Coordinating health & health care
for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Kansas Health Policy Authority

Medicaid Savings Options

Presented to the Kansas Legislature

March 1, 2010

INTRODUCTION

The state of Kansas faces an historic challenge to balance its budget while preserving the most critical safety net services for residents in need. On January 1, 2010, Governor Mark Parkinson issued a series of fiscal year 2010 budget allotments that included a ten percent reduction in payments to Medicaid service providers. Nevertheless, the budget is not yet balanced, and many would like to identify alternatives to the payment reductions that have already been made.

Since its inception in 2005, the Kansas Health Policy Authority has advanced transparent, participatory, interactive policymaking in the Medicaid program. Those efforts have included the 2009 and 2010 Medicaid Transformation initiative, which is designed to lay out clearly the state's health care purchasing and coverage policies, the rationale for those policies, trends in the program, and policy options. In each case, research is performed and a report is published to the KHPA website: http://www.khpa.ks.gov/program_improvements/default.htm: 22 are currently posted, with several additional reports to be published this month Options have been focused on reducing costs, improving quality, enhancing our level of program oversight.

Now, we have been asked to accelerate and summarize the search for program improvements and savings.

On February 18, 2010, the Kansas House and Senate both adopted Senate Substitute for House Bill 2222 (the "Rescission Bill") which adjusts the state Fiscal Year 2010 budget to align with current revenue projections.

Section 13 of that bill, which addresses funding for the Kansas Health Policy Authority, includes a proviso calling on the agency, "to evaluate and describe short-term and intermediate-term options, adjustments and improvements to the state medicaid plan and to the policies, contracts, waivers, procedures and other administrative actions to attain economies and efficiencies in the provision of aid and services under the state medicaid plan."

The proviso goes on to direct that, "in the development of plans for such short-term and intermediate term adjustments and improvements, the Kansas health policy authority shall consult with the governor, the secretary of aging, the secretary of social and rehabilitation services, the legislature, and, to the extent practicable and appropriate within the time available to develop such adjustments and improvements, representatives of persons and entities receiving or providing aid or assistance under the state medicaid plan: *Provided further*, That, in addition, during the regular session of the legislature in 2010, the Kansas health policy authority also shall consult with and report short-term and intermediate-term options, adjustments and improvements to the state medicaid plan to the senate committee on public health and welfare, the appropriate subcommittees of the senate committee on ways and means, the house of representatives committee on health and human services, the house of representatives committee on aging and long-term care, and the house of representatives social services budget committee, on or before March 1, 2010."

The following report represents KHPA's efforts to comply with that directive. In addition to policy options and initiatives developed through our own ongoing Medicaid Transformation process, we have consulted with other cabinet secretaries, the governor's office and legislative

caucuses of the House and Senate. In addition, we solicited input from Medicaid providers and beneficiaries through a web-based survey that generated dozens of thoughtful and useful suggestions.

Through that process we have identified several policy options for the legislature's consideration. To the extent possible, we have tried in each case to provide estimates of the cost savings of each option, as well as any start-up or administrative costs associated with the option and the methodology used to develop those estimates. Also, whenever possible, we have provided references to any studies, research or pilot projects related to the policy options, and examples of other states that have implemented similar policies. Due to the level of information available to KHPA, the time available to prepare this report, and the large number of ideas offered, most options lack a specific estimate of the expected impact on Kansas.

To help put these policy options in context, this report begins with brief summary of the Kansas Medicaid program and our own high-level analysis of cost trends in recent years and the factors which drive those costs. The report concludes with observations by KHPA staff regarding the options which appear most feasible to implement, those that would have an impact in the short term versus the longer run, and a brief list of options KHPA would recommend at this time. KHPA staff recommendations are not designed to meet a specific savings target, but instead reflect those items that appear most likely to offer efficiencies and improvements in care without a reduction in service.

KHPA stands ready to provide additional information to the legislature in order to support its deliberations on the Medicaid budget.

A note regarding longer-term savings initiatives

This document includes short- and intermediate term savings options. However, since its creation KHPA has also emphasized the longer-run goal of improving the health of Kansans through a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The most powerful strategies to lower health costs are those that reduce the need for the expensive health care treatments. These strategies entail an overall improvement in health status through prevention, public health efforts, and improved individual behaviors. Smoking, obesity, and inactivity explain a significant percentage of the growth in both Medicaid spending and overall health care spending. The KHPA Board's coordinated health policy agenda has always emphasized the value of public policies aimed at these behaviors. Last week the Legislature passed a clean indoor air bill. This legislation is likely to reduce Medicaid spending in the long run by decreasing the incidence of second-hand smoke. The bill may also reduce the incidence of smoking. Other options for improving the health of the state – and generating a proportionate reduction in Medicaid costs – include additional measures to deter smoking, improved nutrition in homes and schools, and increased physical activity among all Kansans, but especially among our children. Improvements in these areas sometimes entail difficult decisions affecting individual behaviors and liberties. KHPA stands ready to assist policymakers as they deliberate these issues.

KANSAS MEDICAID – THE BASICS

The Medicaid program in the United States was established in 1965 through the same piece of legislation that established Medicare. Medicare is generally thought of as the federal health insurance program for the elderly. Medicaid, on the other hand, is a joint federal-state program that provides health and long-term care for the poor.

The two programs were established as amendments to the Social Security Act. The statutes governing Medicare are generally found under Title XVIII of the act. Medicaid statutes are generally found under Title XIX of the act. For that reason, Medicaid programs often are also referred to as Title XIX programs.

Medicaid programs are primarily administered at the state level, and states have a certain amount of latitude to design their own programs as long as they meet minimum federal requirements and do not conflict with federal standards. There are certain mandatory populations that must be served in a state Medicaid program, and certain mandatory services that must be covered. But states have discretion to cover additional, optional populations and to provide additional optional services.

It is important to note, however, that once a state elects to provide optional services, or to serve optional populations, it must provide all of its services to all populations statewide, on a non-discriminatory basis. States may not provide optional populations with any more, or any less, service than it provides to the mandatory populations. The only exception to this rule is if the state receives a "waiver" from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees both programs.

The most notable examples of waivers that are used in Kansas are for Home and Community Based Services (HCBS). Under this program, the state provides in-home and outpatient health care and other personal assistance services to people who would otherwise qualify for placement in nursing homes. Kansas currently operates HCBS waiver programs for specific target populations: the frail elderly (FE); the physically disabled (PD); people with mental retardation or developmental disabilities (MR/DD); and people who suffer from traumatic brain injuries (TBI). Under the waiver granted to Kansas by CMS, the state can, and does, limit the number of people who can be enrolled in HCBS services at any given time. Whenever there are more people applying for HCBS services than there are slots available, applicants can either elect to receive nursing home care, or be placed on what is commonly called a "waiting list."

In 2006, administration of the Kansas Medicaid program was shifted to the newly created Kansas Health Policy Authority. KHPA now serves as the "single state Medicaid agency," meaning it is responsible for managing the programs, enrolling applicants and paying claims. KHPA has direct responsibility for administering the medical portions of Medicaid. The Department of Social and Rehabilitation Services directly administers HCBS programs under the PD and MR/DD waivers, while the Department on Aging directly administers long-term care provided by nursing homes and HCBS services under the FE waiver.

Financing

Nearly all health care services purchased through Medicaid are financed through a combination of state and federal matching dollars. In normal years, the federal government pays about 60 percent of the cost, and the state pays the remaining 40 percent. In 2009, the federal share was temporarily increased with passage of the American Recovery and Reinvestment Act (ARRA) as a way of providing fiscal relief to states during the economic recession. As of March 2010 the enhanced federal match rate is approximately 70 percent. The increased federal share is scheduled to expire in December 2010, after which time funding will return to the traditional 60-40 split.

The Federal government mandates certain minimum thresholds for eligibility and services that states must offer. Beyond that, the state is allowed to extend benefits and services at its option, sets reimbursement rates for providers of these services, and administers these benefits. It is important to note that Medicaid is an entitlement program, which means anyone who applies for services and meets the state's eligibility guidelines is entitled to receive services that the state offers. Thus, subject to the program the state chooses to offer, there is no upper limit on the costs that may be incurred by the program in any given year. While the entitlement nature of the program helps ensure that Medicaid remains a viable safety net program for the neediest populations, it also presents a significant challenge to policymakers and administrators in trying to control costs.

Medicaid Mandatory Populations

Under federal law, states that elect to participate in Medicaid must serve the following populations:

- Infants and children up to age 6 whose families earn less than 133% of the Federal Poverty Level (FPL) - $24,352 a year for a family of three
- Children, age 6 and older, in households with incomes below 100% FPL - $18,310 a year for a family of three
- Parents whose income is below the state's threshold to receive Temporary Assistance to Families (TAF). In Kansas, that is roughly 30% FPL – or $4,362 to $5,148 per year for a family of three, depending on the county of residence.
- Pregnant women with income up to 133% FPL.
- Elderly and disabled persons who receive Supplemental Security Income (SSI) with incomes at or below 74% FPL - $8,088 a year for an individual.
- Certain working disabled
- Medicare Buy-In groups: Qualified Medicare Beneficiaries (QMB); Special Low-Income Medicare Beneficiaries (SLMB); and Qualifying Individuals (QI).

Medicaid Mandatory Benefits

Under federal law, states that elect to participate in Medicaid must cover a minimum package of benefits:

Acute Care

- Physician services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-Qualified Health Center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Home health services, including durable medical equipment (DME)
- Transportation services

Long-Term Care

- Institutional services: Nursing facility (NF) services for individuals age 21 and over

State Children's Health Insurance Program (CHIP) and "HealthWave"

In 1997, Congress established a third major health care program known as the State Children's Health Insurance Program, or SCHIP. This program was established under Title XXI of the Social Security Act. The Kansas legislature elected to participate in the program in the following legislative session, and services were offered beginning in 1999. The purpose of the program is to provide low-cost coverage to uninsured children whose families earn too much to qualify for Medicaid. In 2009, Congress passed a bill to reauthorize and expand the program. In so doing, it also renamed the program as simply the Children's Health Insurance Program, or CHIP.

Like Medicaid, CHIP is jointly funded by the federal and state governments. In Kansas, the federal government pays about 72 percent of the cost, while the state pays the remaining 38 percent. Unlike Medicaid, however, CHIP is not an entitlement program. Instead, it is funded annually with a block grant to states, which means the state pays its share of the cost, up to the maximum amount of the block grant. If, in any given year, the total costs exceed the amount of block grant, the state must either pay 100 percent of the additional cost or cut off enrollment. So far, however, this has never happened in Kansas.

The term "HealthWave" began as the state of Kansas' brand name for SCHIP in Kansas. Early on, it was also administered differently than Medicaid. All children in HealthWave were enrolled in a managed care program. Under the managed care model, the state contracts out with Managed Care Organizations (MCOs) to provide the coverage and it pays the MCO's a flat, per-person (or "capitated") rate. The MCOs, in turn, make available their own network of providers to provide health care services.

In 2007, KHPA expanded the managed care model to include nearly all non-disabled children and families enrolled in Medicaid. This made it possible for families with members in both

programs (for example, a pregnant woman in Medicaid and a child in CHIP) to receive a seamless package of services with standardized benefits, regardless of whether they are enrolled in Medicaid or CHIP.

For this reason, "HealthWave" now refers to the blended program of managed care. It consists of HealthWave-19, referring to the Title XIX program (Medicaid), and HealthWave-21, referring to the Title XXI program (CHIP).

HealthWave-21 is now available to children up to age 18 who are uninsured and whose families earn less than 241% FPL. Families with children enrolled in the program pay a modest premium, ranging from $20 to $75 per-family per-month, depending on income. Premiums at higher levels of income are designed to ensure affordable coverage but discourage families from using CHIP in place of a private health plan.

HealthWave-21 is *not* available to children who are eligible for coverage under the State Employee Health Plan. For state employees who otherwise meet the income guidelines for HealthWave-21, the State Employee Health Plan offers *"HealthyKids,"* an optional form of coverage that is similar to HealthWave, but which receives no federal funding.

