Welcome!

Brenda Sharpe
President and CEO
REACH Healthcare Foundation
Status Report on Kansas Medicaid
Study of Health Access in Kansas, Indiana and Ohio Offers Insights into Expansion Approaches

September 17, 2018

Today’s Agenda

• Review of National Research and Harvard Study Project Introduction
  – Sara Collins, The Commonwealth Fund
• Status Report on Kansas Medicaid: Study of Health Access in Three States
  – Benjamin Sommers, Harvard T.H. Chan School of Public Health
    – Audience Questions
• Panelist Reflections and Discussion
  – Audience Questions
• Closing Remarks
Medicaid and Kansas: A National Perspective

Status Report on Kansas Medicaid, Lenexa, KS

Sara R. Collins, Ph.D., Vice President
Health Care Coverage and Access
September 17, 2018
In 2017, nearly 28 million people under age 65 remained uninsured

The uninsured rate has fallen in all states since 2013, but gains have been larger on average in states that expanded Medicaid

Nearly one of five people with the lowest incomes were uninsured in 2017


Uninsured rate in KS exceeds that of other nearby states that have expanded Medicaid

Note: For the purposes of this exhibit, we count the District of Columbia as a state.
Data source: U.S. Census Bureau, 2017 1-Year American Community Survey.
More than one-quarter of KS adults with low-incomes are uninsured, higher than nearby states with expanded Medicaid

Percent of adults ages 19-64 with income under 200% of poverty who were uninsured

Notes: 200% of poverty is equal to $24,120 for an individual and $49,200 for a family of four.
For the purposes of this exhibit, we count the District of Columbia as a state.
Data source: U.S. Census Bureau, 2017 1-Year American Community Survey.

States that expanded Medicaid saw greater declines in the share of adults age 18 and older who went without care because of costs

Average percentage-point change, 2013 to 2016*

<table>
<thead>
<tr>
<th></th>
<th>All Adults</th>
<th>Low-Income Adults</th>
<th>Hispanic Adults</th>
<th>Black Adults</th>
<th>White Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-expansion</td>
<td>-3.1</td>
<td>-2.5</td>
<td>-6.3</td>
<td>-4.1</td>
<td>-2.3</td>
</tr>
<tr>
<td>Nonexpansion states</td>
<td>-1.5</td>
<td>-2.3</td>
<td>-5.0</td>
<td>-4.8</td>
<td>-1.5</td>
</tr>
</tbody>
</table>

Notes: *Average percentage point change is defined as the rate of adults 18 and older who reported going without needed care because of costs in 2013 less the rate in 2016. Rates were calculated in expansion and non-expansion states by summing the number of individuals who did and did not forgo needed care. For the purposes of this exhibit we count the District of Columbia as a Medicaid expansion state, and Louisiana, which expanded its Medicaid program after Jan. 1, 2016, as a non-expansion state.

Ben Sommers, M.D., Ph.D.

Associate Professor of Health Policy and Economics
Harvard T.H. Chan School of Public Health and Brigham & Women’s Hospital

Medicaid & Health Care Access in Kansas

Ben Sommers, MD, PhD
Harvard T.H. Chan School of Public Health and Brigham & Women’s Hospital

September 2018
Acknowledgments

• This work was co-authored with Carrie Fry, Bob Blendon, Arnie Epstein at the Harvard School of Public Health

• The research was supported by the Commonwealth Fund and REACH Healthcare Foundation.

• The content is the sole responsibility of the authors and does not represent the views of the Commonwealth Fund or REACH.

