



Children's Mercy
FAMILY HEALTH PARTNERS

**Medicaid Managed Care & CMFHP:
A Proven Record of
Providing Value**

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I. Introduction

Since 1995 the State of Kansas has contracted with a number of managed care organizations (MCOs) to provide Medicaid and Children's Health Insurance Plan (CHIP) services. According to the Kansas Health Policy Authority, managed care is designed to create financial incentives for private health plans to provide access to appropriate care and to improve health outcomes while eliminating unnecessary services through administrative control.¹ Currently 34 states utilize capitated managed care contracts for some portion of their Medicaid and/or CHIP populations.

In addition to the reasons stated above, states also utilize contracts with capitated MCOs in large part to achieve budget predictability which is particularly critical in tough budget situations. Further, by contracting with private companies, states are able to harness the expertise provided by those organizations without dramatically growing the size of government.

As part of the state's most recent competitive bidding process, completed in 2006, it moved a large portion of its HealthWave population to the capitated MCO model by transferring approximately 50,000 beneficiaries² from the HealthConnect Kansas (HCK) fee-for-service (FFS), non capitated, program. KHPA awarded contracts to two MCOs, Children's Mercy Family Health Partners (CMFHP) and Unicare Health Plan of Kansas. Previously, one MCO, FirstGuard Health Plan was the only statewide MCO, and the remainder of the families and CHIP population was enrolled via HCK. KHPA estimated that by awarding the two MCOs these contracts it would save the state of Kansas an additional \$10 to \$15 million annually.³

In November 2009, there were more than 173,000 HealthWave members being served by MCOs in Kansas. Of that group, more than 67% (about 115,000) are served by the State's only not-for-profit, safety net health plan, CMFHP.⁴

This document highlights the value of capitated managed care in general and CMFHP's performance in particular and how the investment of public dollars to care for Kansas' medically vulnerable population has resulted in the following:

- **Affordability** through budget predictability and cost savings
- **Better health care access and outcomes**
- **Outstanding provider and customer satisfaction** results, and
- **Accountability** for taxpayers and policymakers.

II. Affordability: Cost Savings and Budget Predictability

States utilize contracts with capitated MCOs in large part to achieve budget predictability and utilize other cost containment mechanisms, which is particularly critical during tough budget sessions. A Lewin Group report in 2009 synthesized cost savings reports from 24 states which had implemented Medicaid managed care programs.

The studies present compelling evidence that Medicaid managed care programs yield savings. The studies **strongly suggest that the Medicaid managed care model typically yields cost savings**. While percentage savings varied widely (from half of 1

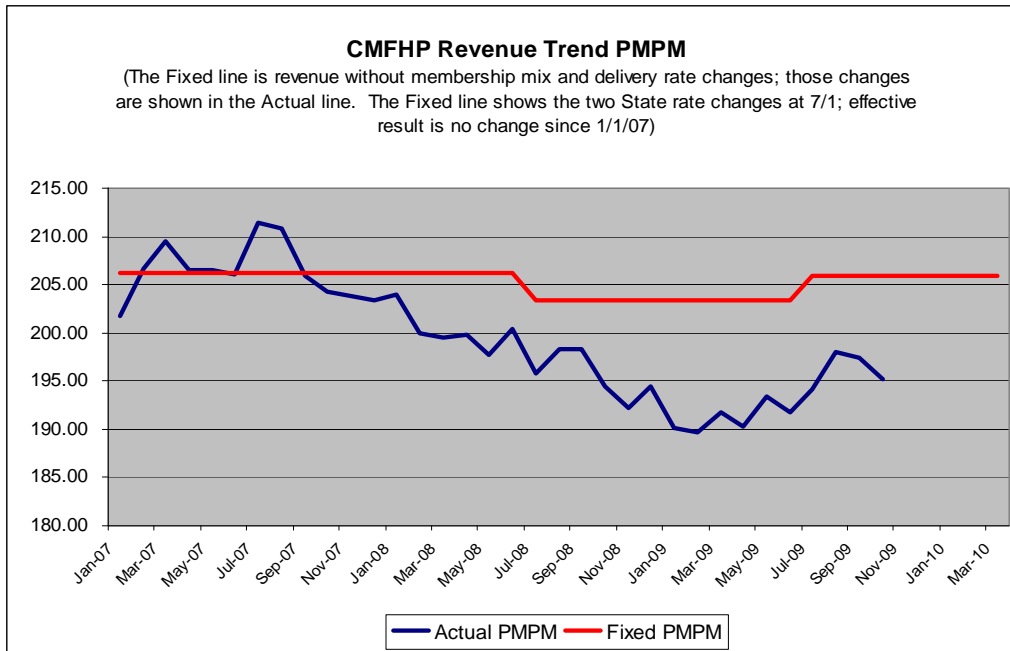
percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting.⁵

Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

- Decreasing inpatient utilization⁶
- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet certain access standards;⁷
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors;⁸
- Providing a “medical home” to members and utilizing a physician’s expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient’s ability to self-refer appropriately);⁹
- Providing individualized care management, disease management and health improvement services;¹⁰
- Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives);¹¹ and
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness.¹²

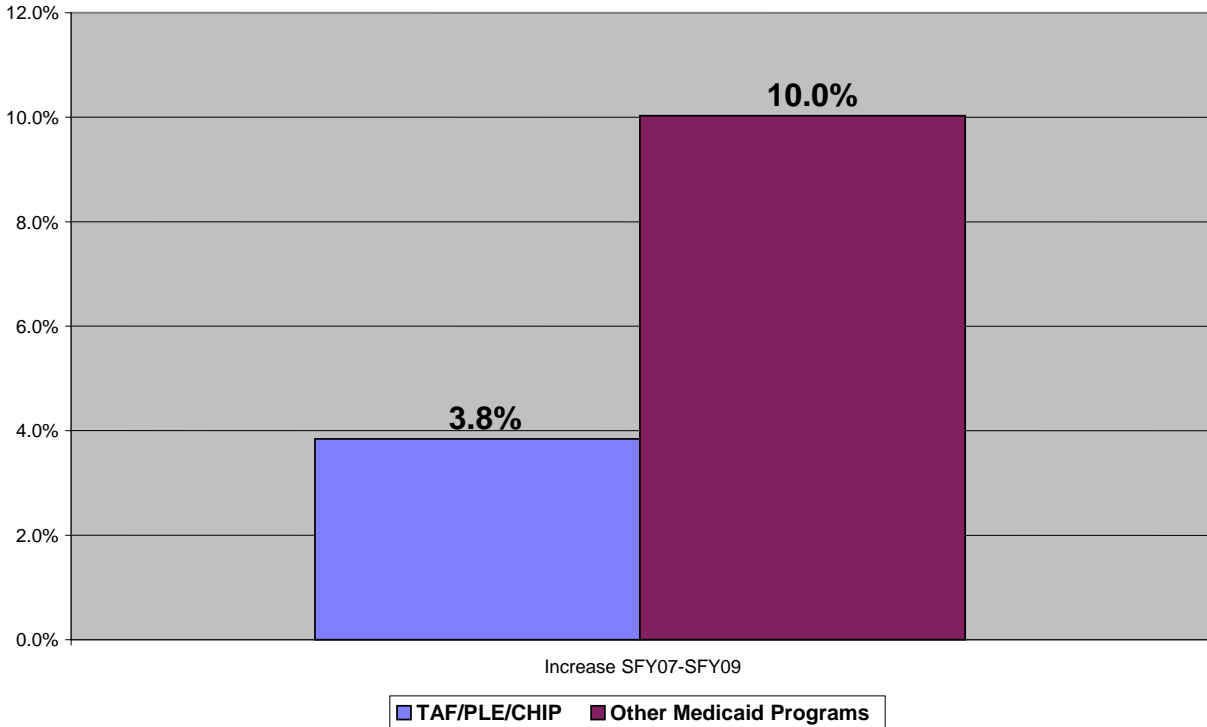
CMFHP also contracts with the State of Missouri’s Medicaid program, known as MO HealthNet. MO HealthNet and the Missouri Medicaid MCOs recently collaborated on a study relating to the effectiveness of managed care in the areas of quality, access and cost savings. Though the cost value study, conducted by an independent actuarial firm (Mercer), will not be released until February 2010, CMFHP has been informed that managed care will show significant cost savings.