NATIONAL RANKINGS

The chart below shows how Kansas ranks nationally according to Kaiser Family Foundation data:

Kansas Ranking	Measurement	Comparison
42nd	Insurance coverage through Medicaid	13% of the Kansas population is covered by Medicaid
43rd	Eligibility for low-income parents	32% FPL, 42 States cover at higher FPL's
33rd	Coverage for low-income children	Ranked 33rd nationally at 241% FPL[1]; reflects CHIP coverage standards
t20th	Eligibility for low-income, non-disabled adults without children	19 States provide at least some benefits at 21-300% FPL; KS and 30 other States have no coverage at any level of income
7th	Home Health and Personal Care including HCBS waivers	52.9% of Medicaid spending is on these services in Kansas compared to 40.1% nationwide
43rd	Percent of SSI disabled as proportion of population	Kansas tied with Iowa at 1.5% of SSI disabled as a proportion of the population compared to a national average of 2.1%
22nd	Developmental Disability waiver enrollment	Ranked 22nd highest in the number of people enrolled nationally
6th	Frail Elderly waiver enrollment	Ranked 6th highest nationally in the number of people enrolled
3rd	Physical disability waiver enrollment	Ranked 3rd highest nationally in the number of people enrolled
14th	Traumatic brain injury waiver enrollment	Ranked 14th highest nationally in the number of people enrolled

COST AND POPULATION TRENDS IN KANSAS MEDICAID

In trying to identify areas of potential savings in Medicaid, it may be helpful to understand first where the money is being spent and services are driving the rising cost of Medicaid. This context should help the Legislature understand which policy options are most likely to slow the growth of Medicaid and produce the greatest amount of savings to the state.

Kansas Medicaid serves diverse groups of low-income residents: children; pregnant women; families; the aged and disabled. There is wide variation among these groups in the types of health care services they use, the cost of those services, and the rate of enrollment growth within each population.

[1] This ranking has been adjusted to reflect the January 2010 expansion1 of Kansas CHIP to 241% of poverty, and may not reflect recent changes in coverage in other states.

Costs by Population Category

Figure 1 demonstrates that the growth in expenditures over the last year cannot be explained by the growth in enrollment alone. While the number of people served by Medicaid has grown about 33% over the last decade (from about 210,000 to just over 300,000), total expenditures (All Funds) have nearly doubled, from $1.25 billion to $2.5 billion.

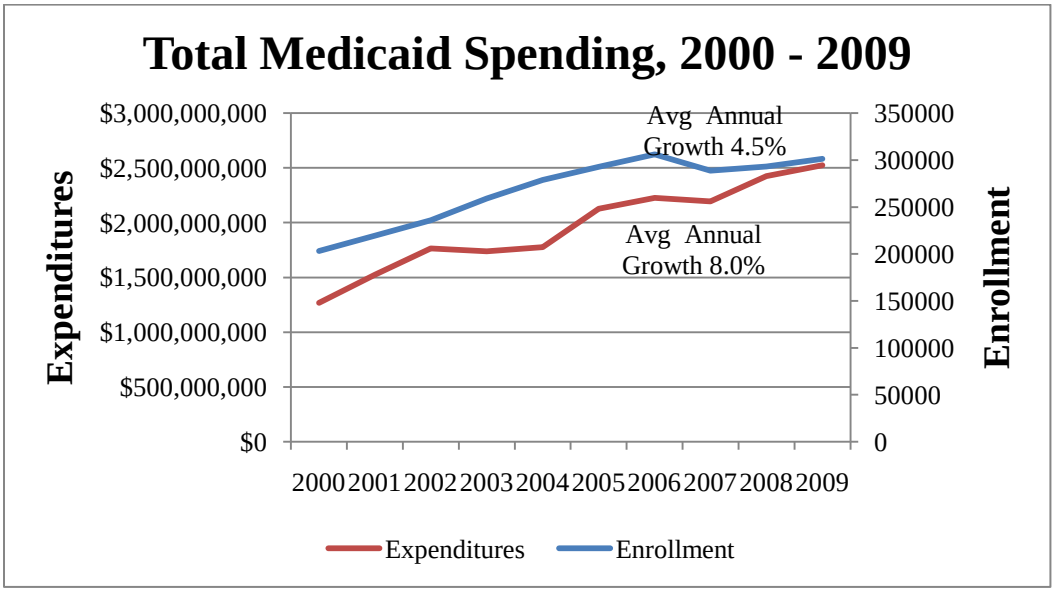

Figure 1

The pie charts in Figure 2 and Figure 3 show the wide variation in costs for the different population groups. In State Fiscal Year 2009, children and families in Medicaid accounted for half (51.9%) of the total population in Kansas medical assistance programs (including CHIP and MediKan), but they accounted for only 20.9% of total expenditures.

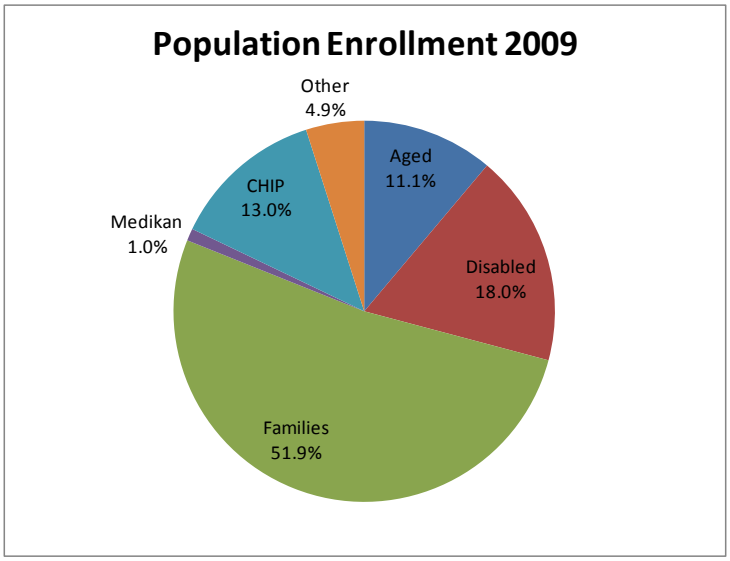

Figure 2

The elderly and disabled make up about 29% of the total population and account for 69% of the total cost.

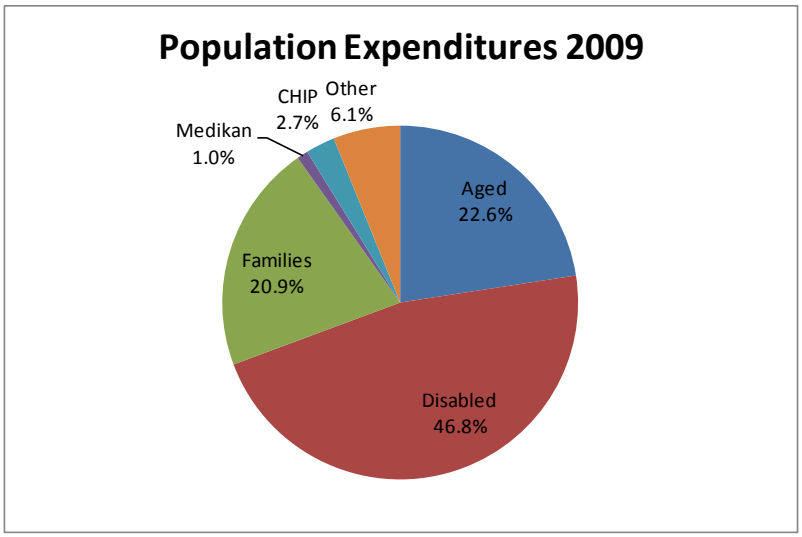

Figure 3

The reason for this is simple and largely self-evident. With notable exceptions, most non-disabled children and working-age adults are relatively healthy, and they typically require only routine, low-cost ambulatory services: check-ups, vaccinations, treatment for minor illnesses and injuries. The exception to that rule is the cost associated with labor and delivery services, as Medicaid covers approximately 40% of births in the state.

The aged and disabled tend to have many more complex and urgent health needs, and they generally utilize services that are more costly: surgery; physical and occupational therapy; mental health services prescription drugs in greater concentrations; cancer treatment; daily home and community-based care; nursing home care; hospice; and other kinds of end-of-life care.

The information in Figure 4 and Figure 5 show the wide variation in spending across these major population groups over the last five years. Among the aged population, enrollment grew 12.9 percent from 2005 to 2009, yet the cost of services for that population grew only 4.4 percent. Over that same period, enrollment among the disabled grew 15.1 percent and the total cost of services for that population grew 27.2 percent. Enrollment among low-income families actually declined by 5%, although expenditures for this population increased 18.7%. The decline in MediKan enrollment is most likely explained by the implementation of a "presumptive eligibility" process which redirected many of those beneficiaries into Medicaid (as presumptively disabled). New lifetime eligibility limits were established in 2009, but this change is not reflected in the data shown. Also not shown is the subsequent growth of Medicaid enrollment in FY 2010 of approximately 7,000-10,000 persons (to date). Given the economic downturn it is not surprising that most of the recent growth has been concentrated among

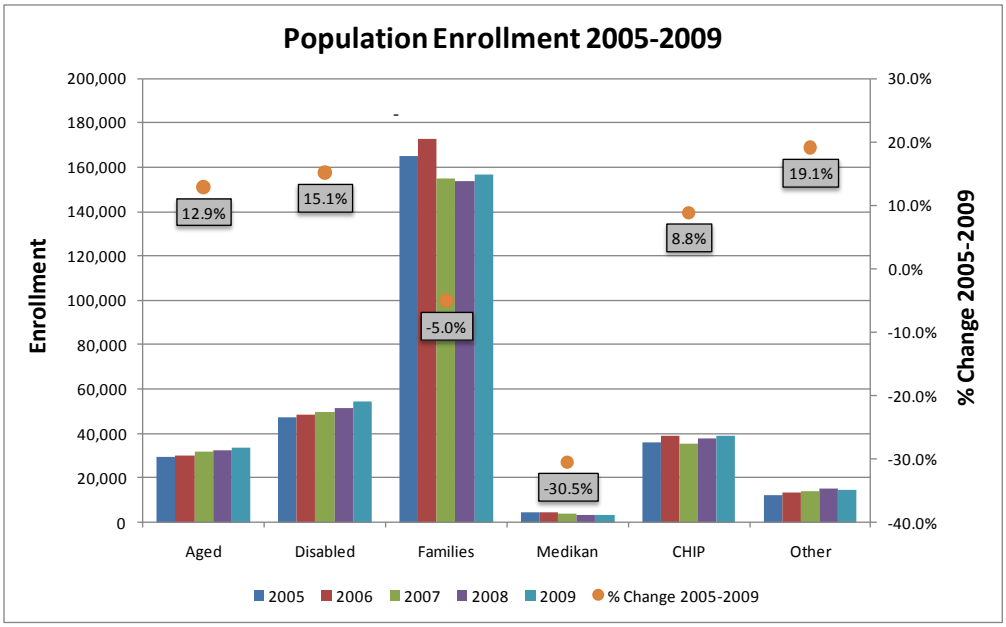

Figure 4

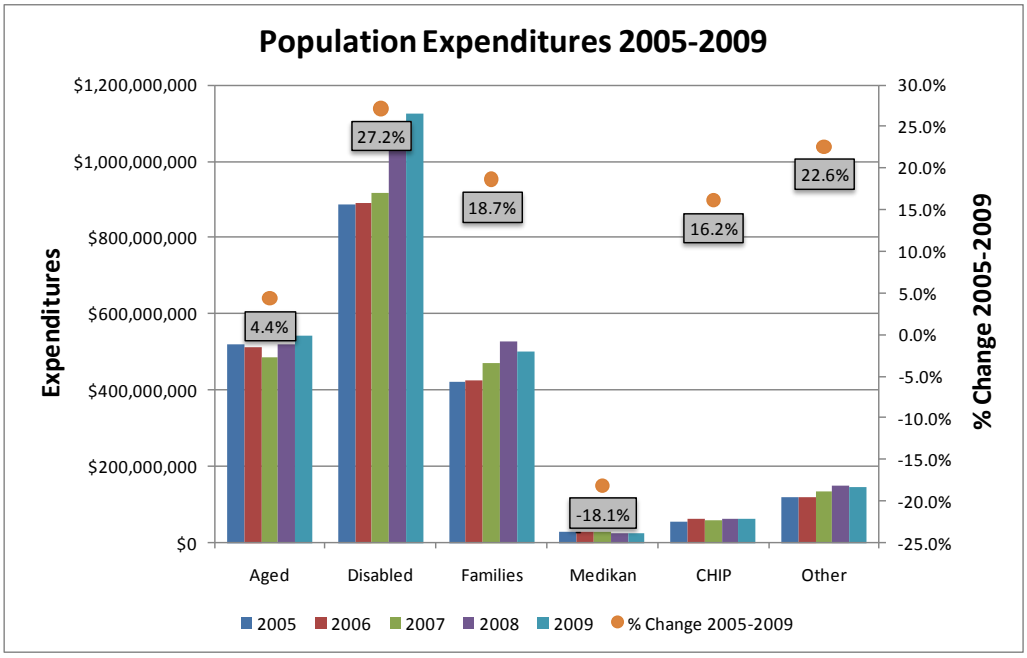

Figure 5

families and low-income children, but the number of disabled enrollees has also grown -- by about 2,000 – in the first seven months of FY 2010.[2] Overall costs among the CHIP population (HealthWave-21) grew 16.2%, and a little over half this growth is explained by the 8.8% rise in the number of children covered.

