



Legislative Post Audit Performance Audit Report Highlights

Medicaid: Evaluating KanCare's Effect on the State's Medicaid Program

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QUESTION 1: *What Effect Did Transitioning to KanCare Have on the State's Medicaid Costs, the Services Provided, and Client Health Outcomes?*

Background Information

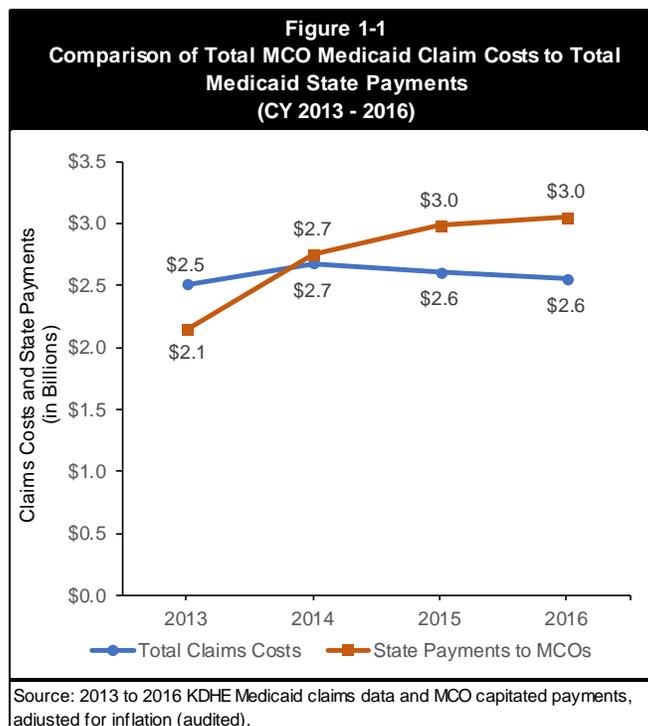
Established in 1965 as part of the Social Security Act, Medicaid is an insurance plan for low-income children, families, the elderly, and individuals with intellectual or physical disabilities. Medicaid is jointly funded by states and the federal government. In 2016, federal funds covered about \$1.7 billion of Kansas' Medicaid costs and state funds covered the remaining \$1.3 billion.

In 2013, Kansas implemented KanCare, bringing the state's most costly beneficiaries under managed care for the first time. Under KanCare, the state contracted with three Managed Care Organizations (MCOs) to administer the state's Medicaid program. Under KanCare, the MCO's, not the state, are responsible for paying providers for services delivered to beneficiaries.

Prior to KanCare, children and families on Medicaid were already served under a form of managed care, whereas individuals with disabilities and the elderly were served under a fee-for-service model.

KANCARE'S EFFECT ON MEDICAID COSTS

- Factors other than KanCare appear to have kept Medicaid claims costs stable since 2012.
- State payments to the state's three Managed Care Organizations (MCOs) were less than Medicaid claim costs in 2013 but exceeded MCO claim costs by about 20% in 2016 (p. 12).
 - Under KanCare, the state pays three MCOs a per-member-per-month rate for administering the state's Medicaid plan.
 - State payments to the three MCOs have grown from \$2.1 billion in 2013 to \$3.0 billion in 2016.
 - During KanCare's first year in 2013, state payments to the three MCOs were about \$400 million less than what the MCOs paid in provider claims.
 - By 2015, state payments to the MCOs were about \$400 million more than what the MCOs paid in provider claims.



- Total Medicaid claims costs have remained stable after KanCare, although per-person costs decreased by about 9% (p. 14).
 - *After adjusting for inflation, beneficiaries' total Medicaid claims remained stable at about \$2.7 billion before and after KanCare's implementation.*
 - *Claims costs per person decreased 9% after KanCare's implementation because of increased enrollment.*
 - *Increased enrollment did not increase Medicaid claims costs because the majority of enrollment growth came from children and adults who were less expensive to serve.*
- However, our model results showed that the implementation of KanCare did not appear to have helped contain Medicaid claims costs (p. 16).
 - *Other factors such as changes in the age, race, and gender of Medicaid beneficiaries likely offset the estimated cost increase after KanCare's implementation, but we could not isolate their specific effects.*
 - *Despite some limitations, our regression analysis is the most appropriate study to evaluate KanCare's estimated effect on costs and service use.*

KANCARE'S EFFECT ON MEDICAID SERVICE USE

- KanCare appears to have increased the use of four of the five Medicaid services we could evaluate (p. 17).
 - *KanCare increased the use of three preventative services (primary care, dental, and behavioral health), which was consistent with the expectations of a managed care model.*
 - *KanCare had little to no effect on inpatient care, implying its emphasis on preventative care did not reduce beneficiaries' time in a hospital.*
 - *KanCare increased the use of nursing facility care, which was not consistent with the expectations of a managed care model.*

KANCARE'S EFFECT ON MEDICAID OUTCOMES

- Significant data reliability issues prevented us from evaluating KanCare's effect on health outcomes (p. 21).
 - *The Kansas Foundation for Medical Care's health outcome data lacked sufficient detail for us to evaluate KanCare's isolated effect on Medicaid health outcomes.*
 - *KDHE's health outcomes data was unreliable for five of the seven datasets we collected.*

KANCARE'S EFFECT ON MEDICAID ELIGIBILITY, SERVICES, AND COVERAGE LEVELS

- Implementing KanCare did not affect the state's Medicaid eligibility requirements (p. 22).
 - *Individuals must meet specific demographic, income, citizenship, and other requirements to be eligible for Medicaid in Kansas.*
 - *Our review of the state's Medicaid plan showed KanCare did not change Medicaid eligibility requirements.*
 - *The federal Affordable Care Act made some minor changes to the state's Medicaid eligibility criteria in 2014.*
- KanCare did not significantly affect services offered under Medicaid but did change who provided case management services (p. 23).
 - *Federal terms and conditions require the state to offer, at a minimum, the same types of services as before KanCare.*
 - *KanCare did not significantly change the services offered but added a few services not previously available to beneficiaries, including annual dental cleanings.*

KDHE estimated KanCare would save \$1 billion over its first five years by improving care coordination and beneficiary outcomes, with the largest savings coming from individuals with disabilities and the elderly.

