

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #3
Modernizing Medicaid Benefits and Reimbursement to Promote Prevention**

Introduction

Kansas Medicaid provides health care coverage for nearly 300,000 of our most vulnerable citizens with a budget of approximately 1.4 billion dollars. The population served by Medicaid (primarily low-income elderly, disabled, pregnant women, and children) has a high prevalence of obesity and smoking^{1,2}. These risk factors often lead to diabetes, cardiovascular disease, and cancer; chronic diseases that contribute disproportionately to the rising cost of medical care³.

The Kansas Medicaid program spends \$196 million a year on health care services related to smoking⁴ and another \$143 million on services related to obesity⁵. With the growing need to improve health outcomes and to constrain cost, states have increasingly turned their focus toward the prevention of chronic diseases and their complications.

A focus on prevention can take many forms, including reimbursement for preventive services, care management programs to prevent complications of chronic diseases, reimbursement for wellness programs, as well as incentives for beneficiaries to use preventive services. Several state Medicaid programs have developed innovative programs in an effort to influence enrollees toward healthier habits and participation in prevention and wellness programs.

Similar to other states' efforts, Kansas is focusing on using prevention methods as a way to improve the health outcomes and status of its Medicaid population. Most recently, the medical home concept and its emphasis on preventive care was one of three tenets contained in the Kansas Health Policy Authority's (KHPA) health reform package of 2007. Goals of the reform package included improving the quality of primary health care, promoting improved health status, and helping control the rising costs of health care. Among the policy options presented by KHPA to advance the medical home model in Kansas, was the recommendation to define a medical home in statute. During the 2008 legislative session, House Substitute for Senate Bill 81 was passed and this legislation defined the medical home in Kansas statute. As stated in statute, a medical home is:

“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

¹ Oncology Times:Volume 25(23)10 December 2003p 59 State Medicaid Coverage for Tobacco-Dependence Treatments[Cancer-Related News from the CDC] Halpin, H A PhD; Ibrahim, J. PhD; Orleans, C T PhD; Rosenthal, A C MPH; Husten, C G MD; Pechacek, T. PhD

² Obesity Research Vol. 12 No. 1 January 2004State-Level Estimates of Annual Medical Expenditures Attributable to Obesity Eric A. Finkelstein, Ian C. Fiebelkorn, and Guijing Wang

³ <http://www.cdc.gov/nccdphp/overview.htm>

⁴ Source: The Toll of Tobacco in Kansas, Campaign for Tobacco-Free Kids

⁵ http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm

needs across the health care system in order to improve quality and health outcomes in a cost effective manner.”

Presently, KHPA is taking steps to operationalize the medical home concept using a multi-phase implementation plan. The emphasis of the medical home model in Kansas is on transforming the health care system from one that reacts when someone gets very sick, to one that provides proactive, comprehensive, and coordinated care to keep people with chronic illnesses as healthy as possible, and to help healthy people maintain their health through prevention and promotion activities.

Prevention in the Kansas Medicaid Fee for Service Program

Preventive Health Visits and Procedures

The Kansas Medicaid Fee for Service (FFS) plan reimburses providers for gender and age appropriate preventive health visits and procedures, such as colonoscopies, pap smears, mammograms, and laboratory tests. In addition Medicaid reimburses for pharmaceuticals used to treat smoking cessation and obesity.

In 2005 Kansas Medicaid increased physician professional fees. The Medicaid program implemented a provider assessment tax for hospitals in 2004. A portion of the revenue collected from the tax was used to increase provider fees including the Evaluation and Management (E&M) and other Current Procedure Terminology (CPT) codes used to bill for preventive health visits and procedures.

As Kansas Medicaid continues to develop the medical home model we will further enhance reimbursement rates for prevention and participation as a medical home.

Care Management

The majority of the beneficiaries who receive health care under the fee for service reimbursement are the aged and disabled population, individuals who account for the highest medical cost. The aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending. Almost half (47%) of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged.

The aged and disabled population is served either through HealthConnect Kansas (a primary care case management program) or the Fee for Service program. HealthConnect Kansas beneficiaries are assigned a Primary Care Case Manager (PCCM) who is responsible for managing their care while receiving a modest per member per month fee. Health care services a provider renders are reimbursed using the fee for service method.