[2] The continuing growth of the disabled population is the subject of an ongoing Medicaid transformation program review by KHPA staff. Analysis is nearly complete and publication is expected in March 2010.

The information presented in Figure 4 and Figure 5 is highly suggestive of the sources of overall growth in Medicaid over the last five years, but does not identify those sources explicitly. Table 1 below shows the combined effect of enrollment and the cost of service within each population on the overall growth in cost of Kansas health care programs, and how much of the growth can be attributed to each factor. This is a relatively uncommon way to present information to policymakers, but the interpretation is straightforward. Each number in the table represents a percentage of the $414 million growth in Medicaid and SCHIP between 2005 and 2009. Negative numbers reflect a decline. For example, when looked at in isolation, increased enrollment among the aged explains 14.7% of the $414 million increase in Medicaid spending, but per-person costs fell among the aged, so on an overall basis the aged accounted for just 6.1% of the total increase in Medicaid spending during this period.

Table 1: Percent Contribution to Total Medicaid Cost Increase, by Population

Population	Enrollment Effect	Cost per Bene Effect	Total Effect Attributable to Sub-population
Aged	14.7%	-8.6%	6.1%
Disabled	38.1%	26.4%	64.5%
Families	-5.4%	26.6%	21.2%
Medikan	-3.5%	2.0%	-1.4%
CHIP	1.4%	1.0%	2.4%
Other	6.3%	1.0%	7.3%
All Populations	12.9%	87.1%	100.0%

From this, it is clear that the rising cost of Medicaid services is the single largest factor driving up the cost of state health care programs in Kansas: increases in enrollment explained about 13% of the growth, while increases in spending per person explained 87% (see totals at the bottom of the table). This view of the data also reveals that growth in spending for the aged and disabled accounts for nearly two-thirds (64.5%) of the total growth in Medicaid expenditures.

A closer examination of the services provided in the Kansas Medicaid program also helps to identify the major cost drivers.

Cost by Service Category

Kansas Medicaid provides a full package of medical and health care services, but they can be broadly sorted into five major categories: Home and Community Based Services (HCBS); institutional care; mental health and substance abuse services; medical care; and ancillary services.

Figure 6 shows that medical care is the largest single category of service expenses, accounting for 46% of all expenses in 2009. But the rate of growth over the last five years (Figure 7) has been greatest in the areas of mental health (59%) and HCBS (37.6%). Moreover, the rising base cost of the mental health and HCBS services themselves (cost per-beneficiary) account for 65.6 percent of the overall growth in Medicaid expenditures over the last five years, while an increase

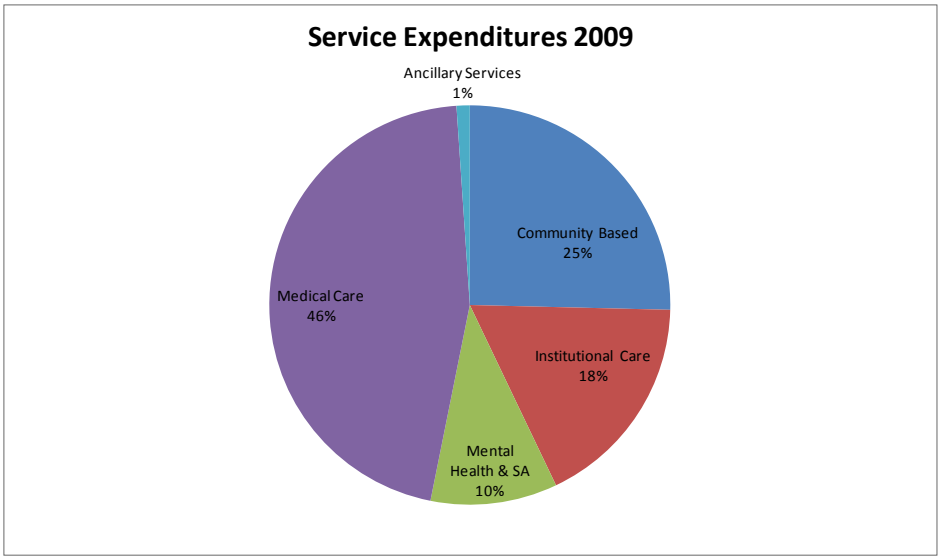

Figure 6

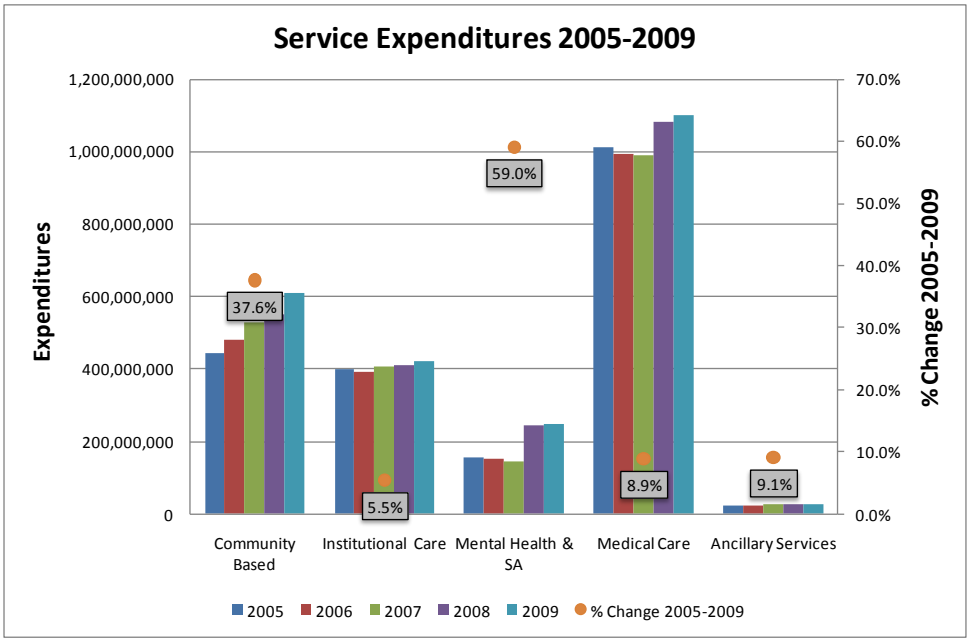

Figure 7

in the number eligible for these services accounts for only 3.8 percent of total growth in Medicaid. (Table 2).[3] Medical services accounted for 24.2% of the growth in Medicaid.

[3] Mental health spending is reviewed in detail in a 2009 Medicaid Transformation program review available at www.khpa.ks.gov . The review was prepared by the Department of Social and Rehabilitation Services.

Table 2: Percent Contribution to Total Medicaid Cost Increase, By Service Area

Service	Enrollment Effect	Cost per Bene Effect	Total Effect Attributable to Sub-Service
Community Based	2.8%	42.0%	44.8%
Institutional Care	2.5%	3.4%	5.9%
Mental Health & SA	1.0%	23.6%	24.6%
Medical Care	6.4%	17.8%	24.2%
Ancillary Services	0.1%	0.4%	0.6%
All Services	12.9%	87.1%	100.0%

Optional Populations and Services

Federal Medicaid standards require states to provide a package of specific services to certain target populations. But states have the option of providing additional services, and of extending Medicaid services to additional populations.

Like most other states, Kansas has elected over the years to fund a wide range of additional health care services and to make services available to additional populations. Many of the additional populations are served through specific programs, some of which receive federal Medicaid funding and some of which do not. Among those are:

- **MediKan** – a state-only program that covers certain disabled individuals. Originally, MediKan was intended as temporary coverage for people who were awaiting federal disability determination in order to receive Supplemental Security Income (SSI). Today, however, KHPA is authorized to make "presumptive disability" determinations if it is deemed the applicant is likely to qualify for SSI. As a result, MediKan now serves people with disabilities but are not likely to receive federal benefits. In 2009, the legislature established a hard, 18-month lifetime benefit limit under MediKan which immediately reduced the MediKan population. In November, as part of his allotment order, Governor Mark Parkinson tightened the lifetime benefit limit even further to 12 months.
- **CHIP (HealthWave**-21) – Low-cost health insurance for uninsured children in families with incomes above up to 241% of FPL
- **Working Healthy** – a program that for disabled Medicaid beneficiaries that is intended to remove the disincentive to return to work. It allows certain disabled beneficiaries to keep their Medicaid coverage even if returning to work puts them over the income threshold. It is based on research that shows employment is beneficial to both the mental and physical health of the disabled.
- **Breast and Cervical Cancer Screening –** a service available to an expanded group of women who seek screening for two of the leading causes of cancer death among women
- **Aids Drug Assistance Program (ADAP)**
- **Tuberculosis –** treatment for TB patients, provided through the Dept. of Health and Environment
- **Foster Care Aging Out –** an extended benefit package for foster children reaching the age of majority

In addition, Kansas also extends Medicaid coverage to the following populations:

- **Medically Needy Aged, Disabled and Families:** These categories include individuals whose incomes are above the threshold for traditional Medicaid, but who have high ongoing medical costs. Individuals in these categories are subject to spend-down requirements.
- **Pregnant women:** Federal rules require coverage up to 133% of FPL. Kansas currently offers coverage up to 150% of FPL.
- **HealthWave-**21 **(CHIP):** There is no federal requirement to participate in CHIP. Kansas currently offers coverage up to 241% of FPL.

The list of mandatory services in Medicaid was largely determined in 1965 when the program was established. Health care has changed significantly since then, and certain services that were not considered critical at that time are now considered to be standard elements of modern health care. The state of Kansas has consistently tried to make sure Medicaid beneficiaries have access to the full package of standard, modern health care services. As a result, the following "optional" services and providers are also covered by Kansas Medicaid:

- Pharmacy
- Vision care
- Maternity care
- Ambulatory surgical center services
- Dental care
- Services provided by local health departments
- Attendant care for independent living
- Hospice
- Community Mental Health Center services
- Psychologist
- Chiropractor
- Podiatrist
- Hearing services
- Equipment supplies – orthotics/prosthesis
- Alcohol/Drug treatment
- Dietician
- Head Start
- Physical therapist
- Head injury rehab facilities
- Local education agencies
- Targeted case management (MR/DD, FE, PD and Mental Health)
- Managed care (HealthWave)
- Mental health managed care (PAHP)
- Substance abuse managed care (PIHP)
- Primary care case management (PCCM)
- Mental health services provided in a nursing facility
- Intermediate care facilities (ICF) for mental retardation (private and state)

- Home and Community Based Services (HCBS)
- State psychiatric hospital services

As shown in Table 3, optional services and services provided to optional populations account for a little over half of all Medicaid expenditures in Kansas. Tables included in the Appendix to this report list the spending associated with each optional service and population.

Table 3: Optional Spending in Kansas Medicaid

Optional Spending in Kansas Medicaid	
	Actual Spending (All funds)
	FY 2009
	All Funds
Optional Services	890,611,400
Optional Populations	982,357,200
Less Crossover*	432,834,500
Total Optional Medicaid Spending	1,440,134,100
Total Medicaid Spending (excludes administration)	2,524,460,000
Percent Optional	57%

Summary

The Kansas legislature faces an enormous challenge to balance the state budget in the face of historic and unprecedented fiscal constraints brought on by the current economic recession. It also faces an ongoing challenge to control future growth in health care costs so the state can continue meeting its obligation to fund the full range of other priorities such as education, public safety and infrastructure development.

KHPA's analysis of cost and service trends over the past five to 10 years identifies those populations and services that currently represent the largest expenditure categories, as well as those populations and services experiencing the most rapid growth in expenditures. KHPA's approach to developing cost-controlling policies is comprehensive. Medicaid Transformation entails a systematic, comprehensive, and ongoing review of the entire program. As with any business, though, sources of greatest growth and expense represent the first and most important areas of focus in the state's effort to control spending.

Kansas also offers a number of services that are not required under federal law but which nevertheless provide critical health care services to vulnerable populations.

One of the largest optional services that Kansas provides is managed care. The theory behind the managed care model is that it provides incentives to promote primary care and preventive medicine in order to achieve long-term savings and efficiencies. Currently, however, managed care is only offered to populations that already have the lowest per-person costs (children and families). It is not offered to populations with the highest per-person costs: the aged and disabled. It may be appropriate, therefore, to examine whether managed care of children and

families is producing the savings that were intended, and whether additional savings might be found by applying managed care to other populations.

Many of the policy options presented below address the need to begin managing the costs of Medicaid's higher-cost population.

