Approved: 02/12/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on January 13, 2009, in Room 136-N of the Capitol. Senator Barnett welcomed all staff and public attending the first 2009 meeting of the Senate Public Health and Welfare Committee.

All members were present.

Committee staff present:
Jan Lunn, Administrative Assistant
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes

Conferees appearing before the committee:
Joe Tilghman, Board Chairman, Kansas Health Policy Authority
Marcia Nielson, PhD, MPH, Executive Director, Kansas Health Policy Authority
Andy Allison, PhD, Deputy Director and Medicaid Director, Kansas Health Policy Authority

Others attending:
Approximately 25 members of the public.

Senator Wysong moved introduction of a bill that would prohibit smoking in indoor areas statewide. Senator Colyer seconded the motion; the motion passed unanimously.

Chairman Barnett recognized Joe Tilghman, Board Chairman, Kansas Health Policy Authority (KHPA), who spoke regarding the Kansas Health Policy Authority's 2008 accomplishments; the state employee health benefit plan; and the 2009 statewide initiatives (Attachment 1).

Dr. Marcia Nielson, Executive Director of the Kansas Health Policy Authority, provided a brief history of the Kansas Health Policy Authority and its programs. She reported that during 2008, the KHPA was able to progress in advancing the KHPA mission, to progress in developing a statewide health policy agenda, and to recommend 2009 health policy initiatives. During 2009, the KHPA intends to build on 2008 progress, to reform the state's Medicaid program that will improve overall cost initiatives, to provide increasing amounts of data and information to consumers/policyholders, and to advance health policies that will increase the affordability of health care in Kansas while improving the overall health of Kansans (Attachment 2).

Several questions were raised relative to KHPA's statistics on its stress management program for state employees, what changes were made in the employer contribution rate for dependent coverage resulting in a cost increase from 45 percent to 55 percent, whether information is available regarding high tobacco taxes and no smoking bans and whether health costs have be reduced in states that have these programs, and what is included in the governor's budget related to KHPA. Dr. Neilson indicated statistics and answers to the questions posed would be forwarded to committee members.

Dr. Andy Allison provided two handouts: "Summary of 2008 Medicaid Transformation," and "Medicaid Transformation Process: Executive Summary" (Attachments 3 and 4). Dr. Allison updated committee members attending on Kansas' Medicaid background; reducing cost growth; Medicaid spending by service and population; improving program integrity, improving payments to hospitals, saving administrative dollars, improving provider reimbursement, and expanding web-based services. He discussed challenges in the short- and long-term, and presented information regarding the Medicaid Transformation Process. This process contains objectives to improve cost-effectiveness, to achieve savings, to develop and apply policy goals, and to increase the program's integrity. He stressed the importance of transparency in policy-making, involvement of stakeholders, data-driven decision making, and policy discussion continuity. KHPA "next steps" for transforming Medicaid in 2009 was outlined.

The next meeting is scheduled for January 14, 2009.

The meeting was adjourned at 2:28 p.m.

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KANSAS HEALTH POLICY AUTHORITY

Senate Public Health and Welfare Committee
January 13. 2009
Kansas Health Policy Authority's 2008 Highlights

Good morning Mr. Chairman, Mr. Vice Chairman, and members of the Committee. I am Joe Tilghman, a retired regional administrator for the Centers for Medicare and Medicaid and the new chairman of the Kansas Health Policy Authority Board. I appreciate the opportunity to update the Senate Public Health and Welfare Committee regarding the Kansas Health Policy Authority's progress this year. I will share with the Committee a short list of accomplishments of KHPA during 2008. Dr. Nielsen will be providing additional detail on the agency's health reform agenda. I'd like to highlight some important achievements by various units of the agency. Additional information will be provided to the Committee as part of the 2009 Annual Report.

Medicaid/HealthWave

- **Reformed Disproportionate Share Hospital (DSH):** The Center for Medicare and Medicaid Services approved a plan submitted by the KHPA to pay hospitals for treating indigent patients. The former payment method resulted in Kansas hospitals receiving $22.2 million of available Federal funding for Medicaid DSH payments in fiscal year 2007. With the reforms, the DSH program will provide at least $26.5 million in Federal matching funds annually.
- **Increased Efficiencies by Using Standard Medical Identification Cards:** In September 2008, KHPA discontinued the production and mailing of monthly paper medical ID cards and implemented a permanent medical ID card using recently developed national standards endorsed by the Workgroup for Electronic Data Interchange (WEDI). Kansas is the first State to make card information conform with the national advanced ID card technology standards.
- **Expanded Dental Care:** During the 2008 Legislative session, KHPA received approval to expand the dental program to pregnant mothers and offer preventive and restorative care, rather than just emergent dental care. Electronic billing for dental has increased to 80% as more dentists are taking advantage of the on-line billing option created by EDS. KHPA and UniCare employees volunteered at KMOM (Kansas Mission of Mercy) in Garden City assisting many needy Kansans received dental care.
- **Increased Enrollment in the *Working Healthy Program*:** An increasing number of people with severe developmental and physical disabilities are now enrolled in *Working Healthy*, a program that offers people with disabilities who are working or interested in working the opportunity to keep their Medicaid coverage while on the job. *Working Healthy* was also awarded a Medicaid Infrastructure Grant to support the competitive employment of individuals with disabilities for 2009.
- **Increased Efficiencies Through Document Imaging:** KHPA procured a document imaging system and began using this technology agency-wide to manage documents, making them more portable and accessible to all users.
- **Complied with Provider Identification Requirements:** KHPA implemented new state and federal requirements for submission of claims with National Provider Identifiers (NPI) and physician's NPA on all pharmacy claims submitted.

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State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

Public Health and Welfare
Date: 01/13/09
Attachment:

State Employee Health Benefit Plan

- **Made Health Care Coverage More Affordable:** The employer contribution rate for dependent coverage was increase from 45 percent to 55 percent.
- **Provided a Broad Range of Wellness Programs for State Employees:** Over 76,000 employees and dependents are eligible to participate in the wellness programs. Approximately 16,300 members took a personal health assessment and over 9,000 individuals participated in health screening events held across the state.
- **Implemented a Health Information Exchange Pilot Program:** The CareEntrust program was implemented in May, 2008 for 15 counties in the Kansas City Metropolitan area.
- **Honored by the Institute for Health and Productivity Management:** KHPA was named a winner of the 2008 *Value-Based Health (VBH) Award* by the Institute of Health and Productivity Management. The Institute recognized KHPA for innovative strategies in the 2009 state employee health plan that were designed to control costs promoting healthy lifestyles and personal responsibility.