The Enhanced Care Management (ECM) pilot project, implemented in March 2006, provides enhanced care services to HealthConnect Kansas members in Sedgwick County who have probable or predictable high future health care costs, usually as a result of multiple chronic health conditions. The project is an Enhanced Primary Case Management (E-PCCM) Model that is member centered, provider driven, and based on a successful model in North Carolina. Service is community based and culturally appropriate with the goal of connecting beneficiaries to social and health care services

already available in the community. Many of the components of the ECM project reflect aspects of the medical home model.

Eligible Medicaid beneficiaries are invited to receive services; participation in the pilot is strictly voluntary. Because this population is socially isolated, ECM staff establishes relationships with members in their homes, using creative outreach techniques. Care managers assist beneficiaries to focus on chronic health conditions, social risk factors and unhealthy lifestyle behaviors that adversely affect their health status. Intervention by ECM staff involves a holistic approach, which focuses on assisting clients in accessing resources in the community, which will improve their health conditions.

The care management team, consisting of a nurse, a social resource care manager, and a physician, provide a broad array of services. Some of these services are: assessing members' health and social needs; reviewing utilization trends; reconnecting members with their PCCM; ensuring members fill and take necessary prescriptions; teaching members how to manage their own health conditions; and assisting members with accessing community resources including safe and affordable housing, food, utility assistance, clothing, mental health and substance abuse services, credit counseling and others. The ECM program may also purchase health-monitoring equipment including digital blood pressure monitors, weight scales, and pedometers if prescribed by the Primary Care Manager (PCM).

Beginning in August 2006, ECM case managers began using the Community Health Record (CHR), a web-based application that allows authorized providers online access to claims data and health transactions regarding a person's office visits, hospitalizations, medications, immunizations, and other relevant healthcare information.

An e-prescribing component of the CHR incorporates drug information so that if there is a contraindication to the prescribed therapy, the clinician is alerted at the time of prescribing, rather than after the prescription is received in the pharmacy. ECM staff report that access to the CHR provides them with a more complete picture of the member's actual utilization of health resources that is often not reported by the member in interview.

As of August 31, 2007, there were 154 beneficiaries enrolled in the program. Preliminary assessment of the program suggests that enrollees may have used fewer acute care services when compared to a reference population in Wyandotte County. However the external evaluation of the outcome data from the first year of implementation is not complete.

ECM leadership and staff are in the process of adding data fields to the client database to assist with tracking disease management outcomes of beneficiaries with targeted diagnoses. These indicators will be used to track clinical treatment milestones that assess whether clinical treatment guidelines are being followed by the beneficiary. These indicators are: HgbA1c test recorded for beneficiaries with diabetes; using a peak flow meter for beneficiaries with asthma; cholesterol, triglycerides, and LDL checked and recorded for beneficiaries with hyperlipidemia; and monitoring weight daily and salt intake for beneficiaries with congestive heart failure (CHF).

A second pilot program is in progress, which also focuses on health outcomes in the disabled population. In February 2007 the Kansas Health Policy Authority was awarded

a Center for Medicare and Medicaid Services (CMS) transformation grant to improve preventive health care for disabled Kansans enrolled in Medicaid. Integral to achieving the outcomes of the pilot project is the use of the Ingenix ImpactPro information technology tool which allows case managers and independent living counselors to review the history of and the need for preventive health care for adult beneficiaries. Specifically, the tool uses Medicaid claims data to “flag” instances when beneficiaries need to have best practice preventive age and gender appropriate screenings (e.g., mammograms, colonoscopies) or other monitoring for chronic conditions. Once the preventive health care opportunities have been identified, case managers and independent living counselors can discuss with beneficiaries and their health care providers the importance and necessity of recommended screenings and monitoring. The overall goal of the project is to improve the provision of quality preventive health care services and quality monitoring for chronic conditions.

Four Community Developmental Disability Organizations (CDDOs) and three Independent Living Centers (ILCs) serve as the project pilot sites. Collectively they provide services to approximately 1,700 people with developmental disabilities and/or physical disabilities. The pilot began in November 2007; preliminary results are expected in early 2009.

