The Medicaid Reform Public Input and Stakeholder Consultation process is supported by the following organizations:

- **Health Care Foundation of Greater Kansas City,**
- **Kansas Health Foundation,**
- **REACH Healthcare Foundation,**
- **Sunflower Foundation and**
- **United Methodist Health Ministry Fund.**

Overland Park, Kansas
August 17, 2011

AD ASTRA PER ASPERA
Kansas

Welcome

Lt. Governor Jeff Colyer, M.D.

Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

Agenda

Topic	Presenter
Welcome	Lt. Governor Jeff Colyer, M.D.
Opening Thoughts	Secretary Pat George Kansas Department of Commerce
Public Input Process	Secretary Robert Moser, M.D. Kansas Department of Health and Environment
Medicaid Reform Principals	Lt. Governor Jeff Colyer, M.D
Medicaid Costs and Key Facts	Theresa Shireman, PhD, RPh University of Kansas Medical Center
Roundtable Discussions	Michelle Raleigh, Deloitte Consulting
Closing	Lt. Governor Jeff Colyer, M.D

Opening Thoughts

Secretary Pat George
Kansas Department of Commerce

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Public Input and Stakeholder Consultation Process

Secretary Robert Moser, M.D.
Kansas Department of Health and Environment

Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

The Challenge

- **Improve Outcomes**
- **Reduce Costs**

How We Got Here

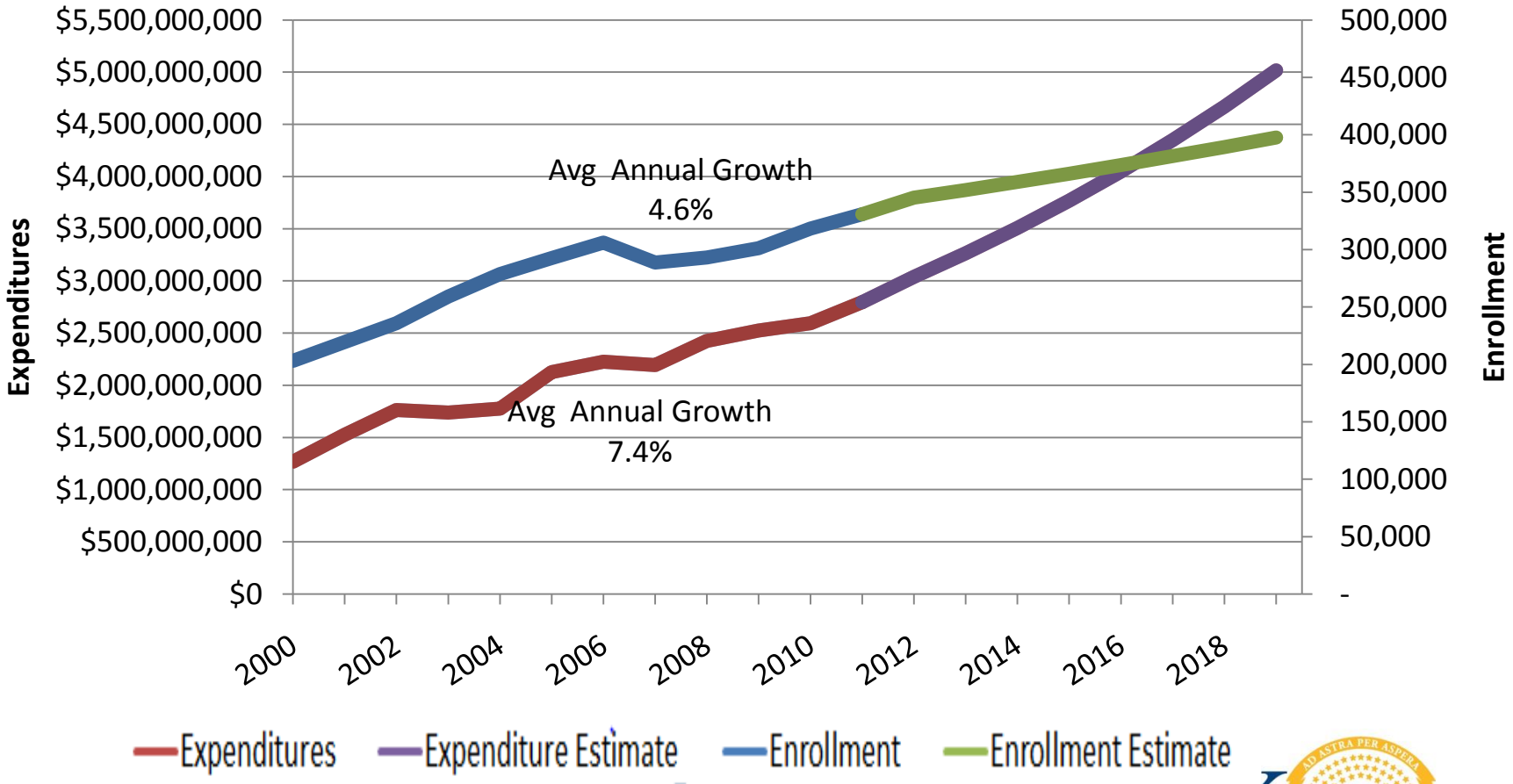
- **Long-run trends in Medicaid are driven by widespread increases in enrollment and spending per person.**

- **It is not "just the economy" – Kansas is in the midst of a sustained period of accelerated growth as baby boomers reach age of acquired disability.**

- **Enhanced federal match rate partially – and temporarily – disguised the scale of the deficit.**