POLICY OPTIONS

In preparing this report, staff at KHPA relied on a wide range of sources, beginning with our own analysis of cost and service trends and our own internal reviews of Medicaid and HealthWave programs. Following the directive in Sec. 13 of H.B. 2222, we also reviewed cost-containment measures that have been implemented in other states. We consulted the secretaries of the Department of Social and Rehabilitation Services and the Department on Aging, as well as the governor's office and members of the legislature. And we solicited suggestions from providers and beneficiaries of Medicaid services, as well as the general public, by launching a web-based survey. Our analysis included both short-term and intermediate-term policy options.

Where possible we have tried to identify estimates of the cost savings each option could produce. We also tried to identify any research, studies or pilot projects that have been conducted to support the feasibility of each policy option. And finally, we attempted to identify other factors about each option which might be important to consider, such as administrative costs or new investments needed to implement the option, the populations that would be affected if the policy option were implemented.

Any discussion of methods to reduce State General Fund expenditures in Medicaid should also include options for increasing revenues through other sources. In our examination of actions taken by other states, as well as survey responses and our own discussions with stakeholders, we examined several options for increasing non-SGF revenue. They included increasing premiums and co-pays wherever allowable and levying various kinds of provider taxes in order to draw down more federal matching funds. Each of these presents an opportunity to reduce the state's reliance on the general fund to pay for Medicaid, but each also has implications for the people or institutions that would be charged the tax or fee.

Given the recent imposition of a 10% across-the-board reduction in provider payments, the options presented below do not include significant new options for savings through provider rate reductions. Some options do entail a restructuring of provider rates for other purposes, such as incentives to coordinate care or prevent unnecessary readmissions to hospitals.

Managing Care for the Aged and Disabled

Description: The aged and disabled make up about a quarter of the Medicaid population, but the cost for their services account for about 70% of Medicaid expenditures. This population also includes persons who have dual eligibility for both Medicaid and Medicare. The majority of services for this population are accessed through fee-for-service. This population has the most complex medical needs which are typically not managed in any organized fashion. Managed care program goals for this population, include improving health outcomes and controlling costs.
Population Covered: Aged, Blind and Disabled (ABD); Dual Eligibles (Medicare and Medicaid)

Options

Option 1: Special Needs Plans: Perform further research on SNPs to determine the requirements and then evaluating the cost benefit taking into account the level of effort required and the availability of resources to support the program.
States Participating

Connecticut is researching enrollment of the ABD population and dual eligibles into Special Needs Plans or some form of managed care. Special Needs Plans (SNPs) are covered under the MMA, Section 231 which created a new type of Medicaid Advantage coordinated care plan focused on individuals with special needs. The targeted individuals were persons residing in institutions, dually eligible and persons with severe, chronic conditions. Congressional SNP authority is set to expire December 2010. The development of SNPs allows targeted enrollment and design of special clinical programs with a target to reduce hospitalizations and institutionalizations.
Expected and/or Documented Savings: Unknown, in research phase

Option 2: Enhanced Care Management: Explore the use of care management as a vehicle to manage the care of high cost individuals with severe, chronic medical conditions.
States participating:
Kansas conducted an Enhanced Care Management pilot project in Sedgwick County. The purpose of this project was to evaluate the ability to identify health outcomes for persons with high risk health conditions by coordinating their health care. Care management service was delivered by teams of nurses and social service professionals collaborating to assist the patient to maintain an effective primary care medical home, access available community resources, and manage their health. Due to the difficulties
Oregon implemented a case management program for high-risk ABD.
More information: http://www.khpa.ks.gov/board/download/02192008/2-19-08ECMInternalEvaluationReport.pdf
Expected and/or Documented Savings: Oregon reports significant claims costs reductions

Option 3: Managed Care Contracts
Description: Review existing managed care contracts to determine if contractors are implementing managed care and if the managed care model is producing the savings intended for the target populations.
States Participating
Kansas: KHPA Program Review:
http://www.khpa.ks.gov/program_improvements/downloads/HealthWave_Annual_Report_02%2011_10_final.pdf
Oklahoma: Mathematica Policy Research, Inc. evaluated Oklahoma's SoonerCare Medicaid managed care program for the Oklahoma Health Care Authority (OHCA), the stand-alone agency that administers the state's Medicaid program. The Mathematica evaluation reviews the history of the SoonerCare managed care program from 1993 to 2008, with a special emphasis on Oklahoma's decision in 2003 to end its urban capitated managed care program and expand its rural PCCM program statewide, with a number of care management and reimbursement enhancements. The evaluation includes several measures of access (health insurance coverage, physician participation, emergency room visits, preventable hospitalizations, and primary care utilization), quality (HEDIS, CAHPS, and ECHO behavioral health measures), and cost (Medicaid costs per member and overall Medicaid budget costs in Oklahoma over time compared to other states). Finally, Mathematica identified lessons and implications of the Oklahoma experience for other states, including program design and management issues, and relationships with external stakeholders.

Medicaid accounted for a smaller share of total state expenditures in Oklahoma between 1996 and 2005 than the national average and 19 comparison states. Medicaid has accounted for a substantially smaller share of total state expenditures in Oklahoma than the national average from 1995 to 2006, and a smaller share than in any of the 19 comparison states that were examined. Medicaid represented 6.5 percent of state expenditures in Oklahoma in 1995, rising to nearly 10 percent in 2006. During that same period, the national average remained relatively stable, with Medicaid expenditures rising from around 12.5 percent of total state expenditures in 1995 to nearly 14 percent in 2006. Medicaid costs per member in Oklahoma were substantially below the national average between 1996 and 2005.

Among children and non-disabled adults, who account for approximately three-quarters of the enrollment in SoonerCare and in managed care programs in most other states, annual per-member costs in Oklahoma have been significantly below the national average every year between 1996 and 2005. Oklahoma's per-member expenditures for those in the disabled eligibility category were also below the national average throughout the period, although by a smaller percentage than in the children and adult categories.
For more information: http://www.chcs.org/publications3960/publications_show.htm?doc_id=835881

Florida reduced their FFS market place by expanding Managed Care and increasing contract requirements for plans to prevent and report Medicaid fraud and abuse.
Expected and/or Documented Savings: Unknown
For more information:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/cost_efficiencies_florida_medicaid_program_012110.pdf

Option 4: Waiver Consolidation
States Participating
Florida consolidated small regional programs – Alzheimer's and Adult Day Health Care into existing larger statewide waivers. Medicare does not cover day care costs, but Medicaid can pay all the costs in a licensed day care center with a medical model or an Alzheimer's environment if the senior qualifies financially.
Expected and/or Documented Savings: Unknown
For more information
http://ahca.myflorida.com/Medicaid/nh-transition/pdf/nh_transition_presentation_102909.pdf
http://www.chcs.org/publications3960/publications_show.htm?doc_id=434341

Option 5: Managed Care Models for Long Term Care Supports and Services
Description: Medicaid pays for nearly 50 percent of the nation's total spending on long-term care, creating a significant incentive for states to better manage the long-term care needs of Medicaid beneficiaries, including those who are also eligible for Medicare (the "dual eligibles"). These options include programs that manage long-term supports and services only, those that integrate acute and long-term care, and, ultimately, those that integrate Medicaid and Medicare. Though not without its challenges, the biggest opportunity lies in improving care for the seven million dual eligibles, who represent only 14 percent of Medicaid's enrollment but drive over 40 percent of total Medicaid expenditures. Close to 70 percent of those expenditures are for long-term care, reinforcing the importance for states of actively managing long-term care supports and services and to integrate them with primary, acute, and behavioral services. States not ready to fully integrate Medicaid and Medicare services can still reap benefits by developing programs to better manage long-term care services and supports and integrate long term and acute services.
Population Covered: Aged, Blind Disabled
Options
Implement a managed long-term care program for Medicaid beneficiaries that also integrate acute care services covered by Medicaid. Implement an integrated care program for dual eligibles with one of the following approaches:

- Wraparound or partially capitated contract for one or all of the services covered by Medicaid (e.g., non-covered Medicare acute care services and drugs, behavioral health, care management, personal care services, nursing facility, and home- and community-based services).
- Capitated contract with a Medicare Advantage Special Needs Plan for the full range of Medicaid services (e.g., primary, acute, behavioral, long-term care supports and services)

States Participating

- **Minnesota**, through its Senior Health Options program integrates Medicare and Medicaid services, significantly reduced the number of preventable hospital and emergency room admissions for enrollees residing both in nursing facilities and the community.
- Managed long-term care programs have been shown to improve quality, cost effectiveness, and community placements in several states, including Arizona, Florida, Texas, and Wisconsin.

Expected and/or Documented Savings: Unknown

For more information
http://www.chcs.org/publications3960/publications_show.htm?doc_id=504045
http://www.cms.hhs.gov/SpecialNeedsPlans/
http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%2013%20-%20Medical%20Services%20for%20the%20Aged%20and%20Disabled.pdf
*Potential for short term options (implement within one year):*None Identified
Potential for immediate term option (implement within 2 two years): Additional managed care arrangements could be put in place but would require policy and RFP development, CMS review and approval and would likely require up-front funding to implement.
Waiver consolidation would require stakeholder input, design, CMS review and approval.

Avoidable hospitalizations and readmissions

Description: In 2007 the Medicare Payment Advisory Committee (MedPAC) recommended Medicare payment changes to hospitals reduce readmissions for the same diagnosis within 30 days of discharge. For federal fiscal year 2010, the Centers for Medicare and Medicaid Services (CMS) developed measures designed to reduce readmissions for three expensive, adverse conditions – acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). CMS noted that such readmissions can be directly affected by hospital care and transition during discharge. Hospitals who fall below the acceptable threshold rate of such readmissions do not receive a higher annual update to their payment rates.
Population Covered: Medicaid FFS Beneficiaries, particularly the Aged and Disabled groups who are most likely to use inpatient hospital care

Options:
Denying reimbursement for inpatient claims for the same diagnosis within 30 days could be implemented relatively easily and managed through the utilization review contractor, who already reviews claims for readmissions within five days for the same diagnosis.

States Participating
Although several Medicaid programs (e.g. **Indiana**, **Montana**, and **Nebraska**) do not currently reimburse for readmissions for the same diagnosis within three to 30 days, providers in these states who do not readmit for the same diagnoses do not receive incentives. Generally, these readmissions are reviewed by the utilization review team or contractor.
Montana: http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter07.pdf
Nebraska: http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-10.pdf
Indiana: http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter07.pdf
Expected and/or Documented Savings: Unknown
Linking payment to readmission rates for selected conditions in the Kansas Medicaid fee-for-service (FFS) inpatient hospital program would help produce better outcomes for patients and could save the Medicaid program significant costs; however, funds to pay an incentive, such as Medicare does, would have to come from savings elsewhere.
States participating:

MedPAC estimates that nationally, readmissions cost the Medicare program $15 billion each year and that approximately $12 billion of this amount is preventable. A recent study in the New England Journal of Medicine found that one in five Medicare patients is readmitted within 30 days of discharge for the same diagnosis and that HF and PN were the most common diagnoses for readmission.
http://content.nejm.org/cgi/reprint/360/14/1418.pdf
Expected and/or Documented Savings
These authors estimated the cost to Medicare, for readmissions in 2004, to be over $17 billion.

For more information:
http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalRHQDAPU200808.pdf
Potential for short term options (implement within one year):
Some version, without incentives, could be implemented fairly quickly and managed through the utilization review contractor.
Potential for immediate term option (implement within 2 two years)
Savings in FY 2011 are unlikely. KHPA is pursuing a collaborative effort with hospitals to develop new payment models for implementation in the intermediate term.