Kansas' Medicaid program involves numerous entities at the federal, state, and private levels. Those entities include the Kansas Department of Health and Environment, the Kansas Department on Aging and Disability, the Attorney General's Office, three managed care organizations, two private contractors, and an external review organization.

Medicaid Requirements

Individuals must meet specific demographic, income, citizenship, and several other requirements to be eligible for Medicaid in Kansas. Federal regulations require all state's eligibility rules to be documented in the state's Medicaid plan and be approved by the Center for Medicare and Medicaid (CMS).

Federal regulations also require the state to cover certain services such as primary and inpatient care. Additionally, KDHE places limits on how far Medicaid beneficiaries must travel to access 29 Medicaid services across the state.

Audit Methodology

We worked with the Kansas Department of Health and Environment (KDHE) to obtain nearly 200 million Medicaid records related to beneficiary demographics, Medicaid claims, service use, and health outcomes. We used that data to determine KanCare's effect on Medicaid costs and services through several trend and regression analyses.

Trend analyses allowed us to understand how Medicaid costs and service utilization has changed before and after KanCare's implementation. However, these analyses cannot isolate KanCare's effect on cost and utilization from other variables like age, race, and gender.

Regression analyses allowed us to isolate, as much as possible, KanCare's estimated effect on costs and service use from the effect of other contributing factors such as a beneficiary's age, race, gender, and geographic location.

- *Under KanCare, most case management services are now delivered by MCO managed care coordinators rather than by targeted case managers.*
- Coverage for most Medicaid services remained the same before and after KanCare's implementation (p. 24).
 - *KDHE places limits on how far Medicaid beneficiaries must travel to access 29 Medicaid services across the state, which we refer to as coverage requirements.*
 - *With a few exceptions, network coverage for Medicaid services did not change significantly after KanCare was implemented.*
 - *In 2016, nearly half of the 29 Medicaid service networks we evaluated covered 80%-99% of the state based on KDHE's requirements.*
 - *Six service networks covered just 35%-65% of the state based on KDHE's requirements.*
 - *Network data the MCOs submit to KDHE had duplicative, missing, and outdated provider information.*
 - *We could not analyze providers' actual capacity to serve Medicaid beneficiaries because KDHE did not require MCOs to submit that data.*

OTHER FINDINGS

- KDHE lacks a process to ensure the accuracy of MCO data used to calculate state payments (p. 27).
 - *MCOs submit claims data to KDHE, which is used to calculate future state payments to the MCOs*
 - *KDHE has a process to ensure MCOs claims are allowable but lacks a process to ensure they are also accurate.*
 - *We compared a judgmental sample of 19 provider claims against MCO reported costs and found no significant discrepancies.*
- One managed care organization inappropriately included interest penalties in the claims it submitted to KDHE. (p. 29).
 - *Sunflower improperly included interest payments in the claims data it submitted to KDHE.*
 - *Including interest in its claims payments may have inappropriately inflated state payments to Sunflower.*
- Stakeholders expressed concerns over claims processing, administrative burdens, and poor communication under KanCare (p. 30).
 - *Seven of nine stakeholders told us they were concerned about the timeliness or accuracy of claims payments, although three groups told us these issues had improved since KanCare was first implemented.*
 - *Four of nine stakeholders told us claims processing issues resulted in increased administrative burdens for providers under KanCare.*
 - *Four of nine stakeholders mentioned communication issues between providers, the MCOs, or the state.*
- KDHE appears to have difficulty providing timely and accurate Medicaid data (p. 30).
 - *Four of nine stakeholders we interviewed expressed concerns over the timeliness or accuracy of Medicaid data requested from KDHE.*
 - *We had similar experiences attempting to get accurate data from KDHE during this audit, which delayed our evaluation.*
 - *Several complicating factors hinder KDHE's ability to produce accurate or timely data, such as inconsistent coding from the three MCOs.*

SUMMARY OF RECOMMENDATIONS

We recommended the Kansas Department of Health and Environment should take steps to help improve the accuracy of the Medicaid claims data it receives from the state's three MCOs and should collect capacity data for the state's Medicaid providers. We also recommended the department should review a large sample of Medicaid claims to determine if interest penalties may have inflated state payments to the MCOs and should consider whether to pursue reimbursement for any overpayments it identifies.

AGENCY RESPONSE

The Kansas Department of Health and Environment generally concurred with the audit's findings and recommendations but expressed concerns with one of our analyses. We worked with KDHE officials and edited our draft language to address several of their concerns. Ultimately, agency officials had some remaining concerns about our analysis which was included in their formal response.

HOW DO I REQUEST AN AUDIT?

By law, individual legislators, legislative committees, or the Governor may request an audit, but any audit work conducted by the division must be directed by the Legislative Post Audit Committee. Any legislator who would like to request an audit should contact the division directly at (785) 296-3792.

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