Sustained Medicaid Growth

Total Medicaid – without expansion



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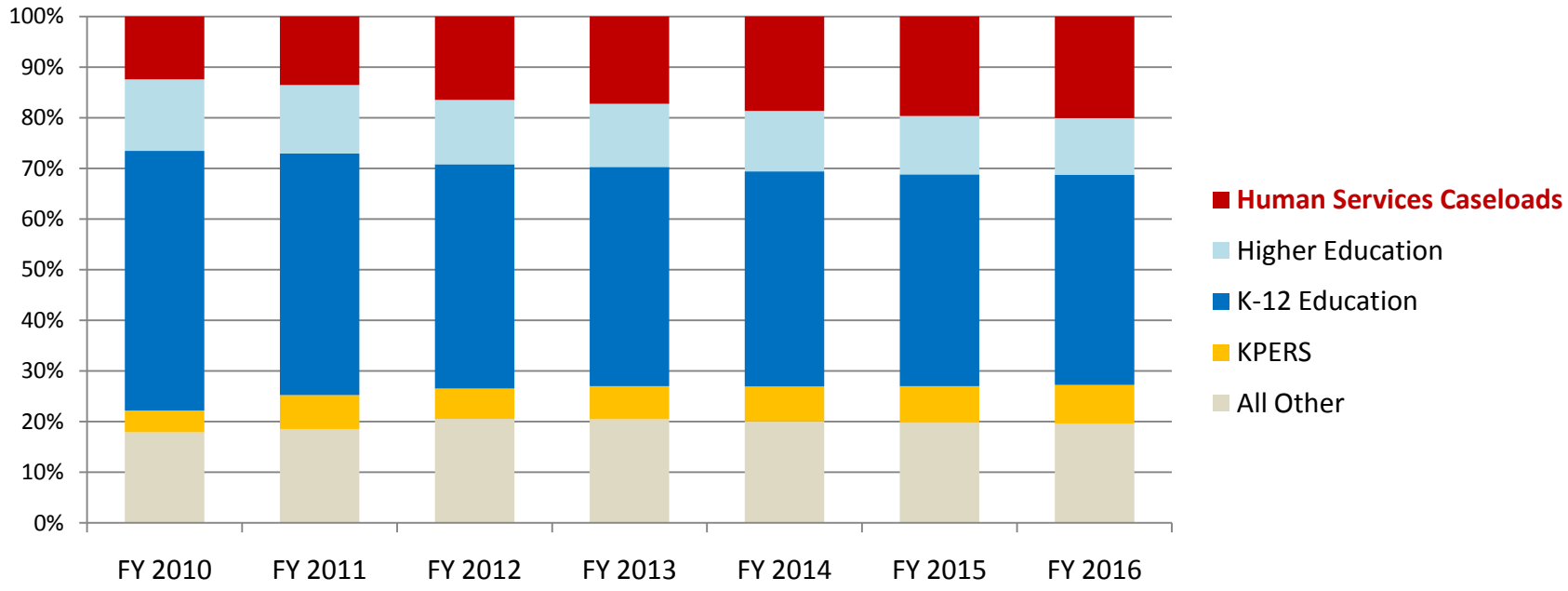
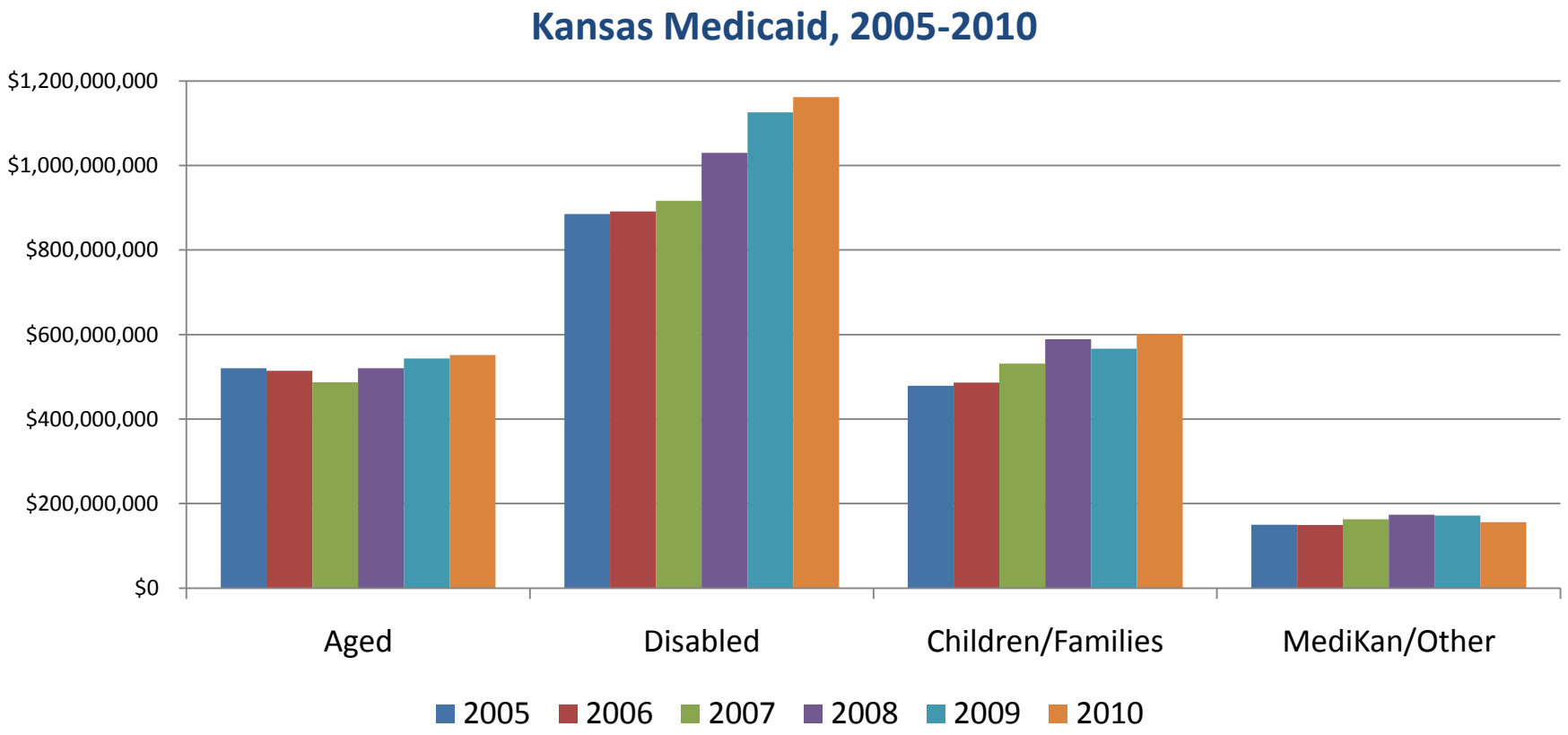
The Crowd-Out Effect

