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.

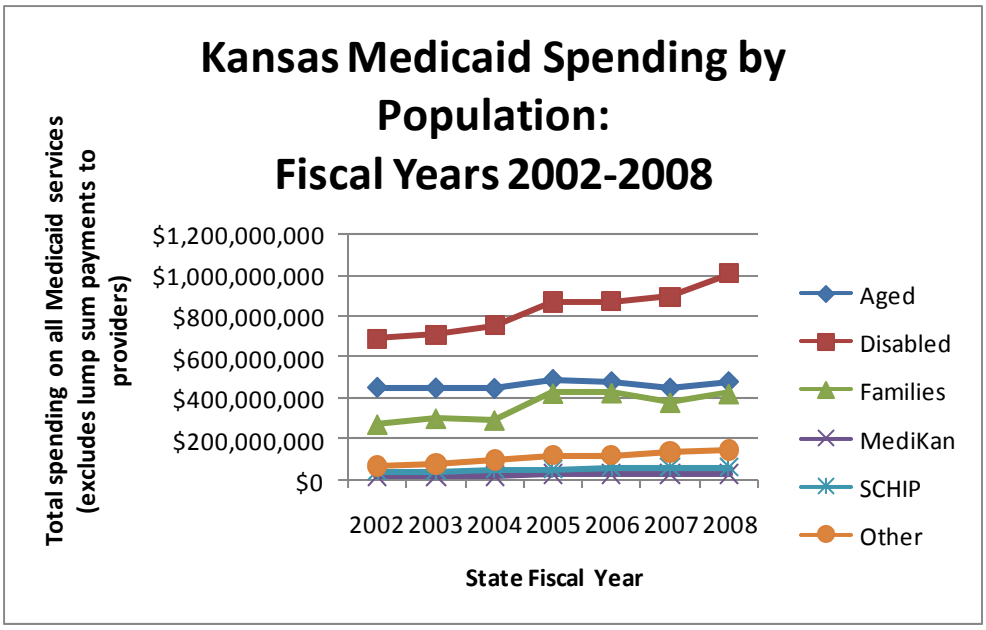
Background

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 **F**indings

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.

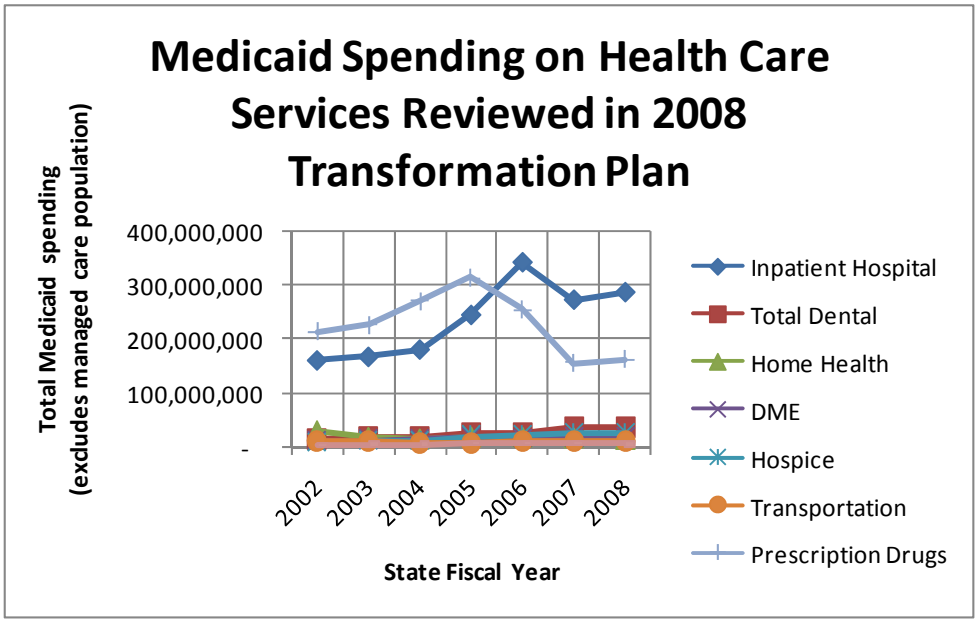


Medicaid fee-for-service expenditures in 2007 were approximately $250 million, with the aged and disabled population responsible for more than half. In January 2007, KHPA moved 50,000 low-income children and families from the fee-for-service HealthConnect program to the managed care HealthWave program. 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.



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.