Broad Agency Statewide Initiatives

- **Completed Plans to Implement Data Analysis Infrastructure:** The KHPA completed the Request For Proposals process and awarded the Data Analytic Interface (DAI) contract to Thomson Reuters. The agency expects to implement this comprehensive data system in the Fall of 2009.
- **Launched Online Health Consumer Search Tool:** The Kansas Health Online Consumer Transparency Portal (www.kansashealthonline.org) was launched in January 2008. It is dedicated to informing health consumers by empowering them with resources to stay healthy, manage their medical conditions, navigate the health system, health literacy, purchase health care, compare provider quality, and understand health policy.
- **Developed the Medical Home Model:** In the fall of 2008, the Kansas Health Policy Authority convened a stakehollder group to begin operationalizing the medical home model that was enacted by the Kansas Legislature in the 2008 legislative session. This process includes a broad array of providers, consumers, health plans, and business. The goal is to create a medical home model – or possible models -- for Kansas with incentives for payment reform.
- **Implemented the E-Health Advisory Council:** Together with Governor Sebelius, the KHPA made appointments to the E-Health Advisory Council. The Council will act in an advisory capacity to the Governor. It will explore options and make recommendations to leverage the state's purchasing power to promote the use of health information technology and provide recommendations on policy issues related to health information technology.
- **Chosen to Participate in the State Quality Improvement Institute**: Kansas, together with eight other states, was chosen to participate in the State Quality Improvement Institute—an intensive, competitive selection effort to help states develop and implement substantive action plans to improve performance across targeted quality indicators.

These achievements reflect the Board's focus on improving our programs to ensure that we provide high quality, cost effective health care to those we serve. The KHPA Board is proud of the achievements of the Kansas Health Policy Authority and I appreciate the opportunity to provide Senate Public Health and Welfare Committee an overview of them. You will hear more from Marci and Andy about anticipated KHPA activities in 2009 but I did want to inform the Committee that the Board received the OIG's resignation letter in November and will be discussing that staffing issue at our meeting next week.

I also want to express the sincere commitment of the KHPA Board to work with policymakers to address the difficult financial situation facing our state. We stand ready to work with the legislature and the in a collaborative fashion. This concludes my testimony and I am pleased to stand for questions. Thank you.

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Testimony on:
KHPA 2009 Health Reform Recommendations

Presented to:
Senate Public Health & Welfare Committee

By
Marcia J. Nielsen, Ph.D, MPH
Executive Director

January 13, 2009

For additional information contact:
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Public Health and Welfare
Date: 01/13/09
Attachment: 2

Senate Public Health & Welfare Committee
January 13, 2009

Good morning Mr. Chairman, Mr. Vice Chairman, and members of the Committee. I am Marcia Nielsen, and I serve as the Executive Director of the Kansas Health Policy Authority Board. I also served as the first KHPA Board Chair from fall 2005 to July 2006. Today I will share with the Senate Public Health and Welfare Committee excerpts from the 2008 KHPA Annual Report which will be approved by our Board next week (and subsequently electronically submitted to the legislature and provided publicly at our website www.khpa.ks.gov). I will also provide some additional information on our health reform priorities, and a brief overview of our early assessment of the Governor's budget.

KHPA History: As background, the Kansas Health Policy Authority was established by the legislature in 2005 with passage of S.B. 272. That bill established KHPA as a state agency within the executive branch of state government (K.S.A. 75-7401, et seq.). The bill called for forming a 16-member Board of Directors to govern the agency, including nine voting members appointed by the Governor, Speaker of the House and Senate President, as well as seven non-voting, ex-officio members. The seven ex-officio members include the secretaries of Health and Environment, Social and Rehabilitation Services, Administration and Aging; the director of health of the Department of Health and Environment, the state Insurance Commissioner and the Executive Director. In 2008, the Kansas legislature passed legislation designating the state Education Commissioner as an eighth ex-officio member. The board provides independent oversight and policymaking decisions for the management and operation of KHPA. The KHPA also answers to the Joint Committee on Health Policy Oversight.

KHPA Programs: KHPA administers the medical portions of Medicaid, the State Children's Health Insurance Program (SCHIP), HealthWave, the State Employee Health Plan and the State Self-Insurance Fund (SSIF), which provides workers compensation coverage for state employees. Our public insurance programs – Medicaid, SCHIP – provided medical coverage to more than 300,000 people last month (December). That includes more than 125,000 infants and children and nearly 88,000 elderly and disabled Kansans. The agency is also charged with gathering and compiling a wide array of Kansas health-related data that is used to guide policy development and inform the public. Certain Medicaid-funded long-term care services, including nursing facilities and Home and Community Based Services (HCBS) are managed on a day-to-day basis by the Kansas Department of Aging (KDOA) and the Kansas Department of Social Rehabilitation Services (SRS). These agencies also set policy for the Medicaid programs under their jurisdictions.

KHPA 2008 Annual Report: Although 2008 was a year of a faltering economy across the country, Kansas fared better than some other states. As 2009 begins, Kansas finds itself facing steep budget deficits and a growing number of Kansans in need. Despite the budget challenges facing the state, KHPA was able to make progress on a number of key initiatives, advancing the statutory mission of the KHPA to "develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies." The Board of Directors (the governing body for the agency) and staff also made significant progress with our statutory mandate regarding the "development of a statewide health policy agenda including health care and health promotion components." And as required, the annual report includes "recommendations for implementation of the health policy agenda recommended by the authority."

Our Board Chairman Joe Tilghman outlined several of the highlights of those efforts for you this morning. I

would like to underscore a few of those key initiatives.

