# PERFORMANCE AUDIT REPORT

## Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program

**A Report to the Legislative Post Audit Committee**
**By the Legislative Division of Post Audit**
**State of Kansas**
**April 2010**

**10PA12**

# *Legislative Post Audit Committee*
# *Legislative Division of Post Audit*

**THE LEGISLATIVE POST** Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $13 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

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April 21, 2010

To: Members, Legislative Post Audit Committee

| | |
|---|---|
| Senator Terry Bruce, Chair | Representative John Grange, Vice- Chair |
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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program*.

The report also contains appendices that provide a Medicaid primer, a bibliography of literature related to Medicaid managed care, and a list of Medicaid cost-savings strategies.

The report includes several recommendations for the Kansas Health Policy Authority related to providing policymakers with information that would help guide decisions on how to better manage care for high-cost Medicaid clients, such as conducting Statewide analyses of medical data. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

# READER'S GUIDE

## *The Big Picture*

| | |
|---|---|
| **Audit Highlights** | The highlights sheet, inserted in each report, provides an overview of the audit's key findings |
| **Conclusions and Recommendations** | Located at the end of the audit questions, or at the end of the report |
| **Agency Response** | Included as the last Appendix in the report |
| **Table of Contents, and lists of figures and appendices** | Lets the reader quickly locate key parts of the report |

## *The Details*

| | |
|---|---|
| **"At-a-Glance Box"** | Used to describe key aspects of the audited agency; generally appears in the first few pages of the main report |
| **Side Headings** | Point out key issues and findings |
| **Charts, Tables, and Graphs** | Visually help tell the story of what we found |
| **Narrative Text Boxes** | Highlight interesting information or provide detailed examples |

This audit was conducted by Justin Stowe and Lynn Retz. Chris Clarke was the audit manager. If you need any additional information about the audit's findings, please contact Justin Stowe at the Division's offices.

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# Table of Contents



# List of Figures



# List of Appendices

# Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program

Since 1998, North Carolina has been using an "enhanced medical home" model of care called Community Care of North Carolina (CCNC) in its Medicaid Program. CCNC serves about 75% of that state's Medicaid clients, and places heavy emphasis on care coordination, disease and care management, and quality improvement. Independent evaluations of the program report that it saved the state between $77 million and $85 million in fiscal year 2005, and between $154 million and $170 million in fiscal year 2006.

Legislators have expressed interest in knowing whether implementing a similar program in Kansas has the potential to save money.

This performance audit answers the following questions:

1. **To what extent are other states using Medicaid managed-care systems, and what results have those states achieved**?

2. **What potential savings could be achieved in Kansas by using managed-care practices employed in other states**?

To answer these questions, we performed extensive literature reviews and talked with staff from several Medicaid policy organizations such as the Kaiser Foundation to determine the extent to which other states commonly use Medicaid managed-care systems. We interviewed staff from eight other states to better understand some of the specific managed-care systems those states use that serve high-cost Medicaid clients, such as the aged and those with chronic health conditions. Finally, we talked with staff from Kansas' three primary Medicaid agencies—the Kansas Health Policy Authority, the Department on Aging, and the Department of Social and Rehabilitation Services—to learn what managed-care systems Kansas currently uses for high-cost Medicaid clients.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in ***Appendix A.*** For reporting purposes, we've collapsed these two questions into one.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require

that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our findings begin on page 11, following an overview of Medicaid managed care.

***Managed Care Is One of Two Primary Ways To Deliver Medicaid Services***

Medicaid is a complex entitlement program established to provide health insurance and long-term care to low-income individuals. For those readers who need more information on Medicaid in general, we included a Medicaid primer in ***Appendix B***.

Medical services covered by Medicaid primarily are administered by the Kansas Health Policy Authority (KHPA), the Department of Social and Rehabilitation Services (SRS), and the Department on Aging, and can be provided either through fee-for-service arrangements or through managed care. These two service delivery models are described below.

- **Fee-for-Service:** Medicaid services traditionally have been provided through a fee-for-service arrangement between the State and the service provider. This delivery system is a form of self-service; clients seek out the services they think they need, and providers are reimbursed for the services provided. This can result in clients being reactive, rather than proactive, in taking care of their health; in other words, seeking medical services only when they are sick.

- **Managed Care:** Under the managed-care model, a relationship is established between the patient and the primary-care provider in which both clients and providers can initiate care services. Managed-care models also can establish and promote preventive health services, such as cholesterol screenings, and can coordinate patient care with other service providers. Two primary types of managed-care models are common:

  - Risk-Based Managed-Care Models – In these models, Medicaid pays managed-care organizations a fixed monthly fee per client (a capitated payment) for delivering comprehensive or specific services. Payment is made regardless of services provided, if any.

    Risk-based models can vary in terms of both the level of risk providers assume, and how many services they provide. Pre-paid health plans (PHPs) are limited to specific services such as mental health services. In contrast, managed-care organizations (MCOs) typically offer "comprehensive" services such as inpatient and laboratory services.

  - Primary-Care Case Management (PCCM) – In this model, Medicaid pays a primary-care provider a small management fee per client per month to coordinate and authorize specialty care provided by others. Primary-care providers themselves usually are paid on a traditional fee-for-service basis for the services they provide.

PCCM models can range from very basic "gatekeeper" models—in which the primary care provider must provide referrals for additional services—to much more comprehensive "enhanced" PCCM models. "Enhancements" are defined differently by different states, and can include providing additional targeted services for patients with chronic illness, performance incentives for providers (paying providers to hit certain health targets), and including mental and social services.

A glossary of many terms relevant to Medicaid managed care is shown in ***Figure OV-1***.

Medicaid expenditures are a large portion of most state budgets. Consequently, better managing client care is important not only because it can improve the quality of services clients receive, but also because it can have significant effects on state spending.

**In general, managed-care delivery models try to better manage the care Medicaid clients receive, while being as efficient as possible.** Improving client care is often the primary goal of many managed-care initiatives. But states also are interested in containing costs as much as possible. In the course of our literature review and interviews with various Medicaid officials, we identified four primary ways to reduce Medicaid costs:

- **Reduce the need for and use of services through better management.** Managed-care models fall under this category. This category includes efforts to improve coordination to reduce duplicative or unnecessary services, and efforts to reduce the use of costly services such as emergency room and inpatient hospitalizations through more proactive patient care, if possible.

Other ways to reduce costs mostly involved cutting services or rates. These are explained below.

- **Reduce or eliminate optional services.** This could include eliminating certain waiver programs, or eliminating benefits such as vision, dental, or prescription drugs.

- **Reduce eligibility.** This could include eliminating services to optional individuals such as low-income adults, modifying the disability determination, increasing income-level requirements, or decreasing the value of assets an individual can have to qualify for Medicaid.

- **Reduce provider rates.** This simply involves reimbursing Medicaid service providers at lower rates. For example, in response to recent budget shortfalls, KHPA reduced provider rates by 10% beginning January 1, 2010.

| Figure OV-1<br>Glossary of Medicaid Managed Care Terms | |
|---|---|
| **Term** | **Definition** |
| ABD | Individuals that are aged, blind and disabled. |
| Aged | Individuals that are 65 years of age or older. |
| Capitation or Capitated Rate | A method of paying for health care services under which providers receive a set payment for each client instead of receiving payment based on the number or cost of services provided. These payments can be adjusted based on demographic characteristics, such as age and gender, or the expected costs of the members. |
| Care Coordination | Any aspect of coordinating the clients care including services among providers, medication management, or type of services to treat a specific condition. |
| Case Management | The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers. |
| Chronic Care Management | The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs. |
| Cost Containment | A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing over-utilization of health services, addressing provider reimbursement issues, eliminating waste and increasing efficiencies. |
| Disability (Disabled) | The inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. |
| Disease Management | Interventions for clients with one or more chronic diseases (such as: diabetes, congestive heart failure or asthma) intended to prevent further disease complications. |
| Dual Eligible | An individual who is eligible for both Medicare and Medicaid services. |
| Enhanced Primary Care Case Management | Additional features are added to PCCM programs that enhance the ability of primary care providers to coordinate and manage care for beneficiaries with chronic physical and mental illnesses and disabilities. |
| Fee-for-Service (FFS) | A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide through Medicaid; a form of self-service. |
| Health Information Technology (HIT) | Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically. |
| HealthConnect | A PCCM Medicaid program administered by Kansas Health Policy Authority that primarily serves individuals with disabilities and those with chronic health conditions, but also provides some services to children and families. |
| HealthWave | A capitated managed care program administered by Kansas Health Policy Authority that provides comprehensive medical coverage to low-income families with children across Kansas. |
| High-Cost | LPA defined as the aged, blind and disabled clients and individuals with chronic health conditions. |
| Long-Term Care | Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in an institutional setting such as a nursing home. |
| Managed Care | A health delivery system that seeks to control access to and use of health care services both to limit health care costs and to improve the quality of care provided. Managed care arrangements generally rely on primary care physicians to act as "gatekeepers" and manage the care of the patient. |
| Managed Care Organization (MCO) | Entities that serve Medicare or Medicaid beneficiaries on a risk-basis through a network of employed or affiliated providers. Generally includes HMOs, PPOs and Point of Service plans. |
| Medicaid Waiver | States can use waivers to implement home and community-based services programs, managed care, and to expand coverage to clients, such as adults without children, who are not otherwise eligible for Medicaid. |
| Medical Home (Kansas statutory definition) | A health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner. |
| Medical Home (general) | A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary care and have access to linguistically and culturally appropriate care. |
| Payment Incentives | Additional payments made to providers who achieve quality and efficiency goals, who provide specific services such as identifying diabetic patients on a registry, or sharing savings produced by the program with providers based on performance. |
| Preventive Care | Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer to reduce health care costs over the long-term. |
| Primary Care Case Management (PCCM) | A program where the State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing them for services they provide on a fee-for-service basis. |
| Primary Care Provider (PCP) | The provider who is responsible for providing primary care and coordinating other necessary health care services for the patient under a PCCM delivery model. Providers can include: a physician specializing in internal medicine, family practice or pediatrics, or a nurse practitioner, physician assistant, or health care clinic. |
| Supplemental Security Income (SSI) | A federal income supplement program funded by general tax revenues designed to help the aged, blind, and disabled who have little or no income to provide assistance to meet basic needs for food clothing and shelter. |

Source: LPA review of Kaiser Foundation and Centers for Medicare and Medicaid Services glossaries.