As mentioned earlier, KHPA estimated that it would save \$10 to \$15 million annually at the start of the current contract cycle for the two MCOs participating in Kansas HealthWave, which began January 1, 2007. In light of the tough budget situation the state has dealt with since 2008, cost savings and budget predictability should be strong considerations when evaluating the value and effectiveness of any program which utilizes state and federal taxpayer dollars. To that end, CMFHP has provided Kansas with a fixed and level capitation expense trend since January 1, 2007. See graph below.



Evidence of Kansas' ability to limit program cost increases utilizing capitated managed care contracts to manage Medical services for TAF/PLE/CHIP Medicaid populations is also illustrated in KHPA's recent budget analysis. The report provided total expenditures and counts of beneficiaries for state fiscal years 2005 through 2009. The Kansas Medicaid Expenditures report shows general revenue funds expended per TAF/PLE/CHIP beneficiaries enrolled in managed care increased only 3.8% during the period from 7/1/06 to 7/1/09 compared to other Medicaid Populations managed by Kansas FFS programs which increased 10% over the same time frame.

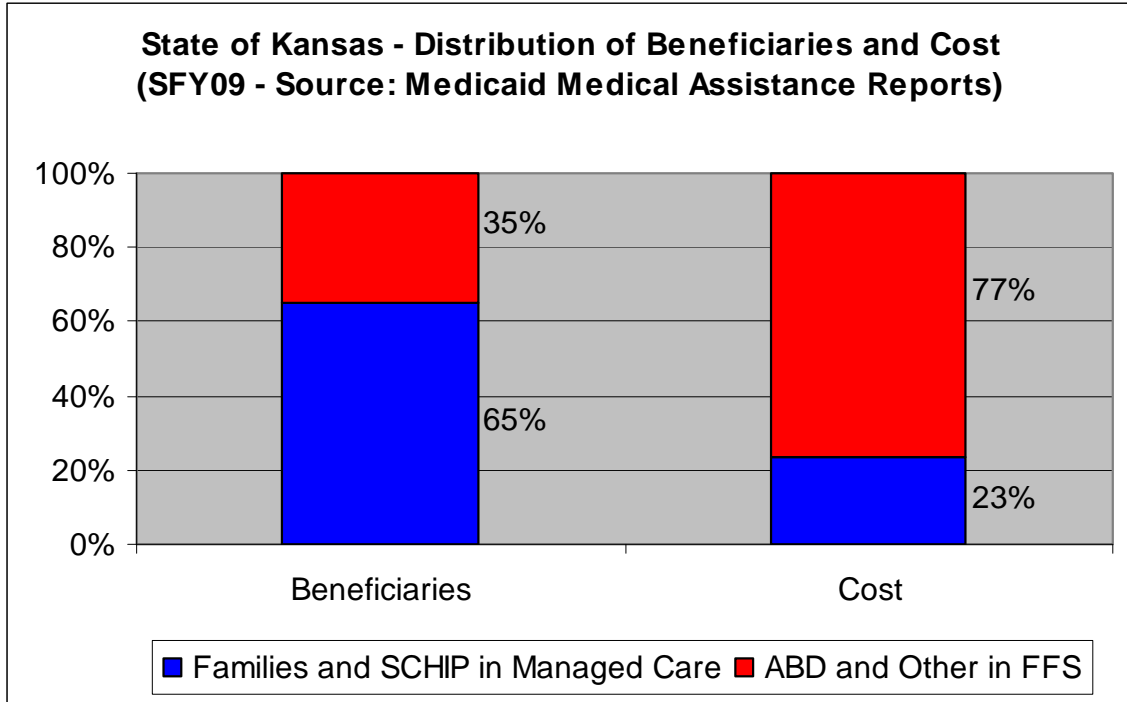
Percentage Increase in Ks State Funds Expended



There are inherent savings in the actuarial rate setting process as well. Under a fully capitated environment, it is reasonable to expect that Medicaid MCOs can generally achieve cost savings estimates in the range of 3% - 7% relative to FFS programs.¹³ Based on current MCO capitation payments, such a range equates to savings ranging from \$11 to \$27 million annually.