Expenses as % of State General Fund



FY 12-16 projected; illustrates impact on other programs if Medicaid spending growth continues unabated. Assumes projected deficits would be offset in other programs.

Growth by Population



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Stakeholder Involvement So Far

- Solicited ideas for reforms or pilots to curb growth, achieve long-term reform, and improve the quality of services in Medicaid
- 60+ submissions with more than 100 proposals submitted in February 2011
- Three public forums this summer with 1,000 participants and more than 1,600 individual ideas
- Web survey generated about 200 additional responses
- Stakeholder web conferences helped define issues and key concerns with emerging themes

Parallel Initiatives

- **Medicaid Reform Data Workgroup**
- **Pharmacy Services Workgroup**

Population Focus/Key Concerns

- **Children, Families and Pregnant Women: Mobile population; moves in and out of eligibility**

- **Aged: Higher-than-average proportion of Kansas seniors in institutions**

- **Disabled: Fragmented service provision**

Type of Service By Population

SFY 2010, in $millions	Children/ Families	Disabled	Aged	MediKan/ Other	TOTAL
Physical Health	**555**	**450**	107	76	1187
Behavioral Health	37	102	12	32	184
Substance Abuse	8	7	0	7	22
Nursing Facilities	NA	111	**312**	1	424
Home and Community Based Services	NA	**479**	121	8	608
TOTAL	**600**	**1149**	**552**	**124**	**2425**

Fragmentation

- **Spending is spread widely across service types, funding streams, state agencies, and providers.**

- **There is no uniform set of outcomes or measures for programs or providers.**

Emerging, Cross-Cutting Themes

Integrated, whole-person care

- Aligning financing around care for whole person
- Patient-centered medical homes
- Enhancing health literacy and personal stake in care

Emerging, Cross-Cutting Themes

Preserving independence/creating a path to independence

- **Removing barriers to work**
- **Aligning incentives among providers and beneficiaries**
- **Delaying or preventing institutionalization**

Emerging, Cross-Cutting Themes

Alternative access models

- Utilizing technology and nontraditional settings
- Thinking creatively about who can deliver care

Medicaid Transformation: Serving Kansans

Lt. Governor Jeff Colyer, M.D.

Our vision is to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

The Challenges

- 100,000 Kansans out of work
- School Funding
- KPERS Underwater
- Medicaid Transformation
- Large Budget Deficits

Major Issues in Medicaid

- Medicaid is 45 years old
- Assure stable healthcare for Kansans
- Assure better health outcomes
- Complex Federal/State/Patient/Insurer/Provider relationship
- Current Costs will overwhelm Kansas

Medicaid Transformation Principle:
Holistic Care focused on Outcomes

- **A Surgeon's Perspective: Care for the Whole Person focused on Outcomes**
- **Quality results improve lives**
- **Need to look at ALL programs, agencies, tax policy, jobs, lifestyle of the person**
- **Respect and account for the connection between physical and mental health. Kansans do not live in silos.**

Medicaid Transformation Principle:
Create a Strong, Dignified Safety Net for our Most Vulnerable Kansans

- **Target Those Most in Need**
- **Home is Best**
- **Make sure the Safety Net is stable**

Medicaid Transformation Principle:
Economically Rational

- **Medicaid Pricing/planning structures are very similar to Soviet military economics**
- **Need to align health decisions, costs, and quality in the same direction**
- **Quality/Outcomes need to be linked to Price**
- **Eliminate needless paperwork**
- **Economic Rationality means everyone needs to feel the link between outcomes and costs**

Medicaid Transformation Principle:
Assist people from Medicaid to the workplace

- **Nearly 20% of Medicaid recipients leave/enter annually**
- **Wherever possible, Medicaid should bridge and transition to work and private financing. Avoid cliff effect.**
- **Need to create incentives for the private sector to employ people with disabilities**
- **Eliminate the disincentives to employment for people with disabilities**

Medicaid Transformation Principle:
Reward Personal Responsibility for Health Outcomes

- **Personal Health Decisions have the biggest impact on quality of life**
- **Need to align Medicaid to reward personal responsibility—just as private insurers do**
- **Example: Reward patients who quit smoking, improve obesity, etc.**
- **Example: Reward patients who actively manage their own healthcare, take their medications, etc.**

Medicaid Reform Vision Statement

To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility.