It's important for the reader to be aware of the distinction between managing patient care and rationing patient care:

- Managing a patient's care is the process of helping clients make good health decisions, and getting clients the services they need in a cost-effective way without reducing service levels or quality.
- Rationing a patient's care is a restriction of patient services for the primary purpose of decreasing costs.

When referring to managed care in this audit, we are referring to managing, not rationing, patient care.

***In Kansas, Most Medicaid Clients Are Enrolled in Managed Care, But Most Costs Are Incurred Through Fee-for-Service***

Medicaid clients generally can be grouped into two categories, described below.

- Children and adults account for 73% of the Medicaid clients, and generally are considered to be "low-cost" clients because their health needs typically are routine in nature and relatively straightforward.
- Aged and disabled individuals account for 27% of the Medicaid clients, and are considered to be "high-cost" clients because they tend to have multiple and complex medical conditions and receive a lot of costly medical services.

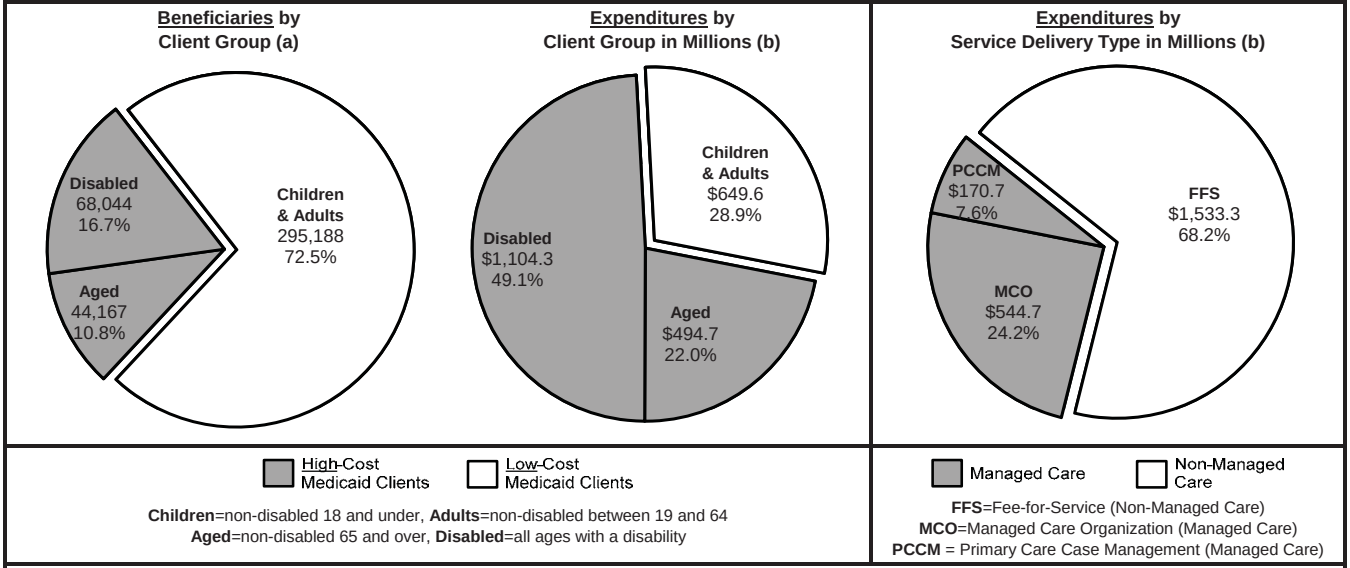
For the purpose of this audit, we defined "high-cost" clients as the aged, individuals with disabilities, and individuals with chronic health conditions. Because individuals with chronic health conditions aren't easily identified in readily available Medicaid data, we had to use aged and disabled clients as an approximation of high-cost Medicaid clients.

**Most low-cost Medicaid clients receive health care services through a managed-care program called HealthWave.** HealthWave was established primarily as a capitated managed-care program (meaning providers receive a fixed rate to provide services) to provide comprehensive health coverage to low-income families and children. Some services, such as dental services, still are provided on a fee-for-service basis.

As ***Figure OV-2*** shows, children and adults account for 73% of all Medicaid clients, but only 29% of total Medicaid costs.

**Most high-cost Medicaid clients, such as the aged and disabled, receive care under a fee-for-service system.** As ***Figure OV-2*** shows, the aged and disabled account for 27% of all Medicaid clients, but 71% of total Medicaid costs. Most services for high-

**Figure OV-2**
**Medicaid Beneficiary Counts and Expenditures by Client Group**
**Fiscal Year 2009**




(a) Some individuals can be double counted because they qualify for multiple Medicaid programs.
(b) Expenditure amounts exclude other Kansas Health Policy Authority non-Medicaid medical assistance programs such as ADAP, Medikan, and CHIP.
Source: Unaudited data from Kansas Health Policy Authority.

cost clients are provided under the traditional fee-for-service model, and not managed care. ***Figure OV-2*** shows that services provided under a fee-for-service system accounted for 68% of all Medicaid expenditures in fiscal year 2009.

Some reasons why high-cost clients generally are excluded from managed-care systems include:

- **They have complex care needs.** Often, clients within this group have one or more chronic conditions, or conditions that require a combination of physical, mental, and social services. This complexity makes it hard to accurately predict costs for these clients, which increases the potential financial risks for providers, and makes it difficult to successfully manage their care.

- **Managed-care models sometimes are perceived to reduce service levels.** That's because, under some models, service providers have a financial incentive to provide as few services to clients as possible. This can result in strong political resistance, as described below.

- **Significant changes in service delivery can face significant political resistance.** Historically in Kansas, high-cost clients have received services under a fee-for-service model. Because of the large number of interest groups that represent high-cost Medicaid clients, making significant changes to the status quo could be difficult.

***Like Kansas, Most Other States Use Fee-for-Service For High-Cost Clients***

The federal agency responsible for the administration of Medicaid is the Centers for Medicare and Medicaid Services (CMS). CMS is the sole source for centralized Medicaid expenditure data for all 50 states and Washington D.C. ***Figure OV-3*** on page 9 shows the percent of total Medicaid expenditures related to aged and disabled Medicaid clients for 42 states in federal fiscal year 2008.

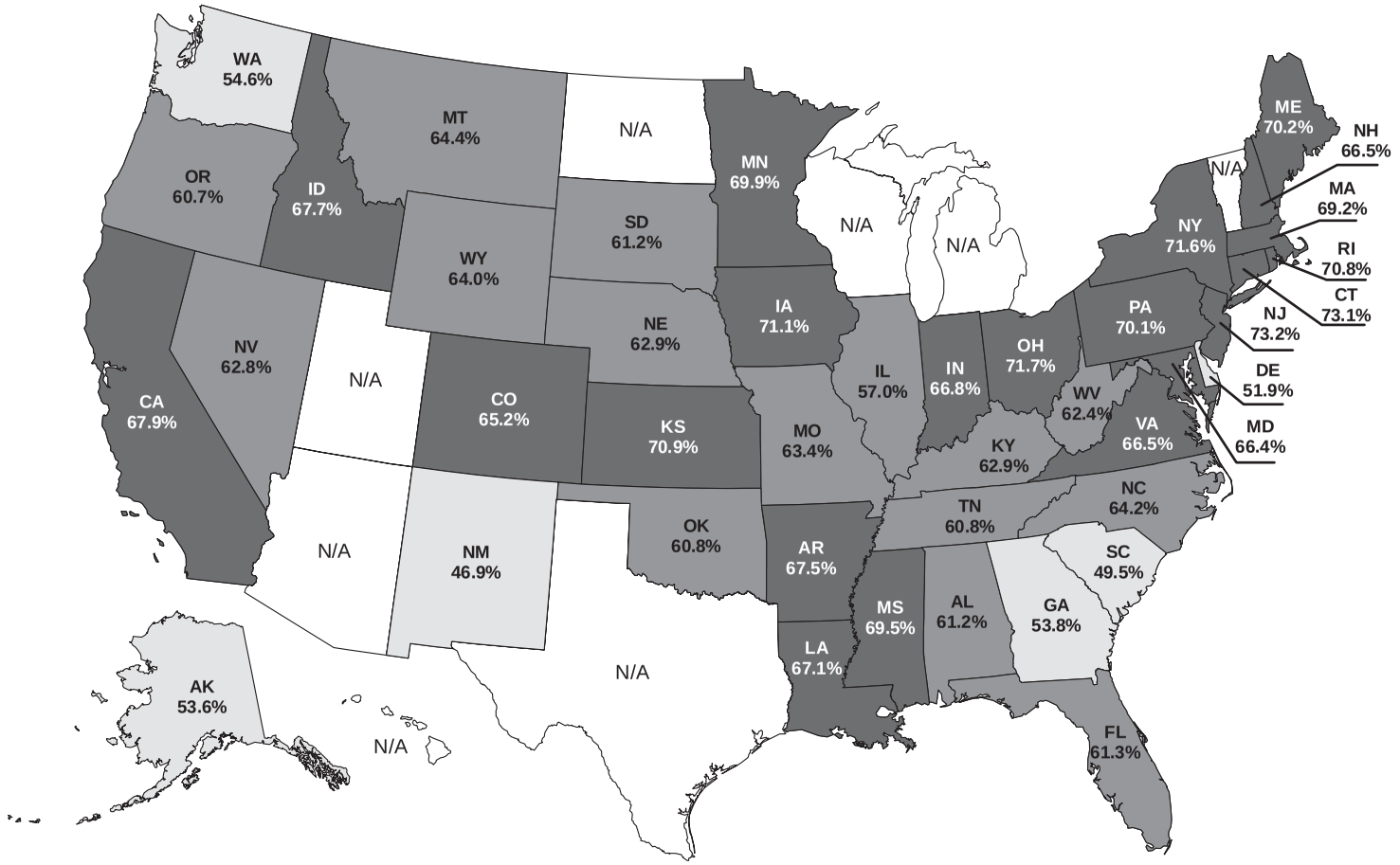
As ***Figure OV-3*** shows, aged and disabled Medicaid clients account for 55% or more of total Medicaid expenditures in 36 of 42 states. As noted earlier, in Kansas the aged and disabled clients account for about 71% of Medicaid expenditures.

A 2010 Kaiser Foundation policy brief determined that, although state managed-care expenditures had almost doubled between 2000 and 2007, managed care still comprised only 20% of all Medicaid expenditures on average nationwide. Conversely, 80% of all Medicaid expenditures were paid on a fee-for-service basis.

Kaiser further noted that although most states had enrolled families and children in managed-care systems, most high-cost clients still were enrolled in fee-for-service programs.

Because Medicaid costs are driven in large part by high-cost clients outside of managed-care systems in Kansas and in other states, we focused our audit work on how managed-care systems could be used to more efficiently deliver needed services.