Further, CMFHP provides affordability in the overall cost to Kansas, while maintaining low administrative overhead. For example, according to a Milliman study based on CY 2008 MCO reported financial data for 141 Medicaid MCOs domiciled in 31 states, the average administrative cost ratio was 11.8%. Based on financial data filed with the Kansas Department of Insurance, CMFHP's administrative cost ratio for CY 2008 was 5.3% and the combined average for the two Kansas MCOs was 5.7%.

It is also important to point out the distribution of beneficiaries and the cost for those receiving medical assistance benefits in Kansas. For example, as you can see from the chart below, families and kids in managed care represent 65% of the total population, however, that group only represents 23% of the overall costs. The ABD and other FFS populations represent only 35% of the population, but more than 77% of the total medical assistance expenditures in Kansas. Since such a small portion of the population accounts for such a large portion of the cost, it makes sense to focus resources on managing those population costs.



Pharmacy Program: Cost Savings Realized and Potential Opportunities

CMFHP contracts with a Pharmacy Benefit Management (PBM) company, Caremark CVS, to establish and maintain a Preferred Drug List (PDL) and extensive pharmacy network, maximizing opportunities to manage pharmacy utilization and cost. Caremark CVS partners with CMFHP to routinely analyze member and prescriber utilization patterns to identify areas where interventions, such as changes to the PDL, generic mandates, member lock-ins, and provider profiling would enhance efficiency and improve quality. Overall drug spend trends for CMFHP have remained below national averages. The 2009 drug spend trend was 5%.

In addition, there are other **potential cost savings opportunities** on the horizon through MCOs. Although we receive modest rebates as part of our PBM contract, historically Medicaid MCOs have not been able to access the same drug manufacturing rebates that are available to FFS Medicaid programs. The recent health reform legislation introduced and, as of December 24, 2009, passed in both houses of Congress includes the provisions of the *Medicaid Prescription Drug Rebate Equalization Act of 2009*. This legislation allows Medicaid MCOs to receive the same drug rebates that are currently available to FFS Medicaid. The savings generated from this legislation will directly benefit the state Medicaid program. The cumulative savings for Kansas for the period FY 2010-2019 are projected to be \$56 million or roughly \$5 to \$7 million per year.

III. Improved Health Care Access & Outcomes

By contracting with MCOs like CMFHP, Kansas has the ability to harness the expertise of private companies that focus on providing comprehensive health care benefits and increased access to specialized services. As in other Medicaid managed care programs, KHPA measures CMFHP on specific performance measures. KHPA recently

provided the following list of some of those measures to the Kansas Joint Committee on Health Policy Oversight:¹⁴