Medicaid Costs and Key Facts

Theresa Shireman, PhD, RPh
University of Kansas Medical Center

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Medicaid Reform Data Workgroup

- Identify and use data to help the Administration better define the challenge, address the challenge, and communicate with stakeholders
- Asked for volunteers to use claims data and KDHE's Data Analytic Interface to help answer questions

The Questions

- How does utilization vary by region?
- Who are the high-cost patients?
- How can spending on the dually eligible (Medicare – Medicaid) be explained?
- How can hospital readmissions and avoidable spending be explained?

The Volunteers

- Cheng-Chung Huang, MPH, KHI
- Ivan Williams, MBA, KHI
- Theresa Shireman, PhD, KUMC
- Amanda Reichard, PhD, University of Kansas
- Suzanne Hunt, MS, KUMC
- Niaman Nazir, MBBS, MPH, KUMC
- Robert Lee, PhD, KUMC
- Chuck Anderson, KU Hospital
- Jean Hall, PhD, University of Kansas

Kansas Medicaid Costs Across Populations

SFY 2010, in $millions	Children/ Families	Disabled	Aged	MediKan/ Other	TOTAL
Physical Health	**555**	**450**	107	76	1187
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Regional Variation for the Medicaid Aged Population

- Regions with more licensed Long-Term Care beds per capita (per 1,000 adults 65+) tend to spend more per member than regions with a smaller number of LTC beds per capita
- Regions that spend more on HCBS services may spend somewhat less on health care overall
- While HCBS increases spending initially, eventually long-term savings come from reduced institutional spending (Kaye, et al., 2009)
- AARP ranks Kansas as having the 6th highest nursing facility utilization per capita and the 4th highest HCBS utilization per capita for adults over 65.

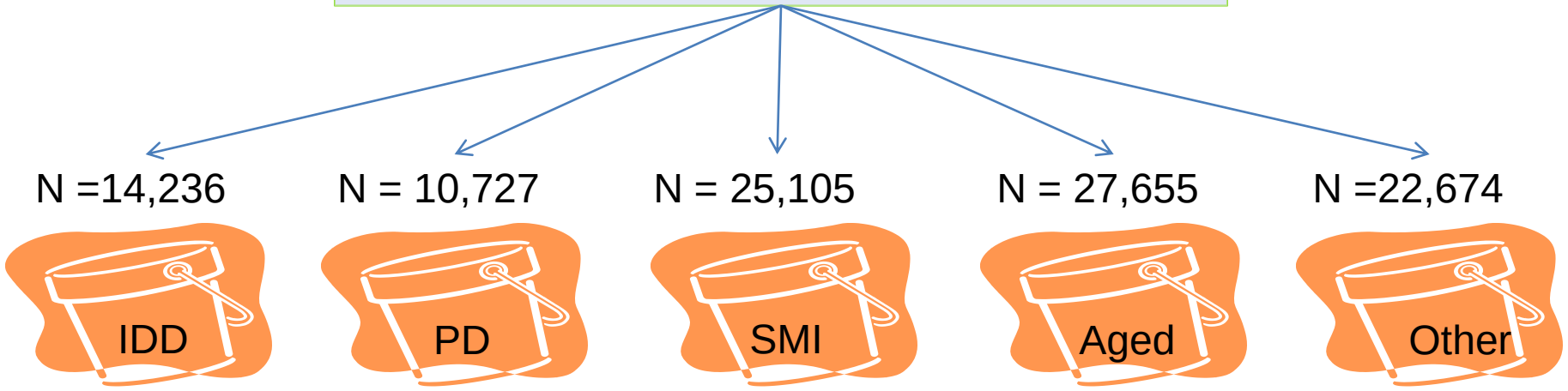
Regional Variation for the Medicaid Adult Blind/Disabled Population

- Regions that spent more on HCBS services for the Blind/ Disabled tended to spend more overall
- Spending a greater proportion on HCBS services was also associated with higher overall costs.
- Regions that spent a higher proportion of their overall spending on physician services tended to spend less overall.
  - Same relationship doesn't exist for actual dollars spent

Regional Variation in Acute Hospital Cost & Utilization

- Acute hospital payments per member per month ranged from $37.94 in the McPherson area to $101.81 in the Kansas City North Area (WY and LV counties).
- Aged acute hospital days per 1,000 members ranged from 1,499 in McPherson to 5,099 in Coffeyville.
- Blind/Disabled adult acute hospital days per 1,000 members ranged from 1,328 in Hays to 3,848 in KC North (WY and LV counties).
- Non-Disabled children and adult acute hospital days per 1,000 members ranged from 351 in Winfield to 630 in Hays

N = 100,397
Adults in Medicaid ABD
(FY2009)



Divided adult aged & disabled program into subgroups:

- IDD = adults with intellectual & developmental disabilities
- PD = adults with physical disabilities
- SMI = adults with severe mental illness
- Aged = older adults NOT in above groups
- Other = persons not classified

Adults with IDD are younger than other disability groups
Adults with PD or SMI are in their early 50s