**Figure OV-3**
**Percent of Total State Medicaid Expenditures for Aged and Disabled Clients**
**Federal Fiscal Year 2008**




Source: Center for Medicare and Medicaid Services (CMS) federal fiscal year 2008 Medicaid expenditure data for 42 states.

## To What Extent Could Managed-Care Practices Employed in Other States Be Used To Achieve Potential Cost Savings in Kansas?

***Answer in Brief:***

*Medicaid costs potentially can be reduced by better managing client care and reducing the use of avoidable high-cost services, such as emergency room visits. Kansas and other states have piloted or implemented a number of initiatives aimed at better managing care for high-cost clients, both to improve services for these clients and to reduce costs. However, few states, including Kansas, have estimated the dollar savings or effects of these efforts (North Carolina's large cost-savings estimates included a number of actions not specific to managing care for high-cost clients, such as the creation of a preferred drug list). As a result, it's difficult to know if these initiatives are cost effective, or to estimate what potential cost savings might be possible by further applying these strategies to larger numbers of high-cost clients in Kansas. Regardless, many states we contacted have implemented these strategies on a statewide scale, despite inconclusive evidence that they contain or reduce costs. That's likely because the ways in which managed-care systems are supported to save money are logically intuitive, even if unproven. Kansas has several options for identifying or pursuing additional cost-savings strategies, including analyses of Statewide medical data or increased use of pilot projects. These and other findings are described in the following sections.*

### *Medicaid Costs Potentially Can Be Reduced By Better Managing Client Care and Reducing the Use of High-Cost Services*

It's important for the reader to be aware that the focus of this audit is on cost reduction, and not necessarily on service improvement. Client care is of course very important, and oftentimes it's possible to both reduce costs and improve service quality at the same time. However, the specific focus of this audit is to try to identify ways to provide at least the same services for less money.

As noted in the Overview, states have four general options for reducing Medicaid costs: improving coordination/management of care or services, reducing or eliminating optional services, reducing "optional" clients served, and reducing provider rates. This audit focused on the first option.

To identify how other states manage care for their high-cost Medicaid clients to help reduce costs or achieve savings, we reviewed academic publications and studies from organizations such as the Kaiser Foundation and Mathematica Policy Research. We also talked with staff of Medicaid policy organizations and staff of Medicaid agencies in Kansas and in other states. ***Appendix C*** provides a bibliography of the literature we reviewed and the organizations we contacted during this audit.

**Other states and Kansas typically attempt to lower Medicaid costs for high-cost clients by exchanging lower-cost services for higher-cost ones.** We identified two primary methods states use to try to lower Medicaid costs for high-cost clients. Those methods, which can overlap, attempt to change the way clients use services by having them:

- **Use fewer potentially avoidable services.** Many states manage client care in an attempt to reduce the use of services that might be avoidable, such as visits to the emergency room, inpatient hospitalizations, duplicative laboratory tests, or long-term care in a nursing home.

  States generally attempt to accomplish this in one of two ways. First, states can **monitor patients more closely** through managed-care models. For example, states can have managed-care staff monitor clients to identify those that have an unusually high number of emergency room visits and intervene as needed. Second, states can attempt to provide clients with lower-cost services in place of more expensive ones, as discussed below.

- **Use less expensive services.** States have a variety of ways in which they can attempt to exchange lower-cost services for higher-cost services through managed-care models. For example:

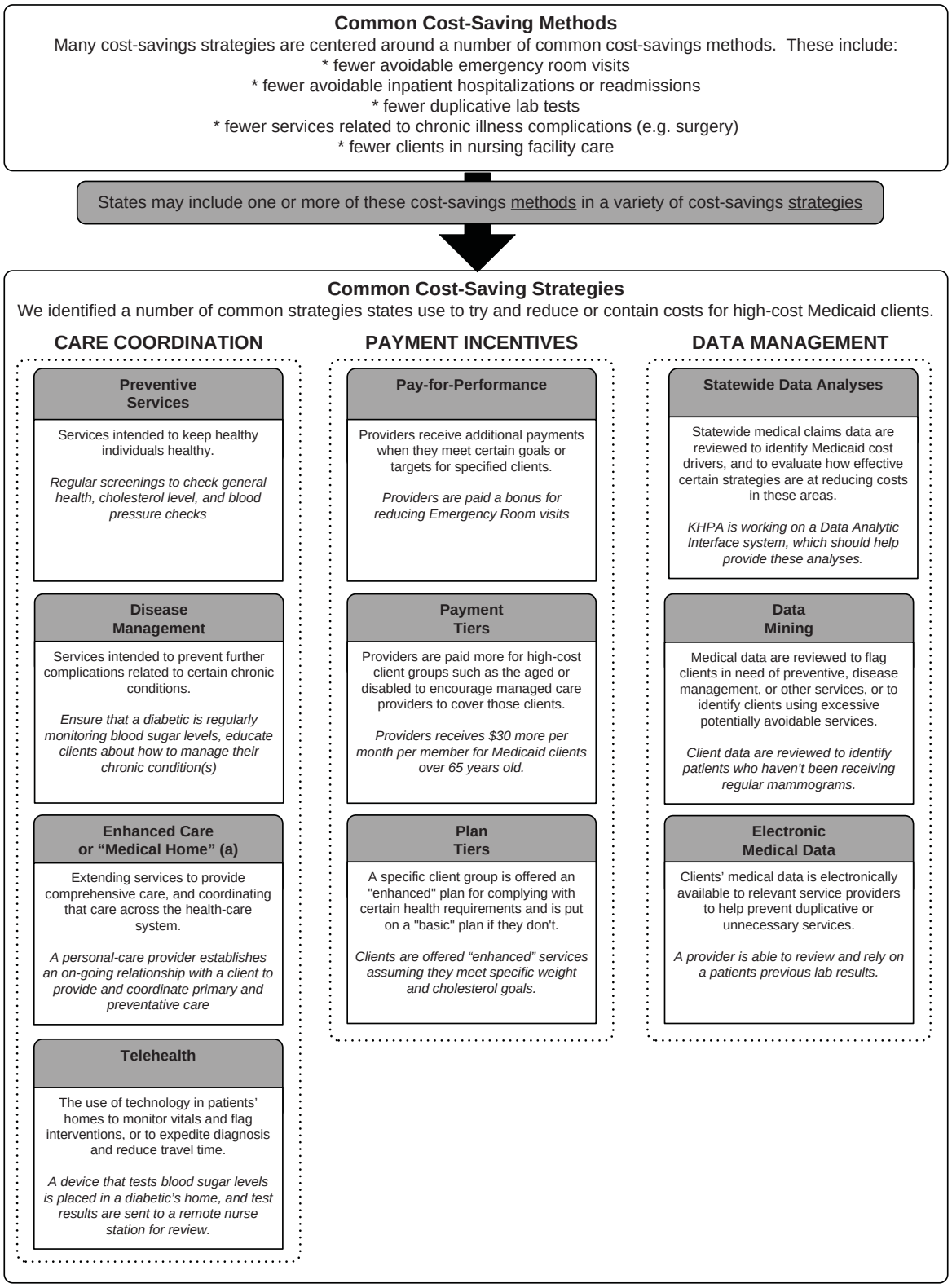
  - ► coordinating drug prescriptions can reduce or eliminate multiple and potentially duplicative drug prescriptions from many providers
  - ► providing more routine pre-emptive primary-care services may be able to reduce emergency room visits or hospitalizations
  - ► providing routine health screenings may be able to prevent certain surgeries
  - ► providing home and community health services can help prevent or delay institutional care

Managed-care systems in Kansas and other states often rely on a number of common strategies aimed at having clients use more less-expensive services, and fewer costly services. ***Figure 1-1*** provides a brief description of those strategies and examples of how they might work. As ***Figure 1-1*** shows:

- **Many of these strategies focus on coordination.** Except for payment incentives, all the strategies we identified attempt to improve coordination in some way, in terms of services, providers, or data.

- **Payment incentives can be used to encourage providers to cover high-cost clients through managed-care models.** High-cost Medicaid clients often have complex or multiple medical issues, and it's very hard to accurately predict their health care costs. Consequently, states sometimes offer managed-care providers additional money to provide services to these more financially risky clients. Payment

**Figure 1-1**
**Managed Care Cost-Savings Strategies for High-Cost Medicaid Clients**



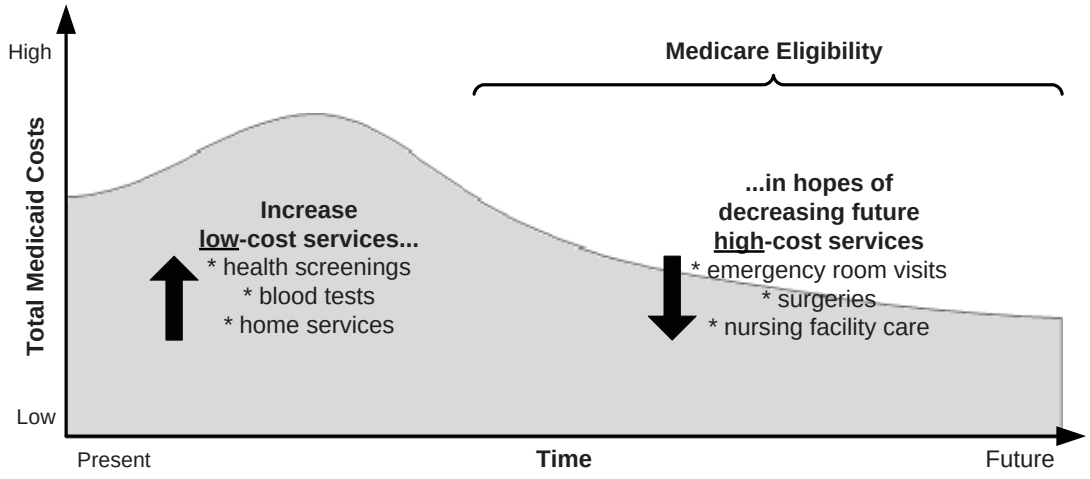

(a) In Kansas, K.S.A. 75-7429 defines a "medical home". We've truncated that definition for the purpose of this figure.
Source: LPA identified cost-savings strategies from literature reviews and interviews with Medicaid agency staff in Kansas and other states.

incentives can take many forms, including bonus payments related to specific health goals, and payment tiers for different types of Medicaid clients.