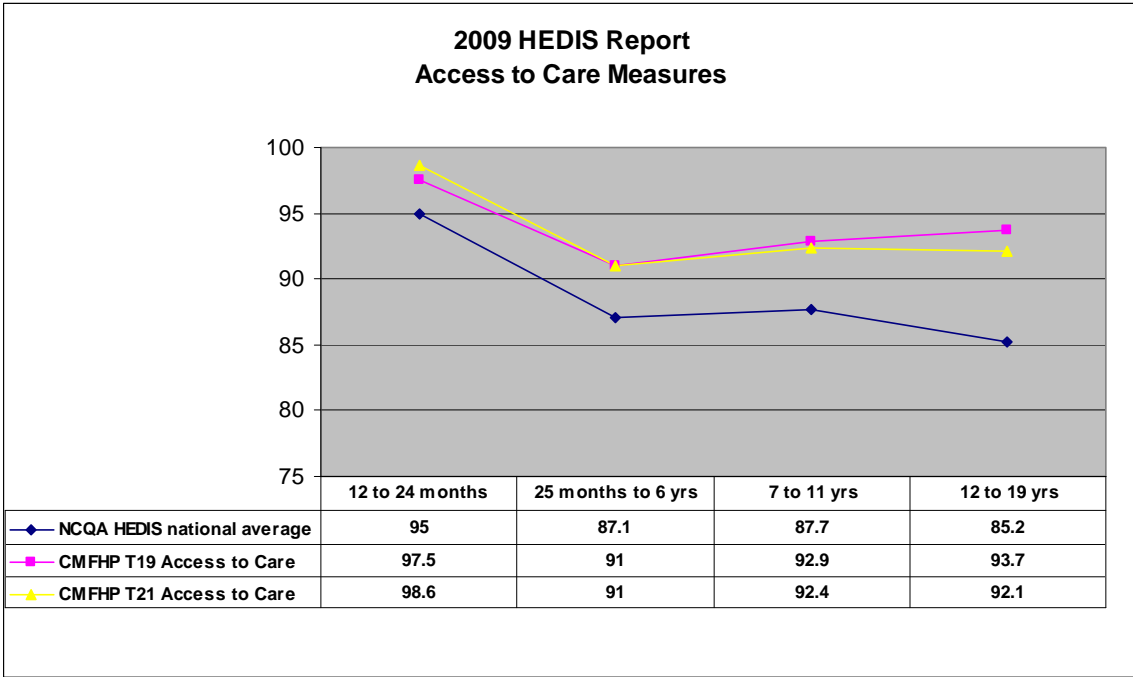
- Adult access to preventive/ambulatory health services
- Comprehensive diabetes care (HbA1c tests)
- Prenatal and postpartum care (prenatal visits)
- Antibiotic utilization
- Children's access to primary care practitioners
- Use of appropriate medications for children with asthma
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th year of life
- Lead Screening in Children

CMFHP's annual HEDIS results are audited by an external, NCQA-accredited entity, as well as Kansas Foundation for Medical Care. The following are highlights of the 2009 report, based on 2008 data.

Strengths: (areas where CMFHP performed at or above HEDIS Medicaid Mean)

- Use of Appropriate Medications for People with Asthma
- Adult Access to Primary Care Providers
- Children's Access to Primary Care Providers
- Well child in the First 15 Months of Life – Title 21 population
- Adolescent Well Care – Title 19 population
- Timeliness of Prenatal Care
- Postpartum Care

As referenced above, CMFHP's 2009 HEDIS results for measuring Access to Services demonstrated performance that exceeds the HEDIS national average for children accessing healthcare services. Results ranged from a low of 91% to a high of 98.6%. See chart below.



CMFHP believes that it is able to achieve such outstanding access measures due in large part to its extensive primary care network. CMFHP’s network is comprised of more than 4,600 contracted providers of which, 1,552 are Primary Care Providers (PCPs). Further, in the urban area of the State, 55% of Kansas licensed PCPs participate in our network. CMFHP’s participation rate in rural areas is 99% which equates to an overall participation rate of 72%.

As part of our continuous efforts at improving quality of care and ensuring positive outcomes for CMFHP’s members, we also are able to identify areas for improvement via the HEDIS review process. The list below represents a few of those opportunities.