	IDD (%)	PD (%)	SMI (%)	Aged (%)
Mean Age (yrs.)	43.6	52.4	52.1	78.5
Distribution				
18-29 yrs.	25.8	4.7	12.4	0
30-39 yrs.	16.9	8.3	12.5	0
40-49 yrs.	21.5	23.0	22.4	0.1
50-59 yrs.	18.8	35.6	23.4	0.3
60-69 yrs.	9.9	25.1	10.6	19.2
70-79 yrs.	4.6	2.3	7.0	35.9
80 yrs. plus	2.7	1.0	11.7	44.4

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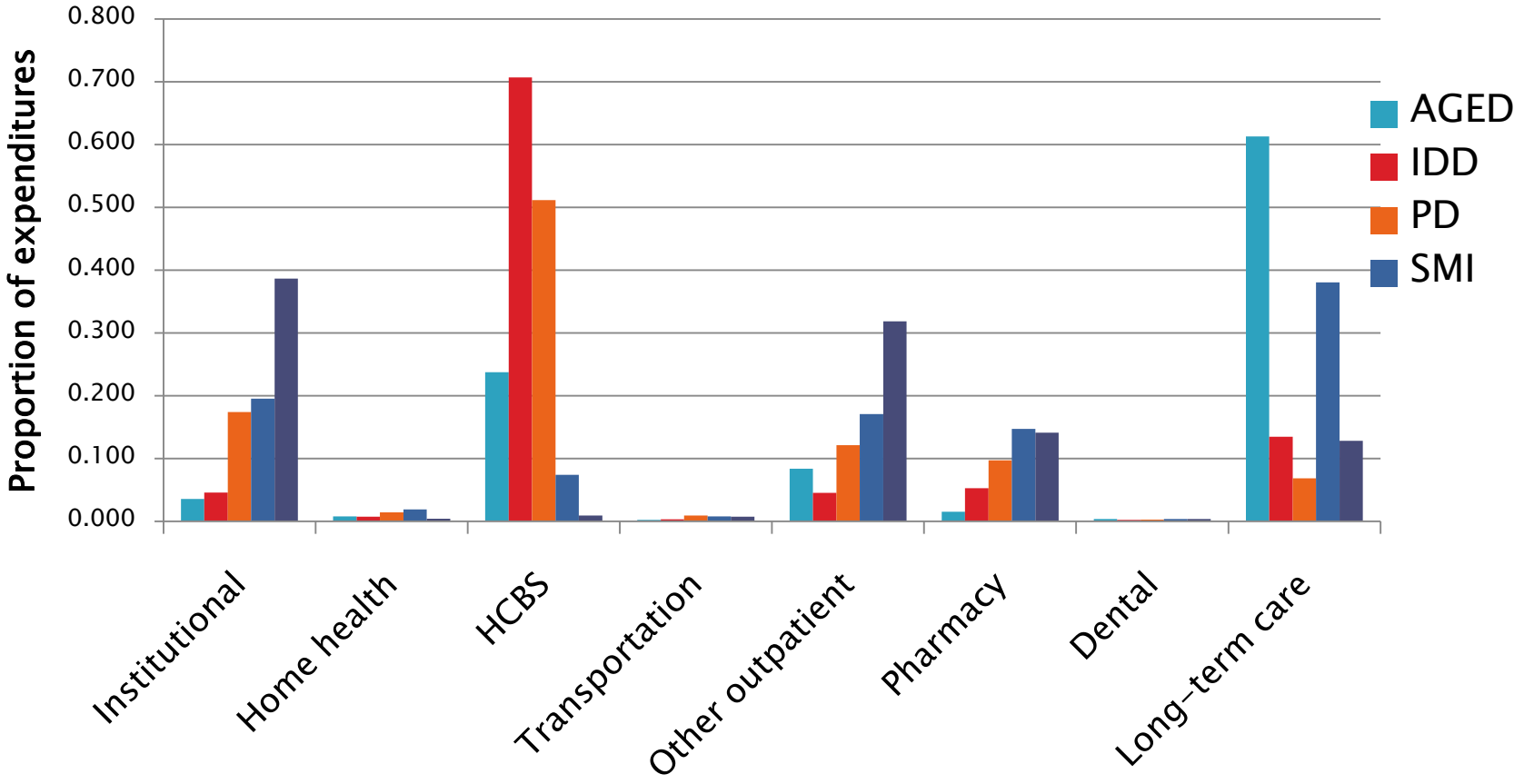
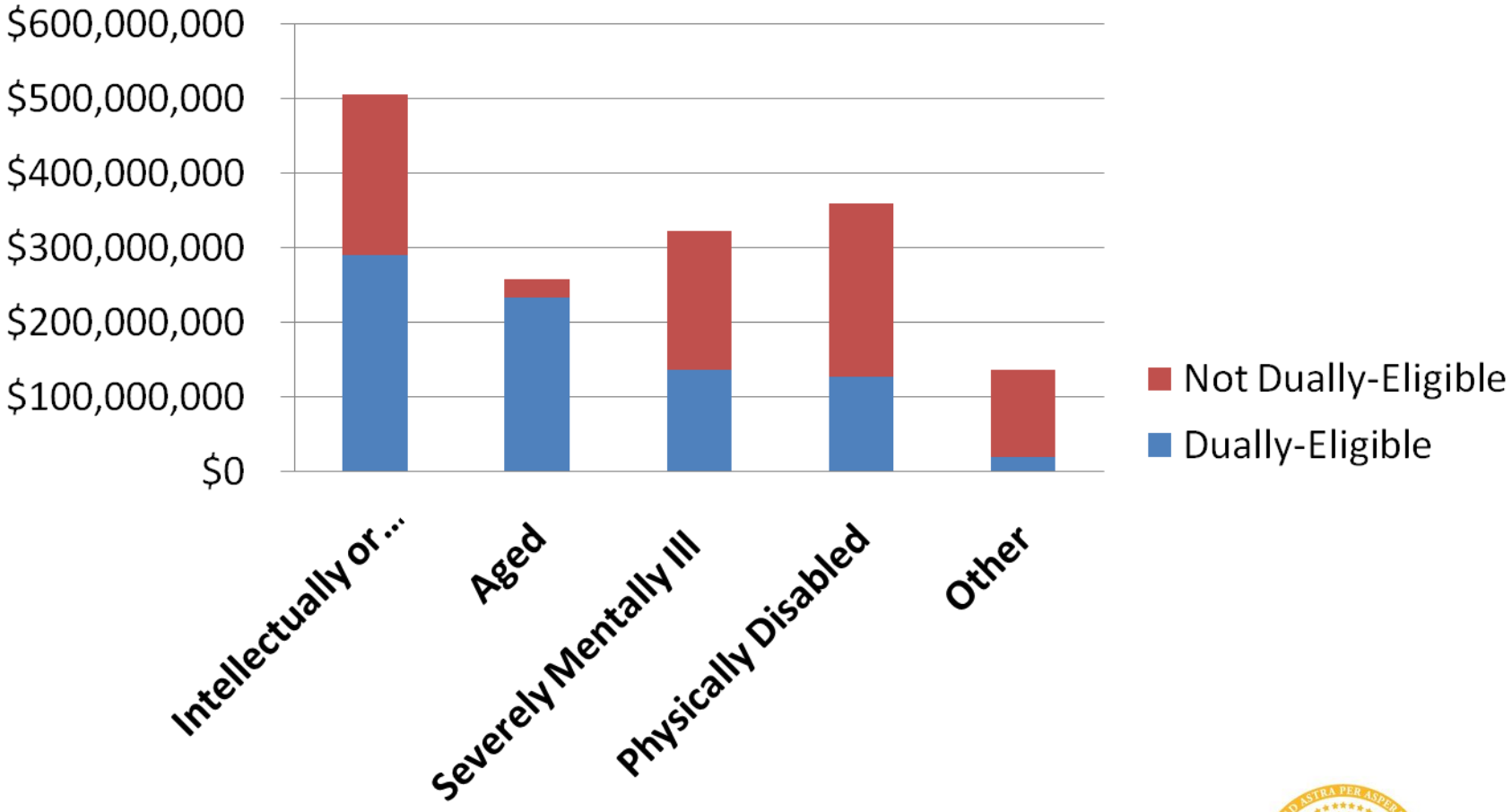
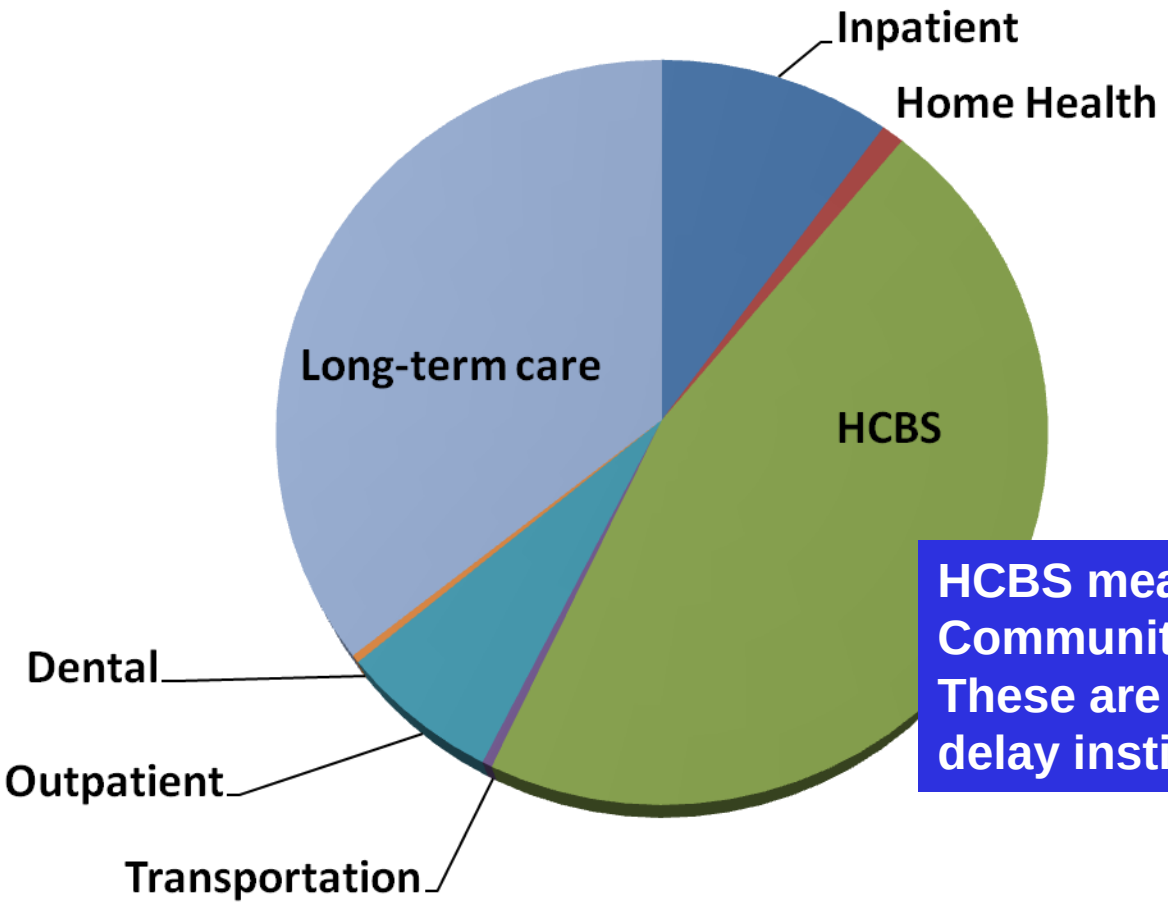
Medicaid Expenditures for Aged & Blind/Disabled adults mostly go toward HCBS or LTC (SFY 2009), but vary by group