Coordination of behavioral health with physical health care

Description: There is often a disconnect between the services a person receives for mental health issues and for their physical care. As a result persons with mental illnesses often also are in poor physical health. Mental health care is often provided by primary care physicians, who often do not know much about how to treat mental illness. Those with serious and persistent mental illness may utilize the mental health system of providers, but this system does not ensure care for physical health problems that often go untreated. In most cases the systems are operated separately under Medicaid. Identified barriers include: cultural differences between primary care and mental health specialty providers, differences in detail and contents of medical records, and the lack of training to primary care providers in the treatment of serious mental illnesses.
Population Covered: Persons with Mental Illness
Options:

- Programmatic Clarifications and Pilot Projects – A number of states are trying a variety of options to better define who should be receiving treatment and where the treatment should occur.
  States Participating
  Michigan has worked to clarify who should be treated in outpatient behavioral health settings that are the responsibility of the HMOs
  Massachusetts and **Oklahoma** require health plans offer behavioral health case management for individuals with mental illness and conduct home visits for persons who fail to show for appointments
  Expected and/or Documented Savings: Unknown

- Integration efforts – States and advocates recognize the ongoing problems of communication and coordination of effort in treatment between mental health providers and primary care physicians. Some models of integration would entail greater coordination between the facility-based community mental health system and the physical health safety net clinics located in some communities. Other models would seek to better integrate care across all physical and mental health providers.
  States Participating
  Oregon and **Massachusetts** encourage pilot projects through grants and financial incentives.
  Pennsylvania is integrating physical and behavioral health services for adults with serious mental illness and physical health co-morbidities within two regional pilot projects
  Expected and/or Documented Savings: Unknown.
  Both of the above models would require an up-front investment

Additional options in Kansas:

- Close psychiatric facilities and use savings to fund community services
  Description: Kansas closed Topeka State Hospital and therefore has experience with closing of state mental health hospitals. The Governor's Facilities Realignment Commission recently considered the closure of Rainbow Mental Health Center but declined recommending its closure.
  Potential for immediate term option (implement within 2 two years)
  Regional projects to integrate mental health and physical health models could be researched and designed. This would likely require an RFP and up-front funding.

- Evaluate prevention and early intervention programs
  Expected and/or Documented Savings: Unknown.
  Currently being coordinated through the use of federal grant funds

- Promote comparable insurance coverage of mental health
  States Participating:
  Ohio offered comparable coverage for their state employees and experienced minimally increased costs
  For more information:
  http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102275077.html
  http://www.heritage.org/Research/HealthCare/BG1341.cfm
  http://governor.ks.gov/files/Facilities_Closure_and_Realignment_Commission_Report.pdf
  http://governor.ks.gov/media-room/45-press-releases/571-012610-governor-parkinson-acts-on-facilities-closure-report
  Potential for short term options (implement within one year)
  None expected

- Introduce mental health expertise to the prescribing of mental health medications by all providers
  KHPA has recommended a change in state law to enable management of mental health drugs for improved safety and savings. A key challenge is to provide effective guidance to primary care practitioners who prescribe a significant percentage of mental health medications. The use of standard pharmacy management techniques could provide a much-needed link between mental health expertise and the provision of mental health services in a primary care setting.
  This was not recommended by the Governor's Hospital and Facility Realignment Commission.
  Potential for immediate term option (implement within 2 two years)
  $2 million in savings expected in FY 2011, limiting management to anti-depressants and stimulants.

Reducing DME costs provided in institutional and non-institutional settings

Description: There are long-standing concerns about over-reimbursement of durable medical equipment (DME), such as wheelchairs and oxygen supplies. CMS has stated that DME costs must be part of an institutions per diem rate. Institutions include nursing homes, hospitals and Intermediate Care Facilities for the Mentally Retarded. CMS has also reduced reimbursements for DME in non-institutional settings and is attempting to implement a competitive bidding process to identify an appropriate level of payment.
Population Covered: All Medicaid
States Participating:
Alabama introduced new reimbursement rates for DME.
Ohio restricted DME reimbursement for targeted populations
Expected and/or Documented Savings: Unknown

Kansas already has DME built into the per diem rate calculations for institutional settings. DME in homes are paid under fee-for-service through DME providers. As a result of its 2009 review of programs, KHPA is:

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

For more information:
http://www.dhh.state.la.us/offices/page.asp?ID=111&Detail=5127
http://www.mediregs.com/blog/2009/10/home-health-and-dme-hit-%E2%80%9Cmost-wanted%E2%80%9D-list-senate-finance-committee-bill.htm
http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%204%20-%20Durable%20Medical%20Equipment.pdf

Potential for short term options (implement within one year):
No additional savings expected. In response to the payment reforms and 10% provider payment reductions, both implemented in January 2010, DME providers are currently refusing to offer services to Medicaid recipients. KHPA is considering alternative payment reforms that would not require submission of cost information, which DME providers have not been able to produce. Additional spending may be required to maintain access for beneficiaries.
Potential for immediate term option (implement within 2 two years)
None identified

Eliminate optional covered services, e.g., HCBS, pharmacy, and hospice

Description: There are no states that offer only mandatory services. Nearly all states cover prescription drugs, Intermediate Care Facilities for Individuals with Mental Retardation, personal care services and targeted case management. Additional optional services include services provided by chiropractors, psychologists, and podiatrists, diagnostic, screening, and preventative services, rehabilitative services, clinic services, dental services, physical therapy, prosthetic devices, including eyeglasses, inpatient hospital services for mental health/inpatient psychiatric hospital care, home and community-based waiver services and hospice care.
Population Covered: Nearly all Medicaid population
Options
Within any given service, whether mandatory or optional, the state has some discretion to set reasonable limits on the extent of services it will provide.

Option 1: Eliminating targeted optional services (children's services are mostly exempt from this option)
States Participating:
Michigan eliminated chiropractic, podiatric, optometric, dental and hearing aid services for adults
Expected and/or Documented Savings: Unknown
Florida discontinued coverage of partial dentures for adults
Expected and/or Documented Savings: Unknown
Michigan and **California** eliminated dental services
Expected and/or Documented Savings: Unknown, but facing a lawsuit over the elimination

Option 2: Reducing allowable benefit maximums

- Subjecting benefits to certain authorization standards; e.g., assessments, medical necessity standards
- Establishing individualized budgets for certain community-based services
- Re-designing benefits
- Eliminate all optional services under the Medically Needy program
- Eliminate General Fund only services

States Participating: No examples

Expected and/or Documented Savings: Unknown. Elimination of established services is onerous on affected populations, though costs savings could be realized. The long term effect of such service reduction or eliminations would be harmful to many citizens, and could result in greater long term costs.

For more information:

The Medicaid Resource Book, The Kaiser Commission on Medicaid and the Uninsured, July 2002:
http://www.kff.org/medicaid/2236-index.cfm
http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=VxmHXqJmuwU%3D&tabid=123&mid=1159

Potential for short term options (implement within one year):

Depending on the optional services identified for either reduction or elimination, the amount of effort and time to implement would vary. Any changes to Medicaid coverage will require state plan amendments, possible changes to state regulations and CMS approval. Depending on the options chosen it could affect enhanced and/or ARRA funding.

Potential for immediate term options (implement within 2 two years)

Elimination of optional services would lower short-run spending in Medicaid, potentially by the full amount of the cost of the service. However, the impact on intermediate and long-run spending is unknown. In most cases, optional services are the preferred substitute for mandatory inpatient or institutional care, which is much more expensive. The negative impact on beneficiaries would be significant, but the degree and type of impact is likely to vary by service.

Eliminate optional covered populations, e.g., medically needy groups and CHIP

Description: The American Recovery and Reinvestment Act of 2009 (ARRA) provides Kansas with a temporary 10 percentage point increase in the percentage of the program paid for by the Federal government. One of the conditions placed on States who choose to take these additional Federal funds is the preservation of eligibility rules in effect at the time of passage. The funding and the eligibility maintenance of effort (MOE) requirement are set to expire in January 2011. If Congress extends supplemental ARRA funding to states, the eligibility MOE is expected to be extended as well. Federal health reform legislation pending in Congress would make current State Medicaid eligibility criteria permanent. The possibility that Federal legislation will make a decision to restrict Kansas' ability to restrict eligibility after the Kansas Legislature finalizes a budget for FY 2011 adds significant risk to this savings option. If Kansas chooses to rely on savings from stricter eligibility criteria beginning in January 2011, the option could be withdrawn later by the Federal government, leaving Kansas with an un-addressed budget gap midway through FY 2011.

Population covered:

See list of optional populations above.

Potential for immediate term option (implement within 2 two years):

See costs associated with each optional population in the Appendix. Savings would be limited to the second half of FY 2011 due to a Federally-imposed freeze on restrictions in eligibility. Also, savings would be reduced to account for payment of claims received through December 31st.

Imposing new or higher copayment requirements, e.g., pharmaceuticals and ER services

Description: Prior to passage of the Deficit Reduction Act (DRA), Medicaid regulations allowed states to impose nominal cost sharing on specified recipients and in general did not allow premiums to be charged. The DRA and subsequently the Tax Relief and Health Care Act (TRHCA) allowed for more options which are complicated, resulting in different treatment based on a person's income, Medicaid coverage category and the type of services being accessed. The rules include many exemptions, limitations and protections.

Medicaid Rules - Children
In general, children under the age of 18 are exempt from premiums and from cost-sharing on most services. States may impose copayments for prescription drugs and use of emergency rooms for non-emergency care in certain circumstances. Premiums and cost-sharing charges may be imposed on some children in families with income above the poverty line. *The total amount of premiums and cost-sharing charges cannot exceed a cap of five percent of the family income.*
Special rules apply for prescription drugs and the use of emergency room for non-emergency services. These allow for nominal cost sharing charges for children who would otherwise be exempt.
Certain services are exempt from cost sharing regardless of the child's income. These include preventive services, emergency services and family planning services and supplies.

Medicaid Rules - Adults
Cost sharing and premium rules depend on income. Many are exempt and limits vary based on income for those who are not exempt.
Population Covered: Mostly adults, subject to exemptions
Options
Option 1: Increase Premiums
States Participating
Rhode Island began charging premiums to families above 150 percent of the federal poverty level in 2002
Expected and/or Documented Savings
Unknown, but in the first 3 months, 18% of affected families were disenrolled due to nonpayment of premiums
Vermont implemented a number of income-related premium sliding scale increases in SCHIP and Medicaid
Expected and/or Documented Savings: Unknown. Approximately 11% of enrollees were disenrolled for non-payment of premiums. Many were eventually re-enrolled but overall enrollment remained below previous levels

Option 2: Increase Co-payments
State Participating
Oregon implemented new requirements of co-pays from $3.00 to $5.00 per service
Expected and/or Documented Savings: The Medicaid co-payments were later eliminated under court order.
Utah imposed nominal co-payments
Expected and/or Documented Savings: 40% of beneficiaries reported the co-payments caused serious financial harm and a significant reduction in health care access
Minnesota will increase MinnesotaCare premiums to 8.8% of household income, and eliminate eligibility for childless adults with incomes above 75% FPL beginning July 1, 2011
Expected and/or Documented Savings: Eliminating MinnesotaCare eligibility: $127.7 Million savings FY 2011l $510.5 M FY 2012-12
Increase MinnesotaCare premiums: no saving 2011; $9.5 Million, FY 2012-2013

Potential for short term savings: Unknown
For more information:
http://www.cbpp.org/files/11-2-04health.pdf
http://www.cbpp.org/cms/?fa=view&id=321
http://www.healthcare4kc.org/uploadedFiles/Publications/CostSharing%20Fact%20Sheet_Electronic%20Version.pdf
http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf
http://www.cbpp.org/cms/?fa=view&id=321
http://www.cbpp.org/files/2-28-07health.pdf
http://www.acnj.org/main.asp?uri=1003&di=1259&dt=0&chi=2&empt=yes
http://www.kff.org/medicaid/upload/7815.pdf
http://www/dhs.state.mn.us
http://www.khpa.ks.gov/board/download/08182009/8-18-09%20FY%202011%20Budget%20Options%20Final.pdf

Potential for short term options (implement within one year):

Option 3: Apply percentage increase to cost-sharing in accordance with the medical care component on the Consumer Price Index.
Potential for immediate term options (implement within 2 two years): None identified
Note: KHPA staff prepared an option to increase copayments for non-emergent hospital emergency room services. The KHPA Board did not forward the option to the Governor due to minimal expected savings and the likelihood that savings to the state would come at the expense of providers who are unable to secure payment for services they are required to provide.

Increase Health Care-Related Sources of Revenue

Description: Health care related taxes are often coupled with increases in Medicaid reimbursement and/or coverage to generate additional Federal matching funds. Most states use these mechanisms. Congress has passed a number of laws to limit and proscribe the use of these mechanisms, which can effectively raise the percentage of Medicaid spending born by the Federal government. The options presented below represent the taxes most likely to raise significant revenue and pass muster with CMS rules and regulations.

Option 1: MCO Privilege Fee

Description: Kansas imposes a fee on Health Maintenance Organizations (HMO's) for the privilege of operating in the state [K.S.A. 40-3213]. The fee (up to one percent) is imposed against premiums or subscription charges for the previous year. The statute grants the Commissioner of Insurance authority to waive the privilege fee in instances where the fee might "cause a denial of, reduction in or elimination of federal financial assistance to the state or to any health maintenance organization subject to this act." For this reason, Commissioners have waived the fee for HMO's contracting for Medicaid and SCHIP services with the state of Kansas. Last week, the Commissioner revoked that waiver and subjected three HMOs serving the Medicaid and SCHIP program to the 1% fee. Legislation was also introduced to eliminate the two-year ramp-up rates of 0% and 0.5%, thereby making the fees uniform and eliminating a potential difficulty in obtaining federal approval for this health care related tax. The tax is expected to generate about $4.1 million per year beginning in March 2010.