Prevention in the HealthWave Program

In Kansas the low-income families and pregnant women are primarily served through HealthWave, our managed care program. Since January of 2007 Medicaid has contracted with two Managed Care Organizations (MCOs) to provide health care for the relatively healthy HealthWave population. UniCare a division of Wellpoint serves beneficiaries statewide and Children’s Mercy Family Health Partners (CMFHP) serves beneficiaries in the eastern two thirds of the state. The Kansas Health Policy Authority pays these organizations a capitated rate to provide health care to Kansas Medicaid beneficiaries.

The MCOs reimburse for preventive health office visits, procedures, and laboratory tests just as the Fee for Service program does. MCOs frequently reimburse providers at a higher percentage of Medicare in order to maintain access and improve their provider network. In addition to the standard preventive health visits and procedures the MCOs offer beneficiaries access to wellness programs and care management services.

Care Management

Both CMFHP and UniCare offer a nurse advice line for their members. Beneficiaries can access the lines to receive information that assists them in accessing the appropriate level of care for their medical condition. The CMFHP nurse line is operated 24/7. UniCare also provides a booklet (*Take Charge of your Health*) on how to appropriately access care and offers basic intervention for persons who access the emergency department frequently.

CMFHP offers case management for certain disease states. In particular CMFHP administers an asthma disease management program, which makes an incentive available (a code that is active with higher reimbursement) to providers who complete an asthma training program and follow the MCO’s protocol with their patients.

Wellness Programs

In addition to the traditional care management programs both MCOs encourage wellness through a number of other programs available to their members. These include:

Children's Mercy Family Health Partners

- *FirstTouch* OB program to educate and guide women through pregnancy
- Obesity/Weight Management program
- Wellness Program with health coaches
- ADHD Education Program
- Web based child health library

UniCare

- *Get Up and Get Moving!* Childhood Obesity Program for children under 12 that trains physicians how to measure and plot BMI and offers health coaching for family.
- *Healthy Habits Count for You and Your Baby*, a nurse prenatal education program
- *Healthy Habits Count for Asthma* education program focusing on coaching members to identify triggers, and institute appropriate lifestyles changes to reduce flare ups.
- *Healthy Habits Count for Diabetes* educational program focusing on diabetic care.
- *The Last Cigarette* smoking cessation program
- *Member Rewards* program which offers nominal gifts if you complete well care visits

Prevention in Other States

Implementation of Medical Homes in Other States

Increasingly, states are indicating an interest in the medical home model concept, with its focus on preventive care, as a way of improving the quality of primary health care, promoting improved health status, and ultimately helping to control the rising cost of health care. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children's Health Insurance Program (SCHIP) populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado, and Massachusetts.

Wellness Incentive Programs for Beneficiaries

Several states have chosen to incentivize wellness behavior by offering enhanced services to beneficiaries who follow prescribed wellness guidelines. States can seek permission to modify their Medicaid program in this way through an 1115 waiver or under the Deficit Reduction Act (DRA). Listed below are examples of states that participate in wellness incentive programs along with a description of their programs.

Florida

Florida implemented an incentive program—Enhanced Benefits Accounts (EBA)—in 2006 under an 1115 waiver. Participants receive credits for certain behaviors such as check-ups, immunizations, and involvement in weight loss programs. Members can earn up to \$125 in credits annually, which are redeemable for over-the-counter drugs, bandages and other medical products at participating pharmacies. As of March 2007, two percent of the approximately \$2 million in credits earned had been redeemed. Reasons for the low redemption rate included delays in pharmacies processing credits and difficulties locating participating pharmacies.

West Virginia

The West Virginia incentive plan has two parts: the Basic Benefit plan and Enhanced Benefit plan. Beneficiaries must opt into the Enhanced Plan, which offers programs such as weight management, smoking cessation, and mental health and substance abuse treatment. In order to receive enhanced benefits enrollees are required to sign a personal responsibility pledge stating that they will take steps to improve their health by engaging in behaviors such as regularly visiting their physician, taking their medication and avoiding seeking care at emergency departments. If beneficiaries fail to follow the agreement they are placed back into the basic plan.