Outline for Today

• Results from our recent survey of low-income Kansans about their health care experiences

• Some context from other research findings on the Affordable Care Act (ACA) and Medicaid:
  – Medicaid expansion impacts on patients
  – Budget effects from Medicaid expansion

• Potential effects of work requirements in Kansas Medicaid
Study Objectives

• Compare rates of coverage, affordability, and access to care in Kansas vs. two other Midwestern states that expanded Medicaid (Ohio and Indiana)

• Assess experiences and attitudes towards the ACA and Medicaid expansion in Kansas

• Examine the potential effect of a Medicaid work requirement in Kansas

Data Source

• We conducted a novel random-digit dialing telephone survey of nearly 3000 low-income adults in three Midwestern states
  – Ohio – traditional expansion
  – Indiana – expansion with consumer-oriented elements
  – Kansas – non-expansion

• Sample contained U.S. citizens ages 19-64, with income less than 138% Federal Poverty Level ($17K for individual, $34K for family of 4)

• Cell phone and landline sample, English & Spanish surveys

• Response rate 15%

• Weighting based on Census benchmarks for age, race/ethnicity, gender, marital status, education, population density, and cell phone use
Coverage and Access to Care

Survey of 2700 low-income non-elderly adults. Results were adjusted for age, race/ethnicity, political identification, marital status, educational attainment, sex, family income, and rurality.

Perceptions of Quality and the ACA

Survey of 2700 low-income non-elderly adults. Results were adjusted for age, race/ethnicity, political identification, marital status, educational attainment, sex, family income, and rurality.
Kansas Medicaid Expansion?

Views of Medicaid expansion in Kansas

Yes, in favor: 77
No, not in favor: 11
Don't know: 11

Views of whether quality of care with Medicaid is better, no different, or worse than with no insurance

Better with Medicaid: 68
No difference: 23
Better with no insurance: 9

Views of whether quality of care with Medicaid is better, no different, or worse than with private insurance

Better with Medicaid: 32
No difference: 37
Better with private insurance: 31

• Data: Authors’ analysis of survey responses from U.S. citizens ages 19–64 with incomes below 138 percent of the federal poverty level.
• Notes: For all questions, n = 1,000 minus item nonresponse. All responses are survey-weighted to produce representative estimates.

Medicaid Expansion: Coverage

Figure 3. Uninsured Rates for Low-Income Adults in Medicaid Expansion vs Nonexpansion States

Source: Sommers, Gunja et al., JAMA 2015
Access to Care

“We have a higher purpose than just handing out Medicaid cards… We will not just accept the hollow victory of numbers covered.”

–Seema Verma, CMS Administrator

“Medicaid is a program that has by and large decreased the ability for folks to gain access to care.”

–Tom Price, Former HHS Secretary

Medicaid Expansion: Better Access & Affordability

Changes from 2013 to 2015 after Medicaid expansion in two states (KY and AR), compared to no expansion (TX)

Source: Commonwealth Fund, “In the Literature,” Adapted from Sommers et al., JAMA Int Med 2016
Types of Health Care Use

- More office-based care, preventive care, and chronic disease management
- Less reliance on the Emergency Department

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016

Prescription Drug Use

- Overall Effect: 19% increase in Medicaid prescription drug utilization by mid-2015
- Largest Gains - Diabetes Medications 24%, Birth Control 22%, Cardiovascular Medications 21%

Notes: "Rx per capita" is per non-elderly adult in the state (not just Medicaid beneficiaries).
Quality and Health Status

Table 2. Changes in Coverage, Access to Care, Utilization, and Health after the ACA Medicaid Expansion

| Excellent self-reported health | 12.2 | 2.4 (-2.3 to 7.1) | .32 | 6.8 (0.3 to 13.3) | .04 |
| Fair/poor self-reported health | 38.6 | 0.9 (-6.7 to 8.6) | .82 | -3.2 (-11.1 to 4.7) | .43 |
| Positive depression screen, PHQ2 score ≥ 2 | 47.5 | 2.0 (-5.5 to 9.6) | .60 | -6.3 (-14.6 to 2.0) | .08 |

• Improved chronic disease management
• Improved perceived quality
• Improved self-reported health status

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016

Self-Reported Health

• Consistent finding in our studies of coverage expansions is improved self-reported health
  – State Medicaid expansions in early 2000s
  – Massachusetts health reform in 2006
  – ACA Dependent Coverage Provision in 2010
  – ACA 2014 Marketplace and Medicaid expansions
• Consistent with the Oregon Health Insurance Experiment (randomized study of Medicaid coverage)
• Not just “subjective” – prior research shows this is a strong predictor of mortality

Surgical Care

Receipt of optimal care among surgery admissions

Notes: Sample contains 281,682 patients admitted to academic medical centers with one of five surgical conditions. "Optimal care" defined as receipt of cholecystectomy when admitted with acute cholecystitis; receipt of minimally-invasive appendectomy or cholecystectomy when undergoing surgery for acute appendicitis or cholecystitis; and avoidance of amputation when admitted with lower extremity peripheral artery disease.

