

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.

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