By July 19, 2008 about 8 percent of eligible individuals, were participating in the Enhanced Benefit Plan. The University of West Virginia is currently undertaking an evaluation of the benefits program, with results to be released before the end of next year.⁶

Kentucky

Kentucky initiated an incentive program in nine pilot counties, for women ages 21-64 that are Medicaid eligible. Women in this age category who complete a mammogram and/or Pap test can receive a \$10 check for one test or \$20 when both tests are completed.

Kentucky also established Health Savings Accounts for enrollees. This state combines its disease management program with an incentive program for some beneficiaries. Get Healthy Accounts are used to promote wellness, self-care, and health management. The accounts are a part of the new *KyHealth Choices* program, created under the DRA, and provide incentives for beneficiaries. Beneficiaries earn incentives and enhanced benefits by successfully participating in one year of an appropriate disease management program. Kentucky Medicaid provides targeted disease management to Medicaid beneficiaries with the following diagnoses:

- Diabetes
- COPD/Adult Asthma
- Pediatric Obesity
- Cardiac – Heart Failure
- Pediatric Asthma

The limited, enhanced benefits include:

- Limited allowance for dental services not to exceed \$50;
- Limited allowance for vision hardware services not to exceed \$50;

⁶ Wellness Incentives In State Medicaid Plans: Carrots Vs. Sticks Volume 29, Issue 520, July 21, 2008 *Kelly Wilkicki*

- Five visits to a nutritionist (registered dietician) for meal planning and counseling; and
- Two months of smoking cessation through a local health department, including two months of nicotine replacement therapy.

Eligibility for the Medicaid program is tied to eligibility for the Get Healthy Benefits Program. Unlike in some state plans, individuals no longer eligible for Medicaid will no longer be eligible for Get Health Benefits.⁷

Care Management

In addition to enhanced benefit programs other state Medicaid agencies also offer care management and disease management programs to enrollees. Some states offer these services statewide, an example is Alabama. Through an arrangement with the Alabama Department of Public Health and as a part of their primary care case management, PCCM, Patient 1st, Alabama Medicaid provides case management services to Medicaid beneficiaries throughout the state. Patients are referred for intervention directly by physicians or by the Medicaid agency.

The program is designed to address:

- Frequent use of ER
- Non compliant patients
- Interaction with disease management
- Issues/patients identified by the Medicaid agency and/or the primary medical provider (PMP)

Through the Wyoming Healthy Together project, Wyoming Medicaid offers a set of specialized services that are centered on the individual and take into consideration the physician/patient relationship while offering support, education, self-management skills and resources for coping with chronic disease.

Prevention efforts focus on educating the participants and providing them with tools to assist them in making healthy lifestyle choices. The program focuses on providing members with the tools to teach healthy eating habits, smoking cessation and the importance of physical activity. The state hopes that these prevention efforts can delay many chronic diseases and disabling conditions.

Wyoming Medicaid focuses on the social context of behavioral decisions and assisting clients to develop the personal and social skills required to make positive health behavior choices. Nurse counseling reinforces information from the clients' healthcare providers and assist them in incorporating the behavior into their daily healthcare and lifestyle decisions. Results are generated through clinical interventions with continuous reinforcement through printed, web-based and verbal education and support.⁷

The Healthy Together initiative, with its focus on disease management, was first offered to Wyoming's Medicaid beneficiaries in July 2004. The program helped the state avoid

⁷ http://www.nasmd.org/issues/docs/Health_Promotion_and_Prevention_Programs.doc NASMD Trend Snapshots, November 2006

just over \$12.3 million in projected health care costs in its first reconciliation year, which ended on December 31, 2005, according to Wyoming Medicaid officials.⁸

Discussion

The projects cited above in Kansas and other states are examples of a move toward consumer directed involvement in health care in an attempt to improve health outcomes and increase participation in prevention and wellness activities. The Center for Health Care Strategies conducted a survey of state Medicaid programs in 2006 to determine how wide spread consumer directed offerings were in Medicaid. Forty-nine out of 51 state Medicaid agencies responded to the survey, a 96% response rate.