As with the existing tax on hospitals in Kansas, at least some proceeds from the tax are expected to be used to increase payments to the tax-paying HMOs (or, in Medicaid terminology, MCOs). The two HealthWave MCOs will be able to count the cost of the tax against their Medicaid and SCHIP business, and KHPA will take steps to increase their capitation payments by at least the amount of the tax. Nevertheless, those payments back to the MCOs will also include a federal matching payment of about 70%, which means that the state will net about 70% of the tax which can be used for other purposes.

Summary

- The privilege fee is currently levied on non-Medicaid MCOs and funds generated go into the state general fund.
- The Insurance Commissioner has now extended the privilege tax to the Medicaid MCOs-Children's Mercy Family Health Partners, UniCare, and Value Options, who had previously been exempt.
- Levying a uniform 1% privilege tax on all three organizations will require a statutory change removing the stairstep ramp-up provisions present in current law. The MCOs have asked for this legislation to be introduced in the 2010 legislature.
- KHPA expects the privilege fee will be allowed by CMS The privilege fee which will be assessed on calendar year 2009 and paid by the MCOs on March 1, 2010 will generate $3.1million in additional new federal funds which could assist in closing the FY2010 budget gap. Net proceeds in subsequent years would be about $2.7 million.
- The HealthWave MCOs have proposed a specific use for the additional funds generated by the tax, and have also offered to pass through to providers some of the increased payments that would be made to them as a result of the tax. This amounts to a donation from MCOs to providers in FY 2010 and FY 2011. In addition, they are recommending that the state use all of the net proceeds from the privilege fee to increase MCO payments to providers. This would be accomplished by using all of the tax proceeds to increase monthly capitation payments to the MCOs, which they would in turn pass on to providers, along with the associated federal matching payments. The MCOs have indicated the increase provider payments would be meant to partially restore the 10% payment reduction imposed by the Governor on January 1, 2010.
- The MCO's proposal is just one of a number of options that legislators may want to consider for the use of the net proceeds from the tax, each of which achieves different policy goals
    - Devote all net proceeds to MCO-based provider rate reimbursement
    - Devote net proceeds proportionally to FFS and MCO-based provider reimbursement
    - Devote net proceeds to lower Medicaid spending on high-cost FFS populations through outsourced care management.
    - Devote net proceeds to state fiscal relief

Spending Options

Options for Spending New Revenue Generated by MCO Privilege Fee FY2011*

	Option 1	Option 2	Option 3	Option 4
Total tax	4.1m	4.1m	4.1m	4.1m
SGF used for FFS rate increase	--	1.6m	--	--
SGF used for FFS care mgt investment	--	--	2.7m	--
Restoration of provider rates: FFS	--	4.5m	--	--
Restoration of provider rates: MCO	10.4m	2.7m	--	--
SGF used for state fiscal relief	--	--	--	2.7m

*The fee would generate revenue in FY 2010 as well. FY 2011 is highlighted as the first full year in operation.

Spending option 1: Devote all net proceeds to MCO-based provider rate reimbursement

- Includes a commitment by MCOs in FY 2010 and FY 2011 to contribute several million dollars in additional funds to provider rate increases
- Because of the additional commitment by the MCOs, this option provides the greatest impact on provider rates.
- Widens the rate discrepancy between providers in the FHP MCO network, UniCare network, and Medicaid FFS providers. FHP would raise rates the most, UniCare second, and FFS providers none at all. Hospitals and some provider networks currently receive as much as an 8% rate premium from MCOs.
- Creates an uneven playing field between the two MCO since UniCare would not make as much of an additional commitment to provider rate increases.
- Narrowly applies new revenue to one aspect of state need

Spending option 2: Devote net proceeds proportionally to FFS and MCO-based provider rate reimbursement

- Equitable restoration of payment rates for all providers regardless of the Medicaid program in which they participate
- Maintains level of access available to Medicaid beneficiaries regardless of geographic residence
- Does not increase provider rates by as much as Option 1, since the MCOs' additional commitment is not assumed. This commitment is voluntary for the MCOs, and KHPA makes no assumption regarding the MCOs' willingness to forego repayment for the tax.
- Maintenance of status quo investment

Spending option 3: Devote net proceeds to lower Medicaid spending on high-cost FFS populations through outsourced care management

- Currently Kansas Medicaid manages the care of low-cost Medicaid beneficiaries but not the aged and disabled who have chronic illnesses and consume the majority of costly medical care
- State Medicaid programs who have invested in better care management of beneficiaries with chronic diseases have improved the quality of care received and achieved cost savings
- Bending the cost curve for the aged and disabled populations requires an upfront investment

- Significant savings would not be expected before FY 2012, but could well exceed $10 million per year (SGF) depending on the size of the investment and the program's design
- This option would likely have the greatest fiscal relief in the long run

Spending option 4: Devote net proceeds to state fiscal relief

- FY 2010 revenue collections have continued to be less than projected and new revenue source would assist in closing the budget gap
- Recession has had a negative impact on a broad range of state programs valued by all Kansas citizens

Option 2: Nursing Facility Provider Assessment

Description: At least 36 states have a CMS-approved tax on nursing facilities. These taxes are levied in conjunction with increases in Medicaid payments to facilities, which generates additional federal matching payments for the state. Over the past 18 months, the KHPA Baord of Directors has discussed the implementation of a nursing facility provider assessment, convening a technical advisory group to pull together disparate interests and develop a working model for a tax program. In January the Board voted to receive the report from the advisory workgroup, but not to take a position on the tax.

Options:
Nursing facility option 1: Recently, bills establishing a nursing facility provider assessment were introduced in both the Kansas House and Senate. KHPA has not yet reviewed the proposal outlined in those bills.

Nursing facility option 2: This option was developed by KDOA staff with assistance from KHPA through the technical workgroup established by the KHPA Board of Directors. The option did not receive unanimous support from workgroup participants, which included representatives from the two major Associations representing nursing home interests.

- Assesses all Licensed Beds except for nursing facilities for mental health and the state operated Soldiers Home and Veterans Home
- Splits revenue 85/15 between NF program and other programs
- Creates an advisory board to provide recommendations to the Secretary of Aging on how the funds should be used
- Add $33.38 million NF reimbursement system with adjustments for:
    - Removing the 85% occupancy rule
    - Passing through the Medicaid share of the assessment
    - Applying additional inflation to all costs
    - Increasing incentive payments 250%
    - Spending up to $1,000,000 on a satisfaction survey program

Pros	Cons
$40 M ($24 M net) Medicaid increase	Potential private pay increases
Reward quality performance	Some providers have net loss
Encourage Medicaid participation	Not all funding tied to quality
Encourage bed closure or recycling	

Expected and/or Documented Savings:

- Fiscal Impact to Nursing Facilities
  - 314 homes (91%) gain and average of $57,408
  - 28 homes (8%) lose and average of $22,669
  - 2 homes (1%) neutral
- Private pay impact
  - 36 new nursing homes would be subject to a private pay limit unless they raised their private pay rates (the average increase would be $4.56)
  - If any provider were to pass the assessment directly through to private pay residents, the expense would amount to about $2.30 per resident day
- Provides $5.98 million for other programs such as HCBS, or for state fiscal relief
- CMS approval would likely enable the imposition of an assessment program in FY 2011.

Option 3: Hospital Assessment
Description: Kansas currently has one provider tax in place. Hospitals pay an assessment of 1.83 percent of net inpatient operating revenue, which generates approximately $32 million per year. With a nearly 60 percent federal matching rate, the total amount of funding available for increased hospital payments each year is roughly $80 million. At least 80% of the proceeds must be used for Medicaid reimbursements to hospitals, while 20% is earmarked for increases in Medicaid physician payment. The increased funding allows for base payment rates for claims related to inpatient hospital, outpatient services and physician services to be increased by a factor of .258.
Population Covered
All Medicaid populations benefit from the hospital assessment program
Expected and/or Documented Savings:
All proceeds from the program have been used to increase provider reimbursements. The long-run net impact on state spending is unknown.

Prescription Drug Cost Containment

Description: Prescription drug coverage represents a large part of Medicaid expenditures. Most strategies employed either limit prescription drug use or control the costs of medications or dispensing fees. Over the past several years mental health drugs in Kansas have been the highest drug expenditure by class of medications and the most-prescribed drugs by volume in the Medicaid program. This has led to expenditure growth in pharmacy services that exceeds growth in other services.
Population Covered
Potentially all beneficiaries
Options
Option 1: Develop preferred drug lists (PDL) or formularies
States Participating
Georgia has included mental health drugs in its Medicaid fee-for-service PDL since 2004
Michigan had included behavior health drugs in their PDL
Expected and/or Documented Savings: Unknown

Option 2: Implementing comprehensive drug utilization review programs
States Participating
Delaware is tightening pharmacy benefit management controls
Expected and/or Documented Savings: Unknown
Oklahoma implemented SoonerPsych in 2004 - Each month, Medicaid behavioral health pharmacy claims are reviewed and compared to nationally recognized best practice prescribing guidelines. Prescribers who show patterns of deviating from guidelines receive educational messages

Expected and/or Documented Savings: Unknown. Savings estimates will depend on whether educational efforts are pursued in isolation, or are combined with direct pharmacy management, as in **Missouri** and **Washington**.

Option 3: Decreasing dispensing fees
States Participating
Michigan eliminated increases to pharmacy dispensing fees.
Virginia reduced pharmacy dispensing fees.
Expected and/or Documented Savings: Unknown. Margins on Medicaid pharmacy sales have declined in Kansas pharmacies over the past year. Kansas reduced pharmacy payments by approximately 10% of the dispensing fee in January 2010. Further reductions could have an impact on access to care, but KHPA cannot be certain whether current margins on Medicaid sales are at or near zero.

Option 4: Requiring prior authorization for certain medications
States Participating
North Carolina established a prior authorization program for high cost specialty drugs
Expected and/or Documented Savings: Unknown
Potential for short term savings
For more information:
http://dch.georgia.gov/vgn/images/portal/cit_1210/20/63/95505868MH_Open_Access.pdf
http://familyimpactseminars.org/s_ncfis01c04.pdf
http://www.okhca.org/about.aspx?id=2519&terms=Mental+Health+Drugs
http://www.kff.org/medicaid/upload/7815.pdf
http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%209%20-%20Pharmacy%20Services.pdf
Potential for short term options (implement within one year):

Pay for Performance

Description: Pay for performance (P4P) ties reimbursement for services to the quality of care and outcomes. KHPA is currently leveraging philanthropic dollars to work with Kansas providers and national experts to develop an operational model for the medical home in Kansas. A likely component of the medical home would be to restructure payment to incentivize high-quality, prevention-oriented care.
Population Covered: Any population could be covered
Options
Option 1: Target a specific group or group of services to reward for good performance
States Participating
Idaho is rewarding primary-care case management in their Chronic Disease Management Program. The initial pilot program will focus on diabetes.
Expected and/or Documented Savings: Unknown, has not started.
Potential for short/intermediate term savings
For more information
http://www.ncsl.org/default.aspx?TabID=160&tabs=832,94,296#832
Potential for short term options (implement within one year):
Any pay for performance would require either 1) additional funds or 2) a major recalculation of rates to accommodate the enhanced payment for quality performance while remaining cost neutral.
Potential for immediate term options (implement within 2 two years)
None identified.

Telehealth

Description: Home Telehealth involves the use of a home technology device that monitors a patient's vital signs and sends them to a centralized nursing station for review and intervention, if needed.

Population Covered: Any population could be covered

States Participating

Kansas implemented a pilot project targeting "at risk" participants receiving HCBS Frail Elderly waiver services, those having two or more hospitalizations in the 12 months prior to the project. The goal was to evaluate any reductions in hospitalizations and emergency department visits and associated costs, and delay or defer nursing home placements for older adults.

Expected and/or Documented savings: This study concluded that home telehealth services are technologically and logistically feasible for use with HCBS-FE clients. The study also concluded that outcomes, including overall spending, trended lower as desired but with weak statistical significance. The conclusion is that home telehealth may have a positive effect on care and spending, but that more time and a larger number of participants are needed to be sure.

For more information: http://www.connections365.com/resources/KDOA_home_telehealth.pdf.

Potential for short term options (implement within one year):

Investigate expanding into a larger pool. This would require up-front funds and the development of an RFP.

Potential for immediate term options (implement within 2 two years):

None identified

Cost Containment Initiatives in Other States, by Service Area

The following are measures that some states have recently implemented or are considering using in budgetary proposals to reign in Medicaid spending and balance state budgets. These measures were drawn primarily from news reports, and often lack specific details.