Effective Purchasing and Administration of Health Care:

- **Developed the Medical Home Model of Delivery:** KHPA convened a stakeholder group to begin implementing the medical home model that was enacted by the legislature in 2008. This process included a broad array of providers, consumers, health plans and businesses. The goal is to create a medical home model – or possible models – for Kansas, with incentives for payment reform that will promote improved health outcomes and lower health care costs. *Transforming the health care system requires a significant change in the ways we coordinate care and reimburse providers for primary care and prevention.*

- **Improved Payments for Hospitals which Treat Low Income Patients:** The Centers for Medicare and Medicaid Services (CMS) approved a plan submitted by KHPA to pay hospitals for treating indigent patients. The former Disproportionate Share Hospital (DSH) payment method resulted in Kansas hospitals receiving $22.2 million of available federal funding for Medicaid DSH payments in Fiscal Year 2007. With the reforms, the DSH program will provide at least an additional $4.3 million in federal matching funds annually. *Legislators have asked us to maximize the use of federal dollars; this is a noteworthy priority in Kansas Medicaid and we have made several State Plan changes this year to do just that.*

- **Implemented a Health Information Exchange Pilot Program:** The Care Entrust program was implemented in May 2008 for state employees who live in15 counties in the Kansas City metropolitan area. This innovative employer-driven community health record gives consumers access to their health information and authority to share this information with providers of their choosing. We have an existing Medicaid community health record pilot on-going in Sedgwick County. *Expanding Health Information Technology is one of the most substantial ways to improve patient safety, health outcomes, and control rising health care costs.*

Regarding our focus on health promotion oriented public health strategies, the KHPA made progress on our goal being to improve the overall health status of Kansans and ultimately lower health care costs. Achievements includes:

Health Promotion Oriented Public Health Strategies:

- **Provided Wellness Programs for State Employees:** More than 76,000 employees and dependents are now eligible to participate in the wellness programs. Approximately 16,300 members took a personal health assessment and more than 9,000 individuals participated in health screening events held across the state. *In order to control health care costs in the long term, we need better manage our own health through improved health and wellness, and disease/care management. This will be an increased priority for Kansas Medicaid in the 2009.*

- **Launched Online Health Consumer Search Tool:** The Kansas Health Online Consumer Transparency Portal (www.kansashealthonline.org) was launched in January 2008. It is dedicated to informing health consumers by empowering them with resources to stay healthy, manage their medical conditions, navigate the health system, improve their health literacy, purchase health care, compare provider quality and understand health policy. *Legislators have us to promote personal responsibility for health behaviors and providing education is the first step.*

- **Honored by the Institute for Health and Productivity Management:** KHPA was named a winner of the 2008 *Value-Based Health (VBH) Award* by the Institute of Heath and Productivity Management. The Institute recognized KHPA for innovative strategies in the 2009 state employee health plan that were designed to control costs by promoting healthy lifestyles and personal responsibility. *Lawmakers expect us to integrate appropriate health promotion and disease prevention in all of the programs we manage – and to use best practices management to help control health care costs.*

The KHPA made impressive progress on advancing data driven health policy, particularly with the exhaustive review of the Kansas Medicaid program through the Medicaid Transformation process. In addition, the KHPA succeeded in the requirement to "develop and adopt health indicators and shall include baseline and trend data on the health costs and indicators in each annual report to the legislature."

Data Driven Health Policy:

- **Completed the 2008 Medicaid Transformation Process to reform Kansas Medicaid:** The KHPA completed 14 program reviews of the Kansas Medicaid Program and have scheduled a regular review schedule for 2009.The overall purpose of the 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, providing a concrete mechanism for professional Medicaid staff within the KHPA to actively recommend new policies. *Our goal is that well-founded, data-driven, and operationally sound Medicaid reform proposals may be advanced to the Board, the Governor, and the Legislature.*

- **Finalized and published Health Indicators:** The KHPA Board adopted a list of nearly 90 different measures which had been recommended by the Data Consortium, divided into four categories that are aligned with the KHPA Board's vision principles: Access to Care; Health and Wellness; Quality and Efficiency; and Affordability and Sustainability. These measures are presented as concise graphics and tables that show baseline and historical trends along with benchmark information for comparison to national and peer state data (see end of testimony for an example). In addition, statistical indicators are included which provide intuitive alerts signaling either the achievement of policy objectives or the need for policy intervention. *Our statute explicitly requires the KHPA to adopt health indicators and include baseline and trend data on health costs and indicators in each annual report submitted to the Kansas Legislature.*

- **Completed Plans to Implement Data Analysis Infrastructure:** This ambitious technology infrastructure development initiative aims to consolidate and manage health care data for several state programs managed by KHPA, including the Medicaid Management Information System, the State Employee Health Benefit Program, and the Kansas Health Insurance Information System, and allow analysis of health care based on episodes of treatment, disease management, predictive modeling, and the measure of cost and outcome effectiveness. This web-based tool is being designed to use public and private data to compare the health care service and utilization patterns, identify trends and areas for focus and improvement. *KHPA is charged with using and reporting data to increase the quality, efficiency and effectiveness of health services and public health programs.*

Finally, the Board and staff also made significant progress with our statutory mandate regarding the "development of a statewide health policy agenda including health care and health promotion components." Last year, the KHPA advanced a set of health reform recommendations that met with limited progress. Legislators asked us to prioritize our reform recommendations for 2009, and requested that we complete 20 studies on a variety of different topics; on 7 studies we worked in collaboration with other agencies. Those

studies have been completed and are being sent to the Legislative Coordinating Council today. In order to prepare our 2009 health reform priorities, we met with Kansans in 54 meetings across the state this summer to discuss their recommendations for moving a health agenda during these difficult budget times. Our reform recommendations are:

Coordinating Statewide Health Policy Agenda

- **Advancing a Statewide Clean Indoor Air Law:** An overwhelming number of studies confirm that smoking is the number-one preventable cause of death and illness in Kansas. Without such a ban, even those who wisely choose not to smoke are made to suffer from exposure to secondhand smoke. This is especially true for people who work in restaurants, bars and other establishments where smoking is allowed, as well as the customers who patronize those establishments. A statewide ban would protect the public from these harmful effects and send a strong social message that smoking in public is unacceptable. We strongly support the clean indoor air legislation being proposed by Senator David Wysong and the Senate Public Health Committee and stand ready to work with you on this common sense legislation that helps control care costs without spending scare state general fund dollars.

- **Increasing Tobacco User Fees:** KHPA is proposing a 95-percent increase in the state excise tax on tobacco. That would increase cigarette taxes by $.75 per pack – from $.79 to $1.54. This is based on findings that show a large amount of health care expense in the United States is directly attributable to smoking. The purpose of the tax is twofold: to make smoking more expensive, thus encouraging smokers to quit and discouraging non-smokers from ever starting; and to generate revenue to fund expansion of health insurance coverage. The budget impact will add $87.4 million in new revenue for FY 2010.

- **Expanding Access to Affordable Health Care and Public Health**: Using the tobacco user fee as funding, the KPHA is proposing to expanding Medicaid to cover all parents and caregivers with incomes below the federal poverty level; as well as other reform measures aimed at making insurance more affordable to small businesses and young adults, expanding access to cancer screening for low-income Kansans and providing tobacco cessation programs for Medicaid recipients.