- **Data management and analyses can help agency officials and staff identify Medicaid cost drivers and identify potential solutions.** This can be done at both a system-wide level and an individual level. At the system wide level, data analysis is perhaps most useful as a means of helping agency officials and staff identify Medicaid cost drivers and select appropriate strategies. KHPA officials told us they currently have a system in place that should allow them to begin this type of work in the near future. Those analyses could help determine whether preventive health programs were increasing client screening rates, cost differences between delivery models (fee-for-service versus managed care), and other such relevant reports.

At the individual level, data analyses can be used to identify clients who use unusually high number of services or prescription drugs, or who are not being screened or tested as they should be. ***Figure 1-2*** illustrates how these strategies—such as preventive health services and disease management—should be able to lower Medicaid costs.

**Figure 1-2**
**Illustration of How Many Cost-Savings Strategies for High-Cost Medicaid Clients Are Intended to Produce Cost-Savings**




Source: LPA illustration of how many cost-savings strategies are intended to produce cost-savings.

As ***Figure 1-2*** shows, making up-front investments to manage the care for aged and disabled Medicaid clients could be expected to reduce their use of high-cost services in the future. However, as described in the sections that follow we found little empirical evidence to support this widely held assumption. In addition, because many high-cost Medicaid clients eventually qualify for Medicare, it's possible that many of the future cost-savings generated through

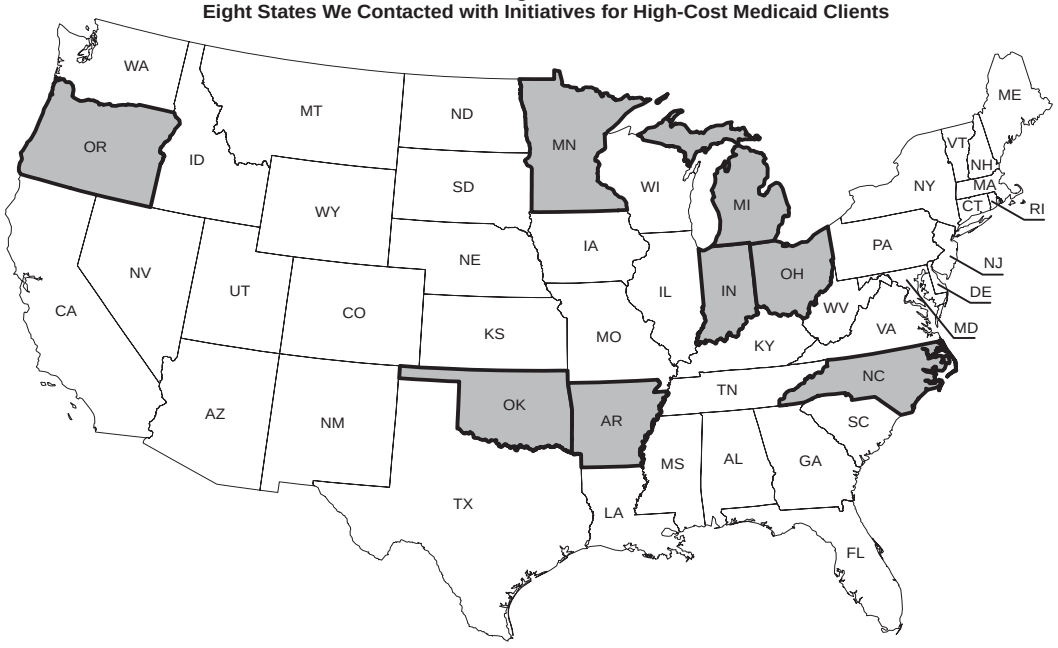
Medicaid managed-care services actually could end up benefitting Medicare.

A complete list of all Medicaid cost-savings strategies we identified—including those not specific to high-cost clients or managed-care systems—is provided in ***Appendix D.***

***8 States That Have Placed Large Portions Of Their High-Cost Medicaid Clients Into Managed-Care Systems Have Reported Positive Results***

Through our reviews, we identified 19 states that have one or more initiatives to manage care for high-cost Medicaid clients. Of those, we interviewed staff from eight states that had multiple initiatives, had estimated cost savings for those initiatives, or were recommended to us by experts we talked to as having effective managed-care models. ***Figure 1-3*** shows the eight states we contacted.

**Figure 1-3**
**Eight States We Contacted with Initiatives for High-Cost Medicaid Clients**




Source: LPA selected states with initiatives for high-cost Medicaid clients.

Like Kansas, most of these states defined high-cost clients as the aged, disabled, and those with chronic health conditions. However, some states modified that definition for some of their initiatives to include clients who use high-cost services, such as narcotic medications or emergency room utilization, regardless of the age or health condition of the client.

High-cost clients that states generally excluded from their managed-care models included those eligible for both Medicaid and Medicare services (called "dual eligibles") and those receiving long-term institutional care.

**Figure 1-4**
**Cost-Savings Initiatives Specific to, or That Include, High-Cost Medicaid Clients in Eight Other States**

| Initiative Name | Cost Savings Strategies Incorporated | | | High-Cost Groups Included | Service Delivery Model | Approximate Year Implemented | Brief Model History / Description | Estimated Cost Effects of Initiatives for High-Cost Clients Reported to LPA | Other Non-Dollar Results | Lessons Learned |
|---|---|---|---|---|---|---|---|---|---|---|
| | Care Coordination | Payment Incentives | Data management | | | | | | | |
| **Arkansas** *Medicaid Assistance Program* | ✓ | | | Aged, Blind, and Disabled | PCCM | 1990 | Arkansas was one of the first states to go from a traditional fee-for-service model to a PCCM model to coordinate care of Medicaid clients. | **None Reported** | None reported | None reported |
| **Indiana** *Care Select* | ✓ | ✓ | | Aged, Blind, and Disabled | PCCM | 2007 in central Indiana; statewide in 2008 | Indiana expanded its "gatekeeper" PCCM model to include a 24-hour nurse hotline and care management. | **None Reported** | It's too early in program implementation to say | Work with advocates and have appropriate parties from the community involved in the developing and transition process, educate clients on the program. |
| **Michigan** Managed Care Initiative | ✓ | ✓ | | Aged, Blind, and Disabled; Social Security Income clients | MCO | 2002 | Michigan transitioned from a PCCM to a capitated MCO program for most Medicaid clients, including a majority of high-cost clients. | **None Reported Specific to High-Cost Clients** (statewide estimated savings for all clients ranged between $28 to $129 million in cost savings in 2005; estimates compared MCO system to four alternatives) | Better care, improved services, improved cost predictability | High-cost clients need to be treated differently, it's beneficial to establish different rates, and program officials need to be able to ride out the initial negative responses. |
| **Minnesota** *Senior Health* | ✓ | | | Aged | MCO | 1980s | A mandatory program that includes long-term care services. | **None Reported** | Better service access | None reported |
| **Minnesota** *Disability Health Plan* | ✓ | | | Disabled | MCO | 2008 | A voluntary program that includes disease-management services for diabetes and heart failure. | **None Reported** | Better service coordination | None reported |
| **North Carolina** *Community Care of North Carolina* | ✓ | | | All | Medical Home | High-cost clients added in 2007 | North Carolina went to an E-PCCM model in 1998, and extended coverage through that model to high-cost clients through a pilot project first, then statewide. | **$6 million cost increase during the first-year implementation phase.** | Increased patient satisfaction, improved provider participation | A chronic-care pilot to service the high-cost clients provided them with valuable lessons learned before being incorporated statewide. Medication management, mental health services, and hospital discharge coordination is critical. |
| **North Carolina** *Telemonitoring Pilot* | ✓ | | ✓ | Individuals with Chronic Conditions | Hybrid | 2007 | Created through legislative mandate to consider cost effectiveness and quality of services able to be provided through telemonitoring. Health conditions included heart failure and diabetes. | **None Reported** | Reduced number of emergency room visits and hospital visits; improved patient involvement in health management | It is more difficult to improve or stabilize an individual with multiple chronic conditions; can't generalize the results to the population at large. |
| **North Carolina** *Integrated Care Pilot* | ✓ | | | Aged | Special Needs Plan | 2008 | Legislative mandate to establish a pilot to provide special needs plans to dual eligible individuals. | **Cost Neutral** | Improved care coordination, improved cost predictability | Evaluation measures have to be established in order to show benefits, savings aren't guaranteed and may actually shift costs from Medicare to Medicaid. |

| Initiative Name | Cost Savings Strategies Incorporated: Care Coordination | Cost Savings Strategies Incorporated: Payment Incentives | Cost Savings Strategies Incorporated: Data management | High-Cost Groups Included | Service Delivery Model | Approximate Year Implemented | Brief Model History / Description | Estimated Cost Effects of Initiatives for High-Cost Clients Reported to LPA | Other Non-Dollar Results | Lessons Learned |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ohio** *Managed Care Program* | ✓ | | | All (a) | MCO | 2005 | Ohio had used a fee-for-service model, but a legislative mandate required the expansion of managed care to reduce costs and improve coordination. | **None Reported Specific to High-Cost Clients** (statewide cost-savings of approximately $72 million for all clients in 2004; estimates compared MCO system to fee-for-service) | Improved service coordination, improved service access, improved cost predictability | Continual communication with clients and providers helped with transition, especially for the high-cost clients. Make certain that the computer technology is sufficient. |
| **Oklahoma** *Sooner Care Choice (b)* | ✓ | ✓ | ✓ | Aged, Blind, and Disabled | Medical Home | 2009 | A medical-home model intended to coordinate care to treat the whole person by maintaining client health, preventing health complications, and managing existing health issues | **None Reported** | Patient satisfaction | When changing a delivery model educate providers and clients. Transition will not happen quickly and the program must be constantly assessed. |
| **Oklahoma** *Health Management Program* | ✓ | ✓ | | All high-cost individuals, regardless of age or conditions | Medical Home | 2008 | 5,000 high-cost clients were identified for emphasized care management by RN's to help manage the individuals' health. | **None Reported** (Preliminary estimates showed mixed results and were too early to be conclusive) | Improved client utilization of services and health management | Assess the program regularly and make necessary changes. If contractors provide the services, make certain you have sufficient oversight. There won't be immediate returns on theses investments |
| **Oklahoma** *Emergency Room initiative* | | | ✓ | Any client with high emergency room costs | Medical Home | 2004 | The program identifies frequent emergency room users, and intervenes to reduce utilization. | **Total estimated savings of $14.9 million avoided in emergency room costs over 5 years** | Improved client utilization of services, reduced ER visits | Annually evaluate the program and perform critical analyses of the program data. Maximize staff roles and use R.N.'s only where necessary. |
| **Oklahoma** *SoonerCare Pharmacy Lock-In program* | | | ✓ | Any client with high pharmaceutical costs | Medical Home | 2004 | The program provides a way to detect potential misuse of narcotic and other medications and a procedure to "lock in" the member to one pharmacy, limiting the opportunity for abuse | **Total estimated cost savings of about $31,500** | Reduced dependency on narcotics | It is difficult to lock the client into a particular physician (they had to drop this requirement). Ensure adequate computer systems and IT support. |
| **Oregon** *Supplemental Income Medicaid Program* | ✓ | | | All (c) | MCO | 1990s | Oregon moved to a managed care preferred system and has about 80% of the total population in managed care. | **Estimated cost savings of about $6 million for a disease management initiative for asthma, diabetes, and congestive heart failure** | Increased patient satisfaction, improved access and quality of care | It helps to have the MCO's community-based and involved in their community. Contracts have to provide specific expectations, requirements, and be appropriately monitored. |

(a) All high-cost clients are included except for dual eligibles, children with disabilities under 20, waiver recipients, individuals in institutionalized care, and spend-down clients.
(b) Oklahoma's medical home includes all three primary cost savings strategies because it encompasses several of the other initiatives described in this figure.
(c) All high-cost clients included except for dual eligibles or those in institutionalized care.
Source: LPA analysis of literature review and interviews with state officials.