The survey looked at 17 consumer directed approaches and found that on average most states were utilizing at least four of these strategies and were planning on implementing another 1.5 by the end of the next year. The most common policies states were planning to implement were disease management and Cash and Counseling programs. Cash and Counseling programs provide recipients with a budget, out of which they purchase needed personal care services. Medicaid agencies reported that they were considering an additional three consumer-directed strategies on average for 2008 or later. Using financial incentives to encourage healthy behaviors was the approach most frequently considered. However, it is yet to be determined whether such programs increase participation in prevention or improve health outcomes.⁹

In 2007 Kansas Medicaid began a transformation process for the purpose of improving the program through a data-driven process. Program managers were asked to assess the strengths and weaknesses of their areas of responsibility, analyze trends in spending and utilization, and make recommendations for improvement based on the data. Program reviews as they are called were centered on major plan benefits in the Fee for Service Program (such as Durable Medical Equipment (DME), hospital, hospice, etc.) as well as plan reviews (HealthWave and HealthConnect) in the managed care program.

The transformation process was expanded. During the draft stage program reviews were shared with stakeholders for input and as they are completed they have been passed on to the KHPA board. The 2008 round of the transformation process will be completed in time for the beginning of the 2009 legislative session. It is the view of KHPA executive staff and its Board of Directors that Medicaid transformation is an iterative process and as such there are no proscribed set of changes that we can institute that will perfect the program. Rather as we continue the process of reviewing and analyzing Medicaid we can make incremental changes and make recommendations to continually improve.

As a result of the program reviews, KHPA staff has recommended several changes that will move Kansas Medicaid toward a focus on prevention. In Kansas, Medicaid has traditionally focused on ensuring reimbursement for preventive services but the purpose of the two pilot programs that provide care management services to the elderly and disabled population is to prevent complications in that high-risk population. Medicaid is in the process of investigating models that will allow us to expand our care management

⁸ Disease Management News: Volume 11(15) 10 August 2006 p 1 National Health Information LLC

⁹ http://www.chcs.org/usr_doc/State_Approaches_to_Consumer_Direction.pdf, State Approaches to Consumer Direction in Medicaid, Jessica Greene

programs statewide. Over the next few months the Medicaid medical director will visit providers throughout Kansas to discuss the results of the Medicaid Aged and Disabled Program Review and illicit their ideas on ways we can better manage this population.

HealthWave members receive value added services such as weight management, health education, and smoking cessation programs. At this time the Fee for Service program does not reimburse for health education programs or health care counseling unless it is in conjunction with an office visit. During the 2008 legislative session a proposal was introduced to reimburse for smoking cessation programs during pregnancy. This proposal was subsequently accepted and was to be funded as a part of the caseload process. However, no additional funding was available for smoking cessation programs during caseload.

Additionally, the Kansas Healthy Choices program (Premium Assistance) was intended to be an extension of private health insurance to low-income families using a combination of federal, state, and employer funds. The program was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. Though it was slated for implementation in January of 2009, it was removed from statute by the 2008 legislature. Kansas Health Choices was designed to help control state health care spending for the poverty level population by providing broader access to preventive care, and strengthening and expanding the private markets rather than replacing them. Inclusion of a pilot on consumer driven health care, including Health Opportunity Accounts (HOAs) which allow the opportunity to provide incentives to beneficiaries seeking preventive care services, was planned.

As a result of budget constraints the Medicaid program is not requesting funding for additional services this fiscal year. We will continue to investigate strategies to include health education and wellness programs into the Fee for Service program in the future as part of our transformation process. These strategies will include incorporating prevention and health education into the criteria we utilize to operationalize the medical home concept in Kansas.

A process to define medical home was included in state statute with legislation passed during the 2008 session. KHPA has since been working with stakeholders in a process to develop an operational definition of the primary care medical home. The definition of a medical home will be a modified version of National Committee for Quality Assurance (NCQA) criteria for medical home. The medical home concept will be adopted by Medicaid and the State Employee Health Plan. An integral part of the medical home is payment for prevention.

The results of the KHPA survey on reimbursement methodology suggest that our reimbursement for professional fees is consistent with that of other state Medicaid programs. As Kansas operationalizes the medical home in the Medicaid program we will enhance reimbursement rates for preventive services and participation as a medical home.

Conclusion

As the Kansas Health Policy Authority continues the transformation process, expanding care management, and implementing the medical home concept we will continue to explore mechanisms to increase beneficiary participation in preventive activities.