KHPA Budget Challenges: As mentioned in testimony from Joe Tilghman, the KHPA Board has expressed a sincere commitment to work with policymakers to address the difficult financial situation facing our state. The Board and staff stand ready to work with the legislature and the Governor in a collaborative fashion. In order to cut costs, we have already begun our administrative belt-tightening, including: instituted a hiring freeze; implemented an out-of-state travel ban; placed limits on printing, communications, and training; and are in the process of reducing some of our contract expenditures.

Although we are still analyzing the specifics of the budget proposed by Governor Sebelius, her budget has not eliminated programs for beneficiaries or asked for reductions in provider reimbursement. She has called for a significant increase in salary dollars or "shrinkage" of more than 10% in FY 2010, and administrative cuts to the agency of 6.7% in FY 2010. We will provide our analysis of how the proposed budget impacts the KHPA in the coming days.

The Governor's budget does include many of the recommendations derived from the Medicaid Transformation process, and also includes two proposed program changes that the KHPA submitted to the Division of Budget in order to meet our reduced resource budget targets for FY 2010.

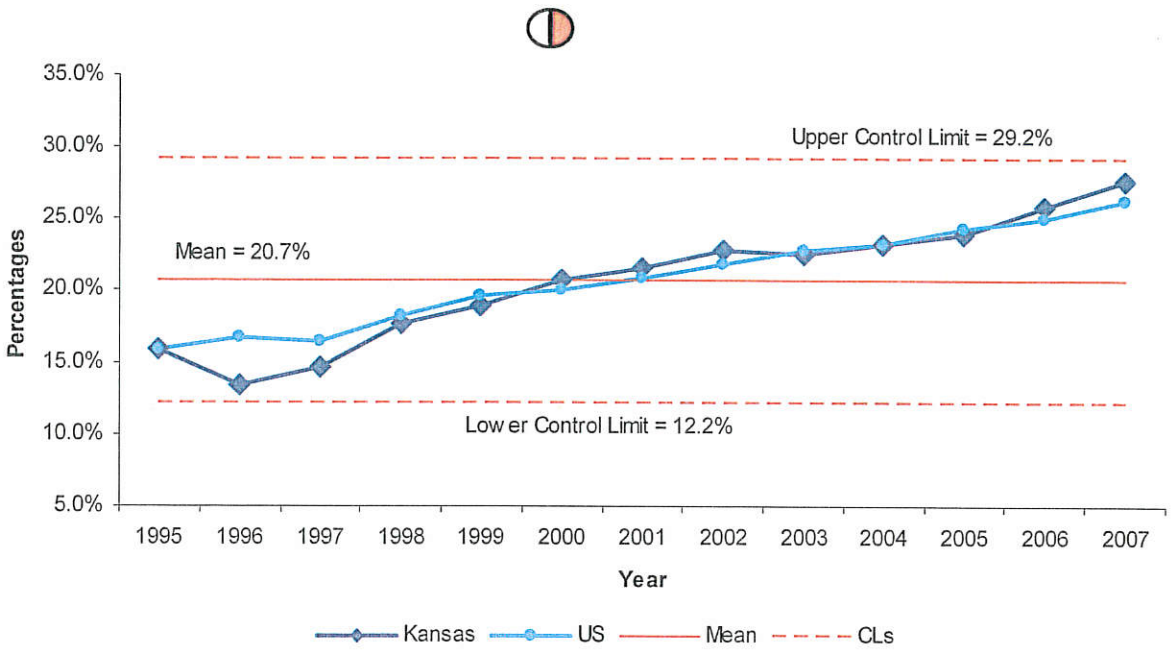
- **Expansion of the preferred drug list.** State law currently prohibits management of mental health prescription drugs dispensed under Medicaid. Under this proposal, that prohibition would be rescinded and KHPA will use the newly created Mental Health Prescription Drug (PDL) Advisory Committee to recommend appropriate medically-indicated management of mental health drugs dispensed under the Medicaid program. Over the past three fiscal years mental health drugs have been the highest drug expenditure by class of medications and the most-prescribed drugs by volume. This has led to cost growth in pharmacy services that exceeds growth in other services. Expenditures for mental health drugs increased from the previous fiscal year by more than $4 million in FY 2007. The KHPA is currently recruiting members for the mental health prescription drug advisory committee and begin development of the Preferred Drug List (PDL). In fiscal year 2010 will continue to expand the PDL and develop criteria for prior authorization of selected drugs. The KHPA proposal would begin using the mental health PDL in January of 2010 with an expected savings of $2,000,000, including $800,000 from the State General Fund in FY 2010.

- **Time limited MediKan.** The reduced resource proposal would place a firm "lifetime limit"on the receipt of MediKan benefits with no exceptions or hardship criteria. Also, using Working Healthy as a model, MediKan would be modernized by redirecting a portion of current expenditures to offer a package of services consisting of basic health care and employment services aimed at re-entry into the workforce and achieving self-sufficiency. MediKan currently provides health care coverage to persons with significant impairments, as determined by the Presumptive Medical Disability Team (PMDT), who do not meet the level of disability necessary to receive Medicaid and are unlikely to meet Social Security Disability criteria. However, people eligible for MediKan are required to pursue Social Security benefits as a condition of eligibility. Although a lifetime limit of 24 months currently exists in the MediKan program, the limit can be waived if the individual is still attempting to receive Social Security benefits, creating a "hardship exception." Almost 30% of the current MediKan caseload receives coverage under the hardship exception. The KHPA proposal estimated that applying the time limit and developing the modified services package would result in savings of $1.5 million from the State General Fund during FY 2010.

Summary: The KHPA believes that we can build from the progress we made in 2008. Beginning with the Medicaid Transformation plan, the KHPA intends to reform our Medicaid program to improve the overall cost-effectiveness of the program while preserving vital services to low income Kansans. Through several innovative initiatives, we are provide increasing amounts of data and information to consumers and policymakers, in order to empower individuals to make healthy choices, and provide lawmakers with needed data to inform health policy decisions. Finally, our goal continues to be to advance a health policy agenda that will not only make health care available to more Kansans but also improve the overall health of Kansans. This will help control the growth of health care costs in the future, an increasing important priority for the state.