***Figure 1-4*** provides information about each of the state initiatives we identified, and some of the results those initiatives reportedly have achieved. As ***Figure 1-4*** shows:

- **Commonly reported positive results included improved coordination of chronic diseases, increased cost predictability, and improved care quality.** As might be expected, states reported that managing client care often resulted in greater coordination of services. Moreover, several states noted that capitated managed-care systems (those where the state pays a single rate for each client, regardless of how many services are provided) improved cost predictability, and that managing care had improved service quality.

- **Few states had estimated the cost effect of managed-care initiatives for high-cost Medicaid clients.** Of the 14 initiatives these 8 states reported, only 5 initiatives included any cost-effect estimates specific to high-cost clients. (Michigan and Ohio reported statewide cost savings for managed-care systems that included high-cost clients, but didn't report savings by client type.) Of these 5 initiatives:

  - Oregon reported cost savings of about $6 million related to its disease-management program (shaded in ***Figure 1-4***)—aimed at diabetes and asthma—which targeted high-cost clients. These savings were achieved through fewer emergency room visits, fewer and shorter hospital stays, and fewer hospital readmissions.

  - Two small initiatives in Oklahoma (shaded in ***Figure 1-4***) reported cost savings for an emergency room utilization and pharmacy lock-in program of about $14.9 million (over 5 years), and $31,500 respectively. Both programs were limited in scope and relied more on data-mining techniques than active care management. Both of these initiatives were part of the state's managed-care system and resulted in cost savings. Those savings weren't necessarily related to high-cost clients, but to high-cost services.

  - North Carolina reported that an integrated-care pilot program for dual-eligible clients (those that qualify for both Medicaid and Medicare) was cost neutral.

  - A 2007 Mercer report performed for North Carolina estimated that including the aged, blind, and disabled Medicaid clients in its comprehensive managed-care system—Community Care of North Carolina (CCNC)—actually had cost the state an additional $6 million for that client group. CCNC officials cautioned that this additional cost was incurred during the implementation phase of the project, which could affect their findings.

    (***Sidenote:*** Although a 2006 Mercer report showed system-wide savings of up to $170 million for North Carolina's Medical-Home Model, most of those savings were achieved by implementing a preferred drug list and by placing low-cost clients in managed care—steps that Kansas already has taken. As noted above, North Carolina didn't include its high-cost Medicaid clients in its Medical-

Home Model until 2007. North Carolina officials reported that using a pilot program first helped them identify problems, and allowed them to make adjustments before implementing the program on a broader scale.)

**We found almost no empirical analyses of the impact of Medicaid managed care on high-cost populations.** That's likely because managed-care systems often are structured very differently from state to state. According to officials from the Kaiser Foundation, centralized Medicaid managed-care data collected and maintained by the Centers for Medicare and Medicaid Services (CMS) isn't reliable because CMS hasn't enforced state reporting requirements, issued reporting standards, or provided states with technical assistance.

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***Kansas Has Incorporated Some Managed-Care Strategies For High-Cost Medicaid Clients On a Limited Basis***

We talked with officials from all three primary Medicaid agencies in Kansas—the Health Policy Authority (KHPA), the Department of Social and Rehabilitation Services (SRS), and the Department on Aging—to identify the extent to which Kansas manages care for high-cost Medicaid clients.

**Kansas currently administers four managed-care programs that provide services to high-cost Medicaid clients.** Those programs are described below:

- **SRS administers two capitated managed-care programs that are <u>specific</u> to mental health and substance abuse services, and that apply to <u>all</u> Medicaid clients.** These programs were created in response to significant concerns expressed by the Centers for Medicare and Medicaid Services (CMS) about how those services were structured, to provide additional services to clients, and to increase service access. Under these two programs, mental health services largely are provided by community mental health centers and providers, and substance abuse services are provided by a network of licensed substance abuse providers.

  The two capitated programs SRS put into place are described below.

  - <u>Prepaid Ambulatory Health Plan (PAHP)</u> – This program provides <u>mental health</u> services to <u>all</u> Medicaid clients Statewide through a contract with Kansas Health Solutions (KHS). State payments for this plan are capitated, meaning the State pays KHS a fixed amount for each client they serve, and KHS pays the provider for health services they provide.

  - <u>Prepaid Inpatient Health Plan (PIHP)</u> – This program provides <u>substance abuse</u> services to <u>all</u> Medicaid clients Statewide through a contract with Value Options. State payments for this plan also are capitated.

SRS spent a combined $177 million in fiscal year 2009 on these two capitated managed-care programs. A 2009 independent review of these programs by the TriWest Group for SRS compared $83 million in claims following implementation of the PAHP and PIHP programs to the prior year. That analysis found a cost decrease in psychiatric inpatient costs from about $24 million to $18 million ($6 million or 26%), but a cost increase in prescription medication costs from about $63 million to $65 million ($2 million or 4%). Based on that, and several other analyses, the report concluded that these programs were cost-effective overall, and improved both service quality and access.

- **KHPA and the Department on Aging administer the Program of All-Inclusive Care for the Elderly (PACE), a long-term managed-care program that serves just over 200 individuals in 8 counties.** This program provides comprehensive long-term care and medical services for the elderly and for people 55 years or older with a disability. Those services include all necessary preventive, primary, acute, and long-term care services, and are intended to keep clients at home instead of being placed in a nursing facility. State payments for this plan are fully capitated.

  In fiscal year 2009 the State spent about $5 million on the PACE Program. Department on Aging staff reported that serving clients through the PACE program—instead of a fee-for-service model—saved the State about $560,000 that year. These savings are built into the PACE contract. An actuarial firm estimates the value of PACE services under a fee-for-service system using claims data, then the State pays PACE contractors a fixed percentage less—about 10% less in fiscal year 2009. We weren't able to assess the reliability of these cost savings estimates for this report.

- **KHPA administers the HealthConnect program, in which primary-care case managers are paid a small fee for each client they serve to provide referrals for specialty services—a fairly limited form of care management.** HealthConnect cost about $171 million in fiscal year 2009 and primarily serves individuals with disabilities and those with chronic health conditions (it also provides some services to children and families). No savings have been calculated or measured for this program.

**Kansas also has experimented with managed care for high-cost clients through a number of recent pilot projects, but cost savings from those projects haven't been completed.** ***Figure 1-5*** on page 20 describes three recent pilot projects and their results. As ***Figure 1-5*** shows:

- **All of these pilot projects have focused on better managing and coordinating client care.** For example, the Enhanced Care Management pilot project located in Sedgwick County aimed to coordinate medical, mental, and social services through a care-management team. Similarly, the Telehealth pilot project located in 11 counties aims to more closely monitor clients' health through a centralized nursing station.

**Figure 1-5**
**Inventory of Recent Kansas Pilot Programs to Manage Care for High-Cost Medicaid Clients**

| Lead Agency | Pilot Name | Time Period | Approximate Number of Participants | Care Coordination | Payment Incentives | Data Management | Brief Pilot Description | Agency Cost-Savings Estimates | Agency Reported Pilot Costs | Other Non-Dollar Results |
|---|---|---|---|---|---|---|---|---|---|---|
| **Kansas Health Policy Authority** | Enhanced-Care Management (ECM) Pilot Project | 2006-2008 | 150 | ✓ | | | Intended to provide enhanced-care management--integrated, interdisciplinary, and individualized--to those with chronic conditions (e.g. diabetes or hypertension) | **None Estimated (a)** | Approximately $2.1 million | Inpatient costs trended downward; emergency room visits were reduced |
| **Kansas Health Policy Authority** | Medicaid Transformation Grant - Health Promotion for Kansans with Disabilities | 2008-2009 | 1,700 | ✓ | | ✓ | Intended to improve preventative health for disabled Kansans by providing care-management information through the use of an on-line claims querying tool to identify patients in need of those services | **None Estimated** | $900,000 | Identified preventative-care opportunities for beneficiaries struggling with chronic diseases such as diabetes, coronary artery disease, and several others |
| **Kansas Department on Aging** | Home Telehealth Pilot | 2007-Present | 30 | ✓ | | | Uses a home technology devise that monitors participant vital signs and sends them to a centralized nursing station for review and interventions, if needed. | **None Estimated (b)** | $460,000 | Patients' perceptions of home telehealth were positive; anecdotal evidence suggests a decrease in nursing home placements |