51% of 2009 Kansas Medicaid FFS spending was on behalf of Duals (persons covered by Medicaid & Medicare)



82% of Medicaid FFS spending for Duals was for HCBS and Long-term Care



HCBS means Home and Community Based Services. These are meant to avoid or delay institutionalization.

Key Findings - Readmissions

- 30-day readmission rates for Kansas Medicaid =9.9%
- Medicare =18%
- Psychoses = highest volume DRG with 3,313 readmissions within 30 days of discharge over a five year period (12.9% readmit rate)
- Next highest volume DRG had 1,141 readmissions over a five year period.
- Average cost of a readmission is approximately 50% higher than the average cost of all admissions.
- While readmissions are not a key driver of increased Medicaid expenditures, but there is potential to reduce Medicaid costs (~$40 million/year)

Readmissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.

Key Findings – Avoidable Admissions

- Avoidable admission rates are 11.8% per year
- 49% of these costs are related to low birth weight
- Only 29% of these cost are related to chronic conditions (Asthma, CHF, COPD, Diabetes and Hypertension)
- While avoidable admissions are not a key driver of Medicaid expenditures, there are opportunities for reducing these costs (~$36-40 million/year)
  - Reducing these admissions would require an improved coordination of care and education in the outpatient setting.

Avoidable admissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.

Promote Work
Reduce Costs

Working Healthy
Making health care work

A work incentive program implemented July 1, 2002 designed to help people get or stay competitively employed by providing Medicaid-funded health care.

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Avoidable admissions defined by Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators.

Working Healthy growth over time

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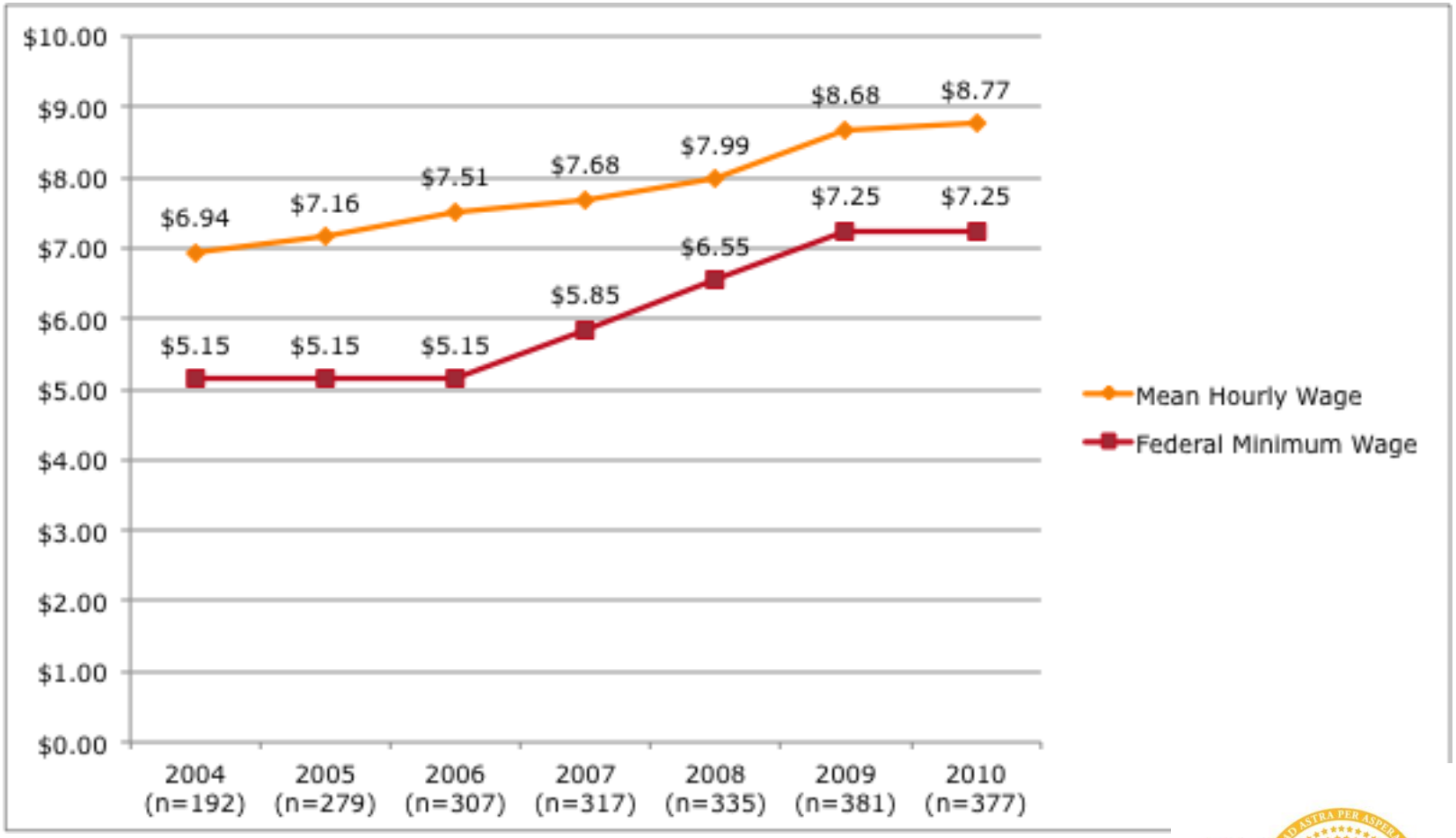
Source: Kansas MMIS
*Does not include retroactive enrollment and premiums