Example of Data Indicator:

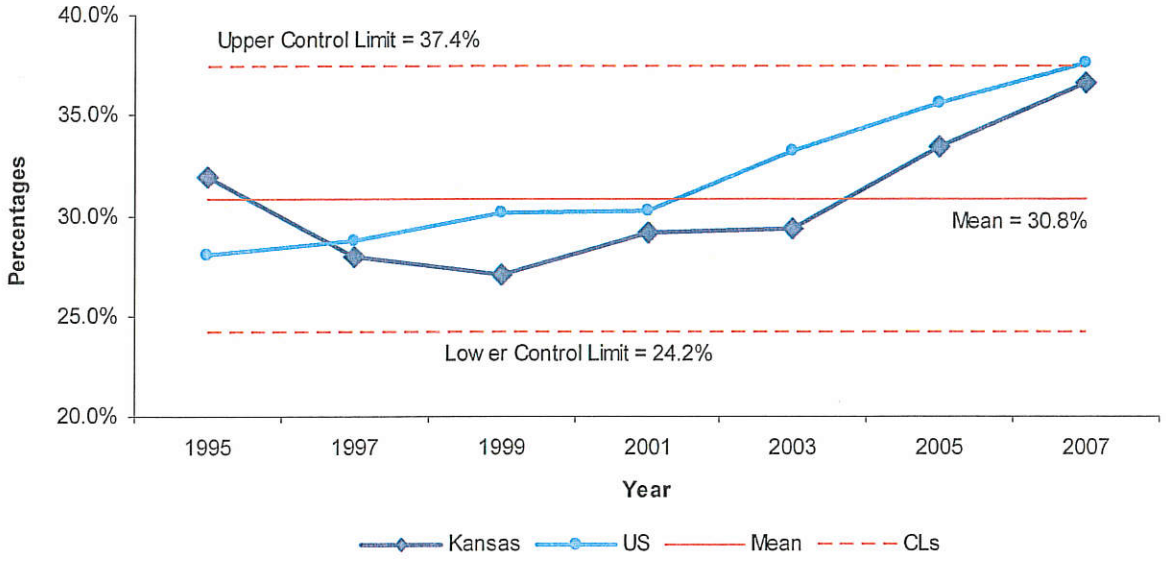
Percentage of Adults Who Are Obese



Source: Behavioral Risk Factor Surveillance System

Year	Data Kansas	US
1995	15.9%	15.9%
1996	13.4%	16.8%
1997	14.7%	16.5%
1998	17.7%	18.3%
1999	18.9%	19.6%
2000	20.8%	20.0%
2001	21.6%	20.9%
2002	22.8%	21.9%
2003	22.6%	22.9%
2004	23.2%	23.2%
2005	23.9%	24.4%
2006	25.9%	25.1%
2007	27.7%	26.3%

Percentage of Adults Who Were Tested and Diagnosed With High Blood Cholesterol



Source: Behavioral Risk Factor Surveillance System

Year	Data Kansas	US
1995	31.9%	28.1%
1997	28.0%	28.8%
1999	27.1%	30.1%
2001	29.2%	30.2%
2003	29.4%	33.2%
2005	33.4%	35.6%
2007	36.6%	37.6%

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Summary of 2008 Medicaid Transformation

Senate Public Health and Welfare Committee
January 13, 2009

Andy Allison, PhD
Medicaid Director and Deputy Director
Kansas Health Policy Authority

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Overview

- Brief update on Kansas Medicaid
  - Costs and trends
  - KHPA's successes
- KHPA's plan for managing Medicaid in a time of fiscal crisis
  - Identify savings through a comprehensive review of the program
  - Accomplish KHPA's core statutory mission through "effective purchasing and administration of health care"

2

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Update on Kansas Medicaid

3

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Kansas Medicaid: Background

- Medicaid is an optional program of federal matching payments for medical and long-term care
- Created along with Medicare in 1965
- Lots of federal strings attached
- Over half of Kansas' program is "optional"

4

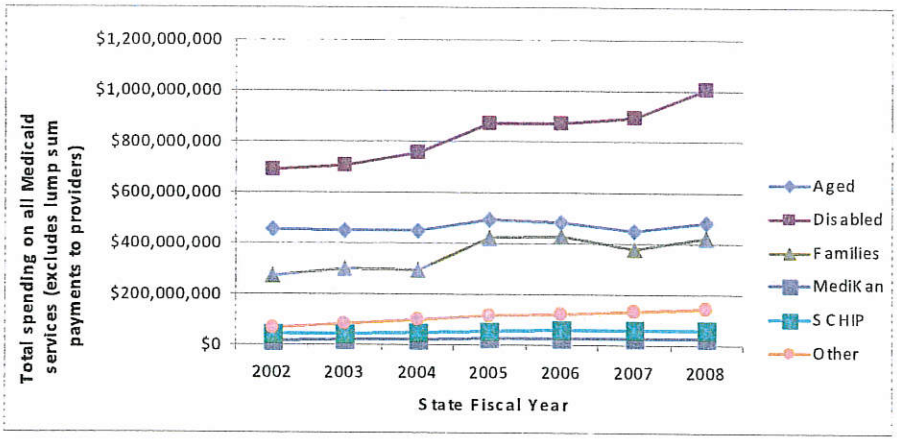
Kansas Medicaid: Reducing Cost Growth

- $2.5 billion in FY 2009 (all funds, all agencies)
  - KHPA Medicaid programs account for $1.3 billion
- *Historic growth of about 8.5% FY 1999-2009*
- *Recent growth of 3% FY 2004-2009*
- Projected annual growth of 5.5% in FY 2009
  - Enrollment growth of 2.2%
  - Costs per person up 3.2%

***Does NOT project impact of economic downturn

5

Kansas Medicaid: Spending by Population



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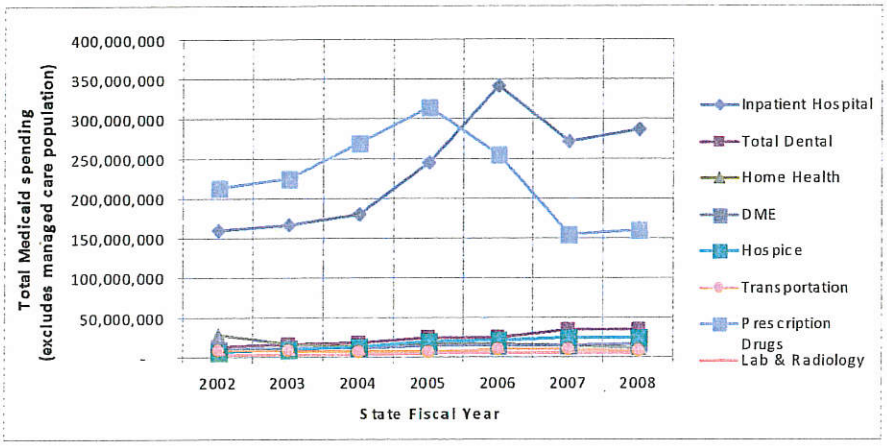
Kansas Medicaid: Spending by Service