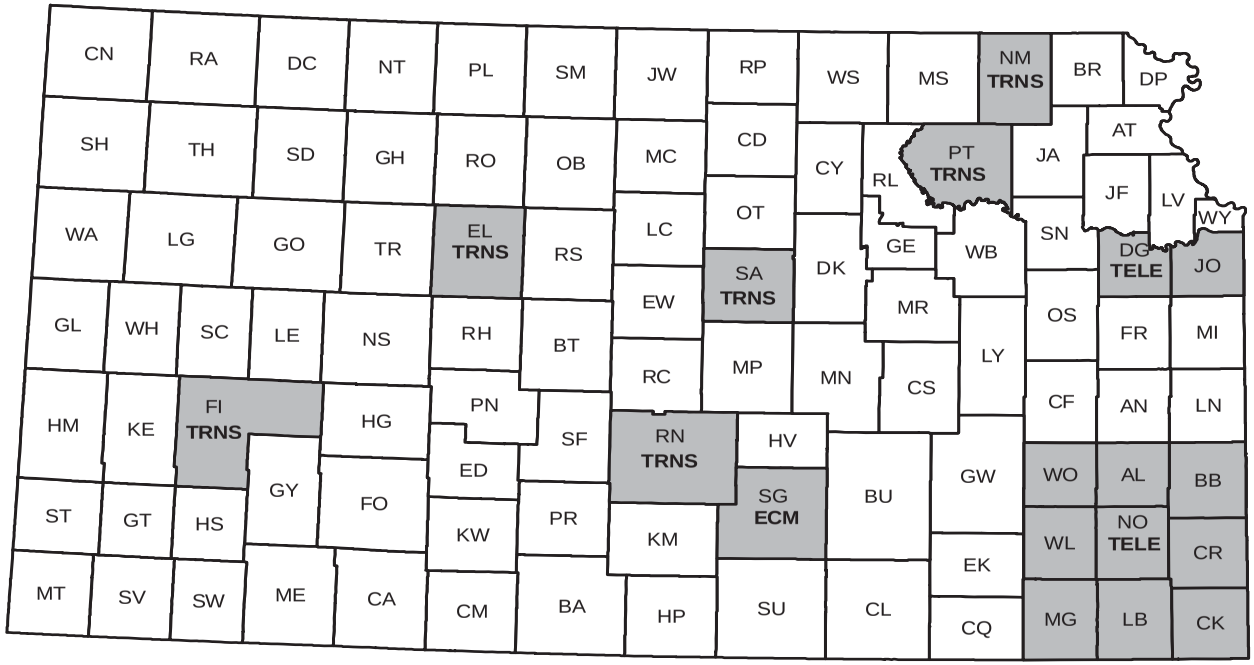
**County Coverage for Kansas Pilots and Initiatives**

Pilot programs for high-cost Medicaid clients included participants from the highlighted counties.

**TRNS** = Transformation Grant Pilot (6 counties)

**ECM** = Enhanced Care Management Pilot (1 county)

**TELE** = Telehealth Pilot (11 counties)




(a) The University of Kansas provided the Kansas Health Policy Authority with a draft evaluation of this pilot, including financial impact estimates, but the agency hasn't accepted the draft at the time of this audit.
(b) The medical equipment contractor for this pilot, Connections365, has estimated cost-savings for this pilot but we were told by Department on Aging staff that those savings would be primarly Medicare, and not Medicaid savings.
Source: LPA review of Kansas Health Policy Authority documents, and phone interviews with agency staff.

- **Disease management and preventive health services were a core strategy in each pilot project.** A primary goal shared by all three pilot projects was to keep healthy participants healthy through increased screenings and tests (preventive health), or to prevent further complications of chronic conditions (disease management).

***Figure 1-5*** also shows that, to-date, the State has spent about $3.5 million on these pilot projects. Only the Department on Aging's Home Telehealth pilot project is still in operation. KHPA officials told us they had to discontinue the Enhanced Care Management project in Sedgwick County because of budget cuts; grant funding for the Transformation project simply ran out.

Preliminary results we reviewed showed that these pilot projects have showed promising results in such areas as reduced emergency room visits or decreases in inpatient hospitalizations, but no cost savings have been reported. Two evaluations for the terminated pilot projects are still not finished, as described below:

- KHPA hired the University of Kansas (KU) to evaluate the results and cost impact of the Enhanced Care Management project, and KU has given the agency a draft evaluation report. However, KHPA officials told us they have serious reservations about the evaluation methodology, and they haven't accepted KU's report yet.

- KHPA intends to publish a final evaluation of the Transformation pilot project in June 2010, although staff told us the report will not specify any cost-savings.

Based on our discussions with agency officials in Kansas and other states, and on our reviews of the literature, we identified the following reasons why cost evaluations often aren't done for Medicaid managed-care initiatives or pilot projects:

- Improvements in patient care and service accessibility are often the focus of these pilot programs; not cost savings.
- The complexity of these clients' care makes it difficult for agencies to reasonably estimate cost-savings associated with their care.
- Many states use pilot programs to test these cost-savings strategies and managed-care concepts. By definition, pilot programs often are performed on a small scale and are voluntary in nature (making projections difficult).
- In some states, agencies can face budget repercussions if they identify savings. For example, agency budgets could be reduced by the reported savings amount. KHPA officials told us this isn't applicable to Kansas, because agency administrative costs are separate from caseload costs.
- Agency staff may not always select good control groups to ensure "apples-to-apples" comparisons after the pilot project is completed.
- Agency staff might not have the right training or evaluative tools to evaluate the cost-effects of taking certain actions, or funding may not be available for such efforts.

***Kansas Has Several Options For Identifying Or Pursuing Additional Cost-Savings Strategies***

Medicaid spending in Kansas totaled about $2.2 billion in fiscal year 2009, about $645 million of which (29%) was State funded. As noted in the Overview, aged and disabled individuals account for only about 27% of the Medicaid clients served, but 71% of the dollars spent. Being able to reduce their future costs by just 1% could represent a savings of up to $16 million a year, but also could involve some significant up-front costs to set-up and administer large-scale programs.

Although there's a lack of good data in Kansas and nationwide about the estimated savings from bringing these high-cost clients under managed-care programs, positive results are being reported. In addition, many of the states we contacted have acted on the conviction that managed-care strategies can reduce or contain costs for high-cost Medicaid clients, regardless of whether there are empirical data to support that conclusion.

As discussed earlier, Kansas officials clearly are aware of the managed-care cost-savings strategies for high-cost Medicaid clients, and have attempted to implement some of them on a mostly small-scale. However, with the exception of several small programs already in place and a few pilot programs, most high-cost clients in Kansas still receive care on a fee-for-service basis.

Kansas has several options for determining which cost-savings strategies to pursue to lower costs for high-cost Medicaid clients. These are described below.

- **Analyze Medicaid claims data to identify the primary cost drivers in Kansas and the strategies that reduce those costs**. KHPA is near the end of a software project that will allow quick analyses of Medicaid, private insurance, and State employer health data. This system, designed by Thomson Reuters, will allow KHPA staff to run a myriad of pre-designed and customized queries and reports based on claims data. These reports fall under a number of different categories, such as disease management, clinical, drug, and payment integrity. Among the many types of analyses that will be able to be performed:

  - ► Statewide analyses to determine whether certain managed care systems and cost-savings strategies are improving the quality and cost-effectiveness of client care.

  - ► Reviewing claims data for excessive emergency room visits, avoidable hospital admissions, or excessive prescription drug use.

  - ► Comparing screening rates for high-cost clients under a fee-for-service system with those under a managed-care system.

- Establishing larger client groups to act as control groups for pilot programs.

- Various other analyses that extend beyond managed care, such as service upcoding, improbable frequency of lab tests, and so on.

KHPA is still in the process of entering and testing data to ensure that they are reliable and accurate, including the managed-care data. Agency staff estimated the data would be entered and tested towards the end of the current calendar year.

- **Invest more money in managed-care pilot projects for high-cost Medicaid clients, but set up appropriate control groups or other mechanisms to identify and project possible cost impacts.** Up to this point, pilot projects haven't yielded much useful cost information in Kansas. That's largely because they've been limited in terms of both geography and participants, and because they often are voluntary, which results in sample bias. Such pilot projects also could be used as a jumping off point for expanding managed-care programs for high-cost clients Statewide, as North Carolina did. However, it's important to remember that North Carolina experienced an initial cost increase in the first year.

- **Implement managed care on a large scale for high-cost clients <u>without</u> conclusive evidence of cost-savings.** Many of the cost-savings strategies related to managed care are logically intuitive, even if unproven. Obviously, this course of action can hold significant costs and risks for the State, and would be a major undertaking. Three states we talked with have addressed managed care for high-cost clients in two primary ways. In these states, high-cost clients were included in managed care through:

  - <u>a provider-focused, gradually expanded pilot project</u>. In North Carolina, the current managed-care system evolved from a pilot project started in 1998. This pilot project established a medical home model of care and focused on strategies such as disease management, client management, and service quality. This pilot was gradually expanded to cover the entire state, with services currently provided through 14 community networks, and available to high-cost clients since 2007.

  - <u>a statewide legislative mandate.</u> In Oklahoma, high-cost clients have been included in various managed care systems since 1999, and most recently were added to the state's medical home model, established through an Advisory Task Force recommendation in 2008. This Task Force included state agency officials, providers, and other stakeholders. In Ohio, most high-cost clients were added to the state's managed-care system since the state moved from a fee-for-service system to the use of managed care organizations in 2005.

| | |
|---|---|
| ***Conclusion:*** | Few states, including Kansas, have collected data or performed analyses that estimate the cost effect of managing care for high-cost Medicaid clients. That's a result of many factors, including programmatic focus on service quality and access rather than costs, the complex care needs of high-cost clients, and so on. Academic literature and organizational studies we reviewed confirm that cost savings information in these areas is sparse. Still, many of the cost-savings strategies we identified in the course of this audit appear logical and intuitive, even if unproven. The Health Policy Authority will soon be able to perform additional analyses of the health-care data it maintains, which should give Kansas policymakers a much-more solid basis for deciding what managed-care strategies are likely to have the greatest impact in terms of health outcomes and cost savings. Armed with such data, Kansas policymakers should be able to identify and select cost-savings strategies that are likely to be cost-effective—either as pilot projects or Statewide. Whichever course of action Kansas takes, our work shows that successfully managing care for high-cost clients will require a strong commitment by all involved (providers, agencies, the Governor, and the Legislature), potentially significant initial investments, continued good data and analyses, and a focus on long-term results. |

| | |
|---|---|
| ***Recommendations for Executive Action:*** | 1. To help ensure that policymakers have the best information on which cost-savings strategies are most effective in reducing costs for high-cost clients, the Kansas Health Policy Authority should do the following:<br><br>a. continue to pursue analyses of Statewide health care data that will provide insight into which clients cost the most, and which cost-savings strategies are most effective in actually reducing costs for Medicaid clients.<br><br>b. ensure that future pilot programs related to managed care for high-cost clients are designed in a way that, at a minimum, will allow for accurate cost-benefit analyses for pilot participants, and ideally would allow those cost-benefit analyses to be applied to larger groups of high-cost Medicaid clients.<br><br>2. To help ensure that care for high-cost Medicaid clients is better managed, the Kansas Health Policy Authority should report on possible ways to determine which cost-savings strategies potentially could be most effective at reducing costs, including statewide data analyses or further pilot projects, by the beginning of the 2011 legislative session. |

## APPENDIX A

### Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on January 20, 2010. The audit was requested by the Legislative Post Audit Committee.

**Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program**

Since 1998, North Carolina has been using an "enhanced medical home" model of care called Community Care of North Carolina (CCNC) in its Medicaid Program. CCNC serves about 75% of that state's Medicaid clients, and places heavy emphasis on care coordination, disease and care management, and quality improvement. Independent evaluations of the program report that it saved the state between $77 million and $85 million in fiscal 2005, and between $154 and $170 million in fiscal year 2006.

Legislators have expressed interest in knowing whether implementing a similar program in Kansas has the potential to save comparable amounts of money.

A performance audit in this area would answer the following questions:

1. **To what extent are other states using Medicaid managed-care systems, and what results have those states achieved**? To answer this question, we would review relevant literature and contact a sample of states that appear to have effective managed-care programs. Using surveys, telephone interviews, and review of documents provided by officials in the sampled states, we would conclude on what practices and programs are proving effective elsewhere in managing rising Medicaid costs.

2. **What potential savings could be achieved in Kansas by using managed-care practices employed in other states**? To answer this question, we would review Kansas Medicaid programs and costs, and, using appropriate accounting and statistical techniques, attempt to determine the likely effect of applying other states' managed-care practices to Kansas. We would review our findings with appropriate agency officials, and would conclude on whether any of the cost-control measures in use elsewhere have the potential to save money in the Kansas Medicaid program. We would conduct additional work as needed.

**Estimated completion time: 6 - 8 weeks**

## APPENDIX B

## Medicaid Primer

This appendix provides a brief primer on the Kansas Medicaid program, including basic information about Medicaid agencies, clients, and services.

Medicaid serves more than 407,000 beneficiaries in Kansas. Medicaid is a complex federal entitlement program established by Title XIX of the 1965 Federal Social Security Act to provide health insurance and long-term care to low-income individuals. To receive federal financial assistance, states must agree to cover certain clients and provide certain services. Kansas has not only agreed to provide mandatory services to federally mandatory clients, but also has expanded the State program to include optional services and clients.

Kansas Medicaid served more than 407,000 beneficiaries (some individuals can be double counted because they qualify as beneficiaries for multiple Medicaid programs) in fiscal year 2009, accounting for total expenditures of more than $2.2 billion. Federal match funds accounted for more than $1.6 billion (71%) and State funds accounted for more than $644.8 million (29%) of the Medicaid dollars spent in fiscal year 2009.

An overview of the Kansas Medicaid program is shown in the figure on the next page.

**Medicaid funds mandatory and optional health services for a variety of low-income Kansans.** As the figure shows, Medicaid funds a variety of services—from inpatient and outpatient hospital care to nursing facility services—to a variety of clients such as low-income families with children, and individuals who are working but disabled.

Since 2005, the Kansas Health Policy Authority has been the single State agency responsible for Medicaid in Kansas. KHPA is responsible for establishing Medicaid eligibility criteria, benefits packages, payment rates, and program administration.

Although KHPA has primary responsibility for the Medicaid program, the Department of Social and Rehabilitation Services and the Department on Aging each administer Medicaid waiver programs. Waiver programs typically are used to help prevent institutional care and reduce long-term Medicaid costs, and are further described in the box on page 29.

## Overview of Kansas Medicaid

### General Background Information

**Authority:**

Originally created by Title XIX of the 1965 Federal Social Security Act, Medicaid is a publicly financed source of health insurance and long-term care coverage for eligible groups.

**Eligible Groups:**

Medicaid provides services to low-income children, very low-income adults, some disabled and elderly individuals, some pregnant women, and others with specific health conditions.

**State Agencies Involved:**

***Kansas Health Policy Authority (KHPA) -*** Since 2005, KHPA has been the single State agency responsible for Medicaid. KHPA coordinates Statewide health policy, compiles and distributes health care data, and administers medical care services such as inpatient hospitalizations and dental services.
***Department of Social and Rehabilitation Services -*** Administers home and community based services, mental health services, substance abuse treatments, and nursing home services.
***Kansas Department of Aging -*** Administers long-term care through home and community based services.
***Juvenile Justice Authority -*** Administers a behavior management program.
***Kansas Department of Health and Environment -*** Administers the Ryan White program (health services for individuals with HIV).

### Services Provided

| ***Mandatory Services Include…*** | ***Optional Services Include…*** |
|---|---|
| ● inpatient and outpatient hospital care<br>● nursing facility services<br>● physician services<br>● laboratory and x-ray<br>● family planning services and supplies<br>● nurse midwife services<br>● pregnancy-related services | ● alcohol and drug abuse treatment<br>● behavior management<br>● dental services<br>● durable medical equipment<br>● home and community based services<br>● prescription drugs<br>● vision services |
| ***Mandatory Clients Include…*** | ***Optional Clients Include…*** |
| ● low-income families with children<br>● aged (>64)<br>● disabled, as defined by CMS.<br>● some low income pregnant women | ● individuals who are working but disabled<br>● nursing home residents who fall above the threshold for social security income (SSI)<br>● the medically needy<br>● children up to age 21 who have aged out of foster care system at age 18 |

### Fiscal Year 2009 Revenues = $2.2 billion

**Federal funds = 71%, State and Fee funds = 29%**

Federal funds accounted for a higher percentage of revenues in fiscal year 2009 than in previous years largely because of federal stimulus funds distributed to the State under the American Recovery and Reinvestment Act funds (7% higher than fiscal year 2008; 5% higher than fiscal year 2007).

Source: 2009 Legislative Research Department Medicaid primer and unaudited fiscal year 2009 revenue data from the Kansas Health Policy Authority.

**Waiver Programs in Kansas Are Intended to Prevent Institutional Care**

Kansas has eight Home and Community Based Services (HCBS) waivers that are used to help prevent institutional care or care that otherwise would be provided in a nursing home, mental health, or developmental disability facility by promoting independent living. The waivers were created to provide both medical and non-medical services to individuals in their homes or assisted living or residential care facilities. The Department on Aging administers the Frail and Elderly waiver, and the Department of Social and Rehabilitation Services administers the other seven waivers.

**The eight waivers in Kansas include:**

- Frail and Elderly: For individuals 65 years of age or older as an alternative to nursing home care.
- Physical Disability: For individuals 16 to 64 years of age who have a physical disability and need assistance with daily living activities.
- Mentally Retarded/Developmental Disability: For individuals 5 years or older defined as having mental retardation or developmental disabilities.
- Severely Emotionally Disturbed: Individuals between the age of 4 and 18 that are at risk of being removed from their homes or hospitalized due to severe emotional and behavioral issues.
- Psychiatric Residential Treatment Facility Alternative: Provides a community based treatment alternative for children between the ages of 4 and 18 who would otherwise be admitted to a Psychiatric Residential Treatment Facility.
- Autism: provides early intensive intervention treatment and family support services for children 5 and younger with an autism diagnosis. Services are limited to 3 years unless determined to be medically necessary.
- Technology Assisted: Provides mechanical ventilators or intravenous administration of nutritional substances or drugs for individuals under the age of 21.
- Traumatic Brain Injury: For individuals who have sustained a brain injury and are between the ages of 16 and 65.

Individuals must establish a medical need to receive waiver services, not exceed a resource or income limit, and in some cases must help pay for their own care. Each individual receiving waiver benefits is assigned to a case manger who is responsible for overseeing the coordination of or accessibility to services. Some waiver programs include “targeted” case management, which is specifically aimed at special groups of individuals, such as those with developmental disabilities or mental illness, to ensure that they have access to the necessary and available services.

## APPENDIX C

## Bibliography of LPA Research on Medicaid Managed Care

This appendix lists some of the academic literature, organizational studies, and Medicaid policy organizations we reviewed and contacted to better understand trends in Medicaid managed care.

### Academic Literature: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Craver, Gerald A., & Longo, Daniel R. (2009). Using Instrumental Variables Regression to Evaluate Medicaid Disease Management Program Effectiveness: An Exploratory Analysis. *Journal of Health Care Finance*, pp. 15-30.

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Eddy, David M. (1997). Balancing Cost and Quality in Fee-For-Service Versus Managed Care. *Health Affairs*, 16, 3, pp. 162-173.

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Glazer, William M., & Goldman, Howard H. (2008). Deciphering the Cost Impact of Managed Care in Medicaid. *The American Journal of Psychiatry*, 165, 2, pp. 171-173.

Lewis, Morgan Jr. (2009). No Place Like Home. *Medical Economics*, 86, 14, pp. 14-17.


### Organizational Studies and Presentations:


Ashbaugh, John. (1996). *Capitation and Risk Management*. Human Service Research Institute Report, pp. 1-7.

Bachrach, Deborah. (2008). *Reforming Medicaid in New York State Targeting Care to High-Need Patients*, Presentation for the Center for Health Care Strategies Medicaid Best Buys Web Conference.

Bailit, Michael. (2009). *Overview of Medical Home Projects and Demonstrations to Date.* Presentation for the National Medical Home Summit.

Beesla, Rohan, et al. (2008). *Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement*. A National Academy for State Health Policy Brief, pp. 1-5.

Bella, Melanie, et al. (2008). *Purchasing Strategies to Improve Care Management for Complex Populations: A National Scan of State Purchasers*. Center for Health Care Strategies Report, pp 1-32.

Bella, Melanie. (2009). *Investing in Quality Medicaid Opportunities for States*, Presentation for the National Conference of State Legislatures Summit.

Cauchi, Dick, et al. (2009). *Health Cost Containment & Efficiencies*. Presentation for the National Conference of State Legislatures, Fall Forum.

Center for Health Care Strategies. (2008). *Medicaid Best Buys: Improving Care Management for High-Need, High-Cost Beneficiaries*, pp. 1-6.

Council of State Governments Midwest Report. (2008). *Practitioners of Change: Regional Case Studies in State Health Care Reform and Cost Containment*, pp. 1-34.

Deloitte Center for Health Solutions. (2008). *The Medical Home: Disruptive Innovation for a New Primary Care Model*, pp.1-18.

Henneberry, Joan. (2008). *Colorado Regional Integrated Care Collaborative.* Presentation of the Colorado Department of Health Care Policy and Financing.

Holahan, John, et al. (1999). *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey*. The Urban Institute, pp. 1-61.

Kaiser Commission on Medicaid and the Uninsured. (2009). *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*, pp. 1-7.

Kaiser Commission on Medicaid and the Uninsured. (2010). *Medicaid and Managed Care: Key Data, Trends, and Issues*, pp. 1-8.

Kansas Legislative Research Department, Kansas Health Institute. (2009). *Kansas Medicaid: A Primer*, pp. 1-20.