Managed Care

- Connecticut is researching enrollment of Aged, Blind, and Disabled population and persons dually eligible for Medicaid and Medicare into a Primary Care Case Management Pilot Program The legislature directed development and implementation of a pilot of alternative approaches in the delivery of health care services through PCCM to not less than 1000 persons eligible for Husky – Medicaid Managed Care benefits. Enrollment Jan 1, 2009
- Florida reduced its FFS market place by expanding Managed Care and increasing contract requirements for plans to prevent and report Medicaid fraud and abuse. FLA plans to consolidated small regional waiver programs – Alzheimer's and Adult Day Health Care into one existing statewide Waivers.

Rate Reductions

- **Nevada's** proposal would cut reimbursement rates to providers and reduce payment for products such as bedpans and adult diapers
- **Tennessee** cut the state portion of hospital reimbursement by $170 million.
- **Florida** did not reduce provider rates, but maximized their provider assessments by 5.5% on NF's, ICF/DD's, Hospital Inpatient and Outpatient.
- **New York** plans a $1 B reduction in Medicaid spending primarily through reducing reimbursements to hospitals and nursing homes.
- **Maine** is proposing a 10% cuts in Medicaid payments –primarily to long term care providers.

- **Missouri's** governor is reducing payments to providers who are currently reimbursed at rates higher than federal guidelines and encouraging pharmacists to use generic drugs

Pharmaceuticals

- **Alabama** implemented new payment for hemophilia clotting factor that includes case management, and continually add more drugs to their PDL
- **Delaware** is tightening pharmacy benefit management controls
- **Michigan** eliminated increases to pharmacy dispensing fees, and included behavioral health drugs on the PDL.
- **Ohio** carved pharmacy out of their Managed Care program
- **Oklahoma** restricted the number of glucose test strips for diabetics to 100 from 300 without prior authorization, reduced pricing by 36 percent for compressor driven nebulizers for children with asthma, and eliminated adult nebulizers.
- **Oklahoma** reduced the number of name brand prescriptions allowed to two from three and raised prescription copayments to $2 and $3.
- **Virginia** reduced pharmacy dispensing fees, adopted additional pharmacy management initiatives including dose optimization and specialty drug classes on the PDL.
- **Virginia** eliminated statewide pharmacy for the mentally ill.
- **Connecticut** will no longer pay for non-prescription medications, vision services or eyeglasses for adults.

DME Reimbursement

- **Alabama** introduced new reimbursement rates for DME
- **Ohio** restricted DME reimbursement for targeted populations

Eliminate Optional and Other services

- **Michigan** eliminated chiropractic, podiatric, optometric, dental and hearing aids services for adults.
- **Florida** has reduced Medicaid reimbursement to hospitals and community based services for the elderly such as meals and homemaker services and discontinued coverage of partial dentures
- **Minnesota** has eliminated General Assistance Medical Care for 33,000 individuals – a program for low income childless adults. Approx 75% of those people will be eligible for MN Care, the public option for the uninsured, though most may not enroll due to inability to afford monthly premiums, 12% will become eligible for Medicaid
- **Michigan** eliminated dental services and faces a lawsuit over the cut.
- Adults in **Nevada** may lose access to vision services, dentures, physical and speech therapy.
- **Tennessee** has reduced community based services to persons with intellectual disabilities, reduced nursing services for some adults with serious disabilities, and could eliminate occupation, physical, and speech therapy services
- **Arizona** eliminated temporary health insurance for people with serious medical problems, general assistance cash assistance to persons with physical or mental disabilities, and independent living supports for 450 elderly residents and respite care funding for 130 caregivers
- **Georgia** has reduced services to the elderly such as elder service centers, prescription drug assistance and elder support
- **Massachusetts** has ordered cuts in elder programs including home care, geriatric mental health services and prescription drug assistance
- **Vermont** has reduced some home based services such as housekeeping and shopping for elderly and disabled citizens.

- **Virginia** has reduced reimbursement for hospitals serving people with mental health, mental retardation or substance abuse needs.

Increased Co-Payments

- **Connecticut** plans to raise Medicaid co-pays and reduce covered services, will no longer pay for non-prescription medications, vision services or eyeglasses for adults.
- **Washington State's** Basic Helth plan budget was reduced 43% which resulted in an increase in premiums and a decrease in the rolls. Premiums increased from an average of $34 per month to $60 per month.
- **California** plans to increase Medicaid co-payments and reduce eligibility for legal immigrants
- **Connecticut** will increase insurance co-payments and some premiums.
- **Nevada** may be required to triple premiums for children

Enrollment Caps

- **South Carolina** proposes to cap total enrollment in the state children's health insurance plan.
- **Virginia** may institute an enrollment freeze for most HCBS waivers for elderly and disabled persons.
- **Tennessee** has frozen enrollment in the state's children health insurance program.
- **Minnesota** capped enrollment for a program that provides expanded health services and care coordination for people with disabilities, restricted the number of programs providing in-home services to elderly and disabled persons.
- **Minnesota** will limit the growth of the Community Alternatives for Disabled Individuals and Traumatic Brain Injury Waivers, effective July 1, 2102, and Developmental Disabilities Waiver effective January 1, 2011 for one year. FY 2011 projected savings $2.1 million.

Sources:

An Update on State Budget Cuts, Governors Proposing New Cuts for 2011: At least 44 States have Imposed Cuts that Hurt Vulnerable Citizens, Johnson, Oliff,Williams, February 18, 2010, Center on Budget and Policy Priorities, http://cbpp.org/cms/index.cfm?fa=view&id=1214&emailView=

Kaiser Health News. www.kaiserhealthnews.org/Dailyreports/2010

Medicaid Reinvestment Fund

Description: Policy, procedure, and technology changes that would save money in the Medicaid assistance budget often require some up front spending to achieve the savings. The proposal would allow identified caseload savings to be partially reinvested in order to make these up-front investments in a timely manner.

Background: KHPA separately budgets administrative matching funds and assistance matching funds. Administrative funds are used to pay the fiscal agent to process and support the claims payment process, to pay for an outsourced eligibility operation to answer calls and process applications, to employ staff to identify cost effective ways of purchasing care, oversee large outsourced operations, and develop policy to improve the Medicaid program, and to work with contractors to provide expertise and technical capacity not available within KHPA. These functions are vital to a well run health insurance program and are the basic tools available to the state to identify and implement cost savings.

Over the past several years through the Medicaid program review process, KHPA staff have identified several administrative changes that would reduce Medicaid expenditures and provide more efficiently delivery of care. These efforts often require an initial investment in administrative costs that leads to Medicaid program savings that can be captured in the Consensus caseload process. Budget reductions since FY 2009 limit KHPA's flexibility to fund

innovations that could create such savings. The structure of the budget prevents KHPA from using savings in caseload assistance programs to pay for the administrative investments that generate those savings. Without a specific new appropriation, KHPA lacks the flexibility to take advantage of cost-saving investments in the administration of the Medicaid program.

The Medicaid Reinvestment Fund would allow for a portion of the savings realized from a specific policy change or initiative to be used to pay the administrative cost of implementation, and to finance a limited number of additional cost-saving investments. The Medicaid reinvestment fund would be a mechanism for agencies to identify a predictable source of funding for cost-saving initiatives, promoting innovative program management with a mechanism to monitor return on investment. One common example would be to invest in cost saving services or technology on a pure contingency basis – a practice numerous vendors have suggested – where the contractor is paid only when caseload savings can be documented. The fund would be overseen within the regular budget and appropriation cycle with the added control of the consensus caseload process.

How would the fund work? KHPA would develop a policy option specifying how Medicaid would be changed, how much is expected to be saved from the actions, and how much would be spent on the investment(s) each year. Each proposed investment would be reviewed as part of the Consensus caseload process to reach an agreement on the estimated savings amount and the amount available for new or previously approved administrative investments. At subsequent Consensus meetings, the amount of actual savings and administrative costs for each investment initiative would be tracked to ensure that legislative limits on the total amount of investments was not exceeded, and to ensure that a positive amount of savings are flowing out of the Reinvestment Fund and back into the State General Fund. On an annual basis, KHPA would certify to the Director of the Budget the total amount that should be transferred into the Medicaid Reinvestment Fund to pay for the administrative costs of its reinvestment initiatives. This could be a reimbursement of an expense already made by KHPA or funds advanced for a savings initiative that requires an initial investment. Except in the first eighteen months of the program, the total amount transferred into the Medicaid Reinvestment Fund each year could never exceed the amount saved through its initiatives in that year. If a savings measure did not save assistance dollars within the expected time period, the reinvestment fund would be used to repay the cost of assistance or refund the State General Fund. The Fund and all associated investment initiatives would be discontinued if total net savings were not realized during the first eighteen months of operation, and at any time thereafter when the fund is insufficient to finance the investments that have been made. Savings exceeding the limited amount of investment would revert to the State General Fund through the caseload process.

Example: KHPA has proposed adopting a smart prior authorization (PA) system to use more automated functionality to accelerate and apply more complex criteria to prior authorizations for prescription drugs and health care services. This mechanism would save assistance expenditures by reducing unneeded or conflicting services based on rules KHPA would develop. The smart PA tool and rules require an initial investment in software and programming before the realizing the savings. The following table illustrates the hypothetical impact of an investment of $600,000 in the first year when $800,000 of first year savings is returned to the state.

Medicaid Improvement Investment Fund - Immediate return				
	Year 1	**Year 2**	**Year 3**	**Year 4**
Initial Investment	600,000			
on going cost		400,000	400,000	400,000
Total Costs	**600,000**	**400,000**	**400,000**	**400,000**
Savings measure agreed to in caseload	800,000	1,250,000	1,375,000	1,512,500
Net Savings	**800,000**	**1,250,000**	**1,375,000**	**1,512,500**
Costs (Savings)	**(200,000)**	**(850,000)**	**(975,000)**	**(1,112,500)**
All amounts from State General Fund				

In most cases, an investment will take two or more years to generate sufficient savings to pay its total cost. That is shown in the following table. By the end of the 4th year, the initial investment and ongoing costs are repaid with additional savings accrued to the State General Fund.

Medicaid Improvement Investment Fund - 2 year return				
	Year 1	**Year 2**	**Year 3**	**Year 4**
Initial Investment	600,000			
on going cost		400,000	400,000	400,000
Total Costs	**600,000**	**400,000**	**400,000**	**400,000**
Savings measure agreed to in caseload	125,000	375,000	625,000	1,512,500
Net Savings	**125,000**	**375,000**	**625,000**	**875,000**
Costs (Savings)	**475,000**	**25,000**	**(225,000)**	**(475,000)**
All amounts from State General Fund				

Caps, controls, and oversight of the fund. The Medicaid Reinvestment Fund would provide a mechanism whereby the Agency could use net savings from previous investments (as in the first example above) to support advance funding for initiatives that take more than a year to pay for themselves (as in the second example), while yielding total net savings to the state. This mechanism would require controls to ensure agreement on how savings would be identified and how much money could be reinvested into program management. A logical control would be to cap the amount allowed into the fund for use, e.g., at $3-5 million. Or, the Legislature could require a minimum level of cumulative net savings be realized and deposited back into the State General Fund, e.g., $1 million net savings by the end of the third year, $2 million in the fourth year, etc. The Legislature may also wish to place a cap on the number of state FTE

supported through the fund, or to prohibit the funding of FTEs altogether (i.e., leaving MRF monies to support outsourced investments only). As a separate fund, the Medicaid Reinvestment Fund would be subject to annual appropriation and included in the budget submission to the Governor. Our conception of the fund is that it would be appropriated through the Consensus Caseload process, ensuring oversight and review by both the Governor's budget staff and legislative staff.

SUMMARY

Feasible Short Term Options (Implement within one year): The following options are most likely to generate savings in the short term, based on the ease of implementation, the initial investment required, and the speed with which savings can be achieved. These options do not constitute recommendations by KHPA. Implications for each option are describe above and are not repeated in this summary list.

Eliminate Selected Optional Services

- Depending on the optional services identified for either reduction or elimination, the amount of effort and time to implement would vary. Any changes to Medicaid coverage will require state plan amendments, possible changes to state regulations and CMS approval.

Increase Copayments/Cost Sharing

- Apply percentage increase to cost-sharing in accordance with the medical care component on the Consumer Price Index.

Enhance Pharmacy Management

- Change state law to allow structured, grandfathered management of mental health prescription drugs.
- Prior authorization could be expanded to additional drugs with corresponding investment in technology and support services.