Source: Loehrer, Chang, Scott, Hutter, Patel, Lee, & Sommers, JAMA Surgery 2018

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Chronic Illness: Kidney Disease

% Uninsured when Starting Dialysis

1-Year Mortality

- Improved access to nephrology specialty care before dialysis
- Increased use of fistula / graft for dialysis, which reduces infection and clot risk
- 1-year mortality: dropped from 6.9 vs. 6.2% (p<0.05)

Source: Shallender, Sommers, Thorsness, Mehrotra, Lee, Gutman, & Trivedi – unpublished (do not cite)
Medicaid Costs

- ACA expansion covered newly-eligible adults with 100% federal dollars until 2016, 93% in 2019, and 90% in 2020 and beyond
- Traditional Federal Medical Assistance Percentage (FMAP) in Kansas is 57%, which continues for those eligible by pre-ACA criteria
- Expansion would bring an estimated $5.3 billion in federal funds into the Kansas economy over 10 years
- Reports indicate that some expansion states have experienced net budget savings, due to federal offsets

Expansion Budget Effects

Source: Sommers & Gruber, Health Affairs 2017
Budget Effects, FY 2010-2015

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>MEDICAID EXPANSION EFFECT</th>
<th>% NEWLY-ELIGIBLE EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent Change from Expansion</td>
<td>p-value</td>
</tr>
<tr>
<td>Total Spending</td>
<td>5.8%</td>
<td>.002</td>
</tr>
<tr>
<td>Source of Funds</td>
<td></td>
<td></td>
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<tr>
<td>Federal Funds</td>
<td>12.2%</td>
<td>.006</td>
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<tr>
<td>State Funds</td>
<td>2.4%</td>
<td>.24</td>
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<tr>
<td>General Revenue</td>
<td>2.9%</td>
<td>.35</td>
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<tr>
<td>Other State Funds</td>
<td>3.1%</td>
<td>.54</td>
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<tr>
<td>Category of Spending</td>
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<td></td>
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<tr>
<td>Medicaid</td>
<td>11.7%</td>
<td>&lt;0.001</td>
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<tr>
<td>K-12 Education</td>
<td>-0.9%</td>
<td>.76</td>
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<tr>
<td>Higher Education</td>
<td>-5.0%</td>
<td>.25</td>
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<tr>
<td>Transportation</td>
<td>8.0%</td>
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<tr>
<td>Corrections</td>
<td>-0.4%</td>
<td>.88</td>
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<tr>
<td>Public Assistance</td>
<td>3.6%</td>
<td>.69</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
<td>.657</td>
</tr>
</tbody>
</table>

Source: Sommers & Gruber, Health Aff 2017

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Work Requirements: Small effects on employment

Kansas Medicaid: Potential Effects of Work Requirements

- Already Employed: 60%
- Would Look for Work if Required: 9%
- Wouldn't Look: 5%
- Disabled: 26%

Note: Survey of 1000 adults in Kansas ages 19-64, with incomes < 138% of the federal poverty level
Concluding Thoughts

• Kansas lags behind other Midwestern states that have expanded Medicaid in terms of coverage, affordability, and access to care
• Kansans overwhelmingly support Medicaid expansion
• Work requirements likely won’t affect employment for most Kansans, but might reduce coverage
• In numerous national studies, Medicaid expansion has improved access to care, quality of care, & health outcomes

To Read More

Kansas and Medicaid: New Evidence on Potential Expansion and Work Requirements

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Questions & Comments?

Thank you!

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Thank you!

For more information & resources
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