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KHPA Medicaid "Successes"

- Improving "program integrity" and resolving federal disputes
  - *Resolution of Federal audits and deferrals*
- Adding competition to HealthWave through new contracts
  - *Rapid implementation of expanded managed care*
- Saving administrative dollars through smart reforms
  - *Conversion to standard ID cards*
- Expanded web-based services for beneficiaries
- Improving reimbursement for providers
  - *Additional federal dollars for KU School of Medicine in KC & Wichita*

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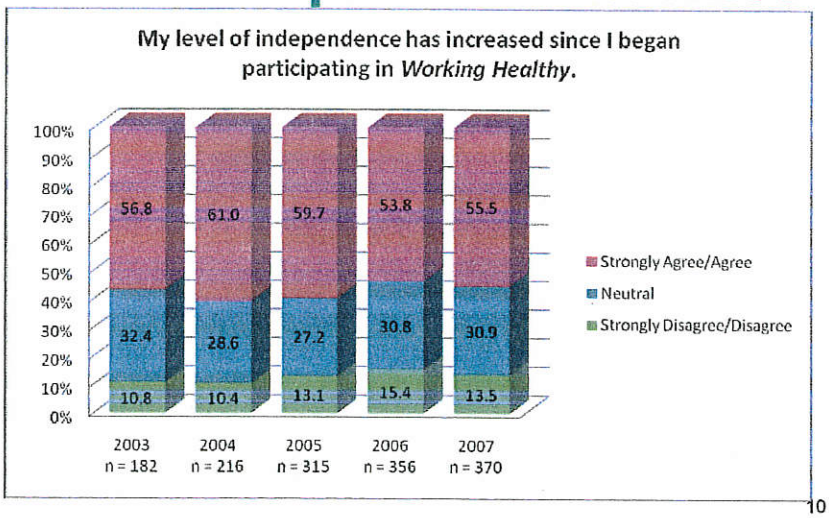
KHPA Medicaid "Successes"

- Improving reimbursement for safety net clinics
  - *Approved state plan amendment increases federally-matched Medicaid payments by $575,000 per year*
- Successful Medicaid Buy-In program to keep individuals in the workforce
  - *Working Healthy Program is a national model (see data)*
- Improving payments to hospitals that treat the low-income
  - *Disproportionate Share Hospital Payment (DSH) payment reform*
- Helping those applying for federal disability to get services with more federal dollars
  - *Implementing "Presumptive Medical Disability"*

9

Working Healthy: Improved Outcomes



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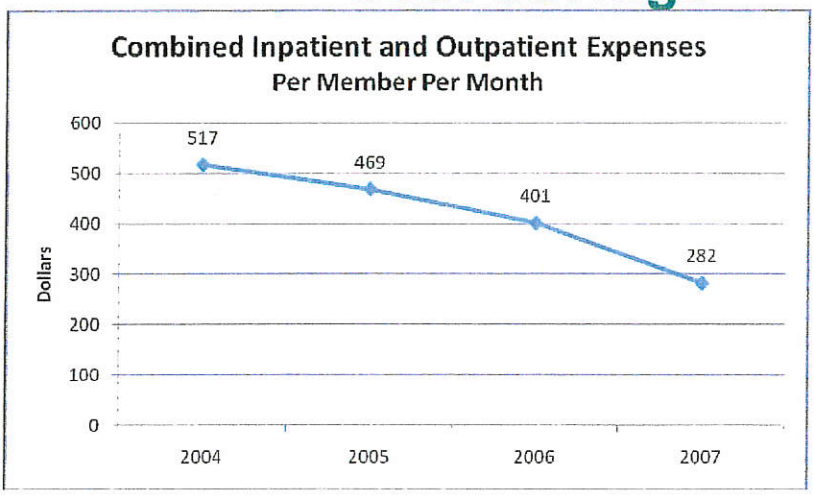
Working Healthy: Cost Savings



11

Kansas Medicaid: Challenges

- **Short run challenges**
  - *Steadily rising costs*
  - *Immediate need for savings*
  - *Major gaps in coverage*
  - *Address questions about program integrity*
- **Long-run challenges**
  - *Emphasize prevention and wellness*
  - *Address health costs*
  - *Increase quality of care*
  - *Ensure access*

Key question in KHPA's management of the Medicaid program…

→ How to meet these challenges?

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The Medicaid Transformation Process

13

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Transforming Medicaid: KHPA Objectives

- Comprehensive, written, data-driven review of the program to:
  - Improve cost-effectiveness
  - Achieve savings
  - Develop and apply policy goals
  - Increase program integrity

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Transforming Medicaid: KHPA Process Goals

- Transparent policy-making
  - Increasing Accountability
  - Disciplined evaluation
- Stakeholder involvement
  - Increasing scrutiny of agency decisions
  - More input and better ideas
- Data-driven decision-making
  - Explaining spending and health care trends
  - Applying program experience
- Continuity in policy discussions

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Transforming Medicaid: Comprehensive Program Reviews

- Evaluations by program staff, reviewed by senior management, approval by KHPA Board (Jan. 20th)
  - Over 40 staff directly involved in review teams
- 14 reviews completed in 2008
  - 8 specific services
  - 2 populations
  - 2 managed care programs
  - 2 over-arching reviews

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Transforming Medicaid: 2008 Reviews

- Roadmap for data driven Medicaid reform and cost efficiencies
  - Over 350 pages of description, data, analysis, and recommendations
- Program recommendations and budget savings
  - Initiatives for FY 2009-2010 Budget
  - Administrative initiatives
  - Revenue-dependent initiatives
- Areas for further study, management, and policy development

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2008 Transformation: Findings illustrate program successes

- Tighter policies have lowered costs and improved integrity of transportation services
  - *but program remains vulnerable*
  - *management resources are limited*
- Tighter program management has reduced spending on home health services
  - *but program policies allow for over-use*
  - *care should be better focused on addressing chronic disease*