Success of Participant Work Efforts



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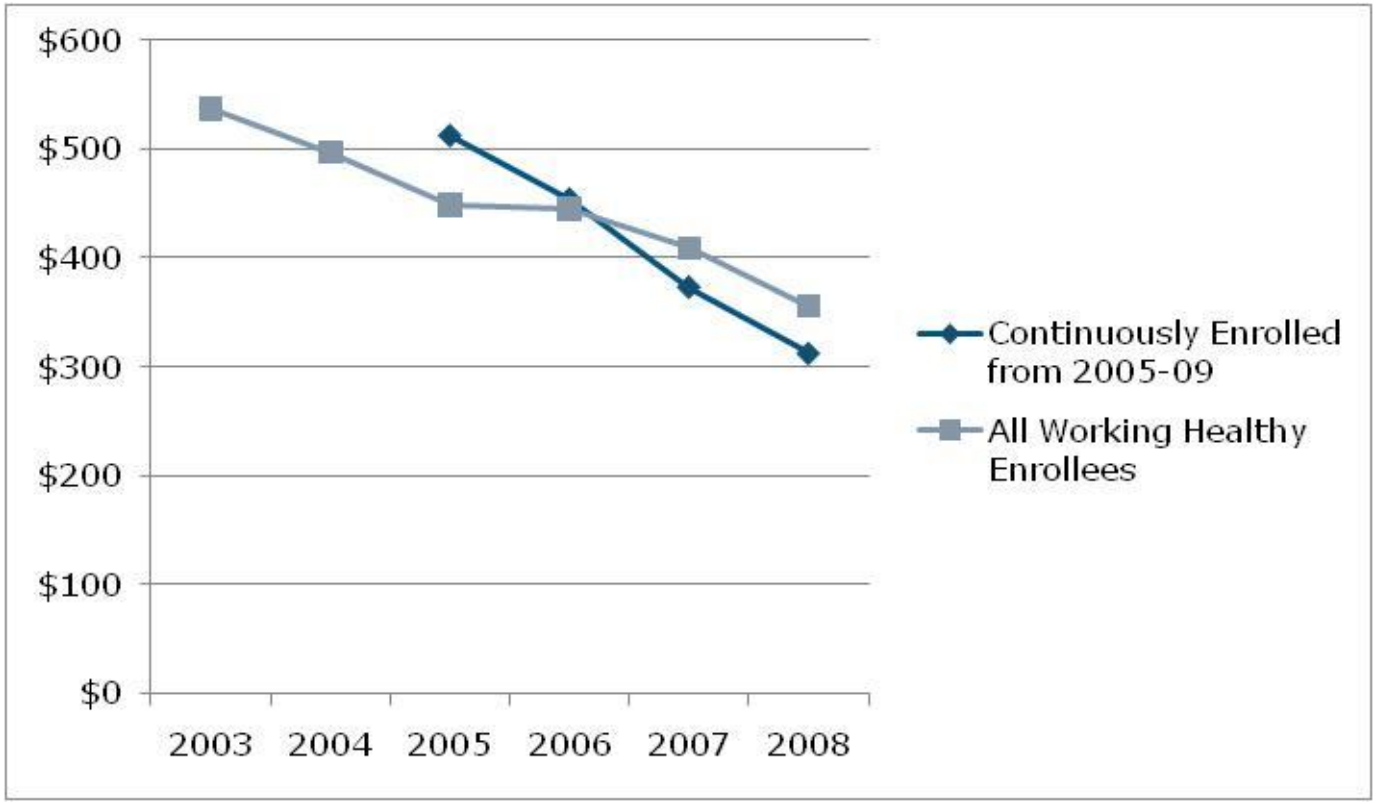
Data source: Kurth, Fall, Hall (2011). *Working Healthy Data Chartbook,2nd Edition.*

Reduced health care costs over time



Working Healthy Participant Medicaid Outpatient Per Member Per Month (pmpm) Expenditure Trends*

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*From MMIS claims data

Roundtable Discussions

Michelle Raleigh
Deloitte Consulting

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Instructions for Roundtable Sessions

- There will be multiple rounds of discussion on many Medicaid reform ideas presented so far in the process. The majority of the ideas cover all populations. There will also be some specific ideas on HCBS and Nursing Facility services.

- Utilize the Feedback forms on your tables to:
  - Discuss recommendations for reforming Medicaid
  - Review pre-populated issues and considerations
  - Add/edit list of issues and considerations (appoint table scribe to take clear notes)

- Report back on selected recommendations (appoint speaker at table)

Closing

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To share any additional thoughts or considerations please complete the Public Input Survey located at the following web address:

https://www.dhe.state.ks.us/Community/se.ashx?s=11B9BDC9212F51AF

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