tr>
<td>Joyce Tibbals</td>
<td>Jones Foundation</td>
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<tr>
<td>Sharon Tidwell</td>
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<tr>
<td>James Trotter</td>
<td>Tobacco Use Prevention Program, KDHE</td>
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<tr>
<td>Becky Tuttle</td>
<td>Health Options for Kansas Communities</td>
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<tr>
<td>Lourdes Vazquez</td>
<td>Dentist, Head Start</td>
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<tr>
<td>Lawrence Walker</td>
<td>KS Department of Social and Rehabilitation Services</td>
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<tr>
<td>Carolyn Weinhold</td>
<td>Kansas Office of Oral Health</td>
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<tr>
<td>Katherine Weno</td>
<td>Kansas Action for Children</td>
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<tr>
<td>Suzanne Wikle</td>
<td>EDS</td>
</tr>
<tr>
<td>Ruth Williams</td>
<td>Kansas Dental Board</td>
</tr>
</tbody>
</table>
Appendix B

References

Workforce

2. 2005 American Dental Association Workforce Data, www.ada.org
5. http://dentistry.umkc.edu/

Financing Oral Health for Underserved Populations

COMMUNITY AND PUBLIC HEALTH


CHILDREN’S ORAL HEALTH

5. www.kacerra.org
6. CDHP Issues Brief, Early Childhood Caries Trends Upward www.cdhp.org

NATIONAL ORAL HEALTH INDICATORS

2. www.healthypeople.gov
3. DNC = Do Not Collect
4. Oral cancer data includes lip/oral cavity/pharynx
5. NA = Not Applicable
As the state’s environmental protection and public health agency, KDHE promotes responsible choices to protect the health and environment for all Kansans.

Through education, direct services and the assessment of data and trends, coupled with policy development and enforcement, KDHE will improve health and quality of life. We prevent illness, injuries and foster a safe and sustainable environment for the people of Kansas.