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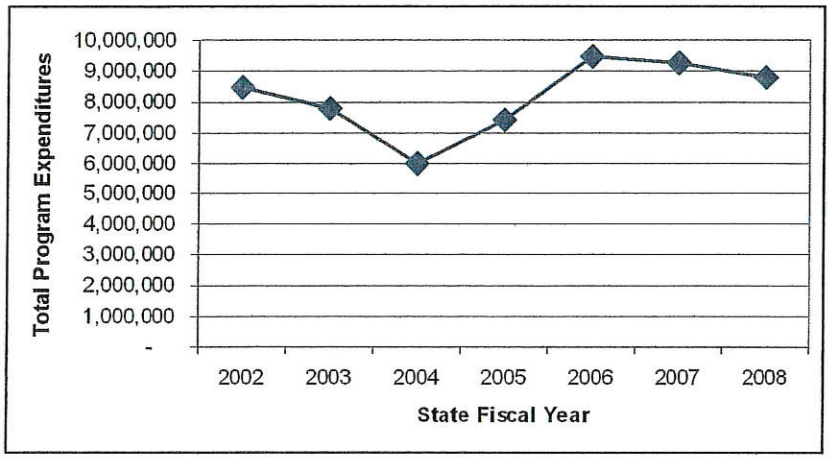
2008 Transformation: Curbing mis-use of transportation



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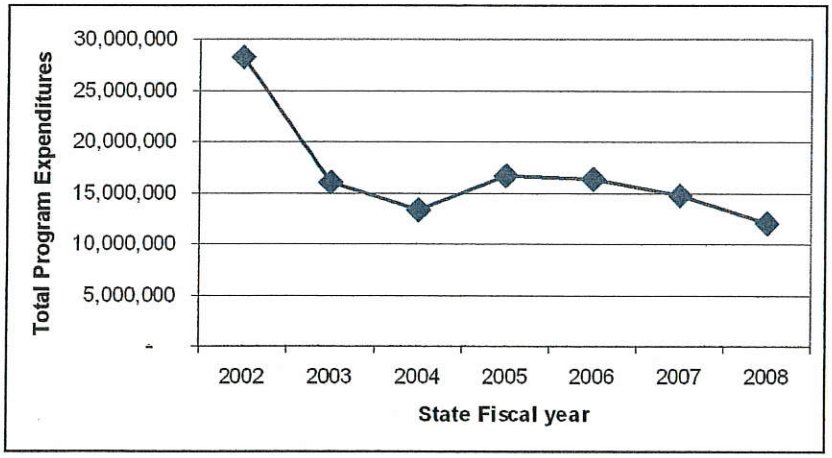
2008 Transformation: Curbing home health costs



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2008 Transformation: Opportunities for improved management and savings

- Pharmacy costs continue to rise faster than inflation and state revenues
  - *Some growth is due to reimbursement*
  - *Much of the growth is due to increased spending on mental health medications*
  - *Safety concerns mounting over the use of mental health medications in children and the elderly*
- Hospice costs have risen faster than any other Medicaid service
  - *driven in part by longer stays*

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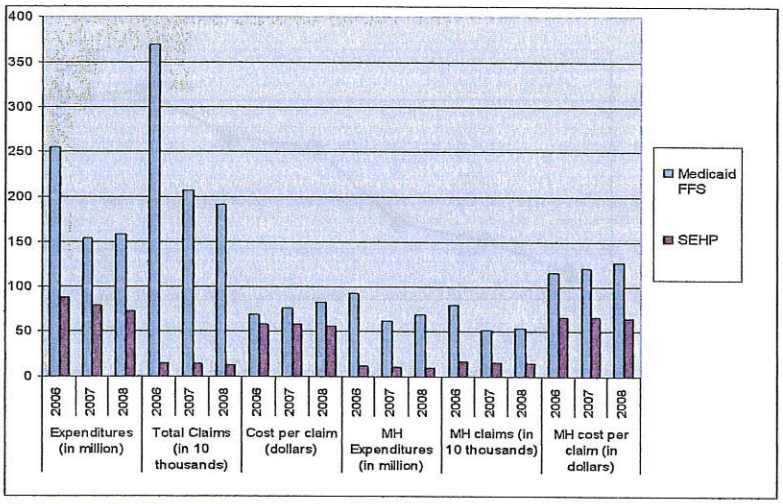
2008 Transformation: Pharmacy Claims in Medicaid v. SEHP



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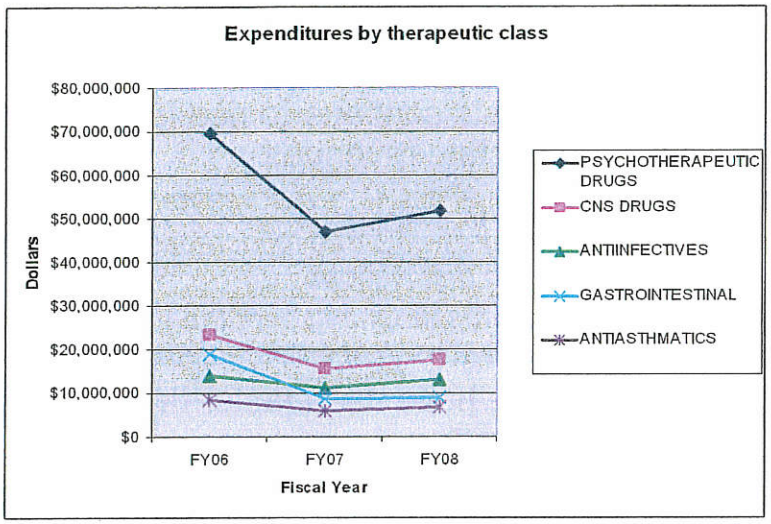
2008 Transformation: Need to Address Pharmacy



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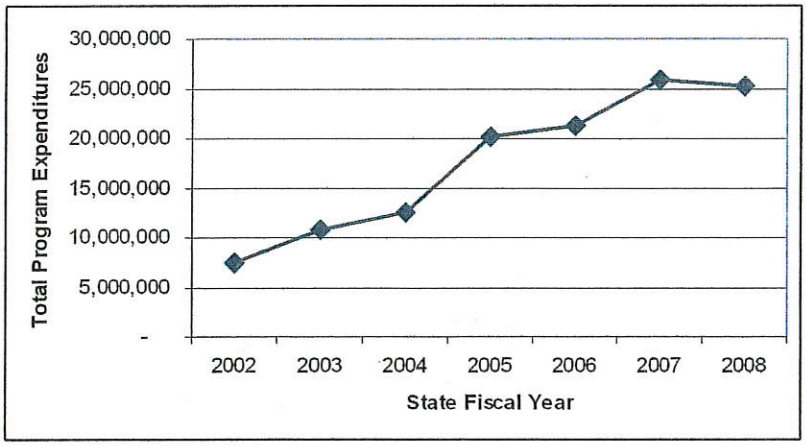
2008 Transformation: Hospice Costs Have Risen Dramatically