Kaye, Neva, & Takach, Mary. (2009). *Building Medical Homes in State Medicaid and CHIP Programs*. National Academy for State Health Policy Report, pp. 1-68.

Kaye, Neva. (2005). *Medicaid Managed Care: Looking Forward, Looking Back.* National Academy for State Health Policy Report, pp. 1-126.

Roohan, Patrick J. (2008). *Preventative Quality Indicators and Pay for Performance*. Presentation for the Center for Health Care Strategies.

Smith, Vernon K., et al. (2009). *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession; Results from a 50-State Medicaid Budget Survey for State Fiscal Year 2009 and 2010*. Kaiser Commission on Medicaid and the Uninsured, pp. 1-112.

The Lewin Group. (2009). *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies* (prepared for America's Health Insurance Plans), pp. 1-54.

Verdier, James M., et al. (2009) *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Mathematica Policy Research (prepared for the Center for Health Care Strategies), pp. 1-50.

In addition to the sources listed above, we contacted staff from the Kaiser Foundation, the Kansas Health Institute, the Kansas Health Policy Authority, the Department on Aging, and the Department of Social and Rehabilitation Services to better understand Medicaid managed care.

## APPENDIX D

### List of Medicaid Cost-Savings Strategies

This appendix lists Medicaid cost-savings strategies we identified throughout the course of our audit work.

| List of Medicaid Cost-Savings Strategies | | | |
|---|---|---|---|
| **Strategy Name** | **Description** | **Relevant to High-Cost Clients?** | **Managed Care Specific?** |
| **CARE COORDINATION** | | | |
| *Disease Management* | Services intended to prevent further complications related to certain chronic conditions. | **Yes** | **Yes** |
| *Enhanced Care Management or "Medical Home"* | Extending services to provide comprehensive care, and coordinating that care across the health-care system. (a) | **Yes** | **Yes** |
| *Preventive Services* | Services provided with the intention of keeping healthy individuals healthy. | **Yes** | **Partial** |
| *Telehealth* | The use of technology in patients' homes to monitor vitals and flag interventions, or to expedite diagnosis and reduce travel time (take a picture of a skin rash and send to doctor) | **Yes** | **Yes** |
| **DATA MANAGEMENT** | | | |
| *Data Mining* | Medical data are reviewed to flag clients in need of preventive, disease management, or other services, or to identify clients using excessive potentially avoidable services. | **Yes** | **Partial** |
| *Electronic Health Records* | Clients' medical data is electronically available to relevant service providers to help prevent duplicative or unnecessary services. | **Yes** | **Partial** |
| *Statewide Data Analyses* | Statewide medical claims data are reviewed to identify Medicaid cost drivers, and to evaluate how effective certain strategies are at reducing costs in these areas. | **Yes** | **Partial** |
| **LONG-TERM CARE** | | | |
| *Create Waiver Programs* | Waiver programs are often implemented as an alternative to placing certain clients in nursing home facilities by providing services at home and through the community. | **Yes** | **No** |
| *Increase Volunteer Services* | More actively tap volunteers and volunteer organizations to increase volunteer services available to clients in Waiver programs such as the physical disability waiver. | **Yes** | **No** |
| *Limit Payments to Family Members* | Limit the number of attendant-care hours that a family member can be paid to provide, or reduce the reimbursement rate paid to family members providing attendant-care. | **Yes** | **No** |
| *Waiver Consolidation* | Consolidate the administration of small regional waiver programs into larger waiver programs to achieve economies of scale. | **Yes** | **No** |
| **PAYMENT RELATED** | | | |
| *Pay-for-Performance* | Providers receive additional payments when they meet certain goals or targets for specified clients. | **Yes** | **Partial** |
| *Payment Tiers* | Providers are paid more for high-cost clients such as the aged or disabled to encourage managed care providers to cover those clients. | **Yes** | **Partial** |
| *Plan Tiers* | A specific client group is offered an "enhanced" plan for complying with certain health requirements and is put on a "basic" plan if they don't. | **Yes** | **Partial** |
| *Cut Provider Rates* | The State could reduce the level at which they reimburse providers of Medicaid services. | **No** | **No** |
| *Increase Copayment/Premium Amounts* | Require certain groups to begin paying premiums for services, or increase the copayment amount fo certain services. | **Yes** | **No** |
| **PHARMACEUTICAL** | | | |
| *Drug Cooperatives* | The State could form a multi-state cooperative to purchase drugs in bulk at discounted rates. | **Yes** | **No** |
| *Preferred Drug Lists; Prior Authorization* | Providers are given lists suggesting certain drugs with a focus on cost-effectiveness; often focus on use of generic drugs when possible. Additionally, the State could require prior authorization for certain medications. | **Yes** | **No** |
| *Provide Guidance for Mental Health Medication Prescriptions* | Provide guidance to primary care practitioners who prescribe a significant percentage of mental health medications through standard pharmacy management techniques. | **Yes** | **No** |
| **SERVICE REDUCTION** | | | |
| *Eliminate Optional Services* | Eliminate or reduce optional services including prescription drug coverage, personal care services, chiropractors, psychologists, podiatrists, clinical, and dental services. | **Yes** | **No** |
| *Stop Serving Optional clients* | Eliminate services to Medicaid clients with optional eligibility such as children and families covered through CHIP or medically needy groups. | **Yes** | **No** |
| *Tighten Eligibility* | The State could tighten eligibility for certain clients by adjusting definitions. | **Yes** | **No** |
| **OTHER** | | | |
| *Durable Medical Equipment* | Explore a variety of means of reducing durable equipment costs including reviewing for potential overpayments, requiring suppliers to show actual costs of manually priced items, and exploring a collaborative manufacturer rebate program for durable medical equipment. | **Yes** | **No** |
| *Reduce Fraud and Abuse* | Continue efforts aimed at preventing and reducing Medicaid fraud and abuse. | **No** | **No** |
| *Review Managed Care Contracts* | Review existing managed care contracts to determine if contractors are effectively implementing managed care, and if those models are producing the savings intended for the targeted clients. | **Partial** | **Yes** |
| *Transportation Improvements* | A variety of actions related to transporting Medicaid clients could be considered including built-in incentives for clients to use public transportation such as a pre-paid pass and use of a broker for non emergency transportation. | **Yes** | **No** |

(a) In Kansas, K.S.A. 75-7429 defines a "medical home". We've truncated that definition for the purpose of this figure.
Source: LPA review of previous legislative Task Force and Committee reports, prior LPA audits, the Kansas Health Policy Authority 2010 Medicaid Cost Savings Option Report, and other academic and organizational studies.

## APPENDIX E

### Agency Response

On April 12, 2010 we provided copies of the draft audit report to the Kansas Health Policy Authority. Its response is included as this Appendix.

The agency generally concurred with the report's findings, conclusions, and recommendations.


April 19, 2010

Barbara Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Ave. Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

The Kansas Health Policy Authority (KHPA) has received the draft of the performance audit, *Medicaid: Determining Whether Kansas Could Save Money by Expanding the Use of Managed Care in the Kansas Medicaid Program,* and appreciates the opportunity to respond to the performance audit. KHPA found the conclusions generated by the audit informative and felt the recommendations provided thoughtful suggestions as to how the agency could proceed in managing care for high cost Medicaid beneficiaries.

**KHPA Comments on LPA Recommendations**

1. To help ensure that policymakers have the best information on which cost-saving strategies are most effective in reducing costs for high-cost clients, the Kansas Health Policy Authority should do the following:

a. continue to pursue analyses of Statewide health care data that will provide insight into which clients cost the most, and which cost-saving strategies are most effective in actually reducing costs for Medicaid clients .

b. ensure that future pilot programs related to managed care for high-cost clients are designed in a way that, at a minimum, will allow for accurate cost-benefit analyses for pilot participants, and ideally would allow those cost-benefit analyses to be applied to larger groups of high-cost Medicaid clients.

*KHPA Response:*
*KHPA agrees with this recommendation.*

*From the time the KHPA took responsibility for the Medicaid and State Children's Health Insurance (SCHIP) programs on July 1, 2006, the agency has engaged in the process of*

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Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

*reorganizing and refocusing the agency to expand capacity for data analysis and to adopt data-driven processes in the management of programs. Beginning in 2007 the Medicaid program has undertaken a new and increasingly comprehensive effort to utilize available data and program management experience to review major components of the program. The reviews also identified areas for improvement, increased efficiency, saving, and improved quality. The 2007 review process began internally and the 2008 and 2009 reviews were published on the KHPA web site. The 2008 Medicaid program review included the topic of "Medical Services for the Aged and Disabled" and the 2009 program review further examined expenditures for various subcategories of that population. In order to allow KHPA staff to access KHPA-managed data more easily and quickly the agency has completed a multi-year investment in creating a Data Analytic Interface (DAI). The DAI became operational in March 2010 and allows for analysis based on episodes of care of individual beneficiaries, disease management, predictive modeling, and evaluative analysis to measure costs and outcome effectiveness. The DAI also enables direct comparisons in prices, utilization, and patterns of care between Medicaid and the SEHP. The DAI will greatly facilitate the capacity of the agency to pursue the LPA recommended analyses.*

*KHPA has adopted data-driven processes in the management of all programs and that philosophy would be applied to any pilot projects that might be undertaken. If the agency was to pilot a managed care pilot program for high-cost Medicaid beneficiaries a rigorous evaluation would be built into the project which would be able to not only evaluate the cost-benefit of the intervention for the participating beneficiaries but also have the capacity to estimate the cost-benefit of state-wide deployment.*

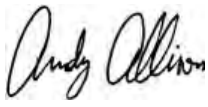
2. To help ensure that care for high-cost Medicaid clients is better managed, the Kansas Health Policy Authority report on possible ways to determine which cost-savings strategies potentially could be most effective at reducing costs, including statewide data analyses or further pilot projects, by the beginning of the 2011 legislative session.

*<u>KHPA Response:</u>*
*KHPA agrees with this recommendation.*

*KHPA is a participant in the Commonwealth State Quality Improvement Institute and through that affiliation KHPA has been able to secure resources to hold a forum for legislators and stakeholders on April 26, 2010 to begin the dialogue about better management of expensive Medicaid populations. Subsequent meetings will be held throughout 2010 to identify promising strategies for Kansas and recommendations will be ready to present to the legislature in 2011.*

KHPA appreciates the efforts of the LPA staff in conducting this audit and being willing to discuss issues during the audit process. Thank you for the opportunity to respond to this draft audit report.

Sincerely,



Andrew Allison, PhD
Executive Director