Areas of Opportunity for Performance Improvement Initiatives in 2010: (areas where CMFHP performed below HEDIS Medicaid Mean)

- Comprehensive Diabetes Care Measures
- Cervical Cancer Screening
- Chlamydia Screening

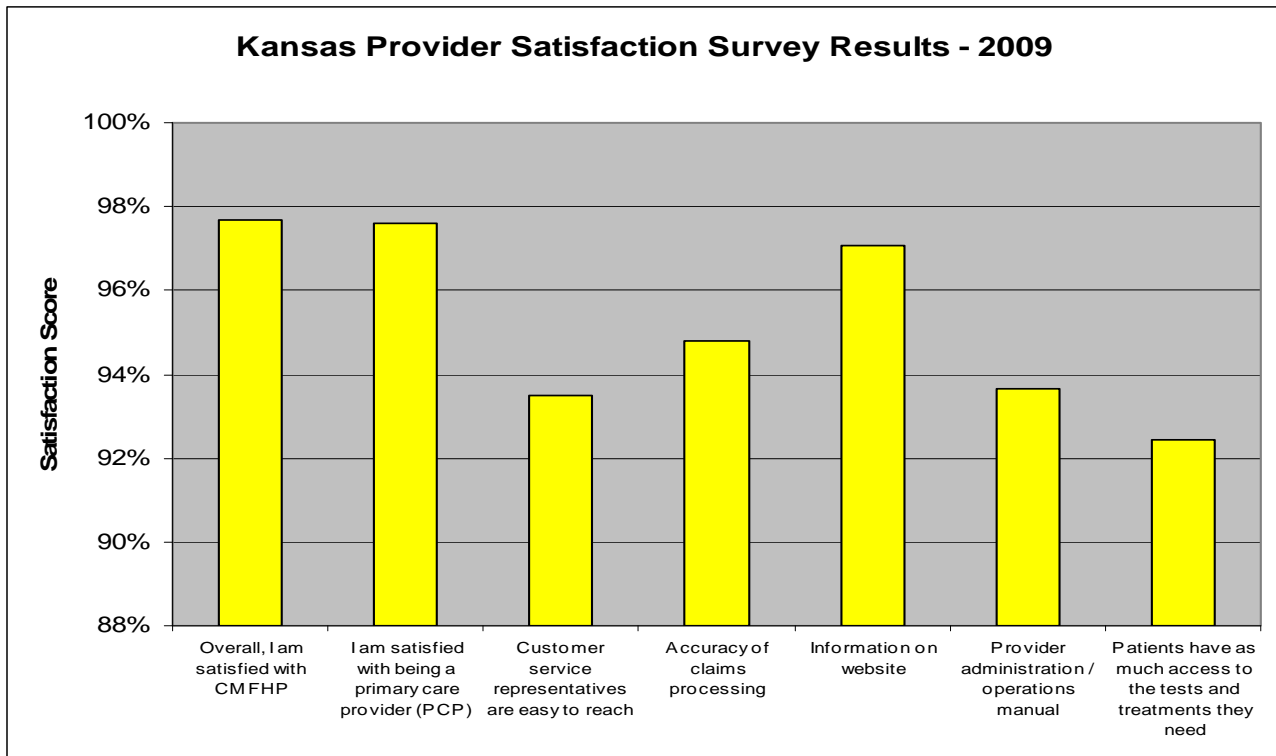
In order to fulfill contract obligations with the State, as well as provide high quality care at the right time for the right cost, MCOs must invest in infrastructure including extensive clinical resources. These resources include nurse care managers, disease management educators, and health improvement coaches. Investments in these resources allow MCOs to focus on long term cost containment strategies instead of short term cost cutting measures.

IV. Providing Superior Provider & Customer Satisfaction

Provider Satisfaction Results

KHPA's awarding of contracts to two new MCOs in late 2006 was not completed without some anxiety from Kansas providers. The Kansas Medical Society (KMS) raised concerns regarding whether the new MCOs would have adequate networks in place to provide the same level of access to Kansas HealthWave & Medicaid beneficiaries.¹⁵ CMFHP and Unicare worked closely with KHPA, KMS and the Kansas Hospital Association (KHA) to ensure a smooth transition process occurred. According to KHPA a relatively seamless transition did indeed occur after the contracts were awarded.¹⁶ Further, neither KMS nor KHA cited any problems in their dealings with CMFHP.¹⁷ CMFHP believes our positive performance with our provider partners is reflected in the satisfaction survey results referenced below.