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Summary of 2008 Medicaid Transformation Recommendations

- Budget initiatives saving $11.7 million (SGF) over 5 years
  - Pharmacy management
  - Outreach initiatives
  - Quality data collection
- Administrative actions saving $16.6 million over 5 years
  - Outsource transportation services
  - Restructure and limit home health services
  - Scrutinize payments for new medical equipment
- Additional options for Board consideration

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Transforming Medicaid: Observations

- Comprehensive approach is imperative
  - But also difficult, disruptive, and time-consuming
- Creates accountability and improves policy-making
  - Lays bare what we know
  - Presents an alternative to speculative Medicaid reforms based on anecdote
- Grounds KHPA recommendations in data and documented experience
- Defines Transformation as a process

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Transforming Medicaid: Next steps

- Process has begun already for 2009 program reviews
- New topics for 2009
  - KHPA Medicaid operations, contract management, and program integrity
  - Medicaid mental health services (SRS)
  - Medicaid funding of health clinics (KDHE)
- Recommendations to Board in June 2009

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Medicaid Transformation Process: Executive Summary

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 re-

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.

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 (KEEP) have been identified as best practices by outside observers. The KEEP 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 increasing 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.

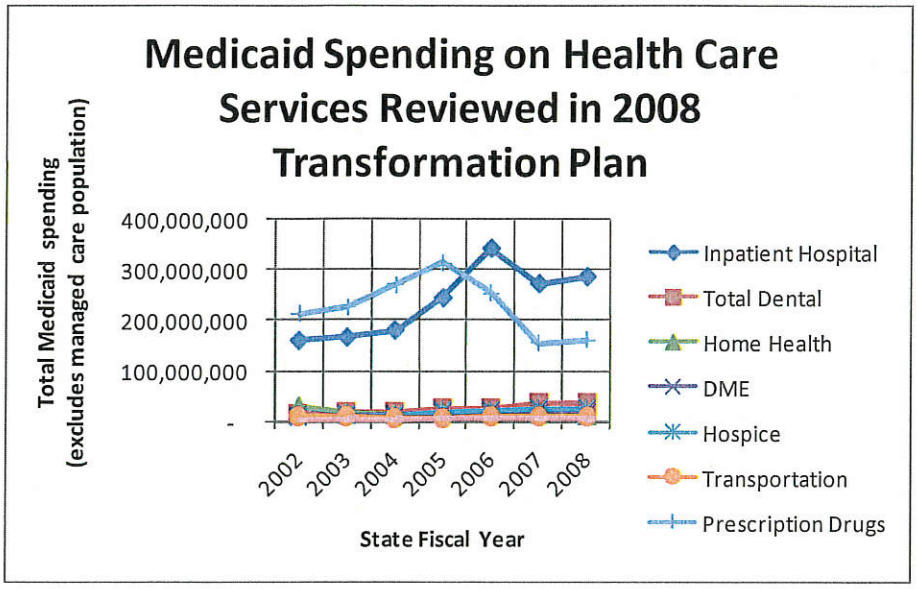
Transportation - Issue a request for proposal to outsource management and direct contracting for

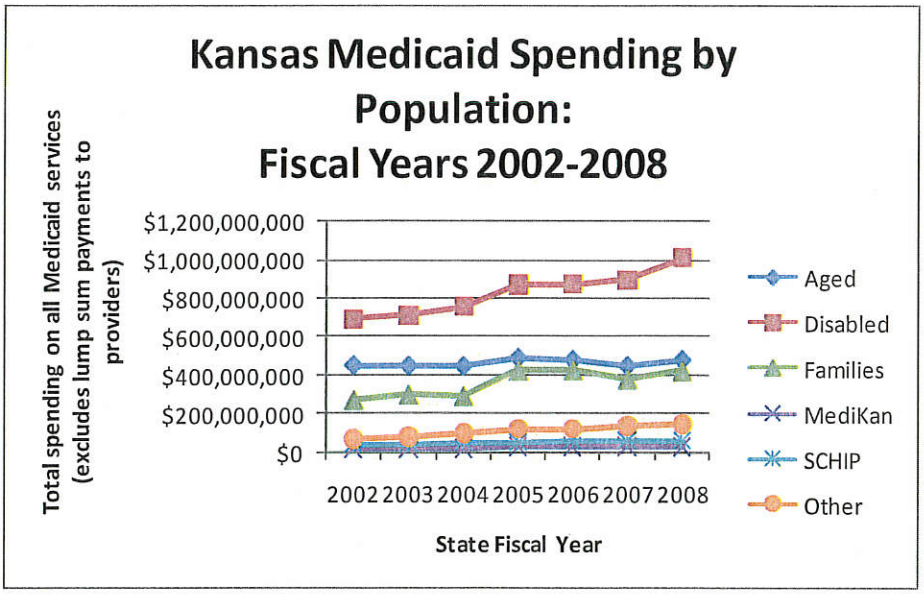
Medicaid transportation benefits to a private broker in order to increase scrutiny, right-size reimbursement, and generate modest net savings for the state.

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.

*** Same as Chapter 1 in full Medicaid Transformation Process document**


Medicaid Spending on Health Care Services Reviewed in 2008 Transformation Plan
Total Medicaid spending (excludes managed care population)
400,000,000
300,000,000
200,000,000
100,000,000
-
2002
2003
2004
2005
2006
2007
2008
State Fiscal Year
Inpatient Hospital
Total Dental
Home Health
DME
Hospice
Transportation
Prescription Drugs


Kansas Medicaid Spending by Population: Fiscal Years 2002-2008
Total spending on all Medicaid services (excludes lump sum payments to providers)
$1,200,000,000
$1,000,000,000
$800,000,000
$600,000,000
$400,000,000
$200,000,000
$0
2002 2003 2004 2005 2006 2007 2008
State Fiscal Year
Aged
Disabled
Families
MediKan
SCHIP
Other