Implement Health Care-Related Taxes

- Follow-through with the extension of the HMO privilege fee to Medicaid/CHIP HMOs
- Create a new assessment program for nursing facilities

Feasible Intermediate Options (Implement within two years): These options require an up-front investment of time and or/money, and are not expected to generate savings immediately. Options listed here are the most practical. These options do not constitute recommendations by KHPA.

Managing and Coordinating Care for the Aged and Disabled

- Additional managed care arrangements for the disabled and aged populations could be put in place but would require policy and RFP development,
- Would most likely entail a new, up-front funding to implement.
- Waiver consolidation would require stakeholder input, design, CMS review and approval.
- Apart from program reductions, this option appears to offer the greatest potential for long-term savings in Medicaid medical costs.
- More comprehensive programs linking medical care with behavioral health and/or long-term care merit a more comprehensive review.
- All options are expected to require large-scale collaborative efforts with the full range of stakeholders.

Authorize Medicaid Investment Process

- Almost all ideas being either implemented or discussed in other states to generate savings require up-front investments in time, staff, other resources and funding. It is difficult to make these investments in the current economic environment.
- KHPA proposes that targeted caseload savings be diverted from reverting to the general fund and instead be reinvested in policies, procedures and technology changes that would save money in the Medicaid assistance budget.

Avoidable Hospitalizations and Readmissions

- Some version, without incentives, could be implemented fairly quickly and managed through the utilization review contractor.
- The best option entails a review of payment methodology in collaboration with Kansas providers.

Introduce Pay for Performance

- Any pay for performance would require either 1) additional funds or 2) a major recalculation of rates to accommodate the enhanced payment for quality performance while remaining cost neutral. Meaningful savings are not expected in FY 2011.

Reduce ligibility for Medicaid

- Although not recommended in the 2010 legislature, this option may become available after Congress decides whether to extend eligibility maintenance of effort requirements through ARRA or Federal health reform legislation.

Survey Results Summary

In an effort to reach out to those who provide and receive Kansas Medicaid services, as required by Sec. 13 of H.B. 2222, KHPA launched a web-based survey that allowed participants to submit ideas and suggestions for cost savings in the Medicaid program. The survey was publicized through the news media, direct emails to KHPA Advisory Council members and through direct messages to the provider community. A link to the survey was also highlighted on the home page of the KHPA website.

The survey required participants to submit verifiable names and contact information. It then asked a number of questions that encouraged participants to submit as much background information and documentation as possible. The deadline for submitting responses was midnight Wednesday, Feb. 24.

In that time, KHPA received 62 completed surveys. The vast majority were from Medicaid providers, with additional responses coming from advocates, stakeholders, beneficiaries and the general public.

The limited time and resources available made it impossible to thoroughly analyze each response. However, several of these ideas warrant follow-up by KHPA and/or other state Medicaid agencies. A summary of the most relevant responses (broken out by topic area) follows:

Home and Community-Based Services (HCBS)

- Restrict Providers who can bill Medicaid for services
- MRDD: Reduce reviews to every 3 years instead of 1 year.
- MRDD/PD: Make day services optional for those who don't need/want it.
- Make HCBS a state plan service instead of waiver: Community First Choice State Plan Option (H.B. 2413, 2005/2006 session.
- PD Waivers – Conflict of Interest: Do not allow companies that certify cases to also provide services. Allow AAA's to provide case management as they do in FE waivers.
- Expand FE waivers to reduce nursing home care.
- Expand waivers for MR/DD population to reduce institutional care.
- Mandate use of automated time and attendance verification to eliminate fraudulent timesheets.
- Control spending in HCBS:
    - Require companies to certify rates: include employer taxes; workers comp; unemployment; 15% administrative costs. Both self-directed and non-self directed consumers.
    - Give tax rebates to those who pay for services without billing Medicaid rather than billing Medicaid with "Money Follows the Person."
    - Develop flat fee-based services
    - Eliminate coverage for Meals on Wheels under PCA
    - Update computers so plans of care don't sit in eval because of a change in client obligation.
- Limit paid services by 1st degree relatives.

SPECIFIC BENEFITS AND SERVICES

- Pharmacy
    - Require drug manufacturers to reimburse for cost of treating negative side-effects that result from faulty drugs.
    - Therapy management: use low-cost therapeutic equivalents instead of high-cost name brand drugs. Incentivize pharmacists who call doctors and convince them to switch to lower-cost drugs. (Community Care Rx.)
    - Mandate use of generics, including mental health drugs. More management of mental health Rx.
    - Increase use of generics system-wide. Est. 1% increase in generic dispensing rate yields $2.8 million in savings.
    - Implement co-pay differential for non-preferred brand name drugs.
    - Limit number of brand name drugs one patient can receive in a month.
    - Add antipsychotics and anticonvulsants to PDL.
    - Require step therapy for anti-convulsants and atypical antipsychotics.
    - Enhance use of prior authorization on off-label uses.
    - Prior authorization of off-label use for children discharged from hospital stays.
    - Dose optimization for drugs such as those used for chronic pain, migraines, as well as atypical anti-psychotics.
    - Electronically enhanced medication therapy management for beneficiaries with multiple chronic medical conditions / Poly-Pharmacy.
    - Implement "counter-detailing" for the 10 most highly utilized categories of drugs.
    - Control use of anagetic medication; increase constraints on formulary; deny Medicaid coverage for those found to use illicit drugs within past month.
    - Tighten Rx formulary – don't cover certain name brand drugs at all: Zyrtec; Claritin; Allegra, etc.
    - More in-depth formulary
    - Allow larger supplies of maintenance drugs – 90 days vs. 30 days. Save cost of refills.
    - Eliminate coverage of OTC medicines.
    - Revise reimbursement levels to reflect the true cost of acquiring and dispensing medicines, offsetting the loss they incur from federal action in 2005 (AMP-Based FULs – 2005 federal Deficit Reduction Act).
    -
- Emergency Room Care
    - Anecdote: Man couldn't get appt. with his doctor so went to ER for chest pains; was told he was not having a heart attack and was referred back to his family doctor; billed $3,000. Medicaid patients have no disincentive to using emergency room care – Medicaid pays for all of it.
    - Reimburse ER's at "office visit rate" for cases that are routine – earaches; sore throats; etc. Provide financial disincentive to Medicaid beneficiaries to use ER services for non emergency care.
    - Impose limits on number of ER visits allowed for a single Medicaid patient. (Refers to Missouri rule.)
- Transportation Services
    - Limit travel distance – e.g., a patient in Topeka who sees a provider in Holton; taxi having to wait until appointment is finished: time plus mileage.
    - Grants for counties: Provider in Sedgwick County using grant funds to modify minivans for HCBS beneficiaries: $20,000, vs. $7,000 to equip full-size van with wheelchair lift.
- Dental Services

    - Charge or fine parents who fail to bring kids in for regular exams instead of waiting years when they need more expensive, preventable procedures.
    - Align Medicaid rates in dental care with private insurance. In some cases, Medicaid pays much more than private insurance would pay. Charge co-pays ($3 - $5).
    - Limit x-rays and sealants. No panoramic x-rays for children under 6; no sealants on bicuspids.
- Psychiatric Care
    - Reduce unnecessary paperwork associated with mental health treatment.
    - More intensive outpatient adolescent treatment to prevent inpatient and PRTF care.
- Vision Care
    - Limit number of eyeglasses, repairs and vision exams allowed in a year. Medicaid currently pays for 3 pair of glasses; unlimited exams and unlimited repairs for children under 21.
    - Reduce number of glasses allowed per year for children.
- Catheters
    - Providing new, sterile catheters for each catheterization is less costly than limiting catheters and paying for care of recurrent urinary tract infections.

MEDICAID/KHPA Operations

- Eliminate self direct / payroll agent services.
- Put more eligibility info on KMAP website – reduce need for providers to speak directly with HP staff to verify eligibility.
- Cut state staff and salaries by an amount equal to the 10% rate reduction.
- Retain multiple payroll agents to reduce unemployment expenses.
- Eliminate paper notices of EFT (electronic fund transfer) deposits.
- Promote Health Savings Accounts within Medicaid.
- Increase Medicaid subrogation recoveries: contract for outside legal assistance.
- Simplify/shorten EOB (Explanation of Benefits) reports.
- Allow hospitals to contract with KHPA to provide staff/resources to help applicants apply for Medicaid and to process applications.
- Establish medical homes with greater access.
- Implement medical home model of health care delivery.
- Use grant funds to place outstation eligibility workers at regional medical centers (Via Christi) in addition to safety net clinics.
- Promote use of Electronic Health Records
- Facilitate adoption of Personal Health Records
- Invest in and promote telemedicine.
- Promote the use of clinical decision support systems.
- Promote use of computerized physician order entry/E-Prescribing.
- Encourage the use of HIT in collaborative chronic care management.
- Fund HIT expansion.
- Consumer-directed care: high deductibles or co-pays with health savings accounts; greater availability of information about cost and quality of health care services.
- Reduce use of unnecessary services
    - Enact a “Certificate of Need” law, requiring state approval before building new facilities or acquiring expensive equipment.
    - Pre-certification/Medical Necessity Reviews
- Use less expensive forms of care
    - Increase and promote use of ambulatory surgical centers

    - Ease provider scope of practice and licensing rules.

- Prevention of fraud and abuse
    - Use electronic prescriptions to identify prescription errors and patterns of fraud and waste.
    - Use "secret shoppers" to probe providers suspected of fraud and abuse.
    - Use "Surveillance and Utilization Review" to detect patterns of fraud and abuse.

REIMBURSEMENTS

- Align/adjust secondary and tertiary crossover payments from Medicare.
- Put Medicaid services up for bid on a DRG payment formula; payments to be based on diagnosis and intensity of service.
- Establish tiered reimbursement rates based on the number of Medicaid patients a provider sees; lower rates for those who see fewest Medicaid patients; higher rates for those who treat more.
- Same – tiered reimbursements: incentivize primary care providers in order to reduce ER use.
- Change MR/DD residential services payments from flat daily rate to a rate based on services actually provided.

ELIGIBILITY

- Restrict eligibility by tightening income guidelines.
- Citizens only – cut off benefits to illegal aliens.
- Mandatory drug screening for applicants and random drug screening to follow up.
- More verification of income, living arrangements and citizenship.
- Put time limits on Medicaid eligibility.
- Limit number of times one can apply for HCBS/FE benefits in a given period – people keep filling out the application over and over until they get the answers right and the score needed for eligibility. Suggest 5-month waiting period before one can apply again unless there's a documented change in condition.

MANAGED CARE

- Remove prescription drug program from Unicare and CMFHP.
- Replace Unicare and CMFHP with Health Connect.
- Eliminate the use of Unicare – prior authorization rules not consistent between MCO's.
- Expand Medicaid managed care to high-cost disabled populations.

ENHANCED CARE MANAGEMENT

- Fresenius Integrated Care Management for Chronic Kidney Disease. (Claim savings of $20,000 per member in first 90 days.)
- Diabetes education, to more effectively utilize services already being paid for.
- Disease management and coordination of care
    - Chronic care model
    - Adherence to medication
- Coordination of care for dual eligibles.
-

REVENUE ENHANCEMENTS

- Reduce Medicaid cut from 10% down to 2 or 3%; raise taxes to make up difference.
- Raise taxes on sodas and snacks; close sales tax exemptions for religious organizations
- Increase taxes on cigarettes and tobacco products.
- Charge $10 co-pays for professional services and $15 for procedures.
- Raise taxes and reimbursement rates.
- Levy a Nursing Home Provider Tax to draw down more federal reimbursement.
- Charge co-pays for Medicaid services.
- Charge co-pays for Medicaid prescription drugs: $2 generic; $3 brand name.
- Charge counties for the state's share when counties provide mental health, DD or other health care services.
- Increase co-pays to reduce unnecessary office visits.

OTHER

- Enact tort reform.
    - Limit malpractice non-economic damage awards
    - Establish a pre-trial screening panel to weed out frivolous lawsuits.
    - Require losing parties to pay winner's attorney fees
    - Create a Medical Errors Commission to systematically identify medical errors, their causes and how to prevent them.
    - Impose a collateral source rule
    - Impose periodic payments on awards to reduce the up-front costs.
- Public health measures/healthy lifestyles
    - Encourage the use of employer-based wellness programs
    - Implement community-based screening and lifestyle interventions.
    - Provide incentives for greater access to certain clinical prevention services.
- State Employee Benefits
    - Pool state and local government employees.
    - Utilize self-insured purchasing model with tiering.
    - "Centers of Excellence – select the best performing providers and give them special designations, with the expectation that patients will more likely select such designated institutions for care.
    - Implement health management programs
    - Connect pharmacy and health benefits decision making.
- State retiree benefits
    - Take into account future costs when setting retiree benefits. Use pre-funding.
-