The Kansas Foundation for Medical Care (KFMC), at the request of the State of Kansas, has conducted a provider satisfaction survey for the last two years to determine the level of provider satisfaction with CMFHP, UniCare and HealthConnect Kansas (HCK). For the last two years, CMFHP has received the highest overall plan satisfaction rate. In 2009 the overall provider satisfaction rate with CMFHP was 98%. Some of the categories measured by the survey are highlighted on the following graph.



As noted in the chart below, in 8 of 9 composite measures of KFMC's survey, the total MCO score was higher than the HCK program. See the chart below.

Composite Category (1)	Survey Questions	Provider Survey Rates - 2009 ¹⁸					
		CMFHP	UniCare	MCO Total (3)	HCK	MCO B(W) HCK	CMFHP B(W) HCK
Satisfaction	1-3	96.2%	93.3%	95.3%	93.4%	1.9%	2.8%
Access to Services/Treatments	4-7	85.4%	85.5%	85.5%	84.1%	1.3%	1.3%
Customer Service	8-9	90.6%	85.4%	88.9%	78.9%	10.1%	11.7%
Non-Pharmacy Prior Authorizations	10-11	83.4%	75.3%	80.8%	77.9%	2.9%	5.5%
Finance Issues	12-15	94.0%	91.0%	93.0%	91.1%	1.9%	2.9%
Pharmacy and Drug Benefits (4)	16-21	83.6%	72.9%	80.2%	76.6%	3.6%	7.1%
Resources	22-23	95.4%	90.5%	93.8%	92.6%	1.2%	2.8%
Program Services/Education	24-28	74.7%	73.0%	74.2%	69.3%	4.9%	5.4%
Quality Improvement (2)	29a-31c	38.9%	35.4%	37.7%	42.6%	4.9%	3.8%

Note (1): The Provider Survey Rates presented are simple average composite scores of the questions noted in Col B.
 Note (2): For the Quality Improvement survey composite, a lower score is better.
 Note (3): The MCO Total Rate is a member month based weighted average of CMFHP and UniCare (67.9% / 32.1%).
 Note (4): Question 21 regarding e-prescribing is excluded from the ratings due to its non-comparability.

Customer Satisfaction Results

CMFHP's annual member satisfaction survey, called the **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**, demonstrates overall satisfaction levels that are higher than national averages in 13 out of 15 measures which can be compared based on the National CAHPS Benchmarking Database (NCBD). CMFHP's customer service department answers nearly 100,000 calls each year from its members and providers. In 2009, it maintained an abandonment rate of 2.5% and its average speed of answer rate was 12 seconds. Both of these measures are well below both CMFHP contract requirements and national call center standards.

V. Accountability

By contracting with MCOs, Kansas can provide accountability for the public dollars spent by ensuring care is managed in the most cost effective and medically appropriate setting avoiding duplication of services. CMFHP is accountable to various government and non-government agencies and participates in regulatory and contractual compliance audits throughout each year. The following table lists those accountabilities:

Agency	Nature of Oversight	Frequency
Centers for Medicare and Medicaid Services (CMS)	CMS Managed Care Regulations	Bi-annually
Healthcaredata.com	HEDIS Auditor	Annually
The Joint Commission	Asthma Program Certification	Ongoing data submission and intra-cycle reviews; tri-annual recertification
Kansas Dept. of Insurance	U/R Certification	Annual renewal
Kansas Foundation for Medical Care (KFMC)	HEDIS, CAHPS, Performance Improvement Projects, Encounter Data, and RFP Compliance	Annually and ongoing
Kansas Health Policy Authority (KHPA)	State Contract Compliance	State contract includes 312 “Must” and 645 “Shall” requirements which CMFHP meets to be fully compliant. Also, an annual audit of those requirements; quarterly reporting obligations; policy review and approval.
NCQA	Utilization Management, Quality Management, Credentialing, Member Rights	Application for accreditation has been submitted; accreditation survey expected in June 2011
Qualis	CAHPS Auditor	Annually
United States Office of Civil Rights	HIPAA Privacy, Security, Confidentiality	Ad hoc reporting obligation

VI. Recommendations

1. The cost for the ABD population covered by the Kansas HealthWave FFS program is disproportionately and significantly higher than the families covered by the MCOs (as illustrated on page 6). This is true both in cost per individual and in overall cost. This is certainly not an unusual or surprising issue in state Medicaid programs. We recommend that KHPA dedicate its available resources to focus on and evaluate all possible options to address this most significant cost driver for the Kansas Medicaid program. These options may include but not be limited to implementing additional care management tools and/or vendor contracts targeted to high cost/high use individuals, consider an enhanced PCCM program targeted to more urban areas and/or multi-specialty physician groups, and consider the use of capitated managed care on a pilot or comprehensive basis.

2. If KHPA is concerned about excessive net income/profits within its current managed care contracts, we recommend it consider modifying existing and future contracts and contract requirements such that the state would only contract with not-for-profit MCOs and/or include provisions to establish Medical Loss Ratio (MLR) requirements. We recommend that these provisions provide that if the MCO has a MLR less than the agreed upon target that the excess funds be returned in full to the state. We believe this approach is reasonable for a mature program like HealthWave, is appropriate for a taxpayer funded program, is currently in place in other states, exists in various forms of the current national health reform proposals, and would provide the state with the necessary assurance they desire that the net income/profits from the contracted Medicaid MCOs are reasonable.

3. We recommend that KHPA move forward to work with the Kansas Legislature regarding modifications to K.S.A. 40-3202(s) to extend the 1% HMO privilege tax to the currently excluded Medicaid HMOs, as discussed in our meeting on October 9, 2009. As previously indicated, CMFHP and Unicare have agreed to work with KHPA and the Kansas legislature on the revision of the statute which could generate an additional \$5.85 million annually in federal matching funds.¹⁹

¹ KHPA Testimony by Dr. Andrew Allison, KHPA Acting Executive Director, provided to the Joint Committee on Health Policy Oversight; December 17, 2009.

² KHPA 2008 Medicaid Transformation Plan – Chapter 12: HealthConnect Kansas Program Review, January 2009; page 171.

³ Minutes from the Joint Committee on Health Policy Oversight Hearing, October 16, 2006; p. 5.

⁴ KHPA Enrollment Report, December 11, 2009.

⁵ Managed Care Cost Savings – A Synthesis of 24 Studies; The Lewin Group; July 2004, updated March 2009; pages 1-2.

⁶ See 2009 Children's Mercy Family Health Partners' Program and Operations Overview, pages 7-14.

⁷ Id. at pages 57-58.

⁸ Id. at pages 28-37.

⁹ Id. at pages 38, 57-58, 65.

¹⁰ Id. at pages 16-19; 40-52.

¹¹ Id. at pages 7-14, 38-52.

¹² Id. at pages 55-59.

¹³ Milliman, Inc. Letter dated December 29, 2009 from Scott A. Wertz, FSA, MAAA to Suzie Dunaway, CMFHP's Chief Financial Officer.

¹⁴ KHPA Testimony by Dr. Andrew Allison, KHPA Acting Executive Director, provided to the Joint Committee on Health Policy Oversight; December 17, 2009.

¹⁵ Kansas Medical Society, e-Connect Newsletter; October 20, 2006. See web address here - <http://www.khpa.ks.gov/healthwave/download/KMSeconnect10-20-06.pdf>

¹⁶ Ranney, Dave (Feb. 20, 2007). Health Policy Authority declares its managed care transition a success; <http://www.khi.org/news/2007/feb/20/health-policy-authority-declares-its-managed-care/>

¹⁷ Ranney, Dave (May 7, 2007) Unicare performance improving, say doctors and hospitals; <http://www.khi.org/news/2007/may/07/unicare-performance-improving-say-doctors-and/>

¹⁸ Provider Satisfaction Survey 2009 – Survey administered on behalf of KHPA by the Kansas Foundation for Medical Care

¹⁹ Assumes a more conservative FMAP rate of 60% which is lower than the current